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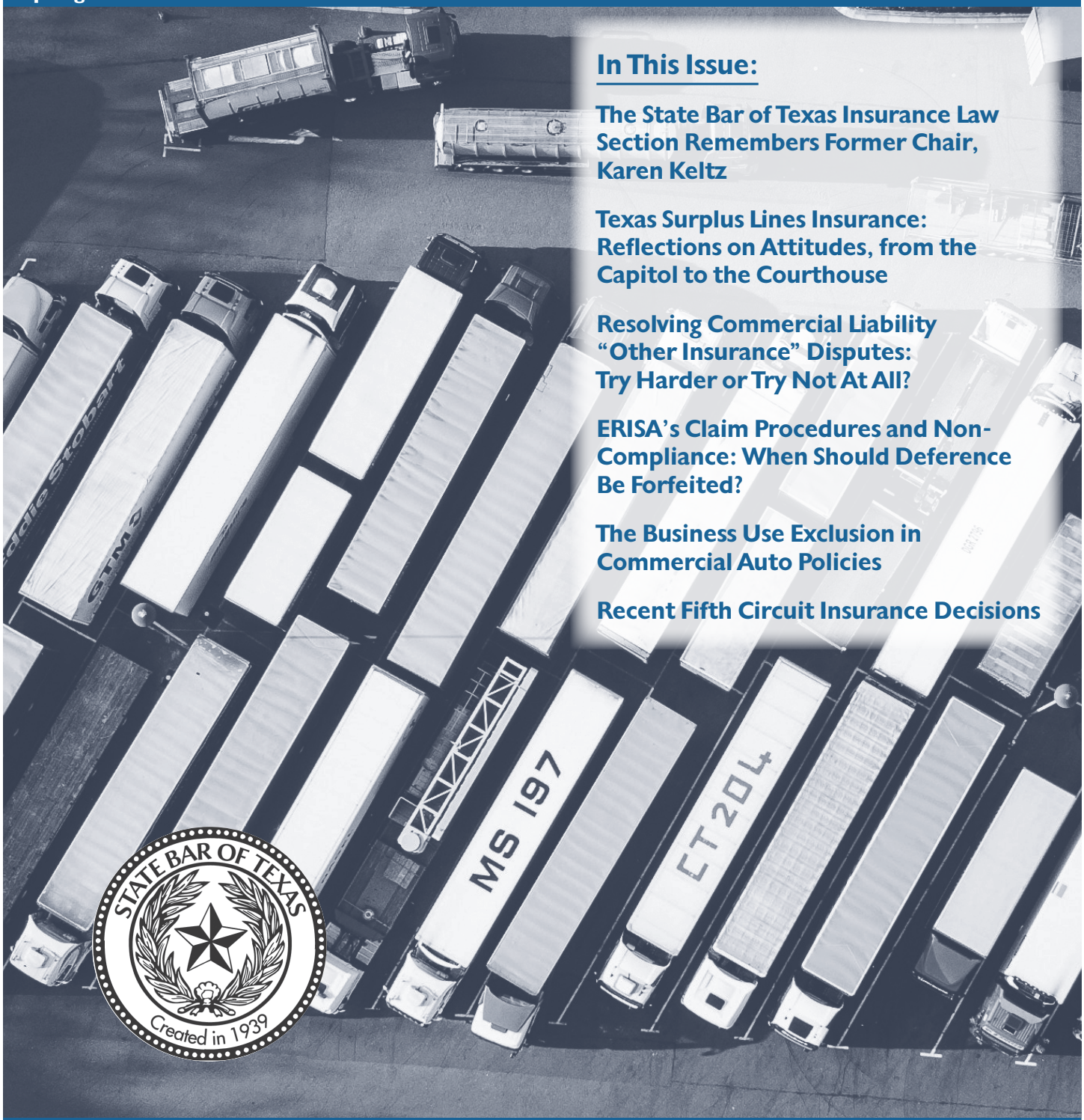

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The Journal of Texas Insurance Law is published by the Insurance Law Section of the State Bar of Texas. The purpose of the ***Journal*** is to provide Section members with current legal articles and analysis regarding recent developments in all aspects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

Anyone interested in submitting a manuscript for publication should contact Rebecca DiMasi, Editor In Chief, at (512) 685-1400 or by email at rebecca@shidlofskylaw.com. Manuscripts for publication must be typed double-spaced with endnotes (PC-compatible disks are appreciated). Replies to articles published in the ***Journal*** are welcome.

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MISSION STATEMENT

The Insurance Law Section serves to promote the understanding and development of Texas insurance law by providing high quality educational resources to the bench, bar, and public and by promoting collegiality among those with an interest in insurance law.

STATE BAR OF TEXAS
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Comments

FROM THE EDITOR

By Rebecca DiMasi
Shidlofsky Law Firm PLLC

With this issue of the *Journal*, I have had the privilege of taking over as Editor-In-Chief from my friend, Pamella Hopper. It has been a challenge to live up to the standards Pam set during her tenure. I appreciate the opportunity to continue in her stead.

In this issue of the *Journal*, you will find practical articles on complex subjects, including claims procedures and deference issues in ERISA claims, drafted by Jeffrey Dahl, and new legislation and case law affecting domestic surplus lines insurance, drafted by Andrew Kunau. Matthew Paradowski and Amber Dunten contributed an article summarizing recent jurisprudence on the interplay of "other insurance" clauses, and Chris Gabriel submitted an article on the "business use" exclusion in commercial auto policies. We again include Rachelle Glazer's and John Atkins' excellent review of recent insurance law decisions from the Fifth Circuit. Finally, you will also see an "In Memoriam" for the late Karen Keltz. While I did not have the opportunity to know her, I know from my interactions with various members of the Insurance Law Section that she had a profound impact on the Section during her time on the Council and as Chair of the Section.

Thanks to the authors, and to Associate Editors Jason McLaurin and Laura Grabouski, for their invaluable assistance. Thanks also to Pam Hopper for her continued assistance.

The *Journal* is always open to publishing articles relating to Texas insurance law for the benefit of the bench and bar. If you have an article to submit, or a proposed topic, please feel free to send me an email at rebecca@shidlofskylaw.com.

Rebecca DiMasi

Editor In Chief

Comments

FROM THE CHAIR

By Meloney Perry

Dear Section Members and friends,

As Chair of the Section for the 2017 year, I want to personally thank you for joining or remaining a member of the Insurance Law Section of the State Bar of Texas. We have had a great start to 2018.

The Section held a well-attended webinar on January 11, 2018, on the topic of Hurricane Harvey. Thank you to Steve Melendi for his coordination on this project. Another webinar is in the works consistent with our goal to offer at least 2 webinars this year.

The Section's Young Lawyers Committee hosted happy hour and networking events in Dallas and Houston at the end of 2017. More events will follow and we invite all young lawyers in the Section to attend. Thank you to the Young Lawyers committee chairs Jennifer Johnson and Tamara Bruno.

The Section also held a successful South Texas Rio Grande Valley Seminar on February 16, 2018. It would not have been possible without the hard work of the Seminar chairs Robert "Bob" Cunningham and Trey Mendez.

The Section has developed a new website and will roll out it out shortly. Thank you to Technology Chair, George Lankford, and the Section's behind the scenes staff, Donna Passons and Bill Seward. Once it is launched you will have the ability to research past *Journal* issues, past conference materials, practice resources and the case law database. You will also be able to use e-commerce right from the website to view CLE and renew your Section Membership. And as soon as the website is finished, *Right Off the Press* will be back to continue providing members with weekly access to recent Texas state and federal insurance cases and other announcements, offering up-to-the-minute developments in insurance law. Thank you to Doug Skelley and his team on continuing this wonderful resource.

Finally, thank you to the new Editor-in-Chief, Rebecca DiMasi, as she spearheads another top-notch issue of the *Journal* for our Members via hard copy as well as an electronic emailed version of each new issue.

These publications, events, seminars and website updates continue our Section's mission to provide high quality educational resources to the bench, bar, and public and to promote collegiality among those with an interest in insurance law.

We hope to see you at our Annual Meeting to be held in conjunction with the 15th Annual Advanced Insurance Law Course and the 4th Annual Casino & Networking Party, which we are co-sponsoring with the State Bar, at the Hyatt Regency Hill Country Resort & Spa in San Antonio on June 28-29, 2018.

It is my honor to serve your Section this year. Please contact me directly at mperry@mperrylaw.com if you have ideas for new programs or benefits, if you are interested in speaking at seminars, writing an article for the Journal, or serving on a Section task force committee, or if you would just like to become more involved in your Section.

Sincerely,

Chair, Insurance Law Section

THE STATE BAR OF TEXAS INSURANCE LAW SECTION REMEMBERS FORMER CHAIR, KAREN KELTZ

Karen Louise Keltz (1957-2017) was a trailblazer. She grew up in Oregon and graduated from Medford Senior High School in Medford, Oregon in 1975. Karen served in the United States Navy from 1975 to 1979, and received the Secretary of the Navy Meritorious Unit Commendation. After serving in the Navy, Karen earned her Bachelor of Science (B.S.) degree *summa cum laude* from Southern Oregon University in Ashford, Oregon. She enrolled in University of Notre Dame Law School, where she was a Thomas J. White Scholar, the Student Director of the Notre Dame Legal Aid and Defender's Office, and recipient of the Dean Konop Legal Aid Award for her contributions to providing legal services to the community. During law school Karen volunteered at the local South Bend homeless shelter, and served as Senior Editor of the *Notre Dame Journal of Law, Ethics and Public Policy* and authored an article for the Journal. Karen earned her Juris Doctor (J.D.) degree in 1985 and was admitted to the State Bar of Texas on November 8, 1985.

Most notable was Karen's enthusiasm for life as evidenced by her devotion to her son, Zac, and loving care for her elderly mother. Second to her dedication to her family, Karen served her clients with exceptional care and honor, and undertook every task for the good of the community. Karen served the Insurance Law Section fervently over many years, distinctly earning the position as the second female Chair in 2007 to 2008. As Chair, Karen made significant strides in establishing the Section's continuing legal education programs by developing solid relationships with the Texas State Bar and the University of Texas. Particularly, Karen's efforts on the Advanced Insurance Law Course elevated the Section's CLE to new heights. Karen also contributed greatly to the Section's growth by encouraging and promoting the advancement of women in the Section. The Insurance Law Section honors Karen for setting a new standard of influence and work ethic for the Section and its council members to follow. We miss Karen and will always remember her warmly and with much appreciation.

By Andrew Kunau

TEXAS SURPLUS LINES INSURANCE: REFLECTIONS ON ATTITUDES, FROM THE CAPITOL TO THE COURTHOUSE

I. Introduction

Surplus lines insurance has been a fixture of the Texas insurance landscape for decades.[1] For much of that time, there was relatively little change in the regulatory framework under which surplus lines carriers were organized, and similar statutory consistency with respect to the classification of insureds that might participate in the surplus lines market. The latest Texas legislative session resulted in new statutory provisions governing surplus lines, which echo in some respects a more focused approach regarding surplus lines taken by the Texas Supreme Court, as well as by other jurisdictions. Although the rate of growth fluctuates, on the whole, surplus lines insurance continues to be an important and growing part of the overall property and casualty industry,[2] and the actions undertaken by the Texas Legislature reflect a recognition of its increasing significance.

II. Purpose and Structure of Surplus Lines Insurance

The majority of insurance offered in the Texas market is underwritten by carriers licensed by the Texas Department of Insurance, also known as the authorized or admitted market.[3] Admitted insurance companies are typically subject to rate and form filing requirements as dictated by the Texas Department of Insurance and must participate in the Texas Property & Casualty Guaranty Association.[4]

Surplus lines insurance exists to serve those who desire to insure a risk, but are unable to obtain coverage from an insurance company that is authorized (admitted) in Texas.[5] Surplus lines insurance is typically sought by business consumers for risks that are unusual or for organizations that might have a poor loss history.[6] Examples of the types of risks that may be amenable to such coverage include mobile home policies, insurance for special events, and coverage for oil and gas refineries and hazardous material transportation.[7] Given the catastrophes experienced during the latter part of 2017, some commentators suggest that surplus lines insurance could play an increasingly important role in potentially providing products to address such incidents.[8]

An insurance company must qualify as an "eligible surplus lines insurer" as set out in the Texas Insurance Code in order to offer surplus lines coverage.[9] Surplus lines insurers seeking eligibility must submit information to the Texas Department of Insurance relating to their qualifications, including SEC Reports, certified actuarial opinions regarding reserve adequacy, biographical affidavits of owners, and lists of current and proposed agents.[10] An insurer wishing to issue surplus lines insurance in Texas must also comply with all applicable national standards adopted by the state.[11] Such national standards are set out in federal legislation, such as the Non-admitted and Reinsurance Reform Act of 2010 (NRRA), and are reflected in the principles of industry trade organizations such as the Wholesale & Specialty Insurance Association.[12] In addition to foreign insurers—those organized under the laws of a different state—the surplus lines market also contains alien insurers, which are carriers that are domiciled in and licensed under the laws of one country but which offer insurance or reinsurance products in another; under the Insurance Code, alien insurers must be listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department, National Association of Insurance Commissioners.[13]

Andrew R. Kunau is Senior Counsel for Travelers. His background includes private law practice where he represented clients in first- and third-party matters, as well as in-house practice involving coverage advice and litigation. Mr. Kunau has experience with issues arising under homeowners, commercial property, public entity general and public entity management liability, builder's risk, excess/umbrella, general liability, auto, and other coverages. He provides counseling regarding operational, legislative and regulatory matters, as well as advice pertaining to the construction and presentation of appellate issues and arguments. The conclusions and opinions expressed herein are solely those of the author and do not necessarily reflect the position of The Travelers Companies or any of its affiliates and should not be construed as legal advice.

With certain limited exceptions, surplus lines carriers are able to provide surplus lines insurance only if: (1) there has been a diligent, but unsuccessful, effort by the agent to procure the required amount of insurance from an insurer authorized to write that particular type of coverage in Texas;[14] (2) the insurance is placed through a surplus lines agent;[15] and (3) the insurer otherwise meets the statutory eligibility requirements.[16] Additionally, an eligible surplus lines insurer may provide surplus lines only in the amount that exceeds the amount of insurance obtainable from authorized insurers.[17]

From an operational standpoint, the receiving, recording and reviewing of surplus lines policies are administered through the Surplus Lines Stamping Office of Texas (SLSOT), a non-profit association that receives funding for their operations from a surplus lines stamping fee.[18] There is also a tax placed on surplus lines premiums (an important part of the case law discussion, below), currently at a rate of 4.85 percent of the gross premium.[19]

III. Becoming Domesticated – A Regulatory Evolution

Prior to January 1, 2018, Texas required that any company doing business in Texas on a non-admitted basis be domiciled in another state; the Texas Insurance Code had no provision allowing Texas-based carriers to write surplus lines coverage in this state.[20] This resulted in the unwieldy, and some would argue unnecessary, situation where a surplus lines insurance company would have to comply with the regulatory requirements of different jurisdictions and bear the cost of duplicate operations.[21]

Before the emergence of domestic surplus lines laws, a surplus lines carrier could sell surplus lines insurance only outside the state in which it was domiciled.[22] If a surplus lines carrier wished to write business in both its domiciliary state as well as other states, it was required to set up two licensed insurance companies; one to write surplus lines coverage outside of its state of domicile, and another to conduct surplus lines business within its home state.[23] Thus, in such a situation, a surplus lines carrier would be subjected to multiple regulatory standards, such as state reporting and capital requirements, and would bear the cost of maintaining duplicative operations.[24]

In 2017, the Texas Legislature passed House Bill 2492, which allowed insurance companies domiciled in Texas to issue surplus lines coverage in this state.[25] The bill amended Insurance Code Chapter 981, allowing a property and casualty insurance company organized in the state of Texas, upon successful application to the Department of Insurance, to sell surplus lines insurance in Texas.[26] The Bill Analysis drafted in relation to HB 2492 provided the following background and purpose behind the bill:

> Interested parties note that the Texas surplus lines insurance market represents a significant portion of the property and casualty insurance market in Texas, but assert that all premium surplus lines payments are paid to non-Texas based insurers. The parties have expressed a need to allow surplus lines insurers domiciled in Texas to insure risks in Texas as certain other states have done. C.S.H.B. 2492 seeks to authorize certain insurance companies in Texas to sell surplus lines insurance in Texas and to provide for the regulation of domestic surplus lines insurers.[27]

The new provision—Texas Insurance Code, Chapter 981, Subchapter B-1. Domestic Surplus Lines Insurer—provides that a property and casualty insurance company that has capital and surplus in an amount required by statute[28] may apply to the department for designation as a "domestic surplus lines insurer."[29] Once approved by the Department of Insurance, the successful applicant will be issued a domestic surplus lines certificate.[30] A Texas domestic surplus lines insurer cannot engage in the business of insurance in the admitted market.[31] Domestic surplus lines carriers are not subject to certain other provisions of the Texas Insurance Code, mirroring in large part the parameters applicable to surplus lines carriers in general (such as the exemption from Chapter 462, the Texas Property and Casualty Insurance Guaranty Association).[32] The statute also allows for the re-domestication of a foreign insurer if it likewise meets the requirements of §981.072.[33]

The new statutory provision for domestic surplus lines carriers also sets out the types of business such companies are authorized to conduct. A domestic surplus lines carrier can only insure a risk in the State of Texas if: (1) the insurance is procured as eligible surplus lines insurance under Chapter 981; and (2) the insurance is a kind of insurance the insurer is authorized

to write under the insurer's articles of incorporation.[34] In addition to the surplus lines premium taxation discussed above, a "domestic surplus lines insurer is subject to an applicable maintenance tax as if the domestic surplus lines were authorized under Subtitle C, Title 3."[35]

Texas was not the only state to pass such legislation in 2017; the Legislatures of Wisconsin and Connecticut also passed similar laws allowing for domestic surplus lines carriers, reflecting a growing trend that began several years ago when Illinois passed the nation's first domestic surplus lines law.[36] The list has since grown to a total of thirteen states—Illinois, Oklahoma, Arkansas, Delaware, New Hampshire, New Jersey, North Dakota, Missouri, Louisiana, Arizona, Texas, Wisconsin and Connecticut—with an indication that more states may be considering such legislation in the coming year.[37] The reasoning behind the legislative change appears to have been driven, in part, by a desire for increased standardization, competition, and efficiencies.[38]

IV. New Surplus Lines Rules for the Industrial (and Industrious) Insured

The introduction of domestic lines surplus carriers was not the only change to Texas surplus lines law enacted during the 2017 legislative session. House Bill 1559, signed into law by Governor Abbot the same day as House Bill 2492, amended the surplus lines statute to include so-called "industrial" insureds.[39] The new statute defines an "industrial insured" as a person who purchases commercial insurance and employs a qualified risk manager to negotiate insurance coverage, and has either paid more than $25,000 in qualifying insurance premiums for the preceding year, or employs at least 25 full-time employees.[40] An earlier version of the bill required that a commercial policyholder, in order to qualify as an "industrial insured," had to satisfy all three requirements, but was later amended to require only one of the secondary criteria.[41]

An "industrial insured" is a type of relatively sophisticated commercial policyholder which is presumed to be sufficiently proficient in risk management and related insurance transactions so as not to require all of the procurement safeguards provided under the surplus lines statute. The inclusion of this particular classification is similar to surplus lines laws in other states which allow for the exemption of "industrial insureds" from the more structured policy placement requirements applied to surplus lines insurance in general.[42] In this regard, it is similar to an "exempt commercial purchaser", already provided for under the surplus lines statute.[43] The threshold qualification under both is the use of a qualified risk manager to negotiate insurance coverage.[44] A qualified risk manager, as defined under the surplus lines statute, has certain qualifications in terms of experience, education, and training.[45]

Similar to the requirements applicable to the "exempt commercial purchaser" addressed in the Texas surplus lines statute,[46] an agent need not make a diligent effort to place insurance for an industrial insured with an admitted carrier, as long as the agent has otherwise satisfied the disclosure and financial competency requirements as set out in the statute.[47] Specifically, the surplus lines agent is exempt from the authorization requirement under §981.004(a)(1) (the "diligent search" requirement) only if: the agent procuring or placing the insurance discloses to the insured that comparable insurance may be available from the admitted market that is subject to more regulatory oversight than the surplus lines market and a policy purchased in the admitted market may provide greater protection than the surplus lines insurance policy; the surplus lines company offering the coverage has a financial strength rating of A- or better from the A.M. Best Company; and, after receiving the aforementioned notice, the industrial insured requests in writing that the agent procure the insurance from or place the insurance with an eligible lines insurer.[48]

The Legislature apparently recognized that there was a need to expand the class of commercial insureds—to include "industrial insureds" that have a comparatively smaller premium footprint and payroll—and extend the potential transactional benefits that flow from the modified procurement parameters.[49] Indeed, the Bill Analysis performed with respect to House Bill 1559, included the following statement regarding the Bill's Background and Purpose:

> Interested parties note that the surplus lines insurance market has developed in Texas as an important resource to insure risks for many lines of insurance but that many commercial insureds do not have access to the surplus lines market. H.B. 1559 seeks to address this issue by allowing an entity that meets certain conditions to purchase commercial surplus lines insurance without the performance of a diligent

effort to determine whether the insurance is available in the admitted market.[50]

The bill analysis done with respect to the companion bill in the Senate, Senate Bill 562, referenced similar motivations.[51]

V. Surplus, *Stowers*, and The Supremes

Similar to the relative dearth of historical legislative activity in the realm of surplus lines insurance, there has likewise been few opportunities for Texas courts in general, and the Supreme Court in particular, to address surplus lines coverage, especially in the context of substantive interplay with certain long-held insurance precepts. The most recent Supreme Court case to address surplus lines insurance in this context is *Seger v. Yorkshire,*[52] which, in some respects, also serves as a harbinger of the current legislative attitudes reflected in the recent changes to surplus lines law.

Stowers Liability Dependent upon Enforceability of Surplus Lines Policy: The Seger case

The most recent Supreme Court case to address surplus lines insurance in this context is *Seger v. Yorkshire,* which, in some respects, also serves as a harbinger of the current legislative attitudes reflected in the recent changes to surplus lines law.

The *Seger* case arose out of drilling rig accident which resulted in the death of Randy Seger. The owner of the drilling rig was Diatom Drilling Co., L.P., which had contracted for oil field services with a company by the name of Employer's Contractor Services, Inc., through which Randy's services as a derrick hand were provided. Diatom was insured under a Commercial General Liability policy (described as a "Lloyd's of London type policy" in the litigation[53]) issued by a variety of insurance companies, all of which were eventually dismissed from the case except for Yorkshire Insurance Co. and Ocean Marine Insurance Co. (the "insurers"). The policy excluded coverage for leased-in workers and employees, but potentially provided coverage for independent contractors or other third parties.

Randy's parents[54] filed a wrongful death suit against Diatom and its partners, subsequent to which demands were made by the Segers to settle the case within policy limits. No settlement was reached, and the matter went to trial—after Diatom's counsel had withdrawn—and a judgment was obtained by the Segers, after which the drilling company assigned its rights against the insurers to the Segers. A *Stowers* action[55] was then brought by the Segers against the insurers, resulting in a judgment for the Segers. The insurers appealed, and the appellate court affirmed in part, reversed in part, and remanded the case.[56] On remand, the trial court entered a judgment that (1) the Segers' claims were covered by Diatom's CGL policy; and (2) the underlying judgment in the wrongful death action was the result of a fully adversarial trial and thus established the Segers damages as a matter of law.[57] On appeal, the court reversed the trial court's ruling, finding that the evidence was legally and factually insufficient to establish that Diatom was damaged by the insurers; this was due to the fact that the underlying judgment was inadmissible and that the trial court proceeding was not a fully adversarial trial.[58] The court did not reach the issue of coverage, reasoning that the ruling on the damages was dispositive.[59] The Segers then appealed to the Texas Supreme Court.

Significant for purposes of the discussion here, although the focus of the appeal was on damages and whether there had been a fully adversarial trial, the Supreme Court first addressed whether all of the elements of a *Stowers* cause of action had been met (even though that issue had not been addressed by the appellate court).[60] To successfully prosecute a *Stowers* action, an insured must show: (1) the claim is within the scope of coverage; (2) a demand was made that was within policy limits; and (3) the demand was such that an ordinary, prudent insurer would have accepted it, considering the likelihood and degree of the insured's potential exposure.[61] Thus, even though not reached by the appellate court due to the focus on damages, the Supreme Court addressed the threshold issue of coverage.[62] Critical to that determination was an analysis of the requirements imposed upon surplus lines carriers and the associated impact as it pertains to enforceability of the contract and the respective obligations of the parties.

The Supreme Court held that even though it had not been not specifically pled in the underlying case or addressed by the lower court, the Segers had nevertheless met their initial burden to prove coverage.[63] As such, the burden to establish that the claim was not covered under the policy, i.e., that the exclusion for leased-in workers and employees applied, was borne by the insurers.[64] The Segers' position was that the insurers could not enforce any exclusion under the policy, as they were unauthorized insurers.[65] Thus, the threshold issue of coverage depended, in large part, upon how

the insurers' status as surplus lines carriers affected the relationship of the parties *vis-à-vis* th enforceability of the policy.

An insurance contract effective in this state and entered into by an unauthorized insurer is unenforceable by the insurer.[66] However, this limitation does not apply to insurance obtained from an eligible surplus lines insurer.[67] As such, the Texas Supreme Court initially addressed the issue of whether the *Stowers* insurers qualified as eligible surplus lines carriers, thereby falling under the statutory exception.

The Texas Insurance Code states that "[a]n insurance contract effective in this state and entered into by an unauthorized insurer is unenforceable by the insurer."[68] As referenced above, the term "unauthorized insurer" includes a surplus lines insurer not licensed in Texas.[69] However, this provision does not apply to "insurance procured by a licensed surplus lines agent from an eligible surplus lines insurer as defined by Chapter 981 and independently procured contracts of insurance, as described in Section 101.053(b)(4), that are reported and on which premium tax is paid in accordance with Chapter 225 or 226."[70]

As discussed above, for a surplus lines insurer to qualify as "eligible" under Chapter 981, the insurer must provide proof of authorization to write insurance from its domiciliary state or country, must maintain at least $15 million in capital and surplus, and must comply with all applicable nationwide uniform standards adopted by the state.[71] Despite the Segers contention to the contrary, the Supreme Court determined that the insurers had in fact complied with all of these requirements.[72] However, in order to meet the exception under 101.201(b), the insurers were also required to establish that they had paid the appropriate premium tax.[73] This last requirement, the Court held, the insurers failed to meet. Thus, the Segers argued that because the policy was unenforceable by virtue of application of 101.201(a) (and the unavailability of the exception under 101.201(b)), the insurers would not be able to assert the exclusions under the policy.[74] The Segers also argued that Insurance Code section 981.005(a)[75] provided an additional reason that the insurers should not be able to enforce the contract, as the jury had found various material and intentional violations.[76] The Court then turned its attention to the issue of what "enforceable" meant in this context.

Applying the reasoning expressed in the Texas Supreme Court case of *Urrutia v. Decker*,[77] the Court held that because the Segers—by virtue of the fact that they were relying on the CGL policy to assert their *Stowers* action—were in essence trying to enforce the terms of that contract, they were bound by the policy's terms, including any applicable exclusion.[78] As such, the Court rejected the Segers' argument that:

> section 101.201 and section 981.005 preclude the *Stowers* Insurers from asserting policy exclusions in a *Stowers* case in which the plaintiffs rely on the policy to present their case. In such a case, the plaintiffs bringing a claim to enforce the policy and asserting coverage under the policy must accept all policy terms and cannot avoid unfavorable ones.[79]

The Court then concluded that "[b]ecause the evidence was legally insufficient to support a jury verdict to the contrary, we hold that Randall Seger was a leased-in worker as a matter of law."[80] As such, the exclusion applied and the *Stowers* action failed.[81]

VI. Conclusion

The statutory amendments discussed above, especially when read together,[82] are arguably indicative of a desire on the part of the Texas Legislature to increase options and accessibility for those insureds who contemplate participation in the surplus lines arena. The passage of House Bill 2459 has created opportunities for carriers who wish to operate as domestic surplus lines insurers in the State of Texas, reflecting a minor, but significant, national trend. This change reflects a recognition by the Legislature that surplus lines insurance makes up an increasing portion of the Texas property and casualty insurance market, with the hope that domestic surplus lines insurers would allow for more product and carrier diversity and economic return to the state.

Similarly, House Bill 1559 provided increased accessibility to surplus lines insurance for certain commercial insureds, optimally translating into increased competition and product specialization. A key purported benefit of the creation of the "industrial insured" category, and the more relaxed requirements pertaining to procurement of surplus lines insurance, is the increased efficiency by which this new class of insured can access the market and shop different products. The move is also in-step with other states that provide for certain "exempt entities"—classes of commercial or governmental insureds—which, given

their higher level of sophistication, are deemed to be sufficiently knowledgeable to seek and obtain surplus lines insurance without the traditional procurement requirements.

Substantive ruling aside, the *Seger* case could perhaps, in retrospect, be viewed as emblematic of an overall increase in consciousness as it pertains to surplus lines insurance law, giving some context to the recent actions undertaken by the Legislature. It will be interesting to see if legislatures in other jurisdictions follow suit.

1 *See Mid-Am. Indem. Ins. Co. v. King,* 22 S.W.3d 321, 322 (Tex. 1995) ("The Texas Insurance Code has long recognized that citizens of this state enter into transactions with eligible surplus lines insurers 'as a result of difficulty in obtaining coverage from licensed insurers.'") (citing Tex. Ins. Code Ann. Art. 1.14-2, §1, repealed 2005).

2 Alex Wright, Risk & Insurance, *Surplus Lines Growth Slows*, https://riskandinsurance.com/surplus-lines-growth-slows/. The market as a whole has more than doubled over the last 20 years from 3.4 percent of total property/casualty (P&C) direct written premiums in 1995 to seven percent in 2015.

3 Texas Department of Insurance, Surplus Lines Insurers, http://www.tdi.texas.gov/licensing/company/surpluslines.html.

4 *Id.* The Texas Property & Casualty Guaranty Association exists to pay claims in the event of carrier insolvency.

5 *See Strayhorn v. Lexington Ins. Co.*, 128 S.W.3d 772, 775 (Tex. App.—Austin 2004), *aff'd,* 209 S.W.3d 83 (Tex. 2006) (citing Tex. Ins. Code Ann. § 981.001).

6 Denise Johnson, *Understanding the Differences Between Standard and Excess/Surplus Lines*, Claims Journal, https://www.claimsjournal.com/news/national/2014/07/31/252642.htm.

7 Texas Department of Insurance, Surplus Lines Insurers, http://www.tdi.texas.gov/licensing/company/surpluslines.html#WhatKindsSLMarket.

8 *See, e.g.*, SLTX Surplus Lines Stamping Office of Texas, *Congress, SL Market Must Respond to NFIP*, https://www.sltx.org/news/enews/congress-sl-market-must-respond-to-nfip/.

9 *See Strayhorn*, 128 S.W.3d at 775.

10 *See* 28 Tex. Admin. Code § 15.8.

11 *See* Tex. Ins. Code Ann. §981.066 (West 2013); 15 U.S.C. § 8204.

12 Wholesale & Specialty Insurance Association, NAPSLO Guiding Principles, http://www.wsia.org/docs/PDF/Legislative/NAPSLO_Uniformity_Principles.pdf. In August 2017, the National Association of Professional Surplus Lines Offices, Ltd. (NAPSLO) and the American Association of Managing General Agents (AAMGA) merged to form the Wholesale & Specialty Insurance Association. See Business Insurance *See* Judy Greenwald, *Wholesale & Specialty Insurance Association to launch Aug. 1*, Business Insurance,http://www.businessinsurance.com/article/20170725/NEWS06/912314709/Wholesale-and-Specialty-Insurance-Association-NAPSLO-AAMGA-merger.

13 Tex. Ins. Code Ann. §981.058.

14 The Texas Insurance Code does not define the term diligent, but declinations by three companies licensed to write the kind and type of insurance sought by the insured have been viewed by certain jurisdictions as a generally accepted standard. *See, e.g.*, National Association of Professional Surplus Lines Offices, *What is Surplus Lines*, https://www.napslo.org/wcm/About/What_is_Surplus_Lines/wcm/About/What_is_Surplus_Lines.aspx?hkey=edaa38ab-2c87-4861-a8ad-aa9b615c620e; Office of Legislative Research, Surplus Lines Insurance, *available at* https://www.cga.ct.gov/2013/rpt/2013-R-0228.htm (California, Florida, and New York generally require three declinations from authorized insurers in order to satisfy the diligent effort requirement).

15 Tex. Ins. Code Ann. § 981.203 (a). Surplus lines agents are required to pass a special qualifying examination, and generally must also have a General Lines Property & Casualty license or Managing General Agent license.

16 *See* Tex. Ins. Code Ann. §981.004(a); *see also Howard v. Burlington Ins. Co.*, 347 S.W.3d 783, 799 (Tex. App.—Dallas 2011, no pet.).

17 Tex. Ins. Code Ann. §981.004(b).

18 Texas Department of Insurance, Surplus Lines Insurance, http://www.tdi.texas.gov/licensing/company/surpluslines.html. The specific requirements surrounding filing with the Stamping Office are set out in Tex. Ins. Code Ann. §981.105.

19 See Tex. Ins. Code Ann. §225.004; §981.075(a).

20 Elisabeth R. Curzan, *The Problem with Domestic Excess & Surplus Lines Insurers*, Insurance Journal, https://www.insurancejournal.com/news/national/2014/09/16/340523.htm.

21 *Id.*

22 See Morgan J. Tilleman, *Wisconsin Adopts Domestic Surplus Lines Insurance Law*, *The National Law Review,* https://www.natlawreview.com/article/wisconsin-adopts-domestic-surplus-lines-insurance-law.

23 *Id.*

24 *Id.*

25 *See* H.B. 2492, http://www.legis.state.tx.us/tlodocs/85R/billtext/html/HB02492F.htm.

26 *Id.*

27 Bill Analysis of CSHB 2492, http://www.legis.state.tx.us/tlodocs/85R/analysis/pdf/HB02492H.pdf#navpanes=0.

28 *See* Tex. Ins. Code Ann. § 981.057(a). With certain exceptions for alien surplus lines insurers, eligible surplus lines insurers must maintain capital and surplus in an amount of at least $15 million. The monetary requirement has increased over the years: in 1987, the requirement was $2,500,000, which successively grew to $3,500,000, then $4,500,000, and finally $6,000,000, before

landing on $15,000,000 in 1993, where it remains today. *See Mid-American Indem. Ins. Co.*, 22 S.W.3d at 331.

29 Tex. Ins. Code §981.072(a). Section 981.071, in a simple but somewhat circular fashion, defines "domestic surplus lines carrier" as an insurance company designated as such under the statute, which is dependent upon the application and approval process described herein.

30 Tex. Ins. Code Ann. §981.072(b).

31 *See* Tex. Ins. Code Ann. §981.072(c); §981.074(2)(b)(1)

32 Tex. Ins. Code Ann. §981.073(b)(2)

33 *See* Tex. Ins. Code Ann. §981.077. On January 1, 2018, Starr Surplus Lines Insurance Company became the first domestic surplus lines insurer in Texas, when it was approved to re-domesticate to Texas and authorized to write coverage here. *See* SLTX Surplus Stamping Lines of Texas, *Texas Approves First DSLI*, https://www.sltx.org/news/enews/texas-approves-first-dsli.

34 Tex. Ins. Code Ann. §981.074(a)(1), (2).

35 Tex. Ins. Code Ann. §981.075(b).

36 *See* W.S.A. 618.41; C.G.S.A. P.A. 17-125, § 1.

37 David Kodama, *Domesticating Surplus Lines Across the States*, Property Casualty 360° (September 15, 2017), http://www.propertycasualty360.com/2017/09/15/domesticating-surplus-lines-across-the-states.

38 Testimony provided in favor of Connecticut House Bill 7013 asserted that a law allowing for domestic surplus lines carriers would "help strengthen Connecticut's insurance industry by leveling the playing field for our domestic companies, make the state more attractive for domicile insurers, and offer consumers more choice of products, particularly with insurance coverage for certain high-risk needs not generally available in the traditional licensed (admitted) market." *See* Testimony, Insurance and Real Estate Committee, *House Bill No. 7013 An Act Establishing Standards to Allow the Insurance Commissioner to Designate Certain Domestic Insurance Companies as Domestic Surplus Lines Insurers*, https://www.cga.ct.gov/2017/INSdata/Tmy/2017HB-07013-R000223-State%20of%20CT%20Insurance%20Department-TMY.PDF.

39 *See* H.B. 1559, http://www.legis.state.tx.us/tlodocs/85R/billtext/pdf/HB01559F.pdf#navpanes=0.

40 *See* Tex. Ins. Code §981.0033.

41 SLTX Surplus Stamping Lines of Texas, *Industrial Insured Bill May Impact Risk Managers in Texas*, https://www.sltx.org/news/legislative/industrial-insured-bill-may-impact-risk-managers-in-texas/. House Bill 1559 was amended on the house floor; the amended (and final) version requires only the satisfaction of the first requirement and one of the following two.

42 *See, e.g.*, Kentucky Department of Insurance – Exempt Policyholders, http://insurance.ky.gov/Static_Info.aspx?Static_ID=17&Div_id=15. According to the Commonwealth of Kentucky, "Industrial insureds, government entity insureds and exempt commercial policyholders are three classes of "exempt entities" created by [Kentucky surplus lines statute] KRS 304.11-020." Additionally, "Policies issued to these three classes by non-admitted insurers are exempt from the diligent effort requirements if the procuring or placing broker has disclosed to the exempt entity that insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight, and the exempt entity has subsequently requested in writing that the broker procure or place insurance from a non-admitted insurer. (KRS 304.10-040(4).)"

43 *See* Tex. Ins. Code Ann. §981.0031. An "exempt commercial purchaser" means a person who purchases commercial insurance while employing or retaining a risk manager; has paid more than $100,000 in premiums over the preceding year; and meets certain financial criteria (unless the consumer is a municipality, where qualification is based on population).

44 *See* Tex. Ins. Code Ann. §981.0031(a)(1); Tex. Ins. Code Ann. § 981.0033.

45 *See* Tex. Ins. Code Ann. §981.0032. A qualified risk manager is a person who: (1) is an employee of, or third-party consultant retained by, a commercial policyholder; (2) provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis and the purchase of insurance; and (3) has the requisite level of education, formal certification, and/or experience.

46 *Id.*

47 *See* Tex. Ins. Code Ann. §981.215(a)(12)(B).

48 *See* Tex. Ins. Code Ann. §981.004(d).

49 *See* House Research Organization, Bill Analysis, http://www.hro.house.state.tx.us/pdf/ba85r/hb1559.pdf#navpanes=0.

The House Research Organization bill analysis regarding HB 1559 indicated that "SUPPORTERS SAY: HB 1559 would allow knowledgeable purchasers to more freely access the surplus lines insurance market, increasing competition and consumer choice in selecting between commercial insurers by expanding the options immediately accessible. This would allow certain industrial purchasers to select a specialized policy to meet the needs of their commercial operation" and that "The bill would allow the agents of industrial insured purchasers to more efficiently do their jobs. Exempting them from the diligent search requirement frees their time and resources to better compare policies on behalf of the purchaser." Conversely, it further noted that "OPPONENTS SAY: HB 1559 could expose commercial insurance purchasers to undue risk by expanding access to the surplus lines market. Surplus lines insurance is not protected by guaranty funds or subject to solvency from the Texas Department of Insurance (TDI) if the insurer goes bankrupt. Surplus lines insurers are not authorized by TDI, and increasing engagement with them could damage both purchasers and the market."

50 *See* Bill Analysis of H.B. 1559, http://www.capitol.state.tx.us/tlodocs/85R/analysis/pdf/HB01559H.pdf#navpanes=0.

51 *See* Bill Analysis of S.B. 562, http://www.capitol.state.tx.us/tlodocs/85R/analysis/pdf/SB00562I.pdf#navpanes=0. The Bill Analysis regarding SB 562 stated that "Retail agents have historically struggled with the issue of following a confusing statute as it relates to the placement of insurance with an admitted market versus providing, in many cases, a better option through a non-ad-

mitted or surplus lines market. Larger sophisticated commercial insurance purchasers, with the advice and guidance of a qualified risk manager, can make an educated decision about what option is the best for their specific circumstance. Oftentimes the decision is not based on price, but coverage options, additional insured language, or other factors that may not be available with a standard market. S.B. 562 will allow the retail agent to offer either option to sophisticated commercial buyer and allow them to make the decision."

52 *See Seger v. Yorkshire Ins. Co. Ltd.,* 503 S.W.3d 388 (Tex. 2016).

53 *Id.* at 396.

54 The plaintiffs were Roy Seger and Shirley Faye Hoskins, individually and as administrator of the estate of Randall Jay Seger (collectively referred to as the "Segers").

55 *See generally G.A. Stowers Furniture Co. v. Am. Indem. Co.*, 15 S.W.2d 544 (Tex. Comm'n App.1929, holding approved).

56 *Yorkshire Ins. Co., Ltd. v. Seger*, 279 S.W.755, 760 (Tex. App.—Amarillo 2007, pet. denied).

57 *Seger*, 503 S.W.3d at 395.

58 *Yorkshire Ins. Co. Ltd. v. Seger*, 407 S.W.3d 435, 438 (Tex. App.—Amarillo 2013), affirmed, 503 S.W.3d 388 (Tex. 2016).

59 *Id*.

60 *Seger*, 503 S.W.3d at 395-96.

61 *Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 849 (Tex. 1994).

62 *Seger*, 503 S.W.3d at 396.

63 *Id.* at 401-402. Although no jury question was submitted on the issue of whether coverage was afforded under the CGL policy for Randy's injuries and death, the trial court nevertheless found in favor of coverage without specifying the grounds. The Supreme Court presumed that "the trial court made all implied findings necessary to the validity of the judgment; i.e. [that] Randy was an independent contractor or other third party."

64 *Ulico Cas. Co. v. Allied Pilots Ass'n*, 262 S.W.3d 773, 782 (Tex. 2008).

65 *Seger*, 503 S.W.3d at 402.

66 Tex. Ins. Code Ann. §101.201(a).

67 *See* Tex. Ins. Code Ann. §101.201(b).

68 Tex. Ins. Code Ann. §101.201(a).

69 *See Seger*, 503 S.W.3d at 402 (citing *Mid-American Indem. Ins. Co.*, 22 S.W.3d at 326).

70 Tex. Ins. Code Ann. §101.201(b).

71 *See Seger*, 503 S.W.3d at 403 (citing Tex. Ins. Code Ann. §§981.051(a), 981.057(a), 981.066).

72 *See Seger*, 503 S.W.3d at 403-04.

73 Tex. Ins. Code Ann. §225.004(a). A tax is imposed on gross premiums for surplus lines insurance. The rate of the tax is 4.85 percent of the gross premiums.

74 *Seger*, 503 S.W.3d at 404.

75 *Id.; see also* Tex. Ins. Code Ann. § 981.005(a) ("[u]nless a material and intentional violation of this chapter or Chapter 225 exists, an insurance contract obtained from an eligible surplus lines insurer is: (1) valid and enforceable as to all parties; and (2) recognized in the same manner as a comparable contract issued by an authorized insurer.")

76 *See Seger,* 503 S.W.3d at 405. Specifically, the jury found that the agent "did not complete a diligent search for authorized insurance, the policy did not contain the requisite informational language in 11-point type, the policy did not contain the address of each insurer, the agent did not make a reasonable effort to determine the financial condition of each insurer, and the agent did not verify that all of the insurers were eligible to write insurance in Texas." *See also* Tex. Ins. Code Ann. §§ 981.004(a)(1), 981.101(b), 981.101(c)(4), 981.211(a), 981.210.

77 *See Urrutia v. Decker*, 992 S.W.2d 440, 443-444 (Tex. 1999). In *Urrutia*, the Court recognized that because an insurance policy written on an unapproved form could not be enforced by the insurer, it rendered the policy voidable at the election of the insured; i.e., the insured could either rescind or enforce the voidable policy. However, if an insured elected to enforce the policy, he or she must do so under the agreed terms.

78 *See Seger*, 503 S.W.3d at 406.

79 *Id*.

80 *Id.* at 410.

81 *Id*.

82 *See Garrett v. Mercantile Nat'l Bank*, 168 S.W.2d 636, 637 (Tex. 1943) (in the situation where two statutes are introduced during the same legislative session pertaining to the same subject matter, "it is presumed that they were actuated by the same policy and imbued with the same spirit.").

By Matthew Paradowski and Amber Dunten

RESOLVING COMMERCIAL LIABILITY "OTHER INSURANCE" DISPUTES: TRY HARDER OR TRY NOT AT ALL?

Insurance practitioners will recognize the familiar judicial mantra "we will not rewrite the policy."[1] This maxim stems from Texas courts' aim to interpret contracts, including insurance policies, based on the intent of the parties as expressed within the four-corners of the contract itself.[2] In "other insurance" disputes, however, courts applying Texas law may and regularly do rewrite the policies.

"Other insurance" disputes occur when two or more concurrent policies on their face provide coverage for a claim or loss, but those same polices simultaneously purport to disclaim or limit coverage where other polices also provide coverage.[3] "Concurrent" policies mean those policies that apply during the same or overlapping policy periods or those which do not constitute "consecutive" policies.[4] Further, "other insurance" disputes are usually limited to "duty to indemnify" cases, because the "duty to defend," where triggered, is regarded as requiring a "complete defense" and not one which is subject to avoidance or reduction because of the existence of other insurance.[56]

The practice of interpreting policies in this context was born of the 1969 Texas Supreme Court case of *Hardware Dealers Mutual Fire Insurance Co. v. Farmers Insurance Exchange*.[7] *Hardware Dealers*, in its most basic iteration, charges courts to reconcile other insurance provisions of concurrent, competing policies. However, in the event such provisions are irreconcilable, courts are to strike the provisions and apply the limits of the competing policies on a pro rata basis.

Whether regular judicial rewriting of commercial insurance policies was the intent of *Hardware Dealers* is questionable. It is likewise worth asking whether courts—especially federal courts in the Fifth Circuit—are properly applying the principles of *Hardware Dealers* consistent with modern practices among sophisticated insureds.

I. Basic Anatomy of the "Other Insurance" Dispute

"Other Insurance" clauses operate whenever multiple insurance policies apply to a specific loss.[8] The clauses were initially designed to prevent overpayment of the loss via "stacking" of multiple policy limits or to govern the interaction of all policies that may provide coverage.[9] A more cynical view might be that "other insurance" clauses are the product of a "drafting war" among insurers to compel some other insurer to pay for an otherwise insurable loss.[10] Even so, when each triggered policy has its own "other insurance" clause determining the priority of coverage among them, this dynamic should result in an application of the policies which reflects the actual intent of the parties.[11]

Other insurance provisions come in many different forms with differing language. These clauses are often described as "pro rata," "excess," or "escape" type of clauses.[12] Regardless of the variety of potential forms, it is standard for commercial liability policies to contain one. As a result, the breadth of the modern case authority reflects that litigation of "other insurance" provisions in commercial liability policies is common.

Hardware Dealers v. Farmers

In 1969, the Supreme Court of Texas made the pronouncement on the issue of clashing other insurance clauses that ostensibly continues to be the governing standard today.[13] In *Hardware Dealers*, the competing policies, which provided coverage for an auto accident, were a personal auto policy with an excess clause and a garage policy with an escape clause.[14] After reviewing the history of such clauses and the various efforts of courts nationwide to resolve them, the court sought to end the "battle of draftsmanship" among insurers by adopting the rule that the court must determine whether the insured "has coverage from either one of two policies but for the other, and each contains a provision which is reasonably subject to a construction that it conflicts with a provision in the other concurrent insurance."[15]

The Texas Supreme Court held that in "resolving issues between double insurers," the court must determine whether, from the viewpoint of the insured, "she has coverage from either one of two policies but for the other, and each contains

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a provision which is reasonably subject to a construction that it conflicts with a provision in the other concurrent insurance."[16] If so, there is a conflict in the provisions and when such a conflict exists, the conflicting provisions must be ignored, and the court must look to the remaining policy provisions to determine coverage.[17] If both policies provide coverage in the absence of the conflicting clauses, "liability is equally prorated between the two companies and each has an obligation to defend the insured."[18]

The resulting *Hardware Dealers* test contains three distinct steps:

> (1) Does the insured have coverage from either one of two policies but for the other? *If yes, then…*
>
> (2) Does each policy contain a provision which, when reasonably construed, conflicts with a provision of the other? *If yes, then…*
>
> (3) The court should resolve the conflict by ignoring the conflicting provisions and prorating the coverage in portion to the policy limits.[19]

Significantly, the foregoing test only allows the court to ignore conflicting provisions if the answer is "Yes" at *both* steps (1) and (2). The court's analysis depended on the reasonable construction of the policy language, and only mandated ignoring terms if they were truly in conflict and could not be harmonized.[20]

II. Texas Courts' Efforts to "Reconcile the Policies" Following *Hardware Dealers*

For some years, it appeared Texas courts understood *Hardware Dealers* to require a careful and deliberate attempt to interpret and reconcile policies containing competing "other insurance" clauses, as reflected in the following opinions of note among Texas intermediate appellate courts.

Insurance Co. of North America v. Fireman's Fund Insurance Co.[21]

Fireman's Fund involved a dispute between two property insurers regarding the priority of coverage between their two policies for a catastrophic property loss.[22] Each policy was a primary policy with an excess "other insurance" provision, but the terms of the "other insurance" provisions were substantively different.[23]

The first carrier's "other insurance" provision provided, in pertinent part, as follows:

> This policy does not attach to or become insurance against any peril upon property... which at the time of any loss is covered by other insurance...until the liability of such other insurance has been exhausted, and then shall cover only such loss as may exceed the amount due from such other insurance...[24]

The second carrier's other insurance provision provided, in pertinent part, as follows:

> where any specific insurance exists in the name of the Assured on property insured hereunder, this insurance shall be considered as excess insurance and shall not apply...until the amount collectible... shall have been exhausted.[25]

The court began its analysis by noting *Hardware Dealers* outlined the "factors involved in resolving conflicts between 'other insurance' clauses . . . ."[26] The court readily found the first carrier's "other insurance" clause applied to render the first policy excess, and then engaged in an extensive exploration of the terms of the policies and pertinent authority to determine whether the second policy's "specific insurance" requirement was satisfied.[27] The court was ultimately able to reconcile the other insurance provisions under *Hardware Dealers* because it found the first policy did not constitute "specific insurance," and thus it applied the second policy on a primary basis.[28]

Liberty Mutual Insurance Co. v. United States Fire Insurance Co.[29]

Liberty Mutual involved a coverage dispute between two liability policies covering the same automobile, one issued to the driver of a vehicle and one issued to the owner.[30] The driver's policy was a primary policy with an excess "other insurance" clause, and the owner's policy was an umbrella policy which by its terms applied specifically excess to the owner's primary policy (which was not at issue in the coverage action).[31] After an auto accident, the owner's primary policy and the driver's primary policy not at issue paid their limits, and the driver's umbrella policy paid a smaller amount.[32] The driver's primary insurer with the excess clause and the owner's umbrella insurer agreed to resolve their dispute regarding the priority of coverage between their policies via judicial determination.[33]

The driver's primary carrier argued that under *Hardware Dealers* the two policies' "other insurance" provisions should strike each other out and apply on a pro rata basis.[34] While initially acknowledging that the primary policy and the umbrella policy conflicted, the court was able to reconcile the policies and the priority of coverage because it found it was required to analyze the *overall pattern of insurance* and

the purposes of the policies.[35] Because the owner's policy was excess in all events, and the driver's policy could act as primary, the court found it was "apparent that the intent of all parties to the policies" that the owner's umbrella policy should apply excess to the driver's primary.[36]

Liberty Mutual is noteworthy, in the authors' view, for its clear effort to reconcile the competing policies, and for the court's observation that it should look to the overall *pattern* of insurance—which is inherently not apparent from the four-corners of any *one* document—in order to ascertain the parties' intent.[37]

Carrabba v. Employers Casualty Co.[38]

Carrabba reflects the continued effort by early Texas courts to reconcile competing "other insurance" clauses and involved the priority of coverage among three policies providing liability coverage for the same accident. The policies analyzed in *Carrabba* were: (1) a truck owner's primary auto policy; (2) a truck owner's umbrella policy; and (3) a truck operator's primary auto policy with an excess other insurance clause.[39] The truck owner's primary policy paid its limits and did not contest the priority of coverage, while the truck's owner's umbrella policy and the truck's operator's primary policy each contributed to the settlement while maintaining that their respective policy should apply excess to the other.[40]

The operator's primary policy's excess clause stated the policy was excess "over any other valid and collectible insurance available to the insured."[41] The owner's umbrella policy stated that it applied excess to all other insurance "other than insurance that is specifically stated to be excess of this policy."[42]

The court recognized that "where provisions of applicable insurance policies appear to conflict, this court has resolved the antagonism by examining the overall pattern of insurance and construing the policy as a whole."[43] But the court focused on the nature of an "umbrella" policy—finding that umbrella policies are intended to be excess over all other coverage—and contrasted it with the operator's primary policy, which by its nature in some instances could act as a primary policy.[44] The court declined to apply the policies on a pro rata basis and held that "the other insurance clauses of a primary policy with an excess clause and an umbrella policy are not equivalent and are not mutually repugnant so that they cancel one another."[45]

U.S. Fire Insurance Co. v. Aetna Casualty & Surety Co.[46]

Shortly after *Carrabba* found that an excess "umbrella" policy applies excess to primary policies, the Houston Court of Appeals held that an excess policy *can* in fact apply before a primary policy with an excess other insurance clause.[47] *U.S. Fire* involved a coverage dispute between two auto policies that insured the same vehicle involved in an auto accident.[48] The driver was insured by a primary policy, and the owner of the vehicle was insured by a primary and an excess policy.[49] The owner's primary carrier defended the suit and paid its limits to settle the case. The owner's excess carrier paid the balance of the settlement to resolve the case, and then sued the driver's primary carrier for the amount of its contribution.[50]

The driver's primary and the owner's excess policy each contained an "other insurance" provision. The court engaged in a substantial discussion regarding the language of the "other insurance" provisions, Texas law, and how the two provisions should be reconciled. In doing so, it made the following observation concerning Texas law: "We do not read *Carrabba* or *Liberty Mutual* as saying that any umbrella policy automatically overlays every applicable primary that contains an "other insurance" clause. The outcome depends on the wording of the umbrella policy."[51] The court found that a close reading of the owner's excess policy revealed that it was not a "true" umbrella policy or one intended to sit atop all other coverage.[52] The court then reconciled the two "other insurance" clauses at issue, by finding that the owner's "umbrella" policy applied before or "primary to" the driver's primary policy because of the language of the driver's primary policy's excess "other insurance" clause.[53]

III. The Fifth Circuit's Truncated Treatment of *Hardware Dealers*

The deliberate approach to reconciling competing "other insurance" provisions reflected in the earlier opinions of Texas state courts became less common once *Hardware Dealers* began receiving treatment by the Fifth Circuit Court of Appeals, beginning with *St. Paul Mercury Insurance Co. v. Lexington Insurance Co.*[54] There, the Fifth Circuit reconciled two separate "other insurance" conflicts: (1) a primary policy with an escape clause vs. a primary policy with a pro rata clause; and (2) an excess policy with an escape clause vs. an excess policy with an excess clause.[55] All four carriers had contributed to settlement of a bodily injury lawsuit and sought to resolve their priority of coverage disagreements.[56] Without any effort at reconciling either conflict or analyzing the "overall pattern of insurance," the Fifth Circuit held that both the pro rata v. escape conflict and the escape v. excess conflict required apparent automatic pro rata application under *Hardware Dealers*.[57] The Fifth Circuit reached this conclusion without any serious exploration of the parties' intent as to the priority of coverage.

A literal interpretation of *St. Paul* could be that *Hardware Dealers* holds that all varieties of other insurance provisions automatically conflict, cannot be reconciled, and must apply on a pro rata basis.[58] A perfunctory response to this holding would be that "of course" an escape clause can be reconciled with a pro rata clause by allowing the escape clause to

"escape" if that is what the parties intended.[59] The result of this truncated application of *Hardware Dealers* led to a series of federal opinions that spent little time reconciling the policies or examining the "overall pattern of insurance."

In 2004, the Fifth Circuit revisited *St. Paul* in *Royal Insurance Co. v. Hartford Underwriters Insurance Co.*, a case involving a pro rata vs. an excess other insurance clause.[60] The *Royal* court, made up of a completely different panel than the three judges who decided *St. Paul*, reached the conclusion that *St. Paul*'s extremely strict interpretation of *Hardware Dealers* was the correct reading and followed it without reservation, holding "this case appears to be just another permutation of the conflict explained in *Hardware Dealers*."[61] The opinion in *Royal* again reflected no attempt at reconciliation of the policy language, apparently because *Hardware Dealers* mandated automatic pro rata application of the competing policies.[62] The Fifth Circuit later demonstrated a more verbose process in striking out competing excess "other insurance" clauses in two primary policies in *Travelers Lloyds Insurance Co. v. Pacific Employers Insurance Co.*, but did so for purposes of reversing the district court which had previously reconciled the provisions.[63]

The same year the Fifth Circuit decided *Pacific*, a different Fifth Circuit panel decided *Willbros RPI, Inc. v. Continental Casualty Co.* and began to express some reservations towards its treatment of *Hardware Dealers* and "other insurance" disputes.[64] *Willbros* involved a conflict between a primary policy with a pro rata clause and a primary policy with a strong excess clause which provided that the policy was excess any other insurance "whether primary, excess, contingent or on any other basis...."[65] The district court had successfully reconciled these two provisions, applying the primary policy with the excess clause on an excess basis.[66]

The Fifth Circuit reversed the district court and held that *Hardware Dealers* required application of the two policies on a pro rata basis.[67] In doing so, the court acknowledged that the district court's interpretation of the policies was, in fact, reasonable.[68] Both the majority and the concurring opinion recognized, however, that the court was bound by controlling Fifth Circuit precedent in *Royal*, "notwithstanding the fact that, as in this case, a plain language reading of the policies would not have left the insured without coverage."[69]

In a concurring opinion, two justices (who were not involved in *St. Paul*) went further, lamenting how far the state of the law had departed from the original mandate of *Hardware Dealers*, and encouraging the entire court to convene *en banc* to correct the error.[70] Soon thereafter, the Southern District of Texas echoed that it likewise felt wed to a restrictive interpretation of *Hardware Dealers* as the result of the Fifth Circuit's opinion in *Royal*.[71]

IV. Effect of Contractual Indemnity on "Other Insurance"

"Other Insurance" disputes are common in commercial liability cases for the basic reason that a variety of commercial contracts contain obligations by one party or the other to make the other party an "additional insured" under their policies. Relatedly, the contracts will often contain indemnity provisions, and state that such obligations must be supported by insurance. The result of this is that one or both parties end up with two "towers" of insurance: one it procured for itself as a named insured, and another that the other party procured, and under which it is an additional insured pursuant to the agreement. These same agreements often contain related obligations and terms that, for example, provide that the coverage procured on the additional insured's behalf will be primary to the additional insured's other coverage tower. When a covered loss arises, therefore, the two towers of coverage will point to the other as primary and these disputes are quite often resolved under the guidance of *Hardware Dealers*.

Principles of insurance policy interpretation seeking to ascertain the "intent of the parties"[72] and the "overall pattern of insurance"[73] seem suited for the consideration of insurance and indemnity-related promises made by their insureds. For example, if the "other insurance" provisions at issue cannot be readily reconciled it seems that consideration of the underlying contract which created the duplicative insurance coverage in the first place might be informative.

Though applied only once among courts applying Texas law, the Fifth Circuit addressed the interplay of the policies where the contract required indemnification of the insured by another insured.[74] *American Indemnity Lloyds v. Travelers Property & Casualty Co.* involved an equitable subrogation action filed by one primary insurer against another arguing that the "other insurance" clauses of the respective policies required a pro rata sharing of the defense and indemnity payments incurred in reaching a settlement of the underlying action.[75] The district court held that an indemnity provision may shift the entire loss to a particular insurer regardless of the existence of "other insurance" clauses in its policies:

> Thus, a well-recognized commentator observes: 'an indemnity agreement between the insureds or a contract with an indemnification clause, such as is commonly found in the construction industry, may shift an entire loss to a particular insurer notwithstanding the existence of an 'other insurance' clause in its policy.'[76]

The Fifth Circuit Court of Appeals affirmed, holding:

> the clear majority of jurisdictions recognizes the foregoing exception and

> gives controlling effect to the indemnity obligation of one insured to the other insured over 'other insurance' or similar clauses in the policies of the insurers, particularly where one of the policies covers the indemnity obligation. We believe Texas would follow this well recognized exception to the general rule.[77]

Various courts across the country have in fact recognized the majority rule that valid contractual indemnification provisions may shift the entire loss to a particular insurer or line of insurance regardless of the existence of an "other insurance" clause in the pertinent policies.[78] Of course, the analysis focuses on the availability of contractual indemnity in addition to coverage for the insured under two policies, one as an additional insured, and one as a named insured. Thus, the holdings recognize that where the insured is entitled to contractual indemnity, the interplay of the "other insurance" clauses is not relevant, because regardless of the priority of coverage available to the additional insured/indemnitee, it will nevertheless be entitled to contractual indemnity, for which coverage will be available to the named insured from its own tower of coverage. Thus, even if the additional insured's own carrier had to share coverage with the named insured's carrier, it would retain subrogation rights under the indemnity provision, which it could then assert against the named insured, and the named insured could seek coverage under its policies. In order to avoid this circuitous litigation, courts have held that the indemnitor's tower should simply provide coverage, regardless of the "other insurance" provisions.

V. The *Deepwater Horizon* Case and Incorporation of Contractual Requirements

In the recent *In re Deepwater Horizon* case, the Texas Supreme Court held that a contract extraneous to the policy can be considered in connection with the scope of coverage if the policy somehow incorporates the contractual requirements.[79] Looking at the interplay of two policies, a court of the Southern District of Texas was recently asked to consider the terms of an apartment management agreement in the context of an "other insurance" dispute between an umbrella insurer for an apartment owner and a primary insurer for an apartment manager.[80] The management agreement included terms that the apartment owner's insurance would be primary to the apartment manager's own insurance.[81] The apartment manager's primary insurer argued that the court should consider management agreement and enforce a provision making the manager's primary insurance excess to the owner's umbrella policy.[82] The manager's insurer's argument was based on the guidance of *In re Deepwater Horizon*,[83] which established the general rule that insurance policies can incorporate terms coverage by reference to extrinsic documents. The court rejected this argument, stating as follows:

> the exception identified in *Deepwater Horizon* does not apply in this case. NAC argues that reference in the Colony Umbrella Policy to "other insurance" manifests an intent to incorporate extrinsic evidence. NAC cites no legal authority to support its argument that reference to one document (or type of document) in an insurance policy allows the Court to consider any and all other extrinsic evidence to construe the policy, and this Court is aware of none.[84]

A legitimate question thus exists on how to give effect to business agreements containing insurance and indemnification terms, and whether such documents can or should be considered in resolving "other insurance" disputes, in order to give effect to the parties' intent. Applying the limited incorporation-by-reference exception in *Deepwater Horizon*, the policies obtained by the parties would need to contain language incorporating the contractual terms in order to give them effect in an "other insurance" dispute. Otherwise, the contracting parties can attempt to give effect to their risk transfer objectives through contractual indemnity provisions.

VI. Conclusion

The resolution of "other insurance" disputes is a unique animal of insurance coverage litigation. In practice, it often rejects plain policy language and rewrites policies as required by *Hardware Dealers* and its progeny. In doing so, courts strive to comport such efforts with "the parties' intent" as reflected in the policies; however, the parties' efforts to reflect such intent has already fallen short or the resolution of the conflicting policies would not be required in first instance. At times, courts of the Fifth Circuit have leaned toward a swift solution to this problem by applying *Hardware Dealers* to readily strike "other insurance" provisions out. Texas law, however, may initially have strived for a more deliberate resolution of the policy language and a determination of the "overall pattern of insurance." Whether a modern approach to identifying the "overall pattern of insurance" should include the consideration of extrinsic commercial contracts with insurance procurement terms may depend, therefore, on whether insurance policies include language that gives effect to the parties' intent.

1 *Cicciarella v. Amica Mut. Ins. Co.*, 66 F.3d 764, 767-68 (5th Cir. 1995); *see also Stevens Transp., Inc. v. Nat'l Cont'l Ins. Co.*, No. 05-98-00244-CV, 2000 WL 567225, at *3 (Tex. App.—Dallas May 11, 2000) ("[w]e will not rewrite the insurance policy to insert a provision requiring consent to settle when the parties could have included such a provision in the policy and did not."); *Am. Mfrs. Mut. Ins. Co. v. Schaefer*, 124 S.W.3d 154, 162 (Tex. 2003) ("[b]ut we may neither rewrite the parties' contract nor add to its

language.") (citing *Royal Indem. Co. v. Marshall*, 388 S.W.2d 176, 181 (Tex. 1965)).

2 *TIG Ins. Co. v. N. Am. Van Lines, Inc.*, 170 S.W.3d 264, 268 (Tex. App.—Dallas 2005 no pet.); *see also Melancon v. State Farm Mut. Auto. Ins. Co.*, 343 S.W.3d 567, 569 (Tex. App.—Houston [14th Dist.] 2011, no pet.) ("Applying the ordinary rules of contract construction to insurance policies, the reviewing court ascertains the parties' intent by looking only to the four corners of the policy to see what is actually stated and does not consider what was allegedly meant.") (citing (*Fiess v. State Farms Lloyds*, 202 S.W.3d 744, 747 (Tex. 2006); *Williams Consol. I, Ltd./BSI Holdings Inc. v. TIG Ins. Co.*, 230 S.W.3d 895, 902 (Tex. App.—Houston [14th Dist.] 2007, no pet.).

3 Allan D. Windt, *Ins. Claims & Disputes* § 7:1, (6th ed. 2013).

4 *See Texas Prop. & Cas. Ins. Guar. Ass'n/Sw. Aggregates, Inc. v. Sw. Aggregates, Inc.*, 982 S.W.2d 600, 606 (Tex. App.—Austin 1998, no pet.).

5 *Id.*; *see also Lyda Swinerton Builders, Inc. v. Oklahoma Sur. Co.*, No. 16-20195, 2017 WL 6334169, at *8, n. 3 (5th Cir. Dec. 12, 2017) ("Texas courts have rejected the argument that the anti-stacking rule overcomes 'the notion that each of several insurers on concurrently triggered policies is obligated to provide a full defense to the insured'."); *Trinity Universal Ins. Co. v. Employers Mut. Cas. Co.*, 592 F.3d 687, 694–95 (5th Cir. 2010) (where "the 'other insurance' provision speaks only to an insured's 'loss'…[t]he 'other insurance' clause applies only to the duty to indemnify, not the duty to defend.").

6 The observation that the duty to defend is generally not subject to avoidance or reduction because of "other insurance" could, of course, be subject to the actual terms of the pertinent policies' duty to defend language. *See N. Am. Specialty Ins. Co. v. Royal Surplus Lines Ins. Co.*, 541 F.3d 552, 559 (5th Cir. 2008).

7 444 S.W.2d 583 (Tex. 1969).

8 Windt, *supra* note 3.

9 *Id.* at §7.1, n.1.

10 *Hardware Dealers*, 444 S.W.2d at 588.

11 *Safeco Lloyds Ins. Co. v. Allstate Ins. Co.*, 308 S.W.3d 49, 58 (Tex. App.—San Antonio 2009, no pet.) ("the policy behind the rule was to give dominant consideration to the rights of the insured.").

12 *Id.* at 53; Windt, *supra* note 3.

13 444 S.W.2d 583.

14 *Id.* at 584–585.

15 *Id.* at 589.

16 *Id.* at 589.

17 *Id.* at 589–90.

18 *Id.* at 590.

19 *Id.* at 589–590.

20 This approach is consistent axiomatic contract interpretation rules calling for an effort to harmonize all provisions, and only ignoring those that are truly in irreconcilable conflict. *See, e.g.*, *Ogden v. Dickinson State Bank*, 662 S.W.2d 330, 332 (Tex. 1983); *Southland Royalty Co. v. Pan Am. Petroleum Corp.*, 378 S.W.2d 50, 57 (Tex. 1964).

21 471 S.W.2d 878 (Tex. App.—Houston [1st Dist.] 1971, writ ref'd n.r.e.).

22 *Id.* at 879.

23 *Id.* at 880.

24 *Id.*

25 *Id.*

26 *Id.* at 880.

27 *Id.* at 882–883.

28 *Id.* at 883.

29 590 S.W.2d 783 (Tex. App.—Houston [14th dist.] 1979, writ ref'd n.r.e).

30 *Id.* at 784.

31 *Id.* at 784–785.

32 *Id.* at 784.

33 *Id.*

34 *Id.* at 785.

35 *Id.*

36 *Id.* at 784–785.

37 *Id.*

38 742 S.W.2d 709 (Tex. App.—Houston [14th Dist.] 1987, no writ).

39 *Id.* at 710–711.

40 *Id.* at 713–715.

41 *Id.* at 713.

42 *Id.*

43 *Id.* at 714.

44 *Id.* at 714–715.

45 *Id.* at 715.

46 781 S.W.2d 394 (Tex. App.—Houston [1st. Dist.] 1989, no writ).

47 *Id.* at 388.

48 *Id.* at 395.

49 *Id.*

50 *Id.*

51 *Id.* at 398.

52 *Id.* at 399.

53 *Id.* at 398–399. Though the court in *U.S. Fire* did not proclaim that it was important to its holding, it did recognize that the insured agreed in the contract between it and the operator to provide insurance for the vehicles, and the operator was added an insured to the owner's policies. *Id.* at 395.

54 78 F.3d 202 (5th Cir. 1996).

55 *Id*. at 204–206.

56 *Id*. at 204.

57 *Id*. at 209–210. The "reconciliation" of the competing primary polices consisted of the following discussion: "[the insured] would be entitled to full coverage under Centennial's policy were it not for the existence of Landmark's policy. In other words, Landmark's pro rata clause conflicts with Centennial's escape clause, so we must prorate liability." The reconciliation of the competing excess policies was essentially nonexistent as the court held it was required to prorate them under *Hardware Dealers*.

58 *Id*.

59 *Id*. at 206 (the escape clause at issue provided "where the Assured is, irrespective of this insurance, covered or protected against any loss or claim which would otherwise have been paid by the Assurer, under this policy, there shall be no contribution by the Assurer on the basis of double insurance or otherwise.").

60 391 F.3d 639 (5th Cir. 2004).

61 *Id*. at 644.

62 *Id*. at 643–644.

63 602 F.3d 677, 684–686 (5th Cir. 2010) ("[w]ith great respect to the district court, the 'other insurance' clauses in the Travelers and Pacific policies could reasonably be construed to conflict.").

64 601 F.3d 306 (5th Cir. 2010).

65 *Id*. at 312–313.

66 *Id*.

67 *Id*.

68 *Id*.

69 *Id*. at 313.

70 *Id*. at 314.

71 *See Millis Dev. & Constr., Inc. v. Am. First Lloyd's Ins. Co.*, 809 F. Supp. 2d 616, 633–34 (S.D. Tex. 2011) ("*Royal Insurance* is controlling...finding that two other-insurance clauses, nearly identical to the ones at issue here . . . in conflict notwithstanding the fact that a plain language reading of the policies would not have left the insured without coverage.")

72 *See* note 2, *supra*.

73 *See* note 32, *supra*.

74 *See Am. Indem. Lloyds v. Travelers Prop. & Cas. Co.*, 189 F. Supp. 2d 630 (S.D. Tex. 2002), *aff'd sub nom. Am. Indem. Lloyds v. Travelers Prop. & Cas. Ins. Co.*, 335 F.3d 429 (5th Cir. 2003).

75 189 F. Supp. 2d 630, 635–636.

76 *Id*. at 636 (citing 15 *Couch on Insurance* (3rd Ed.1999; Russ & Segalla) § 219:1 at 219–7).

77 335 F.3d 429, 436.

78 *Am. Indem.*, 335 F.3d 429, 436; *Wal-Mart Stores, Inc. v. RLI Ins. Co.*, 292 F.3d 583, 588–94 (8th Cir. 2002); *St. Paul Fire & Marine Ins. Co. v. Am. Intern. Specialty Lines Ins. Co.*, 365 F.3d 263, 271 (4th Cir. 2004) ("the anticipated result of considering the policies without consideration of the indemnification agreement—would simply be the first step in a circular chain of litigation . . ."); *J. Walter's Const. Inc. v. Gilman Paper Co.*, 620 So.2d 219 (Fla. App. 1993); *Rossmoor Sanitation, Inc. v. Pylon, Inc.*, 532 P.2d 97 (Cal. 1975).

79 470 S.W.3d 452, 460 (Tex. 2015).

80 *N. Am. Capacity Ins. Co. v. Colony Specialty Ins. Co.*, No. CV H-16-3371, 2017 WL 3447107, at *5 (S.D. Tex. Aug. 7, 2017).

81 *Id*. at *1.

82 *Id*. at *5–6.

83 470 S.W.3d at 460.

84 2017 WL 3447107 at *5. *See also U.S. Fid. & Guar. Co. v. Coastal Ref. & Mktg., Inc.*, 369 S.W.3d 559, 567–68 (Tex. App.—Houston [14th Dist.] 2012, no pet.) (refusing to consider insurance terms in an extrinsic services agreement in finding excess policies' other insurance provisions conflicted).

By Jeffrey Dahl

ERISA'S CLAIM PROCEDURES AND NON-COMPLIANCE: WHEN SHOULD DEFERENCE BE FORFEITED?

I. Introduction

Although sometimes viewed as mundane by the federal courts, benefit claims by individuals who are covered by employee benefit plans or policies governed by the Employee Retirement Income Security Act of 1974 (ERISA) are vital to claimants and their families. An ERISA claim denial means that the claimant did not receive the medical treatment, disability income, life insurance or retirement benefits that she expected under a retirement plan or an employee group welfare benefit plan or policy. Sometimes a medical benefit denial can mean the difference between life and death.[1]

II. The Power of Deference

Whether or not the parties will play on a level playing field if a denied claim is challenged in federal court is a recurrent issue in ERISA cases. In the unique realm of ERISA benefit claims litigation, the playing field is generally slanted in favor of the insurance carrier or claims administrator who made the final denial. The claim decision will only be overturned if the carrier or claims administrator abused its discretion. Under this common scenario, the claimant bears a heavy burden. She must prove that the fiduciary claims administrator had no reasonable evidence to deny her claim.

The Fifth Circuit Court of Appeals recently described the power of ERISA judicial deference:

> As any sports fan dismayed that instant replay did not overturn a blown call learns, it is difficult to overcome a deferential standard of review. The deferential standard of review our court applies to ERISA decisions often determines the outcome of disputes that are far more important than a sporting event: decisions made by retirement and health plans during some of life's most difficult times, as this case involving a teenager with a serious eating disorder demonstrates.[2]

For Texans and others living within the jurisdiction of the Fifth Circuit, there are two factors that determine whether or not a final denial on an ERISA claim is entitled to judicial deference: 1) when the plan terms grant discretion to the claims fiduciary (the final decision-maker), deference is required when the claim denial hinges upon plan interpretation, and 2) the *Pierre* decision in 1991, providing that factual determinations by ERISA fiduciaries must always be afforded judicial deference.[3]

Since the other federal circuits have not followed the reasoning of *Pierre*, instead holding that factual determinations by fiduciaries should not automatically receive deference, the Fifth Circuit is now questioning whether *Pierre* should be modified or jettisoned. In a rare mood of uncertainty, the Fifth Circuit notes that there is now "robust case law" that indicates that its decision in *Pierre* was wrong.[4]

This article is not meant to speculate over what the Fifth Circuit will do about *Pierre*. Rather, this paper assumes the most common occurrence, namely that the court is required to defer to the decision of the claims fiduciary. The focus of this article is whether or not deference can or should be forfeited if the claims fiduciary does not comply with the claim procedures that were established by the U.S. Department of Labor (DOL) for ERISA claims.

III. Improper Claims Processing Accompanied by a Carrier's Denial: Discovering the Differences Between ERISA and the Texas Insurance Code

Our protagonist needs health insurance. Chances are she will not think much about the origins of her medical coverage. If both an individual health policy and a health policy offered through her work are available, she will probably consider the premium costs, the extent of coverage, the identity of the in-network physicians, and perhaps the reputation of the carrier when deciding which policy to purchase. Naturally, she does not consider the differences in litigating a denied claim. She decides to purchase the group policy offered by her employer. Her premium is deducted from her paycheck each month.

Had she chosen the individual policy, she would have retained her rights under the Texas Insurance Code. Claims

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under the statute's listed "Unfair Settlement Practices" would be available to her.[5] She would have the potential to be awarded consequential damages, even punitive damages for a bad faith or unreasonable denial of her claim. If coverage is decided in her favor, she would be entitled to 18% interest on the amount of covered claim as penalty damages for the carrier's failure to timely pay the claim. She would be entitled to a jury trial and she and her physicians could testify. She could cross-examine the insurance carrier's medical consulting experts. Her case would be decided by a preponderance of the evidence. These factors would give her leverage beginning the day that she submits her claim.

After all, one of the primary purposes of the Texas Insurance Code is to level the playing field for insureds:

> An insurance policy, however, is a unique type of contract because the insurer generally "has exclusive control over the evaluation, processing[,] and denial of claims," and it can easily use that control to take advantage of its insureds. *Arnold v. Nat'l City Mut. Fire Ins. Co*., 725 S.W.2d 165, 167 (Tex. 1987). Because of this inherent "unequal bargaining power," we concluded in *Arnold* that the "special relationship" between an insurer and insured justifies the imposition of a common law duty on insurers to "deal fairly and in good faith with their insureds." *Id*. Similar to that common-law duty, the Insurance Code supplements the parties' contractual rights and obligations by imposing procedural requirements that govern the manner in which insurers review and resolve an insured's claim for policy benefits. *See, e.g.,* Tex. Ins. Code, §541.060(a) (prohibiting insurers from engaging in a variety of "unfair settlement practices."). The Code grants insureds a private action against insurers that engage in certain discriminatory, unfair, deceptive, or bad faith practices, and it permits insureds to recover "actual damages…caused by" those practices, court costs, and attorney's fees, plus treble damages if the insurer "knowingly" committed the prohibited act.[6]

Since our protagonist chose the group policy offered by her employer instead, all of her potential claims under the Texas Insurance Code are preempted by ERISA.

On the positive side, she is entitled to a fiduciary *de novo* review of a denied claim. The insurer or third-party administrator is required to have a dialogue with her concerning the denial and allow her the opportunity to provide evidence that rebuts the insurer's denial.

On the negative side, if a final denial is issued after a fiduciary review, neither she nor her physicians are permitted to testify at trial. The evidence will be limited to the claim file. She cannot make a claim for consequential damages or punitive damages, even if she incurred additional economic loss as a result of the denial. She is not entitled to a jury. She cannot cross-examine the insurance carrier's experts. The claims fiduciary's medical consultants will stay behind the scenes; they can tender their consulting medical reports to the claims administrator without fear of cross-examination. Her case will probably be decided under the abuse of discretion standard, meaning that if there is some reasonable evidence within the claim file to support the denial, the carrier will prevail. If she is wildly successful at trial, *i.e.* if the denial of the claims administrator is deemed unreasonable after the federal judge's review of the claim file, her maximum recovery is the plan benefits that should have been paid. She may or may not be granted attorney's fees.

She becomes ill. She is told that she needs surgery. Her insurer disagrees and denies her claim. Claim denial in hand, she visits an ERISA lawyer's office. Leaving the office after receiving a primer on ERISA law, she is staggered by the differences between the individual health policy and the employee group health policy that she purchased. She wishes she had this information on the front end, before she chose to purchase the group health policy.

IV. ERISA Claim Regulations

ERISA claims procedures originate from 29 U.S.C. §1133 and 29 U.S.C. §1135. Section 1133(1) requires that a carrier or claims administrator provide adequate notice of the reasons for denial that can be readily understood by the claimant. Section 1133(2) requires ERISA plans to afford claimants a full and fair review (often called an appeal) of a denied claim by a plan fiduciary (hence the term used here, claims fiduciary, for the party who conducts the required full and fair review).[7] The full and fair review is usually conducted by the same entity that issued the denial, typical an insurance carrier or third-party claims administrator, but must be conducted by someone other than the adjustor who denied the claim. Naturally, the adjustor cannot review his or her own decision to deny benefits.

Section 1135 grants the power to the Secretary of the U.S. Department of Labor to establish claims regulations that comply with ERISA, allowing the DOL to specify what is adequate notice to the insured of a denied claim as required by §1133(1), what shall constitute a full and fair review of a denied claim, as required by §1133(2), and to specify the time requirements for a claims decision and a decision on appeal.[8]

The ERISA claim regulations established by the Secretary of Labor are within 29 CFR 2560.503-1. According to the Secretary, adequate notice of a denial must include the following information:[9]

1) The specific reason or reasons for the adverse benefit determination;

2) Reference to the specific plan provisions on which the determination is based;

3) A description of any additional material or information necessary for the claimant to perfect the claim and any explanation of why such material or information is important; and

4) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) (§1132) of the Act (ERISA) following an adverse benefit determination on review."[10]

For pension and group life insurance claims, the claims administrator is required to decide the initial claim within 90 days of receipt of the claim, which can be extended for another 90 days by written notice prior to the expiration of the initial 90-day period.[11] The time periods for deciding health care claims are shorter—urgent health care claims must be decided within 72 hours which can be briefly extended if additional information is necessary to decide the claim; pre-service claims must be decided within 15 days with a possible 15-day extension if, due to matters beyond the claims administrator's control, the extension is needed; post-service health claims must be decided within 30 days with a possible 15-day extension if, due to matters beyond the claims administrator's control, the extension is necessary. Disability claims must be decided within 45 days of receipt of the claim, with two potential 30-day extensions if, due to matters beyond the claims administrator's control, the extensions are necessary. For any of the extensions to be valid, the claims administrator is required to notify the claimant in writing during the initial period that the extension will be taken and explain the reason or reasons that the claims administrator needs more time.

As mentioned previously, Section 1133(2) of ERISA requires that a fiduciary conduct a full and fair review of the denial if a review is requested by the claimant. The request for review must be made in writing. The minimum time period that a plan must allow a claimant to submit a written request for review of a denied claim, also called an appeal of a denied claim, is 180 days for health and disability plans and 60 days for pension and life insurance claims.[12]

Review of a denied claim has the following requirements:

1) the claimant has a right to obtain the claim file for the purposes of appealing the denied claim, may rebut the reasons given for denial, and may provide additional information in support of her claim;

2) no deference is to be given to the original decision and the same person, or his or her subordinate, cannot decide the appeal of a denied claim;

3) if the denial involved a medical determination, the adjustor must hire a different medical expert than the one involved in the original decision and that expert must have appropriate training to address the medical issue presented; and

4) the medical and vocational experts whose opinions were obtained in the initial review must be identified.[13]

If the claim is denied after a full and fair review, in order to be adequate notice, the denial must contain the following information:

1) specific reasons for the denial after review;

2) reference to the specific plan provisions upon which the denial is based;

3) a continued right to obtain the claim file; and

4) any additional voluntary appeal and the claimant's right to bring a lawsuit under 502(a) of the Act.[14]

The time period for the fiduciary to decide appeals of pension or life insurance claims is 60 days, which can be extended for another 60 days under certain circumstances.[15] For post-service health care claims the appeal is to be decided within 60 days.[16] The time periods for deciding urgent health care claims and pre-service health claims are shorter.[17] For disability claims, the time period is 45 days with a possible extension of another 45 days.[18] Again, if extensions are necessary, the claimant must be given notice that the extension will be taken and the reason for such extension.

Addressing the consequences for the failure to follow these claims procedures, the claim regulations, as revised in 2000, provide as follows:

> [I]n the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.[19]

Along with these revisions, the Secretary of Labor added a preamble, emphasizing that the regulations are minimum standards for benefit plans and a decision that does not comply with the minimum standards "*should not be entitled to any judicial deference*."[20]

The Fifth Circuit has not followed this admonition by the Secretary of Labor.

V. ERISA's Limited Remedies: There is no Monetary Remedy for Non-Compliance

Generally, the Supreme Court has not allowed any remedy that is not clearly expressed within ERISA's remedial provision 29 U.S. §1132. Section 1132 allows for injunctive relief and the monetary remedies limited to (1) up to $100 per day for a plan administrator's failure to provide certain documents to a plan participant within 30 days of a proper written request, 29 U.S.C. §1132(c), and (2) benefits that should have been paid under the plan. 29 U.S.C. §1132(a)(1)(B).

A narrow opportunity for an additional monetary remedy is created by allowance of "other appropriate equitable relief" under §1132(a)(3). The Supreme Court's decision in *CIGNA Corp. v. Amara* opened the door to a potential monetary remedy under paragraph (a)(3), reviving the term "surcharge" relief from decisions by the equity courts during days of the divided bench (equity courts and courts at law).[21] Surcharge relief is available for certain consequential damages that might result from violations of ERISA.[22] In *CIGNA*, the claimants alleged violations of ERISA due to improper notice of modifications to the Cigna pension plan that resulted in financial harm to some pensioners. The court allowed that monetary relief might be available to some plan participants as a "surcharge" remedy.[23]

Circumstances that invite a legitimate claim for the surcharge remedy are rare. As a general rule, no monetary award is permitted other than benefits due under the plan. No consequential or punitive damages are available for the delay in processing a benefit claim made under an ERISA plan.[24] In *Russell*, the plaintiff was paid the disability benefits due her under the plan, but she sued due to a delay of 132 days in payment. She asserted that during the delay her husband had to cash out retirement savings in order for them to make ends meet and that her disabling impairments were exacerbated by the delay. The Court held that the claimants' request for consequential and punitive damages interfered with the Act's remedial provision, §1132(a):

> The six carefully integrated civil enforcement provisions found in §502(a)[25] of the statute as finally enacted, however, provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.[26]

As a result, there are no serious negative consequences for a claim fiduciary's non-compliance with the claims procedures established by the Secretary of Labor. The only redress that an ERISA plaintiff can hope to obtain for a fiduciary's abuse of the claims process is (1) gaining a level playing field, *i.e.* a judicial decision vacating the abuse of discretion standard of review in favor of a preponderance of the evidence standard, or (2) obtaining a remand by the district court to the claim fiduciary for another review, a decidedly hollow victory.

VI. The Fifth Circuit's View of Non-Compliance with ERISA's Claims Procedures: Allowing Remand But Protecting Deference

The Fifth Circuit has never found sufficient claims procedure abuse to warrant a change in the standard of review from abuse of discretion to a preponderance of the evidence. In that regard, the court has noted that:

> [t]his circuit has rejected arguments to alter the standard of review based upon procedural irregularities in ERISA benefit determinations, such as delays in making the determination . . . . Absent potential wholesale or flagrant violations that evidence an "utter disregard of the underlying purpose of the plan," this court does not heighten the standard of review from abuse of discretion to de novo. [27]

Oddly, the Fifth Circuit has protected deference to the factual determinations of the claims fiduciary even when the claims fiduciary did not make any factual determinations.[28] This resulted from the Fifth Circuit's overriding concern that allowing *de novo* review of ERISA benefit claims will clot the veins of the federal court system. The court held as follows:

> The courts simply cannot supplant plan administrators, through *de novo* review, as resolvers of mundane and routine fact disputes. Considerations of expediency therefore support reference to factual determinations made in the administration of the plan. Otherwise, federal trials are encouraged in the vast number of claims that are filed in the thousands of ERISA plans throughout this county. . . We therefore conclude that a deferential standard of review for factual determinations is buttressed, if not compelled, by practical considerations.[29]

Although the Fifth Circuit has bristled at the idea that claimants should receive a level playing if claims procedures are violated, the tribunal has found an instance in which substantial abuse of the claims procedures can merit a remand to the claims administrator for further review.[30] Although this may lead to an award of benefits, it may also lead to an extended claims process that results in another

denial that must be challenged again at the courthouse under an abuse of discretion standard.

VII. The Second Circuit Holds that Deference Should be Forfeited Unless the Claims Administrator's Violation was Inadvertent and Harmless

The Second Circuit disagrees. In *Halo v. Yale Health Plan*, Halo, a Yale law student, alleged that the fiduciary claims administrator committed a number of claims procedure violations in denying her claim for health benefits (eye surgery) under the Yale Health Plan.[31] Considering Halo's request for *de novo* review due to procedural violations, the Second Circuit gave substantial weight to the Department of Labor's view. The Court held that unless the claims administrator can show that its other procedures are in compliance with the regulations and the failure to comply was both inadvertent and harmless, the claimant is entitled to *de novo* review.[32] The Court declined to award any civil penalties for the claims administrator's failure to comply with claims procedures.[33] Following *Russell*, it found no justification for such an award within the ERISA statutes and regulations, noting that "because ERISA is a comprehensive reticulated statute, and is enormously complex and detailed, it should not be supplemented by extratextual remedies."[34]

The circuits are split. Whether the U.S. Supreme Court will resolve the split is uncertain, of course, but the Supreme Court has shown its affection for deference. In *Conkright v. Frommert*, the Court held that an abuse of discretion that leads to remand does not cause the fiduciary to lose its discretion and right to deference when it decides the claim a second time (described by the Court as the "one strike and you're out" approach that was taken by the Second Circuit in that case).[35] The Court reasoned as follows:

> *Firestone deference . . . preserves the "careful balancing" on which ERISA is based.* Deference promotes efficiency by encouraging resolution of benefit disputes through internal administrative proceedings rather than costly litigation. It also promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from *de novo* judicial review. Moreover, *Firestone* deference serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions . . . .[36]

VIII. Conflicting Views on the Impact of Deference: Many States, Including Texas, Outlaw Discretionary Clauses

In protecting deference even in the face of substantial claims procedure violations, the Fifth Circuit's position not only conflicts with the Second Circuit but with the Texas Department of Insurance and other state insurance commissioners regarding what is fair to an insured. In the balance between an individual insured's rights and the efficiency of the federal court system, the Fifth Circuit has found the latter to be more important, perceiving *de novo* review to be a threat to the court system's efficiency.[37] The Texas Department of Insurance and Texas legislators perceive deference to be a greater threat.

In 2010, the Texas Commissioner of Insurance wrote as follows regarding discretionary clauses in policies that are meant to bind a court to a deferential standard of review:

> "Discretionary clauses are unjust, encourage misrepresentation, and are deceptive because they mislead the consumers regarding the terms of coverage. For example, a consumer could reasonably believe that if they are disabled they will be entitled to benefits under the policy and will be able to receive a full hearing to enforce such rights in court. Instead, a discretionary clause permits a carrier to deny disability income benefits even if the insured or enrollee is disabled, provided that the process heading to the denial was not arbitrary or capricious."[38]

The State of Texas outlawed discretionary clauses in disability, accident, or health policies effective June 17, 2011.[39] Other states have acted in a similar fashion. Statutes prohibiting discretionary clauses have consistently been found not preempted by ERISA.[40]

ERISA has a broad preemption provision but also a savings clause that protects certain state insurance laws from preemption. The savings clause is invoked when the courts find no preemption, thereby causing the discretionary clause within ERISA policies to be illegal under state law and therefore unenforceable. These cases, finding that discretionary clauses are prohibited by state law and unenforceable, are limited to claims made under insured ERISA plans. A state statute outlawing discretionary clauses in insurance policies does not apply to an employer's self-insured plan, nor does it change the Fifth Circuit precedent established by *Pierre*, that factual determinations by an ERISA claims fiduciary should always be given deference.

IX. Conclusion

Insurance claims made on an individual policy and claims made on an ERISA plan are remarkably different. ERISA requires that the insurer or third-party claims administrator engage in a dialogue with the claimant about the claim and the reasons for denial, allowing the claimant an opportunity to rebut the reasons for denial and compelling a fiduciary review of a denied claim. The downside of that review is that if the claimant asks for judicial review of a denied appeal, the federal court will probably have to defer to the claim fiduciary's decision and the evidence will be limited to the contents of the claim file.

There is no monetary remedy within ERISA for a violation of claims procedures nor does ERISA allow for consequential damages. The remedies for claims violations are potentially (1) a remand to the claims fiduciary for another try, or (2) forfeiture of deference, *i.e.* a change in the standard of review from abuse of discretion to a preponderance of the evidence. The Fifth Circuit has never awarded an ERISA claimant a change in the standard of review as a result of claims handling violations.

The collective philosophy of Texas and other states is that deference is harmful because it impairs the rights of insureds. The Fifth Circuit takes a different view, believing that ERISA deference provides a needed lubricant to a federal court system. According to the Fifth Circuit and many other federal courts, any harm to individual claimants is outweighed by the harm that requiring *de novo* review of each ERISA benefit claim would bring to the court system. The Fifth Circuit is also at odds with the DOL, as the Department considers deference to be forfeited if the claims procedures are not followed.

In the author's view, the Second Circuit has it right. Compliance with the claims procedures, or minimum standards created by the DOL that are to be followed by a claims administrator of an ERISA welfare or pension benefit plan, are important. There should be some negative consequences for non-compliance. Remand offers no deterrent; it merely gives the claims administrator another opportunity to decide the claim. Claimants should receive a level playing field, *i.e. de novo* review, unless the fiduciary claims administrator can prove that the claims procedure violation or violations were both harmless and inadvertent.

1 *See, e.g.*, *Conway v. Louisiana Health Service & Indemnity Co. d/b/a Blue Cross Blue Shield,* Case No. 14-cv-34 (M.D. La., Dkt No. 26, filed 3/25/2015), in which the ERISA claimant (the plan participant's wife) died as a result of a denial of a claim for surgery to remove a cancerous tumor. *See also Robertson v. Blue Cross Blue Shield*, 99 F. Supp. 3d 1249, 1253 (D. Mont. 2015) (ERISA claimant was denied a hemopoietic stem cell transplant for diffuse systemic sclerosis, a decision which the Court described as akin to the decision of a "death panel"). Notably, because these are claims made under ERISA plans, the heirs cannot make wrongful death or other tort claims against the plan administrator. Due to ERISA preemption, if benefits were wrongfully denied the heirs are limited to the benefits that should have been paid. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 216 (2004).

2 *Ariana M. v. Humana Health Plan of Texas, Inc.*, 854 F.3d 753, 762-63 (5th Cir. 2017), *rehearing en banc granted,* July 10, 2017.

3 *Pierre v. Connecticut Gen. Life Ins. Co./Life Ins. Co. of N. Am.*, 932 F.2d 1552, 1558-1559 (5th Cir. 1991).

4 *Ariana*, 854 F.3d at 763.

5 Tex. Ins. Code Ann., §541.060(a) (West 2016).

6 *USAA Tex. Lloyds Co. v. Menchaca*, No. 14–0721, 2017 WL 1311752, *3 (Tex. April 7, 2017), *rehearing granted*, Dec. 15, 2017.

7 The term Plan Administrator is used throughout the ERISA statutes, regulations, and case law as if they are the entity making the final decision. As a practical matter, companies generally either buy group insurance to fund employee benefits or hire third-party administrators and so the Plan Administrator identified in the plan is not the entity deciding the appeals of denied claims.

8 *See* 29 U.S.C. § 1135.

9 This description of the claims procedures does not include the amendments that go into effect for disability claims made on or after January 1, 2018. The amendments contain additional requirements aimed at assuring independence, impartiality, and full disclosure of the evidence relied upon in making the final decision to deny disability benefits, allowing the claimant to respond to any new medical consultants that may be hired by the claims fiduciary on appeal.

10 29 CFR 2560.503-1(g). There are some additional requirements for denial notices of health and disability claims including the disclosure of internal rules or protocols relied upon in denying the claim and additional information to be provided by the claims administrator when a health claim denial is based upon the alleged absence of medical necessity or experimental treatment.

11 29 CFR 2560.503-1(f).

12 29 CFR 2560.503-1(h).

13 *Id.*

14 *See* 29 CFR 2560.503-1(j). The same additional disclosure requirements required when a health or disability claim is denied are also required when an appeal of a health claim or disability claim is denied.

15 *Id.*

16 *Id.*

17 *Id.*

18 *Id.*

19 29 CFR §2560.503-1(l).

20 Pension & Welfare Benefits Admin., 65 Fed. Reg. at 70,255 (Nov. 21, 2000) (emphasis added).

21 563 U.S. 421, 441-42 (2011)

22 *Id.*

23 *Id.* at 444.

24 *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985).

25 Section 502(a) of ERISA is now codified as Section 1132(a).

26 *Russell*, 473 U.S. at 146.

27 *Atkins v. Bert Bell/Pete Rozelle NFL Player Ret. Plan*, 694 F.3d 557, 567 (5th Cir. 2012) (internal citation omitted).

28 *See Southern Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98 (5th Cir. 1993).

29 *Pierre*, 932 F.3d at 1559 (internal citation omitted).

30 *Lafleur v. La. Health Serv. & Indem. Co*., 563 F.3d 148, 159 (5th Cir. 2009).

31 819 F.3d 42, 46 (2d Cir. 2016).

32 *Id.* at 58.

33 *Id.59*

34 *Id*. (internal citation omitted).

35 559 U.S. 506, 517 (2010).

36 *Id.* at 517 (emphasis added).

37 *Pierre*, 932 F.3d at 1559.

38 Texas Commissioner of Insurance, Order No. 10-1035 (Dec. 3, 2010).

39 *See* Tex. Ins. Code Ann. §1701.062 (West 2016).

40 *See Orzechowski v. The Boeing Co. Non-Union Long-Term Disability Plan,* 856 F.3d 686, 695 (9th Cir. 2017) (finding no preemption for California's anti-discretionary statute); *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 849 (9th Cir. 2009) (finding Montana anti-discretionary statute not preempted); *Am. Council for Life Insurers. v. Ross,* 558 F.3d 600, 609 (6th Cir. 2009) (finding no preemption for Michigan's anti-discretion standard); *Zaccone v. Standard Life Ins. Co*., No. 10-CV-00033, 2013 WL 1849515, *5, (N.D. Ill. May 1, 2013) (finding Illinois' statute prohibiting discretionary clauses not preempted).

By Chris Gabriel

THE BUSINESS USE EXCLUSION IN COMMERCIAL AUTO POLICIES

Commercial auto policies often contain business use exclusions that exclude coverage when a scheduled auto is used "in the business" of a lessee. A policy containing such a provision is effectively known as a "bobtail" or "non-trucking use" policy. The business use exclusion is often contained within an endorsement and is intended to exclude coverage from the auto owner's commercial auto policy when a party with whom the truck owner has entered into an exclusive lease hauling agreement has agreed to provide coverage for that auto. Consequently, when the auto is being operated on behalf of the lessee, the lessee's liability insurance should be on the risk. Inclusion of the business use exclusion results in the owner's insurer owing no duties if an accident occurs while the auto is being operated in furtherance of the lessee's business.

Under the business use analysis, the driver is almost always an independent contractor and the relevant determination usually is whether he or she is "in the business" of the lessee while "bobtailing" or "deadheading." "Bobtailing" means without trailer, while "deadheading" means operation of the vehicle with an empty trailer.[1] Though similar, a course and scope of employment analysis is not used to determine whether the driver was an employee. Nonetheless, course and scope analyses such as the "coming and going" and "special mission" doctrines are sometimes used to inform a court's decision. Analyzing coverage in almost any factual scenario pertaining to this exclusion is a sliding scale on which the balance can be tipped by a specific, minute fact.

I. Bobtailing and Deadheading

The purpose of the business use exclusion is to preclude coverage when the truck is being used to further the commercial interests of a party to whom the truck is being leased.[2] A non-trucking or bobtail policy provides auto liability coverage for a powered unit only when it is being used for transportation, as opposed to hauling cargo or otherwise being used in the trucking business.[3] Non-trucking use insurance typically describes bobtail or deadhead coverage which attaches only when the listed vehicle is used without a trailer or with an empty trailer and when it is not being operated in the business of a lessee.[4] "Bobtail insurance covers drivers when they are driving their trucks but not on dispatch from a carrier, and broadly encompasses the 'non-trucking use' of a vehicle."[5]

A typical business use exclusion reads as follows:

> This insurance does not apply to:
>
> a. A covered "auto" while used to carry property in any business.
>
> b. A covered "auto" while used in the business of anyone to whom the "auto" is rented, leased or loaned.

The Fifth Circuit has held that the phrase "in the business of" in a standard business use exclusion is unambiguous.[6] "That 'contractual language may, on occasion, pose difficult factual applications ...' and that the parties disagree as to coverage, does not create ambiguity."[7] Although the application of the exclusion "may pose difficult questions, the difficulty of the questions does not create an ambiguity" in the policy language.[8]

II. *Mahaffey*, *Brantley*, and the "Commercial Interest" Test

There are numerous reported coverage cases on whether and when a truck is considered to be "in the business" of a lessee. Perhaps the most instructive case is *Mahaffey v. General Security Insurance Co.*, in which Farr Auto Sales leased a truck and provided a driver, Arthur Wynn, to First Coast Intermodal Service to haul a load from Bowling Green, Kentucky, to New Orleans, Louisiana.[9] Wynn dropped off the load in New Orleans late in the afternoon and was then instructed by the First Coast dispatcher to take the rest of the night off and call in the morning to see if they had another load.[10] Wynn bobtailed to a truck stop where he had dinner, watched television, showered, played slot machines over the course of about six or seven hours.[11] Wynn made the decision not to spend the night in the truck's sleeper berth because of a leak, and while proceeding to a motel, was involved in the automobile accident with Mahaffey.[12]

Farr carried a bobtail policy that contained an endorsement for business use and provided that "the insurance does not apply to ... [a] covered 'auto' while used to carry property in any business ... [or] a covered 'auto' while used in the business of anyone to whom the 'auto' is rented."[13] The court held the truck was being used in the business of First Coast because

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Wynn was not heading home, but rather was on standby for further deliveries because the First Coast dispatcher told him to take the night off and call the next day about a load.[14] Thus, the court determined that First Coast had not effectively released Wynn.[15] First Coast did not, however, direct Wynn's activities that evening; he was "free to go where he pleased."[16] The deciding factor was First Coast's instruction that he stay in New Orleans to be available to pick up the next load.[17] Even though Wynn was not compensated for his time or mileage during the wait, if he had gone before checking back in for the next load in the morning, First Coast would have had to find another driver, and Wynn would have lost the opportunity to haul the load.[18] Thus, the court found Wynn was furthering First Coast's commercial interests, triggering application of the business use exclusion.[19]

Although *Mehaffey* was decided under Louisiana law, Texas courts likely would follow its reasoning because the Fifth Circuit stated in the *Mehaffey* opinion[20] that its holding was consistent with its "commercial interest test" articulated in *Empire Fire & Marine Insurance Co. v. Brantley Trucking, Inc.*, decided under Texas law.[21] In *Brantley,* the driver of a leased truck bobtailed to have an oil change, have other maintenance performed, and pick up auto parts while waiting for cargo to load at the lessee's terminal yard.[22] On his way back to the lessee's terminal, the driver was involved in an accident.[23] The court held that the driver was acting in the lessee's business because he was furthering the commercial interests of the lessee when he was "only biding his time while the cargo loaded" and was not "out pursuing leisurely engagement."[24]

In applying the "commercial interest test," *Brantley* held the exclusion "clearly refers to occasions when the truck is being used to further the commercial interests of the lessee."[25] As to when the tractor is not within the lessee's commercial interests, the *Brantley* court instructed that when the driver is "out pursuing leisurely engagement, he would not be 'in the business of' [the lessee]."[26] The court gave factual examples of when drivers were in furtherance of the lessee's commercial interests:

- Driver was only biding his time while the cargo loaded, had the truck serviced, and was en route back to yard to pick up the load when the accident occurred;[27]
- Driver was using the truck in the business of the lessee and the injury occurred while the driver was en route to pick up the trailer which had been repaired;[28]
- Driver was on his way to obtain an oil change after which he was to proceed to pick up a load for the carrier;[29]
- Driver was directly on his way to pick up the trailer, using a normal route for that purpose;[30]
- Driver was operating a truck leased to the lessee, headed toward the lessee's terminal knowing he was next on the list to haul a load to Chicago, and knowing that timing was important.[31]

The *Mahaffey* court stated that driving home is generally not found to be "in the business" of a lessee[32] and also provided examples of its own, adding to the *Brantley* test, which is quite helpful in the fact-driven determination:

- "[D]river was in the business of a lessee when returning to pick up a trailer he left at a truck stop in order to bobtail to spend a night at home and noting the fact that the driver went home instead of a hotel was not determinative as the driver 'had to sleep somewhere;'"[33]
- Driver "going to find a place to sleep the night before picking up an assigned load was in the business of a lessee because he was 'on business far from both his home and the home base of his employer,' the lessee 'expected him to get rest so that he would be eligible to pick up a load the next morning,' and the 'essential purpose of [the driver's] actions was to benefit [the lessee] by getting the required hours of sleep and ensuring his ability to make a pick up the following morning;'"[34]
- Driver was not in the business of lessee where he was not under dispatch or standby for further deliveries, and his drive home was more of a personal nature rather than a work-related function;[35]
- Driver "was not in the business of lessee where the driver was driving to his home after being told there was no cargo available for hauling and to call back a few days later."[36]

III. *Brantley's* and *Mehaffey's* Forbearers and Progeny

In *Brantley*, the Fifth Circuit relied on the Seventh Circuit's decision in *Hartford Insurance Co. v. Occidental Fire & Casualty Co.*, 908 F.2d 235 (7th Cir. 1990), to formulate the "commercial interest" test.[37] In *Hartford,* Lykes Transport, dispatched a tractor owned by Rich Transport to deliver frozen orange juice cargo from Florida to Indiana.[38] Prior to leaving Florida, the driver had been instructed to have the trailer's faulty freon valve repaired after he delivered the orange juice.[39] The trailer leaked Freon during the haul, and, upon delivery, the orange juice was rejected because of its warm temperature.[40] The driver was instructed to drop the cargo at a cold-storage facility and have the trailer's freon valve repaired.[41] The next day, while returning to the shop for the trailer, the driver was involved in an accident.[42] The driver made another attempt to deliver the orange juice, and then returned to Florida after it was again refused.[43]

The policy excluded coverage "[w]hile the automobile is being used in the business of any person or organization to whom the automobile is rented."[44] The court held the business use

exclusion applied because the driver had not completed his delivery for the lessee and was on his way to pick up his trailer to attempt another delivery of the orange juice.[45] The court found the truck was being used to further the commercial interests of the lessee because the lessee instructed the driver to remain in Indiana to attempt another delivery of the juice, and then return to Florida after it was again rejected.[46] Several federal appeals courts throughout the country have followed the *Hartford* test.[47]

The court in *Sentry Select Insurance Co. v. Drought Transportation, LLC* explored the "commercial interest" test within the boundaries of the "eight corners" rule to determine the duty to defend, and determined that the "commercial interest" test cannot be conflated with a course and scope analysis[48] In *Drought*, the driver was under dispatch of truck lessee, Circle Bar A., Inc. to pick up and drop off frac sand, and was en route to pick up a load at the time of the accident.[49] In the underlying petition, the plaintiff sought recovery under a theory of respondeat superior, alleging the driver was working in course and scope of employment.[50] The policy excluded coverage for the truck "while used in the business of anyone to whom the auto is rented, leased or loaned."[51] The court concluded it was necessary to examine extrinsic evidence to determine the duty to defend because it was impossible to discern, on the face of the pleading, whether the truck had been leased by or was being used to further the commercial pursuits of Circle Bar.[52] The court also found the petition's course and scope allegation insufficient in determining whether the truck had been leased by the insured or used in in the lessee's business.[53] The court held that evidence outside the pleading establishing the driver was on dispatch and the truck was under lease to Circle Bar did not overlap with the merits in the underlying dispute because the petition included no allegations concerning how the truck was used.[54] Thus, the two requirements[55] for allowing extrinsic evidence were met.[56]

Following *Brantley* on the business use exclusion and *Ooida* on the duty to defend exception, the court held that the there was no duty to defend or indemnify because the truck was being used in the business of the lessee, regardless of whether the driver was working in the scope of his employment or whether there was vicarious liability.[57] The *Drought* case is currently pending before the Fifth Circuit and has the potential to be the next big decision on extrinsic evidence and on the business use exclusion.

In contrast to the *Drought* opinion is the opinion in *RLI Insurance Company v. Great American Insurance Company*, which involved a coverage dispute between the two carriers regarding Great American's non-trucking policy.[58] In the *RLI* case, the driver had delivered a load for the lessee, and was driving the tractor home from the lessee's terminal when the accident occurred.[59] RLI asserted the driver was not in the business of the lessee at the time of the accident because he was not hauling a load.[60] Because the driver was returning home for his own convenience and not under dispatch with the lessee, the court held that the drive "was nothing more than a commute to and from work, and that alone is not enough to establish [the driver] as being 'in the business' of [the lessee]."[61] Interestingly, in reaching this decision the court looked to the "coming and going" and "special mission" doctrines employed in a course and scope of employment analysis.[62]

In *Drought* the district court analysis focuses on the truck, while in *RLI*, the court focuses on the driver. It remains to be seen in the *Drought* appeal whether the Fifth Circuit will find an overlap with the course and scope analysis and the "commercial interest" test, and how such analysis may affect the duty to defend and introduction of extrinsic evidence.

In *Richardson v. Zurich American Insurance Co.*, the driver picked up a load of sand in Tyler, Texas, and dropped it in Dubach, Louisiana.[63] On his way back to Tyler to pick up another load, he stopped in Greenwood, Louisiana, to have tires replaced.[64] He informed the dispatcher of his stop and the dispatcher told him to call when the tire replacement was complete and he was ready to pick up a new load.[65] The driver spent the night in Greenwood at a truck stop and was involved in a collision the next morning before leaving the truck stop to get the tires.[66] The court found the driver to be in the business of the lessee:

> [A]t the time of the accident, he was serving the commercial interests of [the lessee] by performing required maintenance on the truck and moving in the direction of the next load. In fact, he was moving away from his home in New Orleans and toward the location where it was likely he would have picked up a new load of sand. Therefore, [the driver] was furthering the commercial interests of [the lessee] by ensuring that his truck was maintained and available for the next load.[67]

In *Williams v. Great American Insurance Co.*, the driver delivered a trailer of goods to the lessee's facility and left the trailer of goods behind at the facility to be unloaded.[68] The driver then drove just outside the warehouse gates, parked the tractor, and retired to sleep in the cabin for his mandatory break.[69] Meanwhile, he waited to pick up the emptied trailer the next day so that he could take it to pick up another load.[70] Sometime thereafter, his parked truck was struck by another vehicle, the driver of which sued for his injuries.[71] Following *Mehaffey*, the court held:

> Under the circumstances, when remaining in the area entirely for work-related reasons, to pick up a trailer to then travel to the lessee's facility to retrieve another load to haul, this is indisputably a work-related function for a commercial driver because commercial drivers are required to have a certain number of rest hours between hauls. Where, as here, the tractor was being used to further the

> commercial interests of the lessee, [the driver] was acting in the business of [the lessee] as a matter of law.[72]

In a Fourth Circuit case that relied on *Mahaffey, Brantley*, and *Hartford*, driver Mahdi had a lease for the exclusive use of his tractor with J & J Logistics.[73] Mahdi was on his way to pick up a load when he had an accident exiting the highway to get something to eat.[74] The policy excluded coverage for "'bodily injury' while … used to carry … property in any business or while … used in the business of anyone to whom the 'auto' is leased or rented."[75] In applying the "commercial interest" test, the court found that the business use exception applied:

> The accident occurred while Mahdi was on his way to pick up a load for J & J; his driving to Jessup was a necessary step in completing his work. As the district court noted, Mahdi was not "pursuing leisurely engagement nor engaged in some frolic [or] detour." Rather, he had received instructions from J & J to go to Jessup to pick up a load and was in the process of completing that task. Although Mahdi had decided just before the accident to stop for a meal before making his way to the warehouse, he was operating his vehicle at the time of the accident solely for the purpose of furthering J & J's commercial interests. We therefore find that the business use exception applies and bars coverage.[76]

In a Louisiana appeals court case cited and discussed in *Mahaffey*, the truck driver was bobtailing home after making a delivery for the lessee.[77] The driver typically drove directly home at the end of the day and did not store the tractor at the yard.[78] One carrier argued that because the driver was sometimes dispatched directly from his home, he worked out of his home, and therefore the drive from his last delivery point to his home would be considered to be "in the business".[79] However, the driver "specifically testified" that he did not consider himself as working from his home.[80] The court found the auto was not being used in the business of the lessee and that the driver's journey home was more of a personal nature rather than a work-related function because he was free to go where he pleased, and he was not subject to the lessee's control, not paid for his time or mileage driving home, and not under dispatch or standby for further deliveries.[81] Of note, the court did not foreclose the possibility a driver could be "in the business" while bobtailing, stating as an example when the driver is between delivery points.[82]

Another case that deserves discussion is *Assicurazioni Generali, S.p.A v. Ranger Insurance*, a bobtail case in which the policy had an exclusion clause whereby any person "engaged in the business of transporting property by auto for others" would not be covered under the policy.[83] The driver was neither under dispatch nor transporting property, but was bobtailing en route to a repair shop to have his brakes repaired.[84] Ruling against the insurer, the court concluded that the exclusion was vague and subject to more than one reasonable interpretation.[85] The *Brantley* court confined *Assicurazioni* to its facts, distinguishing it on the basis that the policy language was significantly different, and requiring that the truck actually be engaged in transporting property for application of the exclusion.[86] In *Assicurazioni,* the Fifth Circuit distinguished *Hartford* on the factual basis that the driver in that case had been under dispatch.[87] Nonetheless, *Assicurazioni* arguably remains good law, especially when applying similar policy language.

IV. Conclusion

As apparent from the caselaw, application of the business use exclusion is an extremely fact intensive determination and many factors are involved in concluding whether an auto is being used to further the commercial interests of the lessee. Many of the cases either involve a driver returning home, en route to have the tractor serviced, on the way to a motel, or sleeping in the cab after dropping a load. *Mehaffey* and *Brantley* provide the roadmap to analyzing coverage under these factual scenarios, and an impending decision in *Drought* may further change the landscape. One thing is certain: minute details, such as whether the driver was awaiting a dispatch the next morning, considered him- or herself to still be on the clock, or was instructed to do something by the dispatcher, can be the deciding factors.

1 *Meade ex rel. Meade v. Great Am. Assur. Co.,* 198 F. App'x 475, 478 (6th Cir. 2006).

2 *Forkwar v. Empire Fire & Marine Ins. Co.,* 487 F. App'x 775, 780 (4th Cir. 2012).

3 *RLI Ins. Co. v. Great Am. Ins. Co.*, No. 1:05-CV-352, 2006 WL 1207899, at *1 (E.D. Tex. May 3, 2006).

4 *Meade ex rel. Meade,* 198 F. App'x at 478.

5 *Owner-Operator Indep. Drivers Ass'n, Inc. v. United Van Lines, LLC*, No. 4:06 CV 219 JCH, 2006 WL 1877081, at *4 (E.D. Mo. July 6, 2006).

6 *Mahaffey v. Gen. Sec. Ins. Co.,* 543 F.3d 738, 741 (5th Cir. 2008) (per curiam) (Louisiana law).

7 *Empire Fire & Marine Ins. Co. v. Brantley Trucking, Inc.*, 220 F.3d 679, 681 (5th Cir. 2000) (quoting *Hartford Ins. Co. v. Occidental Fire & Cas. Co.*, 908 F.2d 235, 239 (7th Cir.1990)).

8 *Mahaffey*, 543 F.3d at 741.

9 543 F.3d at 739.

10 *Id.*

11 *Id.*

12 *Id.*

13 *Id.* at 740.

14 *Id.* at 742.

15 *Id.*

16 *Id.*

17 *Id.*

18 *Id.* at 742-43.

19 *Id.* at 743.

20 *Id.*

21 220 F.3d 679, 680 (5th Cir. 2000).

22 *Id.* at 680.

23 *Id.*

24 *Id.* at 682.

25 *Id.*

26 *Id.*

27 *Id.*

28 *Id.* (citing *Hartford Ins. Co. v. Occidental Fire & Cas. Co.*, 908 F.2d 235, 235 (7th Cir.1990)).

29 *Id.* (citing *Empire Fire & Marine Ins. Co. v. Ins. Co. of the State of Penn.*, 638 So.2d 102, 104 (3rd Dist. Ct. Fla.1994)).

30 *Id.* (citing *Liberty Mut. Ins. Co. v. Connecticut Indem. Co.*, 55 F.3d 1333, 1337 (7th Cir.1995)).

31 *Id.* (citing *Lime City Mut. Ins. Ass'n v. Mullins*, 83 Ohio App.3d 517, 615 N.E.2d 305, 307–308 (1992)).

32 *Mehaffey,* 543 F.3d at 743.

33 *Id.* at n. 31 (citing *Liberty Mut. Ins. Co. v. Conn. Indem. Co.*, 55 F.3d 1333, 1334, 1337 n. 5 (7th Cir.1995)).

34 *Id.* (citing *Auto-Owners Ins. Co. v. Redland Ins. Co.*, 522 F.Supp.2d 891, 898 (W.D.Mich.2007)).

35 *Id.* at 741 (citing *LeBlanc v. Bailey*, 700 So.2d 1311, 1314 (La. Ct. App. 4 Cir.1997).

36 *Id.* at 743 (citing *Acceptance Ins. Co. v. Canter*, 927 F.2d 1026, 1028 (8th Cir.1991)).

37 *Brantley,* 220 F.3d at 682.

38 908 F.2d 235, 236 (7th Cir. 1990).

39 *Id.*

40 *Id.*

41 *Id.*

42 *Id.*

43 *Id.* at 236–37.

44 *Id.* at 237.

45 *Id.* at 239.

46 *Id.* at 236-37, 239.

47 The Fourth, Fifth, Sixth, Seventh, and Eighth Circuits have followed the "commercial interests" test. *See Forkwar,* 487 F. App'x at 776; *Brantley,* 220 F.3d at 682; *Auto–Owners Ins. Co. v. Redland Ins. Co.,* 549 F.3d 1043, 1049 (6th Cir. 2008) (truck was "in the business of" lessee when accident occurred while driver was stopping to rest for the night while traveling toward next presumed, though not confirmed, dispatch); *Hartford,* 908 F.2d at 239; *Great W. Cas. Co. v. Nat'l Cas. Co.,* 807 F.3d 952, 961 (8th Cir. 2015) (explosion occurring while worker was attempting to repair leaking pipe on driver's trailer happened "in the business of" the trucking company lessee).

48 No. 15–cv–890, 2016 WL 6236375 (W.D. Tex. Oct. 24, 2016).

49 *Id.* at *1.

50 *Id.*

51 *Id.* at *2.

52 *Id.*

53 *Id.* at *4-*5.

54 *Id.* at *5.

55 Courts may consider extrinsic evidence when (1) it is initially impossible to discern whether coverage is potentially implicated, and (2) when the extrinsic evidence goes solely to a fundamental issue of coverage which does not overlap with the merits of or engage the truth or falsity of any facts alleged in the underlying case. *Ooida Risk Retention Group, Inc. v. Williams*, 579 F.3d 469, 475–76 (5th Cir. 2009).

56 *Id.*

57 *Id.*

58 No. 1:05-CV-352, 2006 WL 1207899, at *1 (E.D. Tex. May 3, 2006).

59 *Id.*

60 *Id.*

61 *Id.* at *2-*3.

62 *Id.* at *3.

63 No. 17-571, 2017 WL 5499792, at *3 (E.D. La. Nov. 16, 2017).

64 *Id.*

65 *Id.*

66 *Id.*

67 *Id.* at *4.

68 240 F. Supp. 3d 523, 525 (E.D. La. 2017).

69 *Id.*

70 *Id.*

71 *Id.*

72 *Id.* at 532.

73 *Forkwar,* 487 F. App'x at 776.

74 *Id.*

75 *Id.*

76 *Id.* at 780.

77 *LeBlanc v. Bailey,* 700 So. 2d 1311, 1312 (La. Ct. App. 1997).

78 *Id.*

79 *Id.*

80 *Id.* at 1314.

81 *Id.* at 1315. *See also Jurey v. Kemp,* 77 So. 3d 83, 87 (La. Ct. App. 2011) (no business use where off-duty driver was returning home after picking up trailer from shop because he was not under lessee's control, not on standby from dispatch, was free to go where he pleased, and was not paid for this trip).

82 *Leblanc*, 700 So.2d at 1315.

83 64 F.3d 979, 981 (5th Cir. 1995) (Texas law).

84 *Id.*

85 *Id.*

86 *Brantley,* 220 F.3d at 683.

87 *Assicurazioni*, 64 F.3d at 981, n.4.

By Rachelle H. Glazer and John P. Atkins

RECENT FIFTH CIRCUIT INSURANCE DECISIONS

After a banner year deciding significant insurance cases in 2017, the Texas Supreme Court has left it to the Fifth Circuit to take up Texas insurance law issues toward the end of 2017 and the beginning of 2018. The Fifth Circuit has not been idle, and has considered several interesting questions, including interpretation of the Texas Supreme Court's important *Menchaca* decision.

Insured did not "own" funds invested in Ponzi scheme, and loss did not occur at time of investment.

***Cooper Industries Ltd. v. National Union Fire Insurance Co. of Pittsburgh, Pennsylvania*, 876 F.3d 119 (5th Cir. 2017).**

In this case, electrical-equipment supplier Cooper Industries invested its pension fund in what turned out to be a Ponzi scheme. The principal defrauders were Paul Greenwood and Stephen Walsh, who set up a joint venture between a pair of investment companies to market a purported "enhanced equity index" investment strategy. The details of this strategy are not particularly important, but Greenwood and Walsh purported to go back and forth between selling and buying the stocks in an index and the futures on those stocks depending upon which was, at any given time, more valuable. This supposedly had the advantage of generating the index rate of return plus an additional amount attributable to exploiting arbitrage opportunities.[1]

There were only two ways to invest in the business—purchase a limited partnership in WGTC, Greenwood and Walsh's company, or loan money to WGTI, one of the limited partners of WGTC. The latter option had the virtue of insulating the "investor" from the risk that the investment company lost money.[2]

Cooper Industries was taken in by a pitch and decided to make considerable investments of its pension funds through two large promissory notes with WGTI. In total, Cooper invested more than $175 million in assets. Luckily for Cooper, it redeemed the larger of its two investments (approximately $140 million) early enough and realized significant gains. Cooper did not, however, redeem its smaller investment.[3]

Eventually, and inevitably, the wheels came off the wagon. Less than a year after Cooper redeemed its larger investment, the National Futures Association discovered that Greenwood and Walsh were caught up in a Ponzi scheme. The Commodity Futures Trading Commission and the Securities and Exchange Commission filed an enforcement action in February of 2009. The appointed receiver found that the pair were running WGTC and WGTI as essentially a single entity, commingling funds, engaging in accounting fraud, and lying about their returns. While the investment companies had made some money through their investments, they were not nearly the gains that had been promised. This was made worse by the fact that Greenwood and Walsh had stolen $130 million from WGTI to buy, among other things, 1,348 collectible teddy bears and a $32 million farm for show horses. Greenwood and Walsh pleaded guilty to securities fraud, commodities fraud, and other charges.[4]

Upon liquidation, the receiver proposed returning a large portion of each investor's net investment. Cooper then engaged in some back and forth with the receiver about the size of Cooper's disbursement and whether the Receiver should withhold some amount for the return Cooper made on its larger promissory note. Cooper was still out about $1.1 million in principal after the liquidation was complete, although including its returns from the promissory note it redeemed before the fraud was discovered, it actually *made* money off of the investment overall.[5]

Cooper had a commercial-crime policy with National Union Fire Insurance Company ("National Union"), renewed and in force at all relevant times. The policy provided that it would pay for loss of "funds" resulting from fraud by an "employee." Under relevant endorsements, "employee" included any fiduciary and any trustee or administrator of a pension plan. The policy provided, however, that Cooper could only recover for property that it "owned." "Own" was an undefined term. The policy also excluded coverage for losses resulting from trading, or "indirect losses" like the inability to realize income that could have been made but for the loss of the money at issue.[6]

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Cooper timely notified National Union of its potential loss and filed a proof of loss (during the liquidation process) indicating it could ultimately lose up to $57 million. National Union denied the claim, and Cooper sued. The district court granted summary judgment to National Union on the basis that Cooper did not "own" its lost earnings, holding that the policy did not intend to incorporate the equitable concept of beneficial ownership. Because Cooper did not "own" the lost assets at the time of the loss, the Court also held that Cooper had not experienced a "loss" under the policy. Although ultimately unnecessary to its take-nothing judgment against Cooper, the Court also held that Cooper was correct that neither the "trading" or "indirect loss" exclusion applied.[7]

Although the appeal presented five issues to the Fifth Circuit, including the definitions of "own," and "loss," a question of imputed knowledge, and the application of the two exclusions, the Court did not get past the second issue before rendering its decision.[8] Cooper's first argument was that the district court's decision was wrong because the undefined term "own," as used in the policy, included both legal and equitable ownership. Cooper based its argument on the frequency of the special use of "own" in the legal field. However, the court declined to apply a special legal meaning to a term in a contract when the ordinary meaning was sufficient. Citing several dictionary definitions and cases defining the term in contracts, the court pointed out that each definition had in common the basic elements of possession and power to control—Cooper had *neither* possession of the funds at issue, nor the ability to control those funds, at the time of the loss. Thus, Cooper did not "own" any of these assets. The Fifth Circuit cited as support for this determination an Eighth Circuit case involving *exactly the same scam* in which the court had found that a limited partner investor in WGTC *also* had not owned the assets lost.[9]

In the alternative, Cooper argued that it at least suffered a "loss," claiming that in the instance of a fraudulently induced loan, the loss occurs the moment the loan is made. National Union contended that fraudulently induced loans were not void but merely voidable, and hence could not result in a "loss" until it was known whether the loan would ultimately be beneficial or not. Moreover, National Union contended that Cooper could scarcely be said to have incurred a loss when, across its two investments, it actually made back more than its principal investments.[10]

The Fifth Circuit agreed with National Union on both counts. First, the court held that since fraudulently induced loans are merely voidable under Texas law, the loss did not occur until Greenwood and Walsh stole the money. Before that time, the loan could have been profitable, as the larger of the two loans actually was. This also distinguished the case from several of the cases Cooper had cited that all dealt with situations in which a fraudulently induced loan had *actually caused* some immediate loss (for instance, because it was secured by less valuable collateral). Second, the court found it strange for Cooper to contend that it suffered a "loss" when, in total, it actually recovered a significant profit from its dealings with Greenwood and Walsh.[11] Having decided these two issues, the court did not need to address the other issues on appeal. The court affirmed the district court's judgment.

This case should instruct policyholders to check their crime policy before entering into a non-traditional investment like the one in this case. Protection from fraud, generally speaking, will only go as far as the policyholder's control of the assets. Giving up control likely means giving up that protection.

Deprivation of benefits as a result of misrepresentations by and insurer sufficient to support statutory recovery under Menchaca, and allegations regarding subcontractors' work sufficient to trigger a defense obligation.

***Lyda Swinerton Builders, Inc. v. Oklahoma Surety Co.*, 877 F.3d 600 (5th Cir. 2017).**

Lyda Swinerton Builders, Inc, ("LSB") was the General Contractor on an office building project in College Station and Willis Company, Inc. was its roofing contractor. In the subcontract Willis agreed to defend and indemnify LSB for lawsuits arising from Willis's conduct. The indemnity agreement in the subcontract was hand-amended by Willis, and LSB did not countersign the subcontract. LSB was a named insured under the Oklahoma Surety Co. ("OSC") policy, but only for Willis's work and only where a written insured contract existed.[12]

LSB allegedly fell behind on its work, and its customer sued, alleging among other things failure to adequately supervise subcontractors. Although Willis was mentioned only as a third-party defendant, and not specifically identified as a subcontractor, the complaint alleged deficiencies in the work on the roof, and further alleged that LSB was responsible for the conduct of the third-party defendants. LSB made claims under various of its subcontractors' policies for defense costs associated with the lawsuit. Willis's insurer, OSC, denied coverage.[13]

LSB was sued for declaratory judgment by a different insurer that denied coverage, and LSB filed third-party complaints against OSC and several other insurers in that matter, claiming breach of contract for failure to defend, violations of Chapter 541 of the Insurance Code, and prompt payment violations. Eventually all claims except LSB's claims against OSC settled. On summary judgment, the district court found that OSC owed LSB a duty to defend and found that OSC had violated the prompt payment statute as well. The district court further found that LSB's request for defense

costs did not violate Texas's anti-stacking rule, but held that LSB could not recover statutory damages under Chapter 541 of the Insurance Code for deceptive practices because it had not experienced an "independent injury"—that is, an injury separate and apart from the denial of policy benefits. The district court ordered a damages award in LSB's favor of nearly $1,000,000 in defense costs and prompt-pay penalties along with reasonable attorney fees and costs.[14]

On appeal, OSC challenged the district court's summary judgment and damages rulings, while LSB challenged the court's ruling that statutory damages for deceptive practices were not available. Addressing the issues in turn, the court first considered OSC's challenge to the determination that it had a duty to defend.

OSC argued that LSB was not an additional insured for the purposes of this specific loss because the underlying subcontract containing the indemnity agreement was not countersigned by LSB. The court quickly noted that the OSC policy did not require that insured contracts be signed by all parties, and that additional insured relationships did not need to be affirmed by the party receiving the benefit—what mattered was whether the named insured agree to assume the liability, and there was no dispute that this occurred. This was not changed by the hand-edits Willis' president made to the indemnity agreement, since the text that was not stricken through still extended an "unconditional" indemnity as expansive as permitted under the law.[15]

OSC then argued that the duty to defend was not triggered. The Fifth Circuit applied the traditional Texas "eight corners" rule to resolve the question, looking only at the four corners of the underlying state court petition and the four corners of the insurance policy, and declining the invitation to review extrinsic evidence. The court explained that under the eight corners rule, if the complaint alleges facts that could even *potentially* implicate coverage, the complaint triggers the duty to defend, regardless of the falsity or baselessness of the allegations.[16] Applying the "eight corners" rule, the Fifth Circuit found that OSC owed a duty to defend because the petition alleged failure to adequately supervise subcontractors, which implicated the work of subcontractors, and Willis was a subcontractor. Moreover, the petition complained, in part, about the work on the roof, and Willis was the roofing subcontractor.[17] Thus, even though Willis was not specifically named in the pleading, the allegations regarding its scope of work were sufficient to trigger a defense obligation. Further, the allegations the petitions were sufficient to support an inference that "property damage" had occurred during the 2006/2007 policy period. The underlying petition "alleged that the project commenced on December 1, 2003, that some amount of work was done on the project thereafter, and that the project was effectively abandoned by February 13, 2008."[18] The allegations did not negate the possibility of damages during the policy period.[19]

The court then turned to OSC's "anti-stacking" argument. The general Texas rule is that an insured cannot add together the limits of multiple non-overlapping policies covering the same lawsuit where there is a "single claim involving indivisible injury." OSC contended that this rule applied here, because a prior insurer of Willis provided coverage of the litigation as well. The court replied that it was not clear that the anti-stacking rule applied to the duty to defend, but that even if it did, it would not apply here. LSB had never represented that it had tendered its whole defense to the prior insurer and allowing OSC to avoid paying because LSB had resorted to submitting defense costs to the prior insurer, which had extended coverage, would reward OSC for "shirking its legal duty." Consequently, the court affirmed the district court's summary judgment determinations on breach of contract and against OSC's anti-stacking argument.[20]

This finding also resolved the first damages question, because OSC's only defense to liability under the prompt pay statutes was that it was not obligated to defend and did not breach any duty to do so. Since the court had just rejected that argument, OSC was subject to the 18% penalty interest imposed by the insurance code.[21]

The court then turned to the independent injury question, which was the sole point on which LSB cross-appealed. LSB had originally claimed that OSC violated the prohibition in Chapter 541 of the Insurance Code against "unfair or deceptive acts or practices" by lying about the scope of coverage and thereby causing LSB to have to incur additional defense costs. The district court found that because all that was at issue was denial of defense costs, this was not an injury *independent* of the denial of coverage, and under then-current Texas state and Fifth Circuit precedent, it appeared that no statutory penalties were available without an injury independent of, and unrelated to, loss of policy benefits. But at the time of the district court's ruling, the *Menchaca* case[22] had not yet been decided by the Texas Supreme Court. In that case, the Texas Supreme Court had attempted to unravel the knot of apparently contradictory precedent on the question of when (if ever) statutory penalties are available in contract actions for recovery of policy benefits.[23]

The Fifth Circuit reviewed *Menchaca,* and extrapolated its explanation of the "entitled-to-benefits" rule, which provides that if an insured is denied benefits as a result of a violation of statute, it may recover those benefits as "actual damages" under the Insurance Code. This, the court found, required it to rethink its precedent on the subject, and further required it to reverse the district court's decision denying LSB's claim for policy benefits as statutory damages. If LSB was correct and OSC's misrepresentations caused it to be deprived of the benefits of the policy, LSB would be entitled to recover those damages under statute without the need for any independent injury and would be entitled to decide whether to recover in statute or in contract. The

court therefore remanded for further consideration of LSB's statutory claim.[24]

The court ended its opinion by affirming the district court's damages rulings, holding that the district court's award of costs was reasonable because when an insurer fails to accept its defense obligation, an insured can proceed with its own defense, and further holding that the prompt payment interest accrued only until judgment was rendered in the trial court—but that this date would change if, after remand, the district court found that LSB was entitled to statutory damages, rather than contractual damages. The court noted that because, after *Menchaca*, it is clear that statutory recovery may be cumulative of contractual recovery, it would not be impermissibly punitive to both recover statutory damages under Chapter 541 and additional prompt payment penalties.[25]

As one of the first major cases to specifically address *Menchaca*, this case is likely to garner some considerable attention.

Additional payments *after* a reasonable appraisal award do not constitute a violation of Texas prompt payment rules.

***Mainali Corp. v. Covington Specialty Ins. Co.*, 872 F.3d 255 (5th Cir. 2017), *as revised* (Sept. 27, 2017).**

In this relatively short opinion, the Fifth Circuit reviewed a property insurance claim involving an appraisal, and a property insurer's additional post-award payment. Mainali Corporation ("Mainali") owned a gas station and convenience store that was damaged by a fire. Covington Specialty Insurance Company ("Covington") sold insurance to Mainali that covered that property, including the building, the gas and fuel pumps, associated personalty, the canopy and awnings, and lost business income. Mainali notified Covington of the fire the day after it happened, and three days later Covington sent an adjuster. Over the next few months, Covington paid out $389,255.59 in damages.[26]

Mainali did not believe the payment was sufficient and filed suit against Covington and its adjuster in state court. Covington removed the suit to federal court, and then exercised its right under the policy to force an appraisal. The parties designated their respective appraisers, and the appraisers designated their umpire—the result was an appraisal award of $387,925.39 cash value, $449,349.61 replacement. Since Mainali did not repair or replace, the smaller number was the relevant one. The appraisal provided that it was inclusive of all fire damage, but although Covington had already paid more than the total appraisal award, it paid an additional $15,175.82 because the amount of damages assessed for the building was slightly greater than that estimated in its original adjustment.[27]

Covington and its adjuster moved for summary judgment based on the appraisal award, but Mainali argued that because the appraisal award did not include separate amounts for fuel and gas pumps, canopy and awnings, or code upgrades, the award was not complete. Mainali further argued that the post-award claim represented a failure to promptly pay under Texas law, and was therefore subject to statutory penalty interest. The district court disagreed and granted summary judgment for the defendants.[28]

On appeal the issues were the same: the completeness of the appraisal award, and whether the post-award payment represented a violation of Texas prompt payment rules. On the first issue, the court began by reciting a litany of cases for the proposition that, as a general rule, a contract claim will not lie where an insurer promptly paid a duly determined appraisal award. This is a rule that admits of only three exceptions: (1) awards made without authority; (2) awards resulting from fraud, accident, or mistake; or (3) awards not in compliance with the terms of the policy. The court considered Mainali's challenge to the completeness of the award as a challenge under exception (3).[29]

Unfortunately for Mainali, the Fifth Circuit found this challenge easy to resolve. Mainali's assertion that the appraisal did not include compensation for certain items was just that: an assertion. The appraisal itself indicated that it compensated Mainali for all fire losses, and it was Mainali's burden to provide evidence showing that these items were not covered by the award. Since Mainali did not, the Fifth Circuit would not reverse on that point.[30]

The more interesting question was Mainali's assertion that, by paying additional compensation *after* the appraisal award, Covington had essentially admitted that it was supposed to have paid that amount at the outset, and thus did not promptly pay Mainali as required by the Insurance Code. This is a question that was addressed by the Northern District of Texas in *Graber v. State Farm Lloyds*, No. 3:13-CV-2671-B, 2015 WL 3755030, at *8-10 (N.D. Tex. June 15, 2015), where the Northern District decided that timely payment of an appraisal award could result in prompt payment penalties if the result is that the timeline in the statute is not met, even if a reasonable pre-appraisal payment had been made. As the Fifth Circuit pointed out, though, there was applicable Texas *state* authority on the point holding precisely the contrary, that prompt payment penalties may *not* be sought from a party who timely pays an appraisal award after a reasonable pre-appraisal payment. *Graber*, the Fifth Circuit held, had failed to follow the central rule of federal courts applying state law: the *Erie* duty to follow state court interpretations of state law.[31]

The Fifth Circuit also refused to analogize Texas courts' rejection of the "good faith" defense to a prompt payment penalty. The court acknowledged that it is not, under Texas law, a defense to a prompt payment claim that the underlying

claim denial was based on the good faith assertion of a reasonable defense. However, that rule applies in situations in which an insurer declines to pay based on a defense, not in a situation in which an insurer makes a reasonable payment, then later supplements that payment after an appraisal award. Because Covington made a reasonable pre-appraisal payment, and because it timely supplemented this award *after* the appraisal award, Covington had not violated the prompt payment statute under Texas state court precedent the Fifth Circuit was bound to follow.[32]

This case should serve to give comfort to insurers that they will not be punished for timely compliance with appraisal processes under Texas prompt pay rules, *provided* insurers make a reasonable pre-appraisal payment.

1 *Cooper Indus., Ltd. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 876 F.3d 119, 122 (5th Cir. 2017).

2 *Id.* at 122-23.

3 *Id.* at 123.

4 *Id.* at 123-24.

5 *Id.* at 124-25.

6 *Id.* at 125.

7 *Id.* at 125-26.

8 *Id.* at 128-29.

9 *Id*. at 129-31.

10 *Id.* at 131.

11 *Id.* at 131-32.

12 *Lyda Swinerton Builders, Inc. v. Oklahoma Sur. Co.*, 877 F.3d 600, 605-06 (5th Cir. 2017).

13 *Id.* at 606-08.

14 *Id.* at 608-09.

15 *Id.* at 609-11.

16 *Id.* at 611.

17 *Id.* at 611-12.

18 *Id.* at 613.

19 *Id.*

20 *Id.* at 613-15.

21 *Id.* at 615.

22 *USAA Tex. Lloyds Co. v. Menchaca*, No. 14–0721, 2017 WL 1311752, *3 (Tex. April 7, 2017), rehearing granted, Dec. 15, 2017.

23 *Id.* at 615-16.

24 *Lyda*, 877 F.3d at 616-18.

25 *Id.* at 618-21.

26 *Mainali Corp. v. Covington Specialty Ins. Co.*, 872 F.3d 255, 257 (5th Cir. 2017), *as revised* (Sept. 27, 2017).

27 *Id.*

28 *Id.* at 257-58.

29 *Id.* at 258.

30 *Id.* at 258-59.

31 *Id.* at 259 (disagreeing with *Graber*, 2015 WL 3755030, at *8-10, and pointing out that *Graber* should have followed *Breshears v. State Farm Lloyds*, 155 S.W.3d 340, 345 (Tex. App.—Corpus Christi 2004, pet. denied) among other cases)).

32 *Id.*

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