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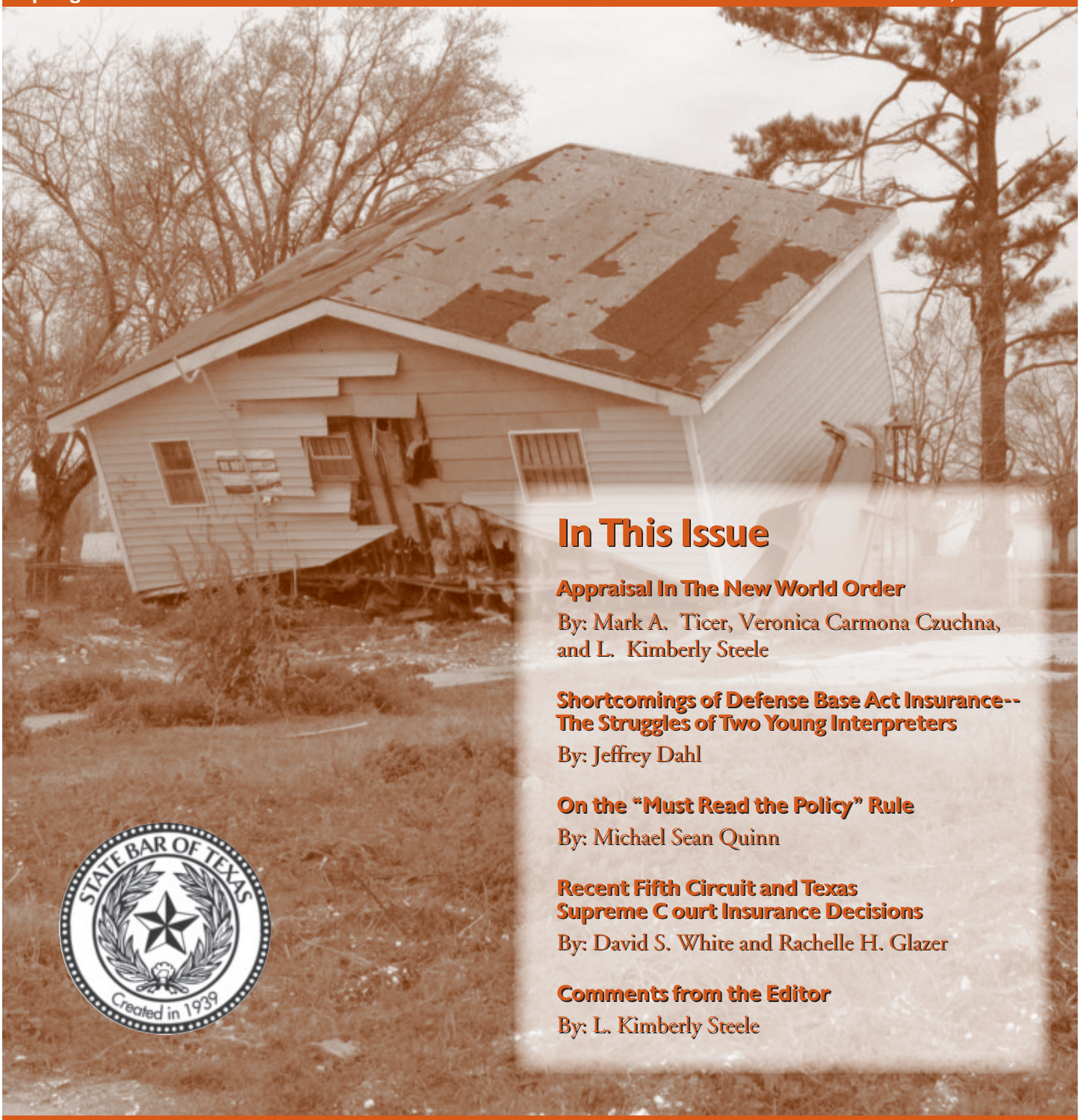

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Anyone interested in submitting a manuscript for publication should contact L. Kimberly Steele, Publications Editor, at 469-227-4639 or by email at kimberly.steele@sedgwicklaw.com. Manuscripts for publication must be typed double-spaced with endnotes (PC-compatible disks are appreciated). Replies to articles published in the ***Journal*** are welcome.

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STATE BAR OF TEXAS
Created in 1939

By Mark A. Ticer, Veronica Carmona Czuchna, and L. Kimberly Steele

APPRAISAL IN THE NEW WORLD ORDER

Property policies, both personal and commercial, typically contain appraisal provisions. Just a few years ago, the law on appraisal seemed relatively settled and uncontestable. Appraisal, when the circumstances were appropriate, was an efficient method to determine the amount of loss under most property policies. It could not be used in every case – if causation, coverage, or liability were at issue, its use was improper. Appraisal was rarely litigated. Between 1888 and 2009, there only were five instances in which the Texas Supreme Court reviewed appraisal. But in 2009, the Texas Supreme Court determined the law on appraisal, although working well, nevertheless needed to be clarified. In *State Farm Lloyds v. Johnson*[1], the Court changed the appraisal landscape. Rather than clarify the use of appraisal in Texas, the *Johnson* decision wreaked havoc on and upset the status quo of a process that seemingly worked well. In the aftermath, the demands for appraisal became automatic which, in turn, has led to an increase in litigation over appraisal, something *Johnson* sought to avoid. This paper will examine the issues, trends, and tactics in appraisal in the post-*Johnson* world.

I. THE HISTORY OF APPRAISAL IN TEXAS

A. Pre-*Johnson*

For well over a century prior to *Johnson,* Texas courts had been rather consistent in their interpretation of appraisal clauses. Appraisal was to be used to provide a simple, speedy, inexpensive, and fair method of determining the amount of loss only.[2] Appraisal is *not* arbitration.[3] If appraisal is properly invoked, carried out, and awarded, the *amount of loss* is binding on the insurer and insured.[4] Appraisal could be waived[5] (or so we thought). Appraisers and umpires were without authority or power in an appraisal to determine "questions of causation, coverage, or liability …."[6]

Every reasonable presumption will be indulged in favor of an appraisal award.[7] However, an appraisal award may be disregarded in three (3) instances: (1) when the award was made without authority; (2) when the award was the result of fraud, accident or mistake; and (3) when the award was not made in substantial compliance with the terms of the contract.[8]

The status of appraisal appeared predictable and settled until the Texas Supreme Court's decision in *Johnson*, followed two years later by *In re Universal Underwriters.*[9] For a more comprehensive overview and history of appraisal before *Johnson*, see "Why You Should Care About Appraisals" by Mark Ticer and "A Primer on Appraisals in Texas" by Mark Ticer. Both articles can be found at www.ticerlawfirm.com/articles.

B. The *Johnson* Decision

1. The Facts.

In April 2003, Becky Ann Johnson's ("Johnson") house was damaged by hail.[10] State Farm Lloyds ("State Farm") inspected Johnson's property, specifically the roof, and concluded that only the ridgeline of Johnson's roof was damaged by hail, a covered peril, and estimating the loss at $499.50 which was less than Johnson's deductible.[11] Johnson requested a second inspection, but State Farm's conclusion remained the same.[12] Johnson did not accept State Farm's determination and contended that the entire roof needed to be replaced, submitting an estimate for $6,400.[13] Johnson hired a lawyer who demanded appraisal, contending the amount of loss necessarily includes the extent of loss or damage.[14]

The appraisal clause in Johnson's policy provided:

SECTION I -- CONDITIONS

***

4. Appraisal. If you and we fail to agree on the *amount of loss*, either one can demand that the amount of the loss be set by appraisal. If either makes a written demand for appraisal, each shall select a competent, disinterested appraiser. Each shall notify

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> the other of the appraiser's identity within 20 days of receipt of the written demand. The two appraisers shall then select a competent, impartial umpire. If the two appraisers are unable to agree upon an umpire within 15 days, you or we can ask a judge of a court of record in the state where the **residence premises** is located to select an umpire**.** The appraisers shall then set the amount of the loss. If the appraisers submit a written report of an agreement to us, the amount agreed upon shall be the amount of the loss. If the appraisers fail to agree within a reasonable time, they shall submit their differences to the umpire. Written agreement signed by any two of these three shall set the amount of the loss. Each appraiser shall be paid by the party selecting that appraiser. Other expenses of the appraisal and the compensation of the umpire shall be paid equally by you and us.

State Farm responded that the dispute was about the extent of hail damage which was a coverage issue therefore, appraisal was not proper or appropriate.[15] Johnson filed a declaratory judgment action to compel appraisal.[16] Ultimately, both parties moved for summary judgment on that issue.[17] The trial court granted State Farm's summary judgment motion and Johnson appealed.[18]

2. The Dallas Court of Appeals.

The Dallas Court of Appeals reversed, finding Johnson was entitled to appraisal and framed the issue this way:

> This case involves the determination of whether the meaning of the term "amount of loss" in an appraisal clause of a homeowner's insurance policy includes the *extent* of loss and whether the insured can compel the insurer to appraisal when there is a dispute about the extent of loss.[19]

Johnson argued that the amount of loss includes a dispute over the extent of the damage.[20] In contrast, State Farm argued that no appraisal can be compelled unless the parties agree on causation, coverage, and liability.[21] Specifically, State Farm took the position that because it only acknowledged coverage on the ridgeline and the remainder of the roof was damaged by an excluded cause – wear and tear – the issue was coverage, not the amount of loss.[22] Therefore, State Farm argued the amount of loss does not include the *extent of loss*, because it would necessarily include determining coverage, causation, and/or liability.[23]

In evaluating both parties' arguments, the Dallas Court of Appeals cited *Wells*[24] which it had decided ten (10) years earlier.[25] *Wells* stood for the proposition that appraisers and umpires do *not* determine coverage.[26] But the Court of Appeals in *Johnson* did hold that under *Wells*, appraisers are to determine the "amount of damage" resulting to the property submitted for their consideration.[27]

According to the Dallas Court of Appeals' analysis, the parties in *Wells* agreed "on the extent of the loss and cost of repairs, but disagreed on whether there was a covered loss at all."[28] According to the Dallas Court of Appeals, the appraisers in *Wells* used appraisal to determine if the loss was caused by a covered peril.[29]

In siding with *Johnson*, the Dallas Court's opinion attempted to distinguish *Wells* from *Johnson* by asserting that the parties in *Johnson* agreed there was a covered loss, but disagreed on the extent of the loss and cost of repairs.[30] The Dallas Court additionally cited *Lundstrom v. United Services Automobile Ass'n*[31] as support for the appropriateness of appraisal in *Johnson* by noting the appraisers in *Lundstrom* had to determine which damages were caused by one water leak covered by a homeowner's policy versus damages occurring at another time, which were not covered.[32] The Dallas Court reasoned that both cases stood for the "narrow proposition that appraisers exceed their authority when they make legal determinations of what is or is not a covered loss based on their determination of what caused the loss or some portion of it."[33] According to the Dallas Court, appraisals which involve "making decisions about the extent of damage" are not precluded by *Wells* or *Lundstrom*.[34] The test for whether appraisal is proper is "if the parties agree there is coverage, but disagree on the extent of damage, the dispute concerns the 'amount of loss' and that issue can be determined in accordance with the appraisal clause."[35]

In very simple terms, the court of appeals in *Johnson* held that the amount of loss *includes* the extent of loss. Therefore, applying the rationale of *Johnson*, if there is damage to an automobile caused by hail on a very small part of the car and other parts are allegedly corroded from rust, a noncovered peril, appraisal would be appropriate to decide the extent of the covered loss. Sound confusing? It is. Under this analysis, where there are concurrent causes of loss, one covered and the other not, appraisers can be called upon to determine causation – something previously prohibited by *Wells* and regardless of how the Dallas Court of Appeals chooses to distinguish *Wells.*

A review of the typical appraisal clause substantiates that the term *extent of loss* is not found. Reading or implying this term into an appraisal clause only confuses the appraiser's task and obligations, and makes it unclear for the insurer and insured to decide when appraisal is proper. Including "extent of loss" into appraisal determinations necessarily translates into how much is damaged and *what caused it*, rather than how much does it cost to repair or replace, which is the stated function of appraisal according to a plain reading of a typical appraisal clause.

Under the Dallas Court of Appeals' *Johnson* opinion, once the parties agree there is *some coverage for a loss*, but disagree how much of the loss is actually covered or what part is covered versus uncovered, the extent of loss can

then be decided by appraisers. If it were only that simple. Obviously, the task of the appraisers in such a situation is to decide *how much of a covered loss exists*; logically, this task would entail an appraiser making a decision on causation – whether the damage was caused by hail as opposed to rust – wear and tear – or both hail and rust – concurrent causation, including perhaps what percentage of each. The actual effect in *Johnson* was to permit appraisers in such cases to decide causation leading to coverage and liability determinations, which is contrary to the plain reading of *Wells.* The ultimate consequence of the Dallas Court of Appeals' opinion in *Johnson* is that an appraisal award where extent of damage is decided is binding on the parties even if causation (covered vs. uncovered) is in play. As a result, decisions regarding causation, and ultimately coverage, could now be decided by appraisal – trial by appraisal through the use of appraisers and in the *Johnson* case – trial by roofer.

State Farm sought review in the Texas Supreme Court, contending that, where issues of causation, and ultimately coverage and liability, are presented and need to be decided, then appraisal is not appropriate.[36]

3. The Texas Supreme Court

The Texas Supreme Court accepted State Farm Lloyds' petition for review to decide whether the dispute between Johnson and State Farm fell within the scope of the appraisal clause.[37] Against most appellate odds (considering that acceptance of review usually translates into reversal and contrary to well-settled law on appraisal), the Court affirmed the Dallas Court of Appeals decision.[38] Implying that its affirmance was a pro-consumer decision, the Court wrote: "… we affirm the court of appeals' judgment *in favor of the insured*."[39] Emphasis added. There were no dissents. The Texas Supreme Court's affirmance of *Johnson* can hardly be termed a pro-policyholder decision. Neither policyholders nor insurers are winners under *Johnson,* only the certainty of satellite litigation and the mucking up of what once was an understandable, simple, and efficient process for some property claims.

The Court at the outset noted it had infrequently written about appraisal.[40] From that fact, the Court then concluded that appraisal was working well and, therefore, should not be limited.[41] (If it was working well, one must ask the question then why change well-settled principles. Like the old adage – "We are here from the government, and we are here to help you" – this decision has only complicated matters instead of simplifying a process that was to be prompt and efficient.)

The Court initiated its opinion by attempting to trace the history of appraisal clauses.[42] The Court recognized that appraisal clauses are enforceable and used to determine *the amount of loss for a covered claim.*[43] But the Court pointed out it had not addressed the scope of appraisal, more particularly the meaning of "amount of loss."[44] The Court acknowledged that appraisal clauses instruct the appraisers to decide the "amount of loss," not policy construction or whether the claim should be paid.[45] Despite these observations, the Court then embarked on a mission of expanding appraisal employing problematic reasoning which has resulted in appraisal being used to decide, at least implicitly, coverage, causation and/or liability.

In evaluating State Farm's appeal, the Court wrote that the Texas courts *have split on the question of whether appraisers can decide causation.*[46] In making this statement, the Court in a footnote cited *one case* allegedly supporting appraisers determining causation and four (4) cases that prohibit it.[47] The Court's footnote was confusing, as it failed to discuss its implicit approval of *Wells* (rejecting the use of appraisers to decide coverage, causation, and/or liability) almost fourteen years earlier when it denied review of the Dallas Court of Appeals' *Wells* decision. *Wells* expressly prohibited an appraiser from deciding causation, as well as coverage and liability.[48] Stating a split of authority existed on whether appraisers can decide causation was misleading at best given other courts heavy reliance on *Wells*.

The Court acknowledged that appraisal clauses instruct the appraisers to decide the "amount of loss," not policy construction or whether the claim should be paid.[45] Despite these observations, the Court then embarked on a mission of expanding appraisal employing problematic reasoning which has resulted in appraisal being used to decide, at least implicitly, coverage, causation and/or liability.

The Court decided that the facts in *Johnson on the record presented to it* did not prove that the dispute was about causation.[49] The Court reasoned that, because State Farm acknowledged some shingles were damaged by hail, a covered peril, the dispute concerned the number of shingles damaged – "A dispute about how many shingles were damaged and needed replacing is surely a question for the appraisers."[50]

To support this conclusion, the Court asserted that the cost of replacing shingles "is a function of both *price* and *number*.…"[51] (emphasis in the original). The Court wrote that which shingles need replacing is a dispute for appraisal.[52] To the extent the parties disagree which shingles need replacing, that dispute would fall within the scope of appraisal.[53] (See a problem here?) According to the Court, nothing in the summary judgment record revealed that the shingles were damaged by anything but hail.[54] Because there was no contrary evidence in the record about covered versus uncovered causes (according to the Court), the trial court could not deny appraisal as a matter of law simply because State Farm contended the dispute was about causation.[55] Additionally, the summary judgment record did not show the dispute was *solely* about how much of Johnson's roof

was damaged.[56] *B*ecause this was a summary judgment proceeding, the trial court erred when it decided the dispute was about causation.[57]

In writing for the Court, Justice Brister wrote, "Even if the parties' dispute involves causation, that does not prove whether it is a question of liability or damages."[58] Reasoning further, the Court determined that causation relates to both liability and damages because it is the connection between them."[59] To justify this contention, the Court referred to the *Texas Pattern Jury Charge* which placed causation in both liability and damage categories.[60] Abstractively, the Court wrote that causation could fall equally into both categories – liability and damages.[61]

To arrive at the conclusion that causation was a proper part of appraisal, the Court cited *Wells* and *Lundstrom*, *Wells* where the appraisers determined damages based on two causes, one covered peril versus another uncovered peril, and *Lundstrom* where appraisers allegedly did the same thing.[62] The Court held that both decisions were correct because courts determine coverage and appraisers decide the amount of damage caused by each peril.[63] According to the Court, this principle is also applicable in evaluating a loss due to a covered event versus a preexisting condition.[64] *T*o hold otherwise would mean that appraisers could never evaluate hail damage unless the roof was brand new, making an appraisal clause invalid or meaningless, a construction which the Court must avoid.[65] To property insurance practitioners, the Texas Supreme Court's reasoning was a departure from precedent and signaled that appraisal was proper in almost every first party property damage claim.

The Court further stated that appraisers "must always consider causation, at least as an initial matter. An appraisal is for damages caused by a specific occurrence, not every repair a home might need."[66] Justice Brister then wrote that appraisal necessarily must include some causation because the appraisers have to decide damages where coverage is claimed versus damages to other property caused by something else. This holding has made appraisal a one size fits all solution for first party property claims.

Attempting to provide some comfort, the Court held that State Farm did not have to pay for wear and tear or other excluded perils.[67] If the appraisers go beyond damage questions, then the award may be avoided, but the mere existence of a causation question is not enough.[68] In making this statement, the Court did not distinguish between the application of this statement versus permitting appraisers to determine causation regarding "extent of loss."

The Court went even further and announced that even if appraisal does involve liability questions, it should not be prohibited initially.[69] In making this statement, the Court provided four (4) reasons.[70] First, appraisals that have yet to occur involve conditions precedent and allowing litigation pre-appraisal would encourage more litigation, thereby defeating the purpose of appraisal.[71] Second, appraisals that have yet to occur can be structured to avoid liability questions; even if the insurer denies coverage, there is no harm in an appraiser setting the amount of loss.[72] Third, the lack of precedent on scope of appraisal suggests that appraisal generally resolves such disputes.[73] Fourth, a flawed appraisal can be disregarded.[74] Based on this reasoning, the Court held that appraisal should occur pre-litigation, without involvement of the legal process and without "preemptive intervention by the Courts."[75] These reasons defy the reality of what results from a flawed appraisal.

Johnson's broad language does a disservice to insurers and insureds. Instead of limiting the reasoning in *Johnson* to the facts in the summary judgment record, the Texas Supreme Court went far beyond the facts to permit futile exercises which needlessly complicate and increase the cost of a claim and ultimately litigation. The Court's opinion seems to require the insurer and insured to go to the effort and expense of an appraisal merely because every claim involves a dispute about the amount of loss and there is no real harm in doing so.

State Farm's petition for rehearing was denied. In its *Motion for Rehearing*, State Farm tried to draw the Court's attention to the fact that its decision confused more than helped, created needless and wasted efforts, increased the costs to all parties to an appraisal, complicated litigation, and that its reasoning was tantamount to re-writing the policy. Based on prior decisions and practical application, State Farm's arguments were meritorious, but rehearing was denied.

II. THE UNANSWERED QUESTIONS FROM *JOHNSON*

The Texas Supreme Court decision in *Johnson* left several unanswered questions and raised a host of others. For example, by allowing the appraisal to determine extent of loss or causation, has the Court created a way for an insured to avoid its burden of proof when concurrent causation issues exist? Similarly, can it provide a means for the insurer to avoid its burden of proving the application of an exclusion? What about the competence of the umpire and appraiser? Certainly competence must be a consideration, otherwise the use of the term "competent" in an appraisal clause would be rendered meaningless, a result that the courts reject in interpreting insurance policies, i.e. contracts. In light of the fact that appraisal can determine causation, does the competence requirement mean that the appraiser and umpire must satisfy *Robinson* or *Daubert* criteria? What does impartial in an appraisal clause mean? Surely, the competence and impartiality of appraisers and umpires can be raised but when one should do so remains unclear; much of the reported litigation indicates that it occurs with frequency post-appraisal.

Johnson cast serious doubt on the possibility of litigating appraisal prior to completion of the appraisal. As the Court noted:

> But in every property damage claim, someone must determine the "amount of loss," as that is what the insurer must pay. An appraisal clause binds the parties to have the extent or amount of the loss determined in a particular way. Like any other contractual provision, appraisal clauses should be enforced. There may be a few times when appraisal is so expensive and coverage is so unlikely that it is worth considering beforehand whether an appraisal is truly necessary. But unless the "amount of loss" will never be needed…appraisals should generally go forward without preemptive intervention by the courts.[76]

So, how does a party, prior to appraisal, persuade a court that appraisal is so expensive and coverage so unlikely that appraisal is not necessary or appropriate? Is a party objecting to appraisal, particularly those with limited resources, required to first incur the costs of appraisal before asserting a challenge?

Furthermore, case law demonstrates that undoing the appraisal puts a tremendous burden on the party seeking to set it aside. The unsophisticated and unrepresented insured may become aware of the binding results of an appraisal too late. As State Farm stated in *Johnson* – it forces the losing party to "unring the bell." Because appraisal will be viewed as presumptively a legitimate process, courts will be swayed to enforce the award no matter how the results are obtained or how unjust.

The *Johnson* decision is neither pro-consumer nor pro-insurer. *Johnson* seems contrary to the Supreme Court's willingness to uncomplicate trials and keep litigation costs down. While appraisal may simplify the trial process in theory, the Supreme Court's tinkering with the scope of appraisal in fact does the opposite. The standard to undo an appraisal is hardly simple or easy to satisfy. The parties to appraisal will bear the costs of appraisal for their own appraiser and likely one-half the cost of an umpire. The parties may then need to assume the additional burden and expense of litigating the competence and/or bias of an appraiser or umpire, that appraisers or the umpire exceeded their authority, or that liability and/or coverage was decided. This will undoubtedly require depositions, the hiring of other experts, and of course, attorney's fees, not to mention time which is the enemy of prompt and efficient. The Court has complicated a rather simple process.

Appraisal was not meant to be used in every first party property case. It was designed to be employed in circumstances such as grandmother's antique diamond ring being stolen, an event covered by a typical property policy. There is *no controversy* as to what extent the ring is covered. Appraisal properly framed is that the insured says the ring is worth $5,000 while the insurer argues the value is $1,000. Appraisal would certainly be proper and an efficient means of resolving the issue of damages, the value of grandmother's stolen antique diamond ring. In contrast though, where there are multiple causes of a loss, some covered and others not, an appraisal which includes appraisers and umpires undertaking causation, implicitly or expressly, whether stated in the award or not, when evaluating the amount of loss confuses the parties, the court, what is to be tried, and the binding effect of the award.

With regard to assessing hail damage versus excluded wear and tear, the *Johnson* court said: "If State Farm is correct that appraisers can never allocate damages between covered and excluded perils, then appraisals can never assess hail damage unless a roof is brand new."[77] But the court went on to say that "[t]his of course does not mean that appraisers can rewrite the policy. No matter what the appraisers say, State Farm does not have to pay for repairs due to wear and tear or any other excluded peril because those perils are excluded."[78] These confusing and contradictory statements demonstrate the material challenges caused by the Court's opinion in *Johnson* which do the opposite of providing a prompt and efficient method of determining the amount of loss.

Texas law is clear about the burdens imposed upon the parties where there are covered and uncovered causes of loss. Under Texas law, the insured only is entitled to recover under the policy for covered events, and it bears the burden of segregating the damage attributable solely to the covered peril.[79] A failure to present evidence of damages from a covered peril with some degree of reliability and precision, or to provide a basis upon which to determine the extent of damage caused by the covered peril, is fatal to the insured's claim.[80] Thus, in a hurricane claim involving wind and water damage, it is the insured's burden to segregate the damages caused by wind, and in a hail claim, it is the insured's burden to segregate which of the damages was caused by hail as opposed to wear and tear or some other event. If the appraiser does not segregate the damages, or if the umpire does not require the appraiser for the insured to segregate the damages attributable solely to the covered peril, the insured will be relieved of its burden of satisfying the concurrent causation doctrine. Or, if the umpire simply declines to segregate covered and uncovered damages, or dismisses the issue by claiming that he only took into consideration the covered damages without any real attempt at segregation, the concurrent causation doctrine will have been circumvented under the guise of appraisal.

Equally significant, the issue of competence has not been litigated with any reported decisions. Common sense would seem to indicate that an appraiser may well have to satisfy the *Robinson* criteria to make his findings valid.[81] Causation in property damage claims is not something that necessarily

is within the general experience and common sense of a lay person. A competency argument is especially compelling when concurrent causation issues exist. Given the substantial number of losses involving multiple perils (hail versus wear and tear and wind versus water), the competency of the appraiser cannot be considered insignificant. Invariably, segregation between covered and uncovered perils – satisfaction of the concurrent causation doctrine – requires expertise in damage assessment and repair, something that the Court has remained silent about.

III. WAIVER AND THE EFFECT OF *IN RE UNIVERSAL UNDERWRITERS* ON LITIGATION STRATEGY POST-*JOHNSON*

Some insureds who did not like *Johnson* changed their strategy to avoid appraisal by asserting waiver. The insured's strategy was to file suit, and, in response to the insurer's attempt to invoke appraisal, argue that the insurer had waived its right to invoke appraisal by waiting until after suit was filed. The insured often was successful in maintaining waiver. Even when the insured was unsuccessful, it could often persuade a court that waiver was a fact issue for discovery, sidetracking the litigation on the merits with costly discovery on the waiver issue. This strategy was dealt a near-fatal blow by the Supreme Court of Texas in *In re Universal Underwriters*[82].

The facts in *Universal Underwriters* were not complicated. Universal insured Grubbs Infiniti.[83] Grubbs' buildings suffered hail damage.[84] Universal paid Grubbs $4,081.95 for the loss.[85] Grubbs was dissatisfied with the amount and asked Universal to reevaluate.[86] Universal responded by sending an engineer to reinspect; the engineer found $3,000.00 in damages and Universal paid this amount.[87] Universal sent the $3,000.00 payment with a letter advising Grubbs that the insurer would hold open its file for another fifteen (15) days.[88] Furthermore, Universal reminded Grubbs that it had two years and one day to file suit pursuant to Grubbs' insurance policy with Universal.[89]

Four months after receiving the $3,000.00 payment, Grubbs sued Universal. In response, Universal invoked the appraisal clause.[90] Universal filed a motion to compel appraisal which the trial court denied.[91] Universal then sought mandamus relief in the Court of Appeals, which also was denied.[92] Universal then sought mandamus relief in the Texas Supreme Court. In granting relief to Universal, Chief Justice Jefferson, writing for the Court, began by discussing previous high court decisions on waiver of appraisal, noting that, of three cases addressing the issue, only one of the three decisions found waiver.[93] That one case, *Brock*, dealt with waiver due to an insurer's selection of a biased appraiser in violation of the insurance policy.[94]

Chief Justice Jefferson noted that the eight-month delay between the last payment and Universal's letter to Grubbs, and Universal's demand for appraisal, was not determinative of waiver.[95] According to the Court, decisions involving 39, 58, or 72 day delays before requesting appraisal were not decided on the lengths of delay but "rather on the parties' conduct, as indications of waiver."[96] The Court noted that "waiver requires intent, either the intentional relinquishment of a known right or intentional conduct inconsistent with claiming that right."[97] The Court held that time periods alone are not determinative of waiver, only a factor.[98]

The Court announced a new two-part test for determining whether appraisal has been waived. First, any delay for purposes of waiver must be measured from the point of "impasse."[99] "Impasse" is defined as when both sides realize that further negotiations would be futile or have no further effect.[100] Thus, "once the parties have reached an impasse – that is, a neutral understanding that neither will negotiate further – appraisal must be invoked within a reasonable time."[101] Because Universal invoked appraisal one (1) month after Grubbs sued, Universal demanded appraisal within a reasonable time.[102]

The second part of the test announced in *Universal Underwriters* was a prejudice requirement: a party must show that it has been prejudiced to avoid appraisal based on waiver.[103] The Court stated that, "it is difficult to see how prejudice could ever be shown when the policy . . . gives both sides the same opportunity to demand appraisal."[104] The Court announced a prong to the waiver test that it recognized no party could likely satisfy.

To summarize, to establish waiver of the appraisal clause, a party must show an actual impasse existed and an unreasonable period of time passed following the actual impasse. And even if an impasse is shown, the proponent of waiver must demonstrate prejudice, something the Court doubted could ever be shown.

The Beaumont court of appeals recently rejected an insured's argument that *In re Universal Underwriters*' requirement of prejudice was dicta. The insurer in *In re Cypress Texas Lloyds* sought mandamus to compel the trial court to abate the pending lawsuit and order appraisal.[105] After the suit was filed and answered, a considerable amount of time had elapsed.[106] The trial court considered "the lapse of time, the significant procedural and substantive matters developed for litigation" and concluded "it is clear that the parties have incurred significant legal expenses which would, undoubtedly, damage their financial position" and that the waiver employed a "deliberate strategy" to refrain from appraisal.[107] The trial court denied the motion to compel appraisal because the insurer had waived appraisal.[108] The insurer sought mandamus relief.[109] In response to insurer's mandamus plea, the insurer urged that *In re Universal's* requirement that the party resisting appraisal show prejudice was dicta, and the Supreme Court did not intend to set an impossible test for waiver.[110]

Although the court of appeals noted that the "record supports a conclusion that Cypress employed a deliberate strategy to not obtain an appraisal and that the Newmans incurred some costs before Cypress filed a motion to compel," it concluded that it was not free to ignore the Texas Supreme Court's statement of law, regardless of whether it was pivotal to the opinion.[111] In granting the insurer relief, the court of appeals stated that the insured could have avoided the litigation costs by requesting appraisal itself, particularly after the insurer answered the suit and pleaded appraisal as a condition precedent.[112]

The extremism of the Supreme Court's philosophy on appraisal and the imprint of *Universal Underwriters* is recently demonstrated by the Beaumont Court of Appeals' decision of *In Re GuideOne Mutual Insurance Company*.[113] The facts are straightforward: after several years of litigation and two (2) months before the trial setting, GuideOne invoked the appraisal clause.[114] The trial court denied GuideOne's request finding an impasse existed as of December 13, 2007 and appraisal was demanded in May 2012. The Beaumont Court of Appeals nevertheless stated impasse was not evident because the parties mediated in October 2011 and, at the time appraisal was requested, there was no trial date.[115] Thus, an impasse was not established.

Moreover, with regard to the policyholder's prejudice argument, the insured demonstrated over $110,000 in expenses; yet, the appellate court ruled this was not prejudice because the insured did not show such expenses would not have been incurred in the absence of appraisal.[116] Finally, the Court of Appeals held to deprive the insurer of appraisal would preclude the insurer's defense of the policyholder's prompt pay claim.[117]

The Beaumont Court of Appeals granted GuideOne mandamus relief, ordering appraisal but leaving the time and effect of appraisal to the trial court.[118] This decision represents appraisal out of control and directly contradicts the purposes of appraisal – that is a prompt, efficient, and inexpensive method to determine the amount of loss. *In Re GuideOne* turns appraisal upside down to the detriment of insurers and insureds.

IV. LITIGATED APPRAISAL ISSUES

Undoing an appraisal award is at best problematic. Every reasonable presumption will be indulged in favor of an appraisal award.[119] Nevertheless, an appraisal award may be disregarded in three instances: (1) when the award was made without authority; (2) when the award was the result of fraud, accident, or mistake; and/or (3) when the award was not made in substantial compliance with the terms of the contract.[120] In attacking or attempting to set aside the appraisal award, the insured and insurer must tailor their arguments to demonstrate an entitlement to relief.

A. Is Competence of Appraiser/Umpire Required?

As previously discussed, the Texas Supreme Court in *Johnson* held that appraisers must consider causation when assessing damage: "Any appraisal necessarily includes some causation element, because setting the 'amount of loss' requires appraisers to decide between damages for which coverage is claimed from damages caused by everything else."[121] Likewise, the duty of the *umpire* is to "ascertain and determine, in the exercise of his own judgment and as a result of his own investigation, the cost values of the disputed items, independent of the findings of the appraisers, or either of them."[122] It follows, logically, that the umpire - whom the court in *Providence Lloyds* called "a third appraiser" - must consider causation when determining the value of a loss. [123]

When a specific cause issue is not within the general experience and common sense of a lay person, expert testimony is required to establish causation.[124] Even when a theory of causation of property damage is posited by an "experienced engineer," courts have disregarded those causation theories when, under the standards set forth in *Daubert* and *Robinson*, those theories amount to nothing more than "subjective belief and unsupported speculation."[125] Absent special knowledge "as to the very matter on which he proposes to give an opinion," a witness is not qualified to proffer causation testimony.[126] General experience in a specialized field does not qualify a witness as an expert on issues of causation.[127]

The factors in *Daubert* have been extended beyond "scientific" causation to a number of matters involving "technical" and "other specialized" knowledge.[128] The Texas Supreme Court has stated that "[j]ust as not every physician is qualified to testify as an expert in every medical malpractice case, not every mechanical engineer is qualified to testify as an expert in every products liability case."[129] It would seem to follow that the *Robinson/Daubert* factors should be extended to a determination of causation in a property damage claim.

Considering these same principles in a Memorandum Order issued in response to the insured's Motion to Appoint Umpire in *Glenbrook Patiohome Owners Association v. Lexington Ins. Co.*, Judge Lee Rosenthal noted that an umpire "must combine competence in evaluating conflicting disputed evidence with expertise and experience in assuring a fair process."[130] Judge Rosenthal emphasized the importance of the umpire's subject matter expertise and experience, stating that such expertise was as important as fairness of the appraisal process.[131] The dearth of other reported decisions on this requirement suggests this could be a fertile ground to challenge an appraisal award or perhaps a preappraisal attack on the appraisal process.

B. Is Bias/Impartiality of Appraiser and/or Umpire to be Considered?

Texas law has held in *Delaware Underwriters* that appraisers

and umpires be competent and disinterested:

> The purpose of the [appraisal] clause is to secure a fair and impartial tribunal to settle the differences submitted to them. In their selection it is not contemplated that they shall represent either party to the controversy or be a partisan in the cause of either, nor is an appraiser expected to sustain the views or to further the interest of the party who may have named him. And this is true, not only with respect to estimating the amount of the loss, but also with reference to the selection of an umpire. They are to act in a quasi judicial capacity and as a court selected by the parties free from all partiality and bias in favor of either party, so as to do equal justice between them. This tribunal, having been selected to act instead of the court and in place of the court, must, like a court, be impartial and nonpartisan.[132]

Following *Delaware Underwriters*, the court in *Pennsylvania Fire Ins. Co. v. W.T. Waggoner Estate*, stated that the term "disinterested" does not mean simply lack of pecuniary interest, but also "not biased or prejudiced."[133] The court in *W. T. Waggoner* affirmed the judgment of the trial court, in which the appraiser and umpire were found to be biased.[134]

It follows that an appraiser who has a financial interest in an appraisal award is not impartial.[135] In *General Star,* the insurer challenged an appraisal that resulted in an award from the insured's appraiser and umpire.[136] The insured in *General Star* agreed to pay its appraiser a 5% contingency of the gross settlement amount.[137] The Houston Court of Appeals reversed the summary judgment granted to the insured on the binding nature of appraisal because the insured's appraiser had a financial/pecuniary interest in assessing the amount of loss and his impartiality could reasonably be questioned.[138]

In *Holt v. State Farm Lloyds*, the insured challenged the impartiality of State Farm's appraiser - Tim Marshall from Haag Engineering.[139] At issue was whether Marshall, who derived approximately one-quarter of his income from State Farm appraisal work, was impartial.[140] The federal court declined to grant summary judgment on the binding nature of appraisal, finding a fact issue on Marshall's impartiality.[141]

In contrast, courts have rejected impartiality challenges where the appraiser's employer, rather than the appraiser individually, was accused of being partial.[142] And even where the insurer's chosen appraiser who had previously rendered an opinion on the cause of the loss before being selected an appraiser did not invalidate an appraisal award on the basis of bias the appraiser.[143]

In *MLCSV10 v. Stateside Enterprises, Inc. v. Hartford Steam Boiler Inspection and Ins. Co.,*[144] the insureds filed suit against several insurers for breach of contract and various extra-contractual causes of action in connection with claims arising out of Hurricane Ike.[145] Prior to filing suit, the insureds invoked the appraisal clause, but the appraisal award was not issued until after suit was filed.[146] The insurers tendered payment of the appraisal award, and then sought summary judgment in the lawsuit.[147] In response, the insureds argued that there were material fact issues as to whether the award was valid or should be disregarded and set aside because the insurer's appraiser and the umpire "failed to disclose a referral relationship between each other's companies, thereby implicating the impartiality of the tribunal and violating the terms of the policy's appraisal provision."[148] The insureds also contended that the umpire and appraiser's failure to disclose this relationship to the insureds' appraiser created "an appearance of partiality" that provides a sufficient basis under Texas law for disregarding the award.[149]

Citing *Franco v. Slavonic Mut. Fire Ins. Ass'n,*[150] the court noted that "[t]he showing of a pre-existing relationship, without more, does not support a finding of bias."[151] The court found no evidence that the umpire referred clients to the insurer's appraiser, that the insurer influenced or exercised control over the umpire or appraiser during the appraisal, that the umpire or appraiser had a financial interest in the outcome of the appraisal, or that the umpire was more likely to side with the insurer's appraiser than with the insured's appraiser because of the preexisting business relationship between the two companies.[152] On this record, the court found that the insureds could not defeat summary judgment simply by arguing that the umpire and appraiser were biased against them. The court also found no basis for setting aside the award based on a failure to disclose a pre-existing relationship. According to the court, "Texas courts require more than an appraiser's failure to disclose a preexisting business relationship between the appraisers' companies to disregard an appraisal award. Texas courts require "evidence that the [challenged] appraiser performed 'some act or conduct tending to exhibit his serving the [insurer's] interest as a partisan would.' "[153]

To summarize, in order to demonstrate bias the challenging party must attack a specific individual, not an entity, company, or firm. Generalities will not work; the challenging party must identify specific act(s) by the appraiser/umpire that will call into question the appraiser/umpire's impartiality.

C. Selection of the Umpire

1. Were Appraisers at an Impasse?

In Texas, an appraisal award is binding if it is made in compliance with the provisions of an insurance contract.[154] Texas courts have recognized that an appraisal award may be disregarded "when the award was not made in substantial compliance with the terms of the contract."[155]

A typical appraisal provision in a property insurance policy will provide that, "[t]he two appraisers will select an umpire," and "[i]f they cannot agree within 15 days upon such umpire, either may request that selection be made by a judge of a court having jurisdiction." In other words, either appraiser can seek appointment of an umpire if they are at an impasse in their selection of a mutually agreeable umpire. Note that the typical language states that either "appraiser" can seek appointment of the umpire. Increasingly, one or the other party, or its lawyer, may seek appointment of the umpire. This begs the question whether or not an application to the court for appointment of an umpire by the insured or the insurer, or by counsel for either, complies with the policy's appraisal provision. Consider the role of the appraiser (and presumably umpires) and the quasi-judicial capacity in which the appraiser serves: "The policy by its terms required that the insured and insurer select competent and disinterested appraisers. They constitute a quasi court and should be free from partiality and bias in favor of either party."[156] The appraiser is not a representative of either party. It stands to reason, therefore, that an application to a court by either the insured or the insurer, or by counsel for either, is not contemplated nor authorized by the policy.

With regard to whether or not the two appraisers are at an impasse, *In re Universal Underwriters* provides guidance as to the meaning of an impasse – "when both sides realize that further negotiations would be futile or have no further effect….the parties have reached…a neutral understanding that neither will negotiate further."[157] If the appraisers have not yet reached the point that both realize that further negotiations will be futile or that there will be no further negotiations, then an attempt to seek court appointment of an umpire arguably does not substantially comply with the policy's appraisal clause. The party resisting appraisal – whether in response to a motion to compel appraisal, in an effort to set aside an order appointing an umpire, or in post-appraisal litigation attacking the appraisal – could argue that the policy's appraisal provision was not complied with when the umpire appointment was sought. When it has been established that the appraisers had not reached an impasse, some parties resisting the umpire appointment have successfully persuaded trial courts to set aside umpire appointments on the basis that the court lacked jurisdiction to enter the order.

Realizing that the umpire appointment may have been premature because of the lack of an impasse, some appraisers have attempted to bait the other appraiser, after the appointment of the umpire, into agreeing that they were never going to agree on the selection of an umpire. Some savvy appraisers appear to recognize, and refuse to fall victim to, the trap. The unwary appraiser, however, may take the bait without understanding the consequences.

2. Do Principles of Fairness and/or Due Process Require Notice when Appointing an Umpire?

Appraisal clauses do not typically specify whether the appraiser seeking appointment of an umpire must give prior notice to the other appraiser and/or allow the other appraiser to have some input into the process, and no reported case law exists in Texas on this issue. Some insurers and policyholders interpret the absence of any such language as an invitation to proceed *ex parte* without any notice to the other side or the opportunity for the other appraiser to have some input with the court prior to its appointment of the umpire. Obviously, principles of fairness and due process would seemingly dictate that there be prior notice. Moreover, to find otherwise would serve to encourage or invite abuse. An appraiser (or worse yet, the party that appointed the appraiser) could feign cooperation and exchange names of proposed umpires, all the while never intending to agree to any proposed umpire from the other appraiser, and then seek to have one of its preferred umpire candidates appointed by the court. By imposing a prior notice requirement and allowing the other appraiser an opportunity to have some input with the court on the umpire appointment, courts would help to preserve the integrity of the process and minimize a basis to challenge the appraisal award.

D. Appraisal/Umpire Exceeded Authority

If the appraiser or umpire attempts to determine liability, whether by making coverage interpretations or determinations about what the insured is entitled to recover or the insurer is obligated to pay under the policy, then the appraiser/umpire may have exceeded his authority and the award should be set aside. While the Supreme Court's *Johnson* decision may have confused the tasks of appraiser and umpire, the Supreme Court's opinion in *Scottish Union* stated:

> If the stipulation [consent to appraisal] was to deny or repudiate the jurisdiction of the courts to determine the rights and liability of the parties arising upon the contract, we would hold, with the weight of authority, such stipulation void. But here the stipulation does not divest the courts of jurisdiction, but only binds the parties to have the extent or amount of the loss determined in a particular way, *leaving the question of liability for such loss to be determined, if necessary, by the courts*.[158]

Scottish Union was subsequently cited favorably by the Dallas Court of Appeals in *Wells*:[159]

> The parties agree that no reported Texas case has decided the issue of whether the authority of appraisers under the appraisal section of an insurance policy is limited to determination of only the *amount* of loss as distinguished from

> determining *cause* of loss, and *coverage* and *liability* for the loss. We conclude, however, that the weight of authority from other jurisdictions discussing the issue follows the rule that appraisers have no power or authority to determine questions of causation, coverage, or liability, which is consistent with the Texas courts' discussion of the effect of the appraisal award.[160]

To recap, in *Wells,* the appraisers were called upon to determine the damages due to foundation movement of a home.[161] The appraisers and umpire arrived at a figure of $22,875.94.[162] However, the insurer's appraiser and umpire determined that the damage related to the plumbing leak was zero.[163] The trial court granted summary judgment in favor of the insurer, denying the Plaintiffs' claim.[164] The plaintiffs appealed and the Dallas Court of Appeals determined that appraisal was limited to determining the "amount of money involved in the controversy" and not to be used to determine liability, causation, or coverage.[165] *Wells* makes it clear that appraisal is improperly used and has no binding effect if causation, coverage, or liability is decided by the appraisers and/or umpire.

Johnson, as previously noted, makes the *Wells* holding unclear. The Texas Supreme Court in *Johnson* explicitly stated that "limiting appraisal to damages and not liability is surely still correct."[166] The Court in *Johnson* specifically noted that the purpose of appraisal is to determine amount of loss, and not "to construe the policy or decide whether the insurer should pay."[167] *Johnson* fully embraced the *Scottish Union* decision when it noted that "the scarcity of suits on the subject suggests the 1888 test is still adequate: the scope of appraisal is damages, not liability."[168] Still, an asterisk needs to be attached to *Wells*, as *Johnson* provides that determining "extent of law" includes coverage – at least in part.

In *MLCSV10*[169], District Judge Lee Rosenthal considered whether there was evidence that the appraisal award was made without authority.[170] There, the insured argued that the appraisal panel exceeded its authority by deciding issues of coverage and causation reserved for the courts.[171] The underlying claim involved commercial property damage resulting from Hurricane Ike and vandalism.[172] As part of its claim, the insured included damaged ductwork, and its appraiser included estimates for replacing the ductwork.[173] The insurer's appraiser and the umpire did not inspect the ductwork because they concluded that neither the hurricane nor vandalism could have damaged it.[174]

Judge Rosenthal concluded that the record evidence supported a finding either that the appraisal award was incomplete because it did not include any inspection of the ductwork, or that the umpire and insurer's appraiser impermissibly found no coverage by finding no covered event caused the ductwork damage.[175] Judge Rosenthal ruled that, to the extent the appraisal award implicitly determined that the ductwork was not covered under the policy, the insured had provided a sufficient basis for setting aside that part of the appraisal award.[176] The court determined that there was no precedent for setting aside the entire award based on a finding that one part of the award implicitly determined a coverage issue.[177]

E. Fraud, Accident or Mistake as a Basis to Avoid an Appraisal Award

As previously noted, an appraisal award may be set aside if it is the result of fraud, accident or mistake. A court may set aside an award on the ground of mistake [or accident] only "upon a showing that the award does not speak the intention of the appraisers."[178] Evidence of dishonesty about the parts of the property that are damaged by the covered event which results in confusion of the appraisers and umpire may be sufficient to establish that the award was the result of accident or mistake.[179] However, a disagreement between experts or appraisers as to the methodology employed in assessing damage is insufficient to establish mistake.[180]

Cases dealing with fraud and misconduct are virtually nonexistent. Only one case seems to deal with fraud and misconduct.[181] Barnes, the insured, made a claim for hail damage to two roofs on buildings he insured with Western Alliance.[182] Following an appraisal where the appraisers could not agree, Barnes' appraiser and the umpire signed an award for $402,978.08.[183] Western Alliance refused to pay the award and Barnes filed suit.[184] The jury found the appraisal award was due to fraud, accident, or mistake.[185] Barnes appealed.[186]

The Fort Worth Court of Appeals found sufficient evidence of fraud to overturn the appraisal award.[187] Specifically, the Court found Barnes had lied about the claim.[188] Barnes admitted that hail did not cause damage to one roof, but rather Barnes put on a new roof before the hail storm, not because of it.[189] Barnes lied to the insurer about whether hail damage occurred and failed to tell the umpire part of his claim was based on fraud.[190] The Court found that more than sufficient evidence existed to avoid the appraisal award based on fraud.[191]

V. DOES EXTRA-CONTRACTUAL LIABILITY EXIST IN THE APPRAISAL CONTEXT?

Texas courts have long held that a completed appraisal, wherein the insurer has paid and the insured has accepted the payment of the amount of the appraisal award, estops the insured from maintaining a breach of contract claim against the insurer unless the insured proves that the award was unauthorized or the result of fraud, accident or mistake.[192]

Two recent decisions from the Southern District of Texas appear to reach inconsistent conclusions with regard to the issue of whether a carrier who initially disputes the extent of

damage, but later pays an appraisal award, can be liable for extra-contractual damages. In *Mag-Dolphus, Inc. v. Ohio Cas. Ins. Co.*[193], Judge Melinda Harmon granted summary judgment for Ohio Casualty Insurance Company, finding that the insureds' invocation of the appraisal provision in the insurance policy and Ohio Casualty's prompt compliance with the provision and award precluded Plaintiffs' claims as a matter of law.[194]

The plaintiffs in *Mag-Dolphus* submitted a claim to Ohio Casualty for damage to an office building in The Woodlands, Texas as a result of Hurricane Ike.[195] Plaintiffs disagreed with Ohio Casualty's estimate of the covered damages and invoked the policy's appraisal provision.[196] The parties each selected appraisers who submitted separate estimates of the amount of covered loss.[197] The two appraisers did not agree on the amount of the loss and submitted the claim to the umpire.[198] Upon issuance of the final appraisal award, Ohio Casualty promptly forwarded payment to the insured for the amount of the award, minus the previous payment made, depreciation and the deductible.[199] Ohio Casualty subsequently sent Plaintiffs a second notice of payment and a check for $52,759.81 for the recoverable depreciation on the repairs to the building.[200] Several months later, Plaintiffs filed a lawsuit asserting claims for breach of contract, common law and statutory breach of the duty of good faith and fair dealing, fraud, and violations of the Texas prompt payment statute.[201]

Judge Harmon granted Ohio Casualty's motion for summary judgment, ruling that Plaintiffs, having accepted timely payment of the binding and enforceable appraisal award, were estopped from maintaining a breach of contract claim against Ohio Casualty.[202] The court also concluded that the absence of a contractual breach likewise precluded Plaintiffs' extra-contractual claims.[203] Finally, the court found that the plaintiffs failed to meet the burden of proof on their fraud claim because they failed to introduce evidence of a material misrepresentation or reliance on such misrepre-sentation.[204]

In contrast, U.S. District Judge Kenneth Hoyt recently denied a similar summary judgment motion filed by Allstate Texas Lloyds in the face of an appraisal award rendered and paid during the pendency of a bad faith lawsuit filed against it.[205] In *Singletary v. Allstate Texas Lloyd's*, a Houston-area homeowner sued Allstate for breach of contract, breach of the duty of good faith and fair dealing, and Insurance Code violations after Allstate allegedly underpaid his Hurricane Ike claim.[206] Allstate estimated the covered damage to be approximately $15,000, while Plaintiff claimed the covered damages exceeded $290,000.[207] After the insured filed suit, Allstate invoked appraisal under the policy. Despite the insured's objection, an appraisal award was entered and timely paid by Allstate.[208] After tendering payment, Allstate moved for summary judgment on the Plaintiff's claims, arguing that its payment of the binding appraisal award prevented the insured from pursuing its breach of contract claim and also precluded the extra-contractual claims.[209]

Plaintiff argued Allstate waived its right to appraisal by failing to timely invoke it after Plaintiff had submitted its repair estimate prior to suit, and challenged the umpire's award due to alleged errors and omissions of damage categories.[210] Judge Hoyt concluded that conflicting evidence presented by both sides created a genuine fact issue concerning, "*inter alia:* (1) whether Allstate waived its right to invoke the appraisal condition contained in the policy; and (2) whether the appraisal award was incomplete and/or the result of mistake, fraud or accident."[211]

Significant distinctions which might, at least in part, explain the difference between the decisions in *Singletary* and *Mag-Dolphus* include the fact that Allstate waited until after suit was filed to pursue appraisal and there was evidence presented by the insured that certain definitive categories of damage were omitted in the appraisal award. These issues seem to open the door to proof of waiver and a flawed appraisal award due to mistake.

VI. CONCLUSION

Appraisal is intended to be an efficient and inexpensive method to determine damages. But when issues of causation, including concurrent causation, and coverage, are at issue, the efficiency, expense, and usefulness of appraisal must be questioned. The Texas Supreme Court's decision in *Johnson* has indicated appraisal should take place without court intervention and let the results be sorted out later even in the face of causation and coverage – i.e., extent of loss requiring an unhappy participant to unring the bell and go through a process that can be both expensive and doomed from the outset. Perhaps the competence and impartiality of appraisers and/or umpires can be open to challenge pre-appraisal. But given the presumption in favor of the results of appraisal, it causes the "loser" of appraisal to have to undo the results. Even waiver is likely not enough to defeat a demand for appraisal. Instead of being a tool for efficiently resolving claims, appraisal in the post-*Johnson* world has resulted in increased litigation between insureds and their insurers.

1 290 S.W.3d 886 (Tex. 2009).

2 Fire Ass'n v. Ballard, 112 S.W.2d 532, 534 (Tex. Civ. App. – Waco 1938, no writ).

3 In Re Allstate Ins. Co., 85 S.W.3d 193, 195 (Tex. 2002).

4 Scottish Union National Ins. Co. v. Clancy, 71 Tex. 5, 8 S.W. 630, 631 (1888).

5 Ins. Service Co. v. Brodie, 337 S.W.2d 414, 415 (Tex. Civ. App. – Fort Worth 1960, writ ref'd n.r.e.).

6 Wells v. American States Preferred Ins. Co., 919 S.W.2d 679, 684 (Tex. App. – Dallas 1996, writ denied).

7 Hennessey v. Vanguard Ins. Co., 895 S.W.2d 794, 798 (Tex. App. – Amarillo 1995, writ denied).

8 Providence Lloyds v. Crystal City Indep. School Dist., 877 S.W.2d 872, 875 (Tex. App. – San Antonio 1994, no writ); *Hennessey*, 895 S.W.2d at 798.

9 In re Universal Underwriters, 345 S.W.3d 404 (Tex. 2011).

10 Johnson v. State Farm Lloyds, 204 S.W.3d 897, 898 (Tex. App. – Dallas 2006, pet. granted).

11 *Id.*

12 *Id.*

13 *Id.*

14 *Id.* at 898 and 900.

15 *Id.* at 898.

16 *Id.* at 898-899.

17 *Id.*

18 *Id.* at 899.

19 *Id.* at 898-899.

20 *Id.* at 900.

21 *Id.*

22 *Id.* at 901.

23 *Id.*

24 *See Wells,* 919 S.W.2d at 685.

25 *Id.* at 902.

26 *Id.*

27 *Id.* (citing *Wells*, 919 S.W.2d at 685).

28 *Johnson*, 204 S.W.3d at 902.

29 *Id.*

30 *Id.*

31 Lundstrom v. United Services Automobile Ass'n, 192 S.W.3d 78 (Tex. App. – Houston [14th Dist.] 2006, pet. denied).

32 *Johnson*, 204 S.W.2d at 920.

33 *Id.* at 902-903.

34 *Id.*

35 *Id.* at 903.

36 State Farm Lloyds v. Johnson, 290 S.W.3d 886, 887-888 (Tex. 2009).

37 *Id.* at 888.

38 *Id.* at 887.

39 *Id.*

40 *Id.* at 888.

41 *Id.* at 888-889.

42 *Id.*

43 *Id.*

44 *Id.* at 888-889.

45 *Id.* at 889-890.

46 *Id.* at 890-891.

47 *Id.* at 890-891, n. 24.

48 *Wells*, 919 S.W.2d at 684.

49 *Id.* at 891.

50 *Id.*

51 *Id.*

52 *Id.*

53 *Id.*

54 *Id.*

55 *Id.*

56 *Id.*

57 *Id.*

58 *Id.* at 891.

59 *Id.* at 891-892.

60 *Id.* at 892.

61 *Id.*

62 *Id.* at 892.

63 *Id.*

64 *Id.*

65 *Id.* at 892-893.

66 *Id.* at 893.

67 *Id.*

68 *Id.*

69 *Id.* at 894.

70 *Id.*

71 *Id.*

72 *Id.*

73 *Id.* at 894-895.

74 *Id.* at 895.

75 *Id.* at 894-895.

76 *Johnson*, 290 S.W.3d at 895.

77 *Id.* at 892-893.

78 *Id.* at 893.

79 Allison v. Fire Ins. Exchange, 98 S.W.3d 227, 258 (Tex. App. – Austin 2002, no pet.); State Farm Fire & Cas. Co. v.

Rodriguez, 88 S.W.3d 313, 320-21 (Tex. App. – San Antonio 2002, pet. denied); Wallis v. United Servs. Auto. Ass'n, 2 S.W.3d 300, 302-3 (Tex. App. – San Antonio 1999, pet. denied).

80 *Allison,* 98 S.W.3d at 259; *Wallis,* 2 S.W.3d at 302.

81 See E.I. du Pont de Nemours v. Robinson, 923 S.W.2d 549 (Tex. 1995).

82 In re Universal Underwriters, 345 S.W.3d 404 (Tex. 2011).

83 *Id.* at 405.

84 *Id.* at 406.

85 *Id.*

86 *Id.*

87 *Id.*

88 *Id.*

89 *Id.*

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91 *Id.*

92 *Id.*

93 *Id.* at 407 citing Delaware Underwriters v. Brock, 109 Tex. 425, 211 S.W 779, 780-781 (1919).

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95 *Universal Underwriters*, 345 S.W.3d at 406-407.

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97 *Id.* citing In re General Electric Corp., 203 S.W.3d 314, 316 (Tex. 2006).

98 *Id.*

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102 *Id.*

103 *Id.* at 411.

104 *Id.* at 412.

105 In re Cypress Texas Lloyds, 2012 WL 1435739 *1 (Tex. App. – Beaumont 2012, orig. proceeding).

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108 *Id.*

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111 *Id.*

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116 *Id.* at *2.

117 *Id.*

118 *Id.* at *3.

119 Hennessey v. Vanguard Ins. Co., 895 S.W.2d 794, 798 (Tex. App. – Amarillo 1995, writ denied).

120 *Id.* at 798; Providence Lloyds v. Crystal City Indep. School Dist., 877 S.W.2d 872, 875 (Tex. App. – San Antonio 1994, no writ); MLCSV10 v. Stateside Enterprises, Inc. v. Hartford Steam Boiler Inspection and Ins. Co., __ F.Supp.2d __, 2012 WL 1098415 (S.D. Tex. 2012).

121 State Farm Lloyds v. Johnson, 290 S.W.3d 886, 893 (Tex. 2009).

122 Providence Lloyds Ins. Co. v. Crystal City Indep. School Dist., 877 S.W.2d at 878.

123 *Id.* at 877.

124 Qualls v. State Farm Lloyds, 226 F.R.D. 551, 558 (N.D. Tex. 2005); *see also*, Mays v. State Farm Lloyds, 98 F. Supp. 2d 785 (N.D. Tex. 2000).

125 State Farm Lloyds v. Mireles, 63 S.W.3d 491, 499 (Tex. App. – San Antonio 2001).

126 Broders v. Heise, 924 S.W.2d 148, 152 (Tex. 1996).

127 Houghton v. Port Terminal R.R. Ass'n., 999 S.W.2d 39, 47 (Tex. App. – Houston [14th Dist.] 1999, no pet.).

128 Kumho Tire Company v. Carmichael, 526 U.S. 137, 119 S. Ct. 1167, 1171 (1999).

129 Gammill v. Jack Williams Chevrolet, 972 S.W.2d 713, 719 (Tex. 1998).

130 Glenbrook Patiohome Owners Association v. Lexington Ins. Co., No. H-10-2929,* 2 (S.D. Tex. July 28, 2011).

131 *Id.; see also*, St. Charles Parish Hosp. Dist. #1 v. United Fire and Cas. Co., 2008 U.S. Dist. LEXIS 34421 (E.D. La. 2008) ("Beyond the requirement of impartiality, subject matter expertise and being knowledgeable about the issues in dispute are relevant to the appointment. In this regard, experience in damage analysis, estimating and/or appraisals weighs in on the positive side"); In Re Travelers Indem. Co., 2004 U.S. Dist. LEXIS 30074 (D. Conn. 2004); Karl A. Schulz, *Accurate Outcomes in Appraisal: The Importance of Umpire's Subject Matter Expertise*, 15 Journal of Consumer & Commercial Law 54 (2012).

132 Delaware Underwriters v. Brock, 109 Tex. 425, 211 S.W 779, 780-781 (1919).

133 Pennsylvania Fire Ins. Co. v. W.T. Waggoner Estate, 39 S.W.2d 593, 594-595 (Tex. Comm'n App. 1931, no writ).

134 *Id.* at 596.

135 General Star Indem. Co. v. Spring Creek Village Apt. Phase V, Inc., 152 S.W.3d 733, 737 (Tex. App. – Houston [14th Dist.] 2004, no pet.).

136 *Id.* at 734-737.

137 *Id.* at 737.

138 *Id.*

139 Holt v. State Farm Lloyds, 1999 WL 261923,*1 (N.D. Tex 1999).

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141 *Id.*

142 *See* Gardner v. State Farm Lloyds, 76 S.W.3d 140 (Tex. App. – Houston [1st Dist.] 2002, no pet.); *see also* Bunting v. State Farm Lloyds, 2000 WL 191672 (N.D. Tex. 2000).

143 Franco v. Slavonic Mut. Fire Ins. Co., 154 S.W.3d 777, 786-787 (Tex. App. – Houston [14th Dist.] 2004, no pet.).

144 MLCSV10 v. Stateside Enterprises, Inc. v. Hartford Steam Boiler Inspection and Ins. Co., CA. NO. H-10-4186, 866 F.Supp.2d 691, 695 (S.D. Tex. 2012).

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147 *Id.*

148 *Id.* at 698.

149 *Id.* at 699.

150 *Franco,* 154 S.W.3d at 786.

151 *MLCSV10,* 866 F. Supp 2d at 699.

152 *Id.* at 700

153 *Id.* at 699-700.

154 *Wells*, 919 S.W.2d at 683; Barnes v. Western Alliance Ins. Co., 844 S.W.2d 264, 267 (Tex. App. – Fort Worth 1992, writ dism'd by agr.).

155 *Wells*, 919 S.W.2d at 683 (citing Providence Lloyds Ins. Co. v. Crystal City Indep. Sch. Dist., 877 S.W.2d at 875. "[A] n award which is not made substantially in compliance with the requirements of the policy will not be sustained." Fisch v. Transcon. Ins. Co., 356 S.W.2d 186, 190 (Tex. App. – Houston 1962, no writ).

156 *See* Pennsylvania Fire Ins. Co. v. W.T. Waggoner Estate, 39 S.W.2d at 594. *See also Delaware Underwriters*, 211 S.W. at 780.

157 345 S.W.3d at 409

158 8 S.W. 630 (emphasis added)

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160 *Id.*

161 *Id.* at 682.

162 *Id.*

163 *Id.*

164 *Id.*

165 *Id.* at 683-684.

166 *State Farm Lloyds v. Johnson,* 290 S.W.3d at 889.

167 *Id.* at 890 .

168 *Id.*

169 *MLCSV10,* 866 F. Supp. 2d at 699-700.

170 *Id.* at 702-703.

171 *Id.* at 703.

172 *Id.* at 695.

173 *Id.* at 705-706.

174 *Id.* at 706-707.

175 *Id.* at 707-708.

176 *Id.* at 707-708.

177 *Id.*

178 *Id.* at 702 citing JM Walker LLC v. Acadia Ins. Co., 356 Fed. Appx. 744, 746 (5th Cir. 2009) (quoting Providence Wash Ins. Co. v. Farmers Elevator Co., 141 S.W.2d 1024, 1026 (Tex. Civ. App. -- Amarillo 1940, no writ)).

179 *See Barnes v. Western Alliance Ins. Co.,* 844 S.W.2d at 270-271.

180 *See MLCSV10*, 2012 WL 1098415 *8; KLM Resources LLC v. Ohio Cas. Ins. Co., 2012 WL 1911801*1 (S.D. Tex. 2012). *See also* Triple S Properties v. St. Paul Surplus Lines Ins. Co., 2010 WL 3911422 *6-8 (N.D. Tex. 2010).

181 *Barnes.*, 844 S.W.2d at 268-269.

182 *Id.* at 266-267.

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185 *Id.* at 267-268.

186 *Id.*

187 *Id.* at 268-269.

188 *Id.* at 269.

189 *Id.*

190 *Id.*

191 *Id.*

192 Hudgens v. Allstate Texas Lloyds, 2012 WL 2887219 at *8 (S.D. Tex. 2012); Breshears v. State Farm Lloyds, 155 S.W.3d 340, 344 (Tex. App. - Corpus Christi 2004, pet. denied); Blum's Furniture Co. v. Certain Underwriters at Lloyd's London, 2012 WL 181413 *2 (5th Cir. 2012).

193 Mag-Dolphus, Inc. v. Ohio Cas. Ins. Co., 2012 WL 4018001 (S.D. Tex. 2012).

194 *Id.*

195 *Id.*

196 *Id.*

197 *Id.*

198 *Id.*

199 *Id.*

200 *Id.*

201 *Id.*

202 *Id.*

203 *Id.*

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SHORTCOMINGS OF DEFENSE BASE ACT INSURANCE--THE STRUGGLES OF TWO YOUNG INTERPRETERS

Introduction

Congress passed the Defense Base Act (DBA), 42 U.S.C. §1651 *et seq.*, in 1942 to protect overseas civilian workers employed by government contractors while those employees are performing work for branches of the U.S. Government. The DBA requires employers to provide their employees injury and death benefits akin to state workers' compensation benefits. These benefits include medical benefits, disability benefits, and death benefits. Government contractors are required to provide DBA benefits to overseas employees regardless of the employee's nationality. The DBA requires employers of civilian workers to "secure compensation" for these benefits. Most overseas defense contractors purchase insurance to secure DBA compensation. Similar to other federal compensation acts like the Outer Continental Shelf Lands Act (OCSLA), the DBA incorporates and is dependent upon the compensation scheme set forth in the Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. § 901 *et seq.* Both the LHWCA and the DBA are overseen by the Department of Labor (DOL).

This article illustrates some of the shortcomings of DBA insurance through its application to two brave young men who were injured by bombs while working as interpreters for American soldiers in Iraq and Afghanistan.

Operation Iraqi Freedom (OIF)[1]: Iraqi Interpreter Omar Nadheer

Omar Nadheer was born and raised in Iraq. After the U.S. invasion of Iraq, Nadheer became an interpreter for L-3 Communications-Titan (Titan), a government contractor headquartered in New York. Nadheer lived on the U.S. base near Baghdad and was required to be available to U.S. Army personnel 24 hours a day, 7 days a week. He was paid extra comparable to other interpreters to be available at any time. He collected his monthly pay, $1,050.00 in cash, at the Titan office on base.

On missions with U.S. soldiers, Nadheer usually rode in the lead vehicle to be readily available as an interpreter when the soldiers leading a convoy needed to speak with local civilians and Iraqi military personnel. Needless to say, travelling in the lead vehicle of a U.S. convoy in war-torn Iraq is dangerous. Nadheer was subjected to hostile fire, rockets, and bombs just like the soldiers with whom he traveled. The most common form of bomb is commonly called an IED, an acronym for Improvised Explosive Device.

Nadheer was well-liked and respected by the U.S. soldiers. A captain who used Nadheer as his interpreter wrote a recommendation for Nadheer that provided, in part:

> I met [Nadheer] upon my arrival and he instantly gained my respect. He provided me basic knowledge of the land and some information about the area. [Nadheer] would always go out of his way to help the unit, by working during his off time, working late to transcribe documents, and motivating other soldiers in the unit to improve their physical fitness. As the commander, I fought hard to get [Nadheer] as my interpreter because of his skills, and being a very dependable man, but my commander also saw these qualities and ultimately took him as his interpreter…
>
> John Soto Jr.
> CPT, MP

On December 17, 2007, while in the lead vehicle on a mission with U.S. soldiers on Baghdad's most dangerous highway, Nadheer was severely injured by an IED that pierced the Humvee in which he was riding. Nadheer's right elbow was shattered along with a substantial amount of bone leading up to his right shoulder. He was taken for emergency treatment to the U.S. Army hospital Ibn Sina, a/k/a 86th Combat Support Hospital, in the International Zone-Baghdad. Nadheer was treated there until January 8, 2008. He underwent a number of painful surgeries while at Ibn Sina, mostly to remove debris from his arm and to treat infection caused by the foreign debris.

Although he needed additional surgeries and in-patient care, Nadheer could not remain at the American combat hospital. He sought a transfer to Amman, Jordan. His American surgeon at the combat hospital recommended

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that Nadheer be treated in Jordan and the hospital records reflect the expectation that he would be transferred there.

The night before he was to be transferred, Titan's casualty officer visited Nadheer at his bedside and told him the DBA insurer determined his condition was not serious enough to justify a transfer to Jordan. Instead, Nadheer would be transferred to a hospital in Erbil, Iraq named Al-Shefaa. Nadheer argued with the casualty officer, as did the American nurse on duty who had been treating Nadheer. The casualty officer told them that Nadheer would either agree to go to Erbil or he would be left without further treatment. Nadheer acquiesced, believing that he had no choice.

Nadheer's five-month stay at Al-Shefaa was a nightmare. There was only one attendant on the second floor where Nadheer's room was located. The attendant slept most nights. Nadheer was bedridden for much of his stay because of an infection to his thigh after a failed skin graft. The sleeping attendant was no help at all. As a result, most nights Nadheer lay awake in constant pain, unable to move from the bed to which he was comfined. Sanitary conditions were no better. Nadheer was not bathed after he became bedridden. Nadheer was discharged from Al-Shefaa on June 29, 2008, without any improvement in his condition during the five-plus months he spent there. Like other Iraqi interpreters who were injured and could no longer work, Nadheer was forced into hiding lest he be killed for having worked for the Americans.

Nadheer eventually made it to Jordan, and was granted asylum in the United States in 2010. He now resides in San Antonio, Texas, and receives Social Security disability and Medicaid health care benefits. Nadheer is finally getting the medical care that he needs at the University of Texas Health Science Center in San Antonio. Nadheer's treatment includes a prosthetic implant designed for him to regain function in his right elbow.

Operation Enduring Freedom (OEF)[2]: Afghan Interpreter Ahmad Mushfiq

Ahmad Mushfiq was born in 1981 in Kabul, Afghanistan. After the war in Afghanistan started, he became an interpreter employed by Mission Essential Personnel (MEP), a large U.S. defense contractor based in Columbus, Ohio. At the time that he was injured, MEP paid Mushfiq approximately $700 a month as an interpreter for the U.S. military. On April 29, 2008, while working for the Kapisa and Parwan Provincial Reconstruction Team (PRT) in Kapisa Province, Afghanistan, Mushfiq and other members of the PRT were attacked by the Taliban. The Humvee in which Mushfiq was riding was hit by an IED blast set off by remote control. Both of Mushfiq's legs were mangled from the blast. His right arm was fractured in several places. Mushfiq was taken to the U.S. combat hospital at Bagram Airfield. There, his right leg was amputated above the knee, his left leg was amputated below the knee, and the multiple fractures of his right arm were stabilized.

Like Nadheer, the MEP's DBA insurer sought to have Mushfiq transferred to a Kabul hospital. The insurer even offered the excitement of a helicopter ride as incentive, but Mushfiq refused to go. Fortunately he was able to stay at the American hospital for further treatment.

Mushfiq, known on base as Ritchie, was embraced by the American soldiers. In the fall of 2008, the military held a memorial 5.7 kilometer run at Bagram Airfield in honor of Senior Airman Jake Yelner, who was killed in the same blast that injured Mushfiq. Mushfiq was driven to the finish line for the run and then crossed the finish line on crutches and prosthetics accompanied by the staff sergeant and the commander of the PRT.[3]

After treatment, Mushfiq was moved from Bagram Airfield to a safe house in Kabul. He received disability benefits of $107.69 per week during this time. His benefits were approximately 66% of his pre-disability earnings, the percentage of pre-disability earnings mandated by the DBA. In March of 2009, Mushfiq was found to have reached maximum medical improvement and was assigned an impairment rating of 80% to his right leg, 70% to his left leg, and 14% to his right arm.

In June 2009, an adjuster working for MEB's DBA insurer left a message on Musfhiq's telephone. When Mushfiq returned the call, the adjuster said he would like to bring over some paperwork. The adjuster, a fellow Afghan, brought a settlement agreement drafted by the DBA insurer's lawyers to Mushfiq at a friend's house where Mushfiq was staying. The settlement agreement provided that Mushfiq would release the DBA insurer from all future liability for disability benefits and medical benefits in return for a lump sum. Half of the sum was allocated to liability for past and future disability benefits, and half was allocated to liability for past and future medical benefits. The settlement agreement was prepared for entry and approval by the DOL's Office of Workers' Compensation Programs (OWCP) or an administrative law judge, which is a requirement for DBA settlements.[4]

When the adjuster arrived and presented the settlement, Mushfiq told the adjuster he wanted lifetime medical for his injuries and a monthly disability income instead of a lump sum. The adjuster responded that this was Afghanistan where there were no rules or regulations regarding these

benefits. The adjuster pointed out that Mushfiq's connection to the American soldiers at Bagram had been severed and told Mushfiq he better take the deal- if he did not, he would end up with nothing.

Not surprisingly, Mushfiq signed the agreement and accepted a lump sum that was a fraction of his expected future medical costs. The insurer then submitted the settlement agreement to Richard V. Robilotti, District Director of the OWCP, Longshore District Office #2 in New York. Director Robilotti oversees all DBA injury or death claims occurring in Iraq and Afghanistan.[5] The settlement was approved and the insurer then obtained full reimbursement for the settlement payment from DOL under §104 of the War Hazards Compensation Act (WHCA). The WHCA provides for reimbursement of amounts paid by insurance carriers to any person for death, disability, and health benefits under the DBA if the benefits compensate injuries due to a war-risk hazard, which includes hostile fire or bombs.[6]

Mushfiq is also a refugee living in the United States. He and his wife, who are expecting their first child, recently moved from San Antonio to Fremont, California, to live in a community with other Afghans displaced by the war.

The Basics of DBA Insurance Coverage

The DBA requires that government contractors such as Titan and MEP provide lifetime medical benefits for injuries sustained as a result of employment, as well as disability benefits, permanent impairment benefits, and death benefits to immediate family members in case of a fatal injury.[7] To be compensable, the injury must be suffered in the course of employment.[8] An employer may be self-insured, so long as they provide the DOL adequate assurance of their solvency and ability to fund benefits.[9] As an alternative, they may purchase such insurance from qualifying insurers.[10]

The compensation provisions that apply to the DBA are found in the LHWCA, 33 U.S.C. §§904-9[11]. They are fairly summarized as follows:

§904	**Liability for Compensation.** The employer shall secure compensation for employees injured in course and scope of employment irrespective of fault.[12]
§905	**Exclusiveness of Liability.** Provided the employer secures compensation in accordance with the requirements of the LHWCA, the employer will have no liability outside of the compensation provisions of the LHWCA. Should the employer not secure compensation as provided by the Act, the employee may seek redress under either the Act or the common law, and the employer forfeits certain defenses.[13]
§906	**Compensation.** This provision sets a ceiling and floor for disability and death benefits, and establishes the time after disability that benefits begin.[14]
§907	**Medical Services and Supplies.** The general requirement under this section requires that the employer furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.[15] This provision also gives the employee the right to choose the physician (as authorized by the Secretary of the U.S. Department of Labor) unless there is an emergency and the employee cannot choose, in which case the employer may choose.[14] This section also has a case monitoring provision, charging the Secretary of the DOL to "actively supervise the medical care rendered to the employee."[16]

§908	**Compensation for Disability** Permanent Total Disability-compensation rate 66 and 2/3 of pre-disability average weekly wage. This provision provides certain presumptions of permanent disability, one of them being the loss of both feet.[17] Temporary Total Disability-compensation for disability @ the rate of 66 and 2/3 pre-disability average weekly wage for disability that is temporary.[18] Permanent Partial Disability-employees that suffer a permanent loss of use of an appendage that is not a permanent total disability shall receive impairment payments on top of other temporary disability payments for specific losses, e.g. loss of a thumb, 75 weeks of compensation (@ the rate of 66 and 2/3 of pre-disability average weekly wage).[19] This section also permits lump sum settlements of future medical and disability payments.[20]
§909	**Compensation for Death**. This provision requires payments until death or remarriage to the surviving spouse of the decedent employee at the rate of 50% of the average weekly wage of the decedent. It also provides for payment to surviving children of the decedent.[21]
§910	**Determination of Pay.** This provision prescribes how the average weekly wage of the employee is to be calculated.[22]

Who Pays Benefits Under The War Hazards Compensation Act

The War Hazards Compensation Act provides that any employer or insurance carrier that pays government contractor employees for injuries caused by war hazards will be reimbursed by the U.S. Government.[23] The Secretary of Labor administers the payments made through a fund established under the Federal Employees Compensation Act. DBA carriers not only get full reimbursement from the U.S. government for amounts paid to the employee under the DBA, but are also reimbursed reasonable claims handling expenses.[24] Under the War Hazards Compensation Act, the carriers for Nadheer and Mushfiq's employers were entitled to full reimbursement of the medical expenses and disability benefits paid to or on behalf of Nadheer and Mushfiq, and the cost of handling those claims.

Congressional Hearings in 2008 Over the Escalating Costs of DBA Insurance and the Profits and Claims Handling of DBA Carriers

DBA insurance is purchased by government contractors in the private insurance market. The premiums for DBA insurance are generally a reimbursable expense under government contracts. During its 2008 deliberations over the escalating costs of DBA insurance, Congress reported 90% of the insurance premiums and costs to insure workers in Afghanistan and Iraq were paid by the federal government.[25] The American taxpayers ultimately foot the bill for DBA insurance on two fronts. First, the contractors include their premium payments as a reimbursable cost in their contracts with the Department of Defense. Then, when benefits are paid by the insurers, the government reimburses the insurer for payments made to a claimant even though the government has already paid the premium on the same insurance for which it is now reimbursing the insurance company.

Selling DBA Insurance to Defense Contractors in Iraq and Afghanistan: A Lucrative Business

In 2008, after receiving financial information from the four primary DBA insurers, American International Group (AIG), CNA, ACE USA, and the Chubb Corporation, the majority staff members from Congress's Committee on Oversight and Government Reform reported that these insurance companies made substantial underwriting profits from the sale of DBA insurance to government contractors.[26] The Committee reported that these four companies received $1.5 billion in DBA premiums between 2002 and 2007, and paid out just $928 million in claims and expenses, leaving net underwriting gains of $585 million; a 39% profit over this five year period.[27] In its memorandum, the congressional committee pointed out that these profits were especially aberrant when compared to other workers' compensation insurance programs. In comparison, the same four companies had a net underwriting loss on the other lines of workers' compensation insurance they offered during the same period.[28] The financial information given Congress from AIG, which reported the majority of the premiums for DBA insurance, indicated AIG had made a 38% profit on its DBA insurance business, but only 1% on its other workers' compensation business over the same five year period.[29] CNA reported a 53% profit on its DBA business during the same period.[30]

Underwriting for War Risks Reimbursable Under the War Hazards Compensation Act

In its report to the full Committee, the majority staff of the Committee on Oversight and Government Reform indicated

that the DBA insurers appear to have been charging an extra premium based on "danger pay."[31] Since DBA carriers are indemnified by the government for payments made due to any war risk injuries (including death), this additional premium is improper. The DBA carrier does not bear the additional risk when its insureds are working in war zones.

The DOL Reports to Congress that DBA Insurers Frequently Delay or Deny Payment on Claims to Injured Employees

Also in its report, the majority staff members wrote as follows in their May 15, 2008 Memorandum to the full Committee:

> Despite the high profits realized by insurers, the Department of Labor told Committee staff that DBA insurers delay or deny payments on almost all claims submitted by injured contractor employees. The insurers lose over 95% of the disputed claims that are brought before administrative judges.[32]

Returning to the Struggles of Omar Nadheer and Ahmad Mushfiq Nadheer and the Medical Services and Supplies Provision of the Longshore Act

The federal compensation act created to protect longshoremen and harbor workers has turned out to be an imperfect fit when adopted as the federal compensation scheme to cover employees in foreign war zones. Nadheer's transfer to a hospital in Erbil, Iraq, instead of Amman, Jordan, exposes one of the disconnects between the compensation provisions as written and their oversight by the DOL. The section that governed Nadheer's transfer from Ibn Sina hospital, titled Medical Services and Supplies, states in relevant part as follows:

Medical Services and Supplies

> **(a) General Requirement**. The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for such period as the nature of the injury or the process of recovery may require.
>
> (b) **Physician Selection**; Administrative Supervision; Change of Physicians and Hospitals. The employee shall have the right to choose an attending physician authorized by the Secretary to provide medical care under this chapter as hereinafter provided. If, due to the nature of the injury, the employee is unable to select his physician and the nature of the injury requires immediate medical treatment and care, the employer shall select a physician for him. *The Secretary shall actively supervise the medical care rendered to the injured employees, shall require periodic reports as to the medical care being rendered to the injured employees, shall have the authority to determine the necessity, character, and sufficiency of any medical furnished or to be furnished, …*"[33]

A gaping hole is made apparent when this provision is applied to DBA medical services needed by foreign nationals injured in the wars in Iraq and Afghanistan. Despite the statutory obligation to supervise medical care, the DOL does not actively supervise the medical care of a foreign national injured in Iraq or Afghanistan. In fact, Richard V. Robilotti, the District Director of the OWCP office in New York, the representative of the DOL that oversees all DBA claims from Afghanistan and Iraq, has indicated that the DOL will not communicate with claimants in Iraq due to safety considerations.[34] While the OWCP District office guidelines are silent on communications with Afghanistan, one can safely presume claimants in that country are treated the same way for the same reasons. As a result, Nadheer and Mushfiq were left very much alone.

The impact of this lack of oversight is that injured foreign nationals, and their families in case of death, must exclusively rely on DBA insurers (and employers, when the employers are self-insured). Since there was disagreement between Nadheer's health care providers (in tandem with Nadheer) and the DBA insurer over the quality of medical treatment that was required to treat Nadheer after his urgent treatment at Ibn Sina, the DBA insurer should have either contacted the DOL or provided Nadheer and his American medical providers the opportunity to petition the DOL so that Nadheer could seek further treatment in Jordan instead of Iraq. Given the mandate that the DOL actively supervise the medical care of the injured employee, that is how the Act is designed to work.[35] DBA regulations require this three-way dialogue (employee, DBA carrier, and the DOL) when a significant dispute arises over medical care.[36] Instead, the casualty officer, acting on behalf of the DBA insurer, told Nadheer that he would either go to Erbil, Iraq, or he would receive no further treatment.

Mushfiq: The Threat of Receiving Nothing

Mushfiq didn't request a lump sum settlement of his claim to continued benefits. The carrier sought him out. By emphasizing the threat of receiving nothing, the carrier closed the deal. The settlement funds that Mushfiq received are gone now, used primarily by Mushfiq to pay for living expenses, health care, bodyguards, and bribes to protect his family and him and to bring his wife and him to the United States as refugees in September 2011.

Section 908 of the LHWCA governs DBA settlements.[37] This provision allows parties to settle their claims, but provides that "no liability of an employer or carrier or both for medical, disability, or death benefits is discharged unless the application for settlement is approved by the deputy commissioner or administrative law judge."[38] A settlement is to be approved by a deputy commissioner or administrative law judge within thirty days of submission unless it is "found to be inadequate or procured by duress."[39]

The settlement approval process is an ex parte procedure. Mushfiq had no representation during the claims process, and was not sent a copy of the documents that were submitted to Mr. Robilotti. In maintaining that the settlement for future medical expenses was reasonable, medical reports were submitted by the insurer that indicated that the projected costs for new prosthetics for Mushfiq would be an expense of $2,500 to be incurred once every ten years along with $500 per year in medical office visit costs. The settlement was approved by Mr. Robilotti's office in reliance upon this information.

The DBA insurer's representations to the OWCP regarding future medical costs is starkly contradicted by the reliable studies that have been done on the medical cost projections for major limb loss from Vietnam and OIF/OEF. To inform the U.S. Department of Veteran's Affairs, a panel of 25 experts was assembled to project the costs of future care for veterans with major limb loss.[40] These experts used 2005 Medicare prosthetic device component prices from a national survey of 581 veterans and service members (298 from Vietnam and 283 from OIF/OEF) with major traumatic amputations.[41] The report, submitted to the VA in 2009, the same year that the projection for Mushfiq's future medical costs was submitted by the DBA insurer, indicated that double amputees from the OIF/OEF wars who were fitted with prosthetics could expect to incur mean future medical costs over a 20 year period of $1,674,333.[42] Over a lifetime, the average costs were projected to be $2,901,365.[43] Other reliable studies published by the National Institute of Health support these projected costs for future care for double leg amputees using prosthetics.[44]

Another troubling aspect of Mushfiq's settlement is it ignores the compensation provisions of the LHWCA, as adopted by the DBA. The settlement states in relevant part as follows:

> "The parties are in dispute as to the nature and extent of claimant's disability. The Claimant asserts that he is entitled to permanent total disability compensation benefits arising out of this incident. The Employer/Carrier asserts that Claimant is entitled to permanent partial disability compensation benefits based upon scheduled disability awards to claimant's right and left legs and left arm."[45]

Section 908(a) of the LHWCA, as adopted by the DBA, indicates in part as follows:

> Permanent total disability: . . . *Loss of both hands, or both arms, or both feet, or both legs or both eyes.... in the absence of conclusive proof to the contrary, constitute permanent total disability.* In all other cases permanent total disability shall be determined in accordance with the facts."[46]

Mushfiq never knew about this provision, and the DBA insurer did not enlighten him. DOL did not contact or question him. Given DOL's administrative decision not to contact claimants in Iraq and Afghanistan, no conclusive proof to the contrary was available. Therefore, none was provided to Mr. Robilotti's office.

Conclusion

This article was written with two purposes in mind: the first was to explain the basics of the DBA and DBA insurance; the second purpose was to show the law's shortcomings when applied in Iraq and Afghanistan by offering a brief account of two brave young interpreters who encountered something that they neither understood nor expected. In the cases of Omar Nadheer and Ritchie Mushfiq we see DBA compensation provisions that are not fully implemented and an absence of protection of injured foreign workers by the DOL. Despite a statutory obligation, the DOL does not oversee the medical care of foreign interpreters who are injured in Iraq and Afghanistan. This lack of oversight has sometimes led to predatory claims practices. Getting to know Nadheer and Mushfiq has been a privilege. Their stories sharpen my sense of good fortune to have been born and live in the United States. Unfortunately, brave interpreters like Nadheer and Mushfiq, and other foreign workers who are essential to our war efforts, have done a better job in protecting us than we have done in protecting them.

1 The U.S. Government has coined the war in Iraq Operation Iraqi Freedom, known by the acronym OIF.

2 The U.S. Government has coined the war in Afghanistan Operation Enduring Freedom, known by the acronym OEF.

3 http://www.leesvilledailyleader.com/news/x199491591/TF-Warriors-honors-fallen-comrades

4 33 U.S.C. § 908(i).

5 http://www.dol.gov/owcp/dlhwc/DBAOWCPProcedures2-22-06.pdf

6 42 U.S.C. § 1711(b).

7 *See* 42 U.S.C. § 1651(a) (incorporating and applying the provisions of the LHWCA to such employers and employees).

8 *Id.*

9 33 U.S.C. § 932(a)(2).

10 33 U.S.C. § 932(a)(1).

11 33 U.S.C. § 904.

12 33 U.S.C. § 905(a).

13 33 U.S.C. § 906

14 33 U.S.C. § 907(a).

15 33 U.S.C. § 907(b).

16 *Id.*

17 33 U.S.C. § 908(a).

18 33 U.S.C. § 908(b).

19 33 U.S.C. § 908(c).

20 33 U.S.C. § 908(i).

21 33 U.S.C. § 909(b).

22 33 U.S.C. § 910.

23 42 U.S.C. §1704(a).

24 *Id.*

25 Memorandum from the Majority Staff, Committee on Oversight and Government Reform, U.S. Congress, dated May 15, 2008, at 1.

26 *Id.*, at 6.

27 *Id.*, at 1.

28 *Id.*, at 2.

29 *Id.*, at 6.

30 *Id.*

31 *Id.*, at 2.

32 *Id.*

33 33 U.S.C. §907 (emphasis added).

34 http://www.dol.gov/owcp/dlhwc/DBAOWCPProcedures2-22-06.pdf

35 33 U.S.C. §907(b).

36 20 C.F.R. §702.405.

37 33 U.S.C. §908(i).

38 *Id.*

39 *Id.*

40 David K. Blough, *Prosthetic Cost Projections for Servicemembers with Major Limb Loss From Vietnam and OIF/OEF*, 47 Journal of Rehabilitation Research & Development 387-402 (2010).

41 *Id.*, at 389.

42 *Id.*, at 397.

43 *Id.* Because the time horizon for lifetime costs was considered to be 100 years, one can argue this figure will exceed Mushfiq's expected future costs related to his loss of both legs. *Id.*, at 394. However, one can also argue that the lifetime costs are underestimated because they do not account for future technologies that may dramatically increase future costs. *Id.*, at 400.

44 In 1994, lifetime prosthetic costs for a group averaging 41 years of age who were single-leg amputees was estimated to be $403,199.18. http://www.ncbi.nlm.nih.gov/pubmed/8156666. In 2007, lifetime healthcare costs of a single-leg amputee was estimated to be $509,275.00. http://www.ncbi.nlm.nih.gov/pubmed/17671005. *See also*, *Prosthetic Cost*, 47 Journal of Rehabilitation Research & Development at 399 (referring to the 1994 NIH study and announcing, "A study by Williams with a population similar to the Vietnam unilateral lower-limb group found costs that compare in order of magnitude to those we obtained for the unilateral lower-limb groups.").

45 It was his right arm. There are many factual errors in the settlement agreement. Not only does the agreement refer to the wrong arm, but it also indicates that Mushfiq's left leg was amputated above the knee and his right leg was amputated below the knee. Actually, Mushfiq's right leg was amputated above the knee and his left leg below the knee.

46 33 U.S.C. § 908(a)(emphasis added).

By Michael Sean Quinn

ON THE "MUST READ THE POLICY" RULE

This rule is often repeated in arguments, briefs, and court opinions that policyholders must read their policies. Some insurers have been known to assert that insureds have an obligation to do this immediately upon receiving a reservation of rights letter in order to determine coverage for themselves. The proposition expressed in this phrase or one equivalent to it, has been for a long time a repeatedly deployed slogan. The truth is that when standing alone—this phrase is not a rule of insurance law and never has been. The same is true of contract law—that body of common law from which much of insurance law is derived. Some observers agree with the "is not" part of the foregoing assertion, though not the "never has been."[1]

In support of what is argued here, only a few cases are cited. Some of them are quite old. Actually, they are often valuable precedent. It is a good thing that a number of important parts of the common law of insurance have not changed much in the last century or so. There are significant exceptions: common law bad faith is one;[2] the requirement of prejudice before enforcing a notice of loss requirement is another.[3] The requirement of prejudice before a violation of the cooperation clause moves toward the same view as *PAJ*, although there is no Texas Supreme Court case unequivocally saying so.[4] And there are others. So far as old cases are concerned, as Oliver Goldsmith, a well -known Eighteenth century writer, once said, "I love everything that is old; old friends, old times, old manners, old books, old wine." He could have added "old cases"; at least some of them.

The rule "*Insureds must read their policies*" must first be analyzed and conceived correctly. It might even have started with contract law in general and then seeped its way into insurance law. The common law of insurance is nothing but a subdivision of the common law of contracts. In the area of contract law, there is no reason why the so-called duty to read the contract must be an ironclad doctrine with uniform and absolute application. To the extent that the correct analysis is determined, it is easy to see that this rule, traditional though it is, should be overthrown. It cannot be much more than jurisprudential laziness why this did not happened years ago. The first thing to understand is that the word "read" cannot mean just *read*. It must mean *read* ***and*** *understand*, taken together. It is completely pointless to force an insured to read a policy she does not understand. This essay will take the word "read" to mean "read and understand" or "read and understood."

Just as one can read a policy without understanding it, one can understand an insurance policy without having read it. No doubt, "understand the policy" is a logically sufficient replacement for "read the policy." Maybe that is the real rule: *Policyholders must understand their policies.*

One suspects that how a policyholder comes to understand her policy makes no difference whatsoever. Of course, it is probably true that reading a policy is the most frequent way entities, including people, at least try to come to understanding contracts of insurance; although, reading documents like insurance policies is certainly a **very** unreliable method of achieving understanding of complex instruments. Instruction helps immensely and can be reliable under some significant circumstances. One suspects that having been told the meaning of a policy by someone who is knowledgeable, perhaps by a knowledgeable intermediary, is a more reliable route to understanding than many others are.

Of course, intermediaries are not required to explain policies, but they better get it right if they try.[5] Then again, one can imagine a plaintiff-oriented lawyer consistently advising clients to explicitly ask for descriptions and explanations of policies. It is hard to imagine intermediaries refusing to do so.

The same would probably be true if the advice for the insurance customer came from a blog or an advertisement and not a lawyer. After all, the former does involve reading, and the latter often does not.

This or something like it is "age old" in Texas common law. If an insured relies upon acts of an agent of the insurer, "it would not be necessary for him to examine the policy to ascertain the terms upon which it was made."[6] It is worth noticing that the rule formulated here refers not to the terms of the policy but to the external facts, which were the context in which the contract of insurance was formed. The law is pretty much the same now. Of course, context is always important, even in the law of contracts.[7] In *Aetna Insurance Co. v. Holcomb*, an intermediary was liable, when it knew that its customer wanted some complex thing in particular to be insured.[8] At the same time, however, it did

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not know relevant facts about the kind of entity for which the customer wanted insurance. As a result, the intermediary bought the insured the wrong kind of policy.[9]

In any case, no insured has ever, ever, ever had—and does not now have—a general **legal duty** to read her contract of insurance. If insureds were to have a general duty to read their insurance policies, then no insured could ever refrain from reading such a policy without violating someone else's rights. Usually the "someone else" is the carrier that sold the policy (or its successor), but it could be a variety of other people and/or banks, other lenders, soon to be ex-spouses, actual ex-spouses, some purchasers, e.g., consumers of various services, some sellers, and so forth. Obviously, they cannot have a legal duty to themselves in this—or any other—regard. Conceiving of duty in this context as a general duty is a secular legal sin.

The idea of the policyholder's duty is not that an insured has a special and distinct duty to read some of her insurance policy must be given up for the idea that a policyholder has a more general contract-based duty to read some or all of her contracts of insurance. But change does not work either. It is not a breach of contract for an insured not to read a whole policy. If coverage were later sought, the breach of duty would be failure to have read the relevant language of the policy before purchasing it. It is hard to see how this could be a contract-based duty, since the point in time the to-be-insured does not read the policy is before contract formation.

Of course, if an insured has a duty to read the policy purchased, the carrier must have one or more corresponding reciprocal duties. This is implied by the duty of doctrine of implied duties of good faith found in all contracts.[10] Of course, Texas has refused to accept this doctrine, at least when worded this way. It is established law that in order for there to be an actionable breach of contract by one party, the other party must have fully performed its obligations under the contract.[11] One would think that the carrier must have the duty to provide a policy, which the other party to the contract can understand.

The historical idea of contract law is that each party involved in drafting the contract, and so each party, has a duty to the other(s) to understand it. This is nonsense in the contemporary age; virtually all contracts involving actual people are standardized. The problem of understanding usually falls upon the insured.

However, in the practical world, could an insurer actually have a duty to make sure that a customer understands a policy she is about to purchase? How might this be done? Is the agent to explain the policy line by line? In general terms? What about the agent asking the question what do you think you might not understand? What about a brochure? What about required classes…with pop quizzes? Most of these, of course, are nonsense. Does it really make sense to put all this kind of risk on the insured?

So are we stuck with an unsolvable dilemma? If so, who should bear the burden of error? Should it really be an insured, especially if the insured is a "mere" person and not more of an experienced venture?

One must think about the rule *Insureds Must Read Their Policies* carefully. It is surely not the case that every insured under a given policy has a duty to read that policy. At least some named insureds, usually the policyholders, at least sometimes, may have restricted duty under most circumstances, if anyone does; but it is not the case that all named insureds have such a duty, even if one of them does. Should the right to compensation be forfeited by an additional named insured, if she had no understanding of the policy, but the first named insured did? Or didn't? Nor is it the case that unnamed insureds must read the policy; this point is completely obvious, even if the previous ones are not; the additional, unnamed insured, may not even know about being an insured until disaster has struck, or thereafter.

Thus, all sorts of features of the so-called duty to read are troublesome. Obviously, there is more than just trouble about requiring blind people to read texts. There is also irrationality inherent in requiring an "ordinary" person to form a contract of the type she must buy to avoid important risks, where she is required to understand language that is obviously vague, unclear, ambiguous or even rather obscure. (In fact it is obvious that a policyholder need not read an insurance policy if it contains a relevant and serious ambiguity, since it will be interpreted in favor of the insured anyway.)

This last paragraph is especially obvious when courts disagree amongst themselves about the meaning of given terms. The idea that an ordinary person can immediately and intuitively grasp the full meaning of complex insurance contract language is also defective. It sometimes takes experienced coverage counsel hours and/or days to determine what such a contract might actually mean. Often they don't it get right even then. In addition, they may not be trying to determine truth but trying to advocate positions that will serve their client's interests. This extraordinary effort is far more complicated and in some sense "deeper" than just reading an insurance contract; it involves reading, legal research, and jurisprudential contemplation.

This point can be stated even more dramatically. It also seems difficult to require an "ordinary" Jill to understand a term in her policy with respect to which millions and millions of dollars have been spent trying to get authoritative rulings as to the meaning of precisely that given term. In passing, it should be noted that the idea of "blindness" to sound public policy cannot be loosened much under Texas law,

and probably that of many states. Huge forces are against it. Even very fine print can be required reading, at least if it is legible to some degree.[12] This is what magnifying glasses are for, after all. Then again, does it make sense to legally require Jill to use a magnifying glass to read a 20 page document in very small print? How many lawyers are really comfortable arguing persuasively, given the actual law, that those with very, very near and uncorrectable vision are subject to the same law as those with vision closer to normal?

When the requirement of reading, simpliciter, is combined with the requirement of understanding, its "sibling," the analytical problems for the legal duty discussed here get more than a little foggy. Yet as lawyers, we have a duty to represent our clients vigorously.

So, what's going on with these central rhetorical slogans: "*Read the policy*" or "*You must read your policy*" or *"Insureds have a duty to read their policies*"? Are they really the essence of the law? Maybe not. A good guess might be that they are designed to be exhortations in the context of legal life. To be sure, they can and are used as major premises in arguing legal disputes. However, perhaps that is pure rhetoric. Many observers, who are thoughtful, take seriously the idea that the slogans are literally—as they stand—either justifiable or true. The only way to do this is to embrace prevailing law, as it currently exists, forgetting about a large variety of intuitively knowable rejectability. In this context, it might be helpful to reflect upon the fact that there are currently several systematic analogies or metaphors that are used by some to analyze the ways to reconceptualize the nature of contract law. Perhaps they might help in rethinking the *"Read It Ruthie"* Rule.[13] Since "the Rules" are valuable exhortations, they are also conceivable as a kind of advice as to prudence in legal contexts. If this is true, the *Must Read It* Rule, would actually not be a commandment of the law at all. A reasonable person would make sure to have read the relevant portions of her policy, as it were, over time or at significant times. Of course, if this is the correct view of the rule under discussion, it would really be better formulated by *Ya'll Ought to Read Policy the Rule & There is Real Legal Danger Not To.* "Better," but perhaps not as compelling as "Ought." There is something disturbing about this idea, however. It is entirely out of kilter with the real world. Then again, one may find this approach attractive, since it is nothing but a weak-ish version of the long-standing rule: *Read the Policy Rule Citizen, for if You Don't the Justice System Will Kick Your Ass*. That is very disappointing to say the least. Still, many find "ought" a very stimulating, even powerful, word and idea, and it can by its self and be guidance to many.

First and simple enough, a vast majority of people buying insurance policies do not read them. "Everyone" knows this. Thus, if the test of prudence is doing what the reasonable person would, prudence does not require that the policies be read.

First and simple enough, a vast majority of people buying insurance policies do not read them. "Everyone" knows this. Thus, if the test of prudence is doing what the reasonable person would, prudence does not require that the policies be read. In some states it is obligatory that the citizenry buy policies; they are standardized; and the majority of residents there do not actually read them. This fact is true for most lawyers regarding some part of most of their contracts of insurance, though not for all lawyers and not all policies.

Second, if an insured can buy only one—or nearly one—type of form policy for a given risk, e.g., auto coverage and/or homeowners coverage, what difference does it make whether Jill has read the one she has bought? She is not taking much risk in not reading them both. For one reason, they will be substantially the same. Usually, there is (almost) no different type of coverage to buy, except for price and deductible.

Of course, for many types of policies, there are form endorsements that will change the policy. However, those are rare: they are likely to be expensive; the endorsements may not fit the rest of the policy very well; the insurers seldom bring attention to them or their availability; intermediaries often do not know of them, what their functions might be, and/or whether to suggest them. Of course, these observations are more common in modestly sized personal and small business policies than they are in larger, more complex commercial policies.

At the same time, sometimes there are several policies available, even for real people. Sometimes one insurer sells two or more of them. At the same time, customers are seldom informed regarding the range of choices. Moreover, sometimes the wording is so subtle between policy choices, that a person is unlikely to be able to tell the difference. Disability insurance policies are like this. One policy might set forth the requirement for coverage that the insured must be unable "to work at any occupation for which you are skilled by your education, training or experience," while the other one says "you are not able to perform the substantial and material duties of any occupation for which you are suited by your education, training or experience." Both share the problem (1) that the key list—education, training or experience"—if virtually not understandable by the "common man," (2) that the "or" in the list makes list un-understandable, and (3) that the two phrasings—"work at" and "perform the"—are quite different, although only subtly different in formulation. One wonders if the reasonable bright insurance adjuster, even one that has worked over time on disability cases, would be able to understand, formulate, and apply the differences as she must be able to do.

It should be recognized that the slogan "*Insureds must read*

their policies" has a significant role in socio-business life other than simply in litigation. Reformers use it to try to get strong laws requiring insurers to write understandable policies, simplicity being best. The axiomatic status of the slogan can help an insurer to resist the temptation to draft overly difficult policies in the service of its own self-interest. For good or for ill, it helps remind those who need it that insurance policies are contracts.

Having discussed some semantic problems with the "*Everyone Must Read Them Rule*," let's look at some more of the reasons why the necessity of having read a policy is not actually by itself a rule of law and/or should not be. Consider the following: at least some insureds are not always obligated to the insurer-issuer of that policy to have read the policy issued. It makes little sense to require a non-English speaker to read an insurance policy she cannot possibly understand. This idea is especially true when the insurer knows that the customer cannot read the policy, much less understand it. It is easy to generate a large number of different cases where this same point holds. It is much harder to draw limits. How non-English speaking must a person be before she is released from the duty to read?

Maybe underlying the rigidity and strength of the *Read It* Rule is precisely the messiness of our legal world. In it legal rules as to what counts as required understanding varies not at all in accordance with degree of intelligence, grasp of language, feel for how "things fit together," and so forth. This system involves all sorts of unintended consequences, and that is the mess. Some would assert that an opposite system would only appear to create justice. Instead it would create a new kind of messiness. For example, it would increase litigation and encourage insurance fraud. There is no evidence for this kind of assertion, but there is none for its negation either.

It is worth pondering whether a good way to deal with the "Problem of Messiness" would be not to require that an insured must understand the policy unless that insured was negligent in failing to understand it. There is not much law favoring this view, but there is a little, even though the inclination of the courts toward it is weak, to say the most.

There is a perfect Supreme Court of Texas case, which does not seem cited much. In *Fireman's Fund Indemnity Co. v. Boyle General Tire Co.*, the court stated: "The rule followed in Texas is that an insured who accepts a policy without dissent, is presumed to know its contents, but the presumption may be overcome by proof that 'he did not know its contents when it was accepted, as by showing that when he received it he put it away without examination, or that he relied upon the knowledge of the insurer and supposed he had correctly drawn it.'"[14] Another Texas Supreme Court case is nearly as good—*Colonial Savings Ass'n v. Taylor*, which cites and quotes *Boyle Tire,* and states that it is Texas law.[15] Strangely, *Boyle Tire* and *Colonial Savings*, while cited for other propositions, are not cited positively for what is being discussed here. It is as if makers of Texas law are trying to avoid it.

There might be a subtle and hidden way to get to the idea that a policyholder is not always commanded by law to understand the language of her policy. It goes this way. Often courts, especially in recent times, say that policyholders are **"presumed"** to have understood the policies. However, presumptions are often rebuttable; indeed, there is a whole category of presumptions which is precisely called "rebuttable presumption," as opposed to "conclusive presumptions." Almost all rebuttable presumptions are linked to the idea of negligence; the whole point is that if it is rebuttably presumed that a person is legally blameworthy for something, then she is not blameworthy if she was not actually negligent.[16] At the same time, presumptions are not always tied to negligence. In all cases, however, a rebuttable presumption is to be thought of as a prima facie case and nothing more.

Some cases do not describe how policyholder plaintiffs are to be conceived. Some do not say "presumed"; instead they say "**deemed**."[17] It is difficult to be sure what the distinction might be. Contemplation-by-hearing or meditation-on-usage might incline one to believe that the word "**deem**" refers to a conclusive presumption. There is truth in this idea. It is not easy to think of a deeming being set aside by evidence, as is the case with presumptions. Then, that whole idea may be an argument from imagination and have no rational grounding at all.

Maybe allegiance to the *Read It* Rule is an attachment to the classical ideas of contract law, one of which is that all contracts are fundamentally alike. They are all exchanges of some sort where consideration is involved and so the reciprocal rights and duties, as it were, "running across the table" are pretty much the same. There has been doubt about this idea for a long, long time. Even then, there are exceptions. Consider the situation in which there are two contracts between the same parties on the same topic, and one of them contradicts the other. Since the second one will take precedence over the first, it is not necessary for a party to have read the first one.[18] (Presumably, the second contract must have failed in some regard. Otherwise, it would be difficult to see why the non-reading of the first contract would not be an issue.)

Nevertheless, consider an observation of Samuel Williston, perhaps one of the two greatest scholars in contract law history:

> To be sure, the law with respect to insurance contracts is subject to other public policies, including the fact that it is a highly regulated industry that the policies are often lengthy, standardized forms filled with complex provisions, and that relative bargaining

> power of the parties is sufficiently uneven to justify some modification of the principles stated in the text. The concept of protecting the reasonable expectations of the insured may therefore lead a court to de-emphasize the so-called duty to read or the implied assent that accompanies receipt and retention or signing of a document, under certain circumstances, where to do otherwise would lead to unconscionable or unfair results. Where, however, the language of the policy is clear and the insured's reasonable expectations are not frustrated by application of the rule, it is regularly applied.[19]

Few would dissent from the spirit of this observation. However, what Williston does not mention is that his term "de-emphasize" really undermines the whole logic of the *Read It* Rule. If you de-emphasize what has been passed off as an axiom, it is no longer an axiom and probably never was.

One of the most respected current scholars of insurance, both in law and in practice, Kenneth Abraham, of the University of Virginia School of Law, who has written a leading book on insurance law, as well as many articles and pieces of his own, has written this:

> In property-casualty lines of insurance, where industry-wide standard-form policies are the norm, all insurers offer the same standard policy on the sametake-it-or-leave-it basis. Comparison of the terms offered by different insurers, except for price differences, is therefore pointless. And in any event, ordinarily the policyholder does not receive the policy containing the terms in question until weeks or months after it has been purchased and the parties are bound by it. Any knowledge of a policy's terms that the occasional policyholder gains by reading the policy upon receiving it has no bearing on the policyholder's intent at the time the policy was purchased.[20]

Professor Abraham is not quite right about that. Not all homeowners' policies are exactly the same; this is especially true where there are endorsements. Significantly, some endorsements are subject to some negotiation, and it is true that most agents know nothing about them. This is particularly true at the high end of property residential policies, including coverages for expensive personal property (such as art, antiques and jewelry), animal insurance (medical and/or life and/or theft), insurance for home functions like banquets, parties, weddings and the like, etc.

At the same time, an earlier edition (the Third) of the Williston treatise has been quoted as saying, "The final and perhaps the most significant characteristics of insurance contracts, is the increasing tendency of the public to look upon the insurance policy not as a contract but as a special form of chattel. The typical applicant buys 'protection' much as he buys groceries."[21]

Perhaps the best way to think of Williston's first observation is to formulate contract and therefore insurance policy interpretations in terms of a "relational theory." In sum, this view is that the nature of the relationship between contract parties, not only one-to-one parties to a contract between only them (and in similar parties to contracts), but also the categories of relationships must be regarded as relevant to interpretation. [22]

To return to the topic of de-emphasis, there are other ways the Rule can be "de-emphasized" and its' axiomatic status be destroyed. One of them is common; one is dramatic. Consider this sample, a very common formulation of the Rule: "**Ordinarily**, a policy holder has a duty to examine the policy and make sure [proper] coverage is provided."[23] The important word here is "ordinarily." That does not mean "always"; that does not even mean "except for rarely." The word "ordinarily" actually means "quite often."

There is also the dramatic and much rarer situation, which "de-emphasizes" the Rule. This is found in the paradoxical relationship between the *Read It* Rule and the law of fraud. At least one important kind of fraud arises when someone selling an insurance policy, deliberately leads a buyer into believing that, the given propositions are in a policy when they are not. A very simple example of this would be the deliberate statement that the policy limit was $1000 and the deductible was $1, while in fact, the limit was $100, and the deductible was $99. No one thinks that the Rule somehow defeats a claim of fraud, although if the *Read It* Rule is axiomatic, then defeating a claim of fraud would be much easier.

> Yes. It is true I did lie to him about what the policy contained. But he cannot now claim that he did not know what was in the policy as the result of what I did. If he had read the policy, as he must do, he would have found out that I was lying to him, and he should not have purchased the policy.

This argument, of course is ridiculous, and would unlikely be taken seriously. This fact, however, indicates that the Rule is not as axiomatic as it appears to be. Even the most militant jurisprudential absurdists in this situation would have to admit that there are situations in which their argument is not likely to work. Consider a situation derived from ordinary contract law. The rule is that when one party reads, describes, and/or explicates the contract to another party, say, because the second party does not, since he cannot read it—perhaps because he lost his glasses—the reading party has an obligation to get the language and meaning of the contract right. Even an absurdist, dedicated to imaginary orthodoxy—absurd because not even classical contract law—would have to admit that in this situation, the fraud

claim would triumph. This is very old law in Texas[24] and it does not even require fraud; apparently all it requires is mistake.

> Of course, it is well-established law in Texas, and pretty much everywhere else in the English-speaking world, that a contract is considered as a whole and each part is given effect.[25] At the same time, specific provisions in insurance contracts control specific matters including grants of coverage, exclusion, conditions, and so forth. These points are first year law school induced common sense. It is not the case, however, that not knowing the whole, distorts reading of one part—or some parts—in all relevant respects, or at all.

There is another approach to the "Read It!" problem, which has been articulated recently by the West Virginia Supreme Court.[26] In that case, an agent (presumably for the insurer, at least) provided the insurance customer a long-ish description of what was to be in the policy. The agent represented that this document expounded the actual contents of the policy to come: "any policy issued would cover the barge and its contents and the two docks." That brochure contained no reference to wear-and-tear as an exclusion. However, the policy itself did, and it did so quite clearly and conspicuously on its first page. The insured entities were lost and New Hampshire denied coverage, partly on the grounds of the wear-and-tear exclusion. The insureds argued that they had a reasonable expectation that there would be no such exclusion. The Texas Supreme Court, like the trial court below, accepted that view of the law based on precedent developed for similar—but only similar—situations. At the same time, the trial court had gone further and issued partial summary judgment in favor of the insured. At the same time, the court reversed the trial court's grant of summary judgment, holding that there was a fact issue as to whether the insured's beliefs were actually reasonable.[27]

As interesting as legal theory is, the right way to understand the *Read the Policy, You Idiot* Rule also has practical importance. Consider taking a deposition. A lawyer's question may be formulated in such a way as to invite the witness to say that she has not read a policy. The lawyer can then indicate by further questions that this "failure" is somehow subject to legal or other non-legal criticism, for example, extra-legal-shamefulness. In doing this the lawyer may have enhanced his client's position. On the other hand, if the witness is clear that she is not required to have read the policy, where that idea means "the whole policy," the confidence of that witness may continue.

And consider how the difference might affect a trial.

> Q. "Have you read the policy?"
>
> A. "Yes, some of it."
>
> Q. "Which parts of it did you read?"
>
> A. "I don't remember, but it was parts—not just one—and I thought at the time they were important, just as I do now."
>
> Q, "Did you read this one [pointing at the screen]?"
>
> A. "Again, I don't remember. It was several years ago. But I might well have done so."

Of course, there are a huge number of ways the theories discussed in this essay might impact practical practice. It is always better for an insured to know that *Read It* does not imply *Read It All*, and it may not, in all situations, imply *Understand It at All Times*, no matter who you are and no matter how the purchase process worked.

It would surprise no one that there are many more theoretical points to consider and many, many more practical observations to consider. However, as least one poet must have put the point, at some time, maybe 3000 years ago, and, in part, more recently by Tim Bergling, "Enough is enough, as is too much."

1 *See* John D. Calamari, *Duty to Read—A Changing Concept*, 43 Fordham L. Rev. 341, 362 (1974).

2 *See* Arnold v. Nat'l County Mut. First Ins. Co., 725 S.W.2d 165 (Tex. 1987) and numerous citing cases thereafter.

3 PAJ, Inc. v. Hanover Ins. Co., 243 S.W.3d 630 (Tex. 2008) (a complex and innovative decision). *See also* Prodigy Commc'ns Corp. v. Agricultural Excess & Surplus Ins. Co., 288 S.W.3d 374 (Tex. 2009).

4 *See* Bituminous Cas. Corp. v. Vacuum Tanks, Inc., 75 F.3d 1048, 1056 n.6 (5th Cir. 1996). Texas courts have, at least on the surface and/or by reference to other remedies, clung to the view that prejudice is not required for insurer victory if an insured has breached a condition precedent in an insurance policy, of which the cooperation clause is one. Members Mut. Ins. Co. v. Cataia, 476 S.W.2d 278 (Tex. 1972). At the same time, the Texas Supreme Court has opened wide the door for declaring prejudice a necessary condition for an insurer's successful contra-insured invocation of the cooperation clause. *Id.* at 281.

5 *See* May v. United Servs. Ass'n of Am., 844 S.W.2d 666, 669 (Tex. 1992). *See also* Frith v. Guardian Life Ins. Co. of Am., 9 F. Supp. 2d 744, 745 (S.D. Tex. 1998) ("Under Texas law, an insurance agent has no duty to explain policy terms, and the insured has a duty to read his insurance policy and is bound by the policy terms even if they were not fully explained."); Avila v. State Farm Fire and Cas. Co., 147 F. Supp. 2d 570, 581 (W.D. Tex. 1999) (same).

6 *See* Aetna Ins. Co v. Holcomb, 89 Tex. 404, 413, 34 S.W. 915, 919 (Tex. 1896). This "ancient" rule is still a rule in many places, but it was recently rejected by the New York Court of Appeals. *See* Am. Bldg. Supply Corp. v. Petrocelli Group, Inc., 19 N.Y.3d 730,

736–37, _)__ N.E.3d ___ (N.Y. 2012).

7 Then again, *see* N. Assurance Co. of Am. v. Stan-Ann Oil Co., Inc., 603 S.W.2d 218 (Tex. Civ. App.—Tyler 1979, no writ), a potential forerunner for the dominance of the *Read It* Rule.

8 *Id.*

9 *Id.*

10 Restatement of Contracts (Second) § 205 (1981).

11 Aquila Sw. Pipeline, Inc. v. Harmony Exploration, Inc., 48 S.W.3d 225, 235 (Tex. App.—San Antonio 2001, pet. denied).

12 *See* Morrison v. Ins. Co. of N. Am., 69 Tex. 353 356, 6 S.W. 605, 606 (Tex. 1887).

13 Jay M. Feinman, *The Law of Insurance Claim Practices: Beyond Good Faith*, 47 Tort Trial & Ins. Prac. L.J. 693, 709 (2012).

14 Fireman's Fund Indem. Co. v. Boyle Gen. Tire Co., 392 S.W.2d 352, 355 (Tex. 1965) (Pope, J.).

15 Colonial Sav. Ass'n v. Taylor, 544 S.W.2d 116, 119 (Tex. 1976).

16 Beck v. Sheppard, 566 S.W.2d 569, 571 (Tex. 1978) (involving bailment: horse killed by auto); Buchanan v. Byrd, 519 S.W.2d 841, 843 (Tex. 1975) (involving bailment: horse killed by train).

17 *See* Shindler v. Mid-Continent Life Ins. Co., 768 S.W.2d 331, 334 (Tex. App.—Houston [14th Dist.] 1989, no writ) ("An insured will be deemed to know the contents of the contract he makes."); Roland v. Transamerica Life Ins. Co., 570 F. Supp. 2d 871, 880–81 (N.D. Tex. 2008), *aff'd*, 337 Fed. Appx. 389 (5th Cir. 2009) ("In Texas an insured has a duty to read the insurance policy and is charged with knowledge of its provisions. An insured is deemed to be on notice of all terms of an insurance policy.") (McBryde, J.) (citations omitted).

18 *See* London Terrace, Inc. v. McAlister, 180 S.W.2d 619 (Tex. 1944).

19 Richard A. Lord, 2 Williston on Contracts § 6:43, 478–49 n.10 (4th Ed. 1991).

20 Kenneth Abraham, *Four Conceptions of Insurance,* University Of Virginia School Of Law: Public Law And Legal Theory Research Paper No. 2012-34, p.8 (March 5, 2012). [This paper may be down-loaded without charge from the Social Science Research Network Electronic Paper Collection: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2016320 and elsewhere.]

21 *See* Feinman at n.11, *supra*; C & J Fertilizer, Inc. v. Allied Mut. Ins. Co., 227 N.W.2d 169, 178 (Iowa 1975 increasing tendency of the public). Then again there is Estin Const. Co, v. Aetna Cs. & Surety Co., 612 S.W.2d 413, 424 (Mo. App. 1981) (purchasing insurance policies more "as a purchase of services rather in the nature of a special chattel"). Tendencies in this same direction may also be found in W.N.McMurry Constr. Co. v. Community First Ins., Wyoming, 160 P.3d 71 (Wyo. 2007) and in the brilliant opinion by District Judge Richard A. Jones in Trident Seafoods Corp. v. Commonwealth Ins. Co., 850 F.Supp.2d 1189, 1197 (W.D. Wash. 2012).

22 *See* Feinman, n.18 *supra*. He discusses the "Relational Theory" throughout his essay, as well as other analogies (or metaphors). He remarks, in effect, that his is the best.

23 *See Stan-Ann, supra* n.7 for a particularly unusual case. In it an insured failed to list certain business facts in required monthly reports required by the insurer. The agent knew that the insured was not listing what was required and failed to mention what he knew to the insured. In this situation, the *Read the Policy Rule* was overridden.

24 *See* Demees v. Bluntzer, 70 Tex. 406, 7 S.W. 820 (Tex. 1888) (involving quick sale of 2100 heifers).

25 *See* Anglo-Dutch Petroleum Int'l, Inc. v. Greenberg Peden, P.C., 352 S.W.3d 445, 449–50 (Tex. 2011).

26 New Hampshire Ins. Co. v. RRK, Inc, 2012 WL 5480054, ___ S.E.2d __ (W.Va. 2012).

27 Although this decision was labeled "per curiam," there was a dissent directed at the decision itself and the relevance of the precedent the majority relied upon. The majority had relied on four to five previous opinions. Incidentally, there was at least one other issue involved in the case; it is irrelevant here.

By David S. White and Rachelle H. Glazer

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RECENT FIFTH CIRCUIT AND TEXAS SUPREME COURT INSURANCE DECISIONS[1]

The Fifth Circuit Holds That the Mere Allegation of "Property Damage" Without Some Factual Allegations of Physical Injury or Loss of Use of Tangible Property Cannot Trigger a Duty to Defend.

PPI assisted in planning and drilling oil and gas wells on certain leases. After completion of one of the wells, non-operator working interest owners sued PPI for negligence and gross negligence. The plaintiffs alleged that PPI drilled the well on the wrong lease, resulting in a "dry hole" and "property damage." PPI tendered its defense to Liberty Mutual, which the insurer refused. Coverage litigation followed. The lower court granted summary judgment to Liberty and held that the allegations of "property damage" in the underlying lawsuit were purely legal in nature and did not include any factual allegations that could trigger the insurer's duty to defend.

On appeal, the Court agreed. Even though a court should construe insurance policies and pleadings liberally in favor of finding a duty to defend, that duty "arises only when the *facts* alleged, if taken as true, would potentially state a cause of action falling within the terms of the policy."[2] The relevant allegations in the underlying lawsuit are:

> PPI caused the drilling rig to be towed to [] and placed upon [] the wrong location [which] resulted in the well being drilled in the wrong location [and] a dry hole. [Plaintiffs seek recovery in excess of $4.2 million for drilling costs and $737,752 in delay rentals to maintain the lease that should have been drilled. One of the plaintiffs also alleged that] PPI caused property damage to [lessor], including physical injury to tangible property, including all loss of use of the property.

"Property damage" is defined in the policy as "physical injury to tangible property . . . or loss of use of tangible property that is not physically injured."

The reviewing panel noted that PPI was not the first to be sued and seek coverage for drilling a well in the wrong location. The lower court had relied on *Lay v. Aetna Insurance Company*,[3] in which a driller misread the surveyor's stakes and drilled on an adjacent, unleased tract. The damages sought were the wasted drilling costs and the cost of an assignment of drilling rights from the owner of the adjacent tract. The relevant policy definitions in *Lay* are identical to those here. The *Lay* court held that these damages were economic only, not damage for physical injury to tangible property. Accordingly, the lower court held that a "claim for damages from a misplaced well did not qualify as property damage."

By way of comparison, the Fifth Circuit panel considered a similar case where a court ruled that the alleged facts were sufficient to allege a "property damage" claim.[4] The underlying lawsuit in *Camaley* alleged that a driller had failed to properly evaluate the location of a well, resulting in the lease line being crossed, which constructively evicted the plaintiffs from their land. The *Camaley* court held that this alleged constructive eviction from land constituted a specific allegation of "loss of use" of tangible property, one prong of the "property damage" definition. Here, the panel said, "loss of use" was not seriously raised because no specific loss of use is mentioned in the underlying pleading or in PPI's briefs on appeal.

PPI cited several cases, which the Court held were distinguishable because they all, in one way or another, alleged items of physical injury.[5] PPI also argued that more detailed pleadings could have mentioned instances of physical injury, which the Court said made the insurer's argument: Texas courts are admonished not to "read facts into pleadings" or "imagine factual scenarios which might trigger coverage."[6] Where, as here, the Court concluded, the pleadings assert no more than a label or legal theory, and not a factual allegation, the insurer has no obligation to defend.

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The Eight-Corners Rule Should Have Barred Consideration of Insurer's Affidavit.

Colony Nat'l Ins. Co. v. Unique Indus. Prod. Co., 487 Fed. Appx. 888, 2012 WL 3641523

(5th Cir. 2012)

In this case, the Fifth Circuit once again applies Texas' eight-corners rule and reverses summary judgment in favor of the insurer based in part on the lower court's consideration of an affidavit that was outside the eight corners of the policy and the underlying petition. However, the panel split on application of a consent-to-settle exclusion, an issue that the lower court had not reached. Two of the judges decided to remand the case for further factual development of the disposition of the underlying lawsuit against the insured. A dissenting judge would have rendered judgment, arguing that the summary judgment evidence sufficiently showed that the insured had breached the consent-to-settle provision.

Unique Industrial produces brass fittings and swivel nuts for use in plumbing systems. One of its customers notified it of complaints that its products were failing, causing damage to residences. As a result, the insured agreed to begin supplying a different type of swivel nut to the customer, but that step apparently failed to solve the problem. Both the insured and its customer were named in two separate lawsuits alleging failures of the swivel nuts, which Unique tendered to its insurer for defense and indemnification. Colony refused the request and sought declaratory judgment against its insured in federal court.

Based primarily on the insurer's testimony in an affidavit, the district court granted summary judgment on grounds that Unique had known of the losses alleged in the lawsuits before purchasing liability insurance policies from Colony, thus triggering a known-loss exclusion. On appeal, the panel considered whether the lower court had improperly considered the extrinsic affidavit evidence in violation of Texas' eight-corners rule. Under this rule, a court determines an insurer's duty to defend only with reference to the allegations in the underlying petition and the terms of the insurance policy. The panel noted that the Texas Supreme Court had not recognized any exception to the eight-corners rule but has stated that "any such exception would not extend to evidence that was relevant to both insurance coverage and the factual merits of the case as alleged by the third-party plaintiff."[7] Some intermediate Texas courts, as well as the Fifth Circuit, have allowed certain exceptions to the eight-corners rule, but only where the extrinsic evidence is relevant to an independent and discreet coverage issue and does not touch on the merits of the underlying third-party claim.

All members of the panel held that the underlying allegations alleged that Unique had acknowledged earlier failures of its product but had indicated that it would provide different swivel nuts going forward. Nothing in the pleadings indicated that the insured was aware of product losses after that representation but before it procured the policies from Colony. Accordingly, the Court held, based solely on the eight-corners evidence, that the allegations in the lawsuit did state a potential for coverage that triggered Colony's duty to defend.

The panel next considered Colony's assertion that the insured agreed, without the insurer's knowledge and consent, to accept responsibility for claims against its customer, which breached the consent-to-settle clause, providing that an insured will not "voluntarily make a payment, assume any obligation, or incur any expense . . . without [Colony's] consent." Colony's assertion is based on allegations in the underlying lawsuits that Unique had agreed at one point to take responsibility for existing and future claims. A majority of the Fifth Circuit panel decided that the issue should be determined on remand to the lower court, reasoning that the alleged agreement might not constitute the type of agreement referenced in the consent-to-settle provision and that the lower court, not having addressed the issue before, should be allowed to consider the issue. One of the judges dissented and found that the lawsuits clearly alleged a breach of the policy.

Although the dissent is probably correct that an agreement was alleged in violation of the policy, the majority seemed to prefer further findings on remand, particularly in light of the Texas Supreme Court's decision in *PAJ, Inc. v. Hanover Ins. Co.*[8], holding that a notice-of-suit requirement in a liability policy was a covenant, not a condition precedent, and the insurer had to prove that breach of the provision caused prejudice. It will be interesting to see if the lower court finds that a consent-to-settle is not a condition precedent, and even more interesting if the insured's settlement, if any, is found not to have prejudiced the insurer.

Careless Drafting Causes Loss of Coverage.

Ace Am. Ins. Co. v. Freeport Welding & Fabricating, Inc., 699 F.3d 832 (5th Cir. 2012)

This case presents a cautionary tale that sloppy drafting can lead to unhappy results. In October 2008, Freeport issued a purchase order to Brand Industrial, a subsidiary of Brand Energy, for installation of a lining, or refractory, in Freeport's vessel. The purchase order was somewhat brief, providing only that acceptance of the order constituted acceptance of all terms and conditions listed in the order and that a detailed scope of work and requirements were to follow, "work to be performed approx. 2nd quarter of 2009." In January 2009, Brand Energy sent a letter to Freeport stating

that Brand Industrial "has turned your work over to our parent company, Brand Energy Solutions, LLC."

Also in January 2009, Freeport and Brand Energy entered into a purchase agreement "effective January 1, 2009 to evergreen,"[9] which was to be applicable to purchase orders issued from Freeport to Brand Energy. The agreement stated that "in the event that Freeport provides notice in writing to Brand Energy that it is to provide goods and/or services to Freeport, then the terms of the purchase agreement, effective January 1, 2009, shall apply." The agreement further stated that the terms and conditions "are hereby incorporated by reference to all purchase orders issued by [Freeport] to [Brand Energy] and shall govern all such transactions." The agreement also required Brand Energy to (1) carry certain insurance coverage, including CGL insurance, with an endorsement naming Freeport as an Additional Insured, and (2) indemnify Freeport from any and all claims and liabilities except those caused by the sole negligence of Freeport. Brand Energy's CGL policy contained several additional insured endorsements broadly adding as an insured under the policy anyone that the named insured agreed in writing to add as an additional insured.

Brand Energy began installation of the refractory in May 2009, and the project was completed in August 2009. Shortly after the work began, several workers installing the refractory were injured and sued Freeport and Brand Energy for various acts of alleged negligence. Freeport tendered the lawsuits to Brand Energy for notice to Brand Energy's insurer, ACE, which subsequently refused to defend or indemnify Freeport. A coverage action ensued. The lower court granted summary judgment in favor of ACE, holding that the insurer did not have a duty to defend Freeport because Freeport was not an additional insured under Brand Energy's policy. The lower court also withheld judgment on the insurer's duty to indemnify until after the underlying suit had been resolved.

On appeal, the Fifth Circuit panel did not state the lower court's basis for holding that Freeport was not an additional insured. However, based on its review of the 2009 purchase agreement, the Court found that Freeport clearly qualified for additional-insured status, but only for purchase orders arising under the 2009 agreement. Because it found that the lawsuit arose out of work under the 2008 purchase order, the panel held that Freeport was not entitled to additional-insured status with respect to the underlying state court claims. The court reasoned that the purchase agreement became effective on January 1, 2009 and applied to purchase orders issued by Freeport to Brand Energy after the effective date. Because 2008 purchase order pre-dates the 2009 agreement, and the 2009 agreement does not reference the 2008 purchase order or the refractory work, the Court found that Freeport was not entitled to defense or indemnity for the lawsuit.

Freeport argued that the 2009 purchase agreement applied to the 2008 purchase order, but the Court found nothing in the purchase agreement indicating that it should have retroactive application. Freeport also argued that the 2009 purchase agreement said that it applied to "all purchase orders," but the Court rejected that argument, holding that it would render the purchase agreement's term of coverage entirely meaningless. Because the parties had settled the underlying state court lawsuit, the Fifth Circuit panel remanded the case back to the lower court to determine if ACE might have a duty to indemnify Freeport by virtue of the indemnification agreement in the 2009 purchase agreement.

This decision raises some questions. It is not clear, for example, whether the appellate Court ignored as extrinsic evidence some of the parties' communications, particularly Brand Energy's letter to Freeport saying that Brand Industrial had turned the refractory work ordered in 2008 over to its parent company, which arguably shows the parties' understanding that at least one of the work items under the 2009 agreement was the 2008 refractory work, particularly since the 2008 purchase order stated that the refractory work would take place approximately in the second quarter of 2009. The panel never says that it is excluding such evidence, but it cites extensively to eight-corners cases as one of the applicable legal standards. Unless either the panel or the lower court applied the eight-corners rule to exclude evidence of something, there would be no reason to refer to that rule at all.

Also, the Court does not explain how the indemnification clause in the 2009 agreement can apply to claims arising from the refractory work ordered in 2008, thus pre-dating the 2009 agreement, if, as the Court held, the additional-insured provision in the 2009 agreement does not cover those claims. On balance, it is probably fair to say that the Court applies a very tight construction of the parties' agreement. Consequently, the lesson here is that the drafter should be careful to nail down the salient details when preparing a contract. All that Freeport would have had to do is make specific reference in the 2009 purchase agreement to the prior purchase order issued to Brand Industrial.

Potential Coverage Defenses Do Not Create a Conflict of Interest When the Insurer Does Not Reserve Rights to Raise Them.

Coats, Rose, Yale, Ryman & Lee, P.C. v. Navigators Specialty Ins. Co., 489 Fed.Appx. 769, 2012 WL 4858194 (5th Cir. 2012)[10]

This is a dispute over whether the insured has a right to select defense counsel when the insurance policy contains an exclusion that could apply to certain claims, but the

insurer explicitly avows not to assert that coverage defense. The insured is a law firm sued by former clients who alleged common law malpractice and breach of fiduciary duty claims and also sought a declaratory relief. The malpractice plaintiffs sought compensatory and special damages, including forfeiture of all attorneys' fees previously paid. The law firm was insured under a professional liability policy that granted to the insurer the right to defend the insured, including the right to select defense counsel. The policy also contained an exclusion for claims arising from any dishonest, intentionally wrongful, fraudulent, criminal, or malicious actions. The insurer agreed to defend its insured in a reservation of rights letter that omitted any reference to the dishonesty exclusion.

The insured refused to accept the insurer's selection of counsel, asserting that a conflict of interest existed that effectively transferred to the insured the right to select defense counsel. The insured hired its own counsel, but the insurer refused to reimburse attorneys' fees incurred in the defense of the malpractice action. Accordingly, the law firm brought a coverage action.

The lower court recognized that the issue was controlled by the Texas Supreme Court's decision in *North County Mutual Insurance Company v. Davalos*,[11] which held:

> Whether an insurer has the right to conduct its insured's defense is a matter of contract. Under certain circumstances, however, an insurer may not insist upon its contractual right to control the defense . . . One such circumstance is when an insurer makes a reservation of rights which, under Texas law, creates a potential conflict of interest. Such reservations create an actual conflict of interest when the facts to be adjudicated in the liability lawsuit are the same facts upon which coverage depends.[12]

The insured argued that the insurer's ability to deny coverage in the future created a present conflict of interest, even though the insured acknowledged that the insurer had not reserved any right to deny coverage based on the dishonesty exclusion. In fact, the insurer had explicitly stated in writing that it had not and would not assert that exclusion as a basis for denying coverage.

The insured also argued that a conflict of interest existed because the policy covers compensatory damages but not the return of fees, and the underlying lawsuit alleges both. Arguably, therefore, defense counsel hired by the insurer could steer any damage award toward the return of fees, such that the award would not be covered. The insurer responded that any factual findings supporting a return of fees award would also support compensatory damages; therefore, the insurer would have no incentive to tilt the damage facts toward a return of fees. The lower court agreed and found that the insurer had no incentive to concede any facts that would tend to prove liability on either basis of recovery.

Finally, the law firm argued that the insurer created a conflict of interest by reserving rights to deny coverage for costs arising from declaratory relief, contending that this provided an incentive for the insurer's selected attorney to litigate the underlying litigation as a declaratory judgment claim rather than malpractice or breach of fiduciary duty claims. The insurer responded that it disclaimed costs arising from the declaratory relief only because there cannot be independent liability arising from declaratory relief. The court agreed, and held that the attorney hired by the insurer would have no incentive to do anything but vigorously defend the declaratory judgment claim because any declaratory judgment relief granted would lead to liability under the malpractice or breach of fiduciary duty claim, both of which are at least partially covered under the policy. Accordingly, no conflict of interest existed, and the insurer had no obligation to reimburse the insured's incurred defense costs.

1 No significant Texas Supreme Court insurance opinions were issued in the relevant period.

2 Quoting *Northfield Ins. Co. v. Loving Home Care, Inc.*, 363 F.3d 523, 528 (5th Cir. 2004). [Emphasis in original].

3 *Lay v. Aetna Ins. Co.*, 599 S.W.2d 684 (Tex. Civ. App.–Austin 1980, writ ref'd n.r.e.).

4 *Mid-Continent Cas. Co. v. Camaley Energy Co.,* 364 F.Supp.2d 600, 602 (N.D. Tex. 2005).

5 For example, PPI r elied on *Admiral Ins. Co. v. Little Big Inch Pipeline Co*., 523 F.Supp.2d 524 (W.D. Tex. 2007) in which the underlying plaintiffs alleged as damage dug-up driveways, slabs, and foundations.

6 Quoting *Gore Design Completions, Ltd. v. Hartford Fire Ins. Co*., 538 F.3d 365, 369 (5th Cir. 2008).

7 *Pine Oak Builders, Inc. v. Great Am. Lloyds Ins. Co.*, 279 S.W.3d 650, 654 (Tex. 2009).

8 *PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 630, 633-37 (Tex. 2008).

9 The panel explained that "to evergreen" meant that the agreement automatically renews unless one of the parties sends the other notice of termination.

10 The Fifth Circuit's decision simply adopts the reasoning and conclusions of the lower court, attached to the decision.

11 *North County Mut. Ins. Co. v. Davalos*, 140 S.W.3d 685 (Tex. 2004).

12 *Id.* at p. 688.

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Comments

FROM THE EDITOR

By L. Kimberly Steele
Sedgwick, LLP

2012 was a good year for the Insurance Law Section--our membership numbers are better than they have been in years. The Chair of the Section, Vince Morgan, continues to do a stellar job in leading the Council, while working toward the future growth and purpose of the Section.

Membership in the Section carries with it a number of benefits, including access to this *Journal of Texas Insurance Law* and the weekly blast email "Right Off The Press", summarizing the prior week's most significant insurance-related cases. We hope that those of you receiving and, possibly even reading, these materials find them to be timely and informative. To that end, if there are ever modifications or additions that any of you would like to see in relation to any of the Section publications or seminars, please feel free to contact me or anyone else on the Council to discuss. We are always open to new ideas.

Special thanks to Pam Hopper of McGuire Woods LLP and Richard G. Wilson of Kerr Wilson, P.C. for their able assistance in editing this round of articles. Their help was indispensable in getting this issue out the door.

As always, we are looking for quality articles on current insurance-related issues. If you are interested in submitting one for inclusion in the Journal, please contact me.

L. Kimberly Steele
Publications Editor

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