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THE HISTORY AND CONSTITUTIONALITY OF THE COMMISSIONER'S POWER OF RESTITUTION AND ITS EXTENSION TO THE PROMPT PAY ACT

A. Introduction

From the earliest beginnings of the Texas Department of Insurance ("TDI" or the "Department") in 1876, neither the Department nor the Commissioner of Insurance had any formal power of restitution.[1] That changed in 1973 when H.B. 417, while not actually using the word "restitution," effectively gave the Board of Insurance the power to order an insurer, in very limited situations, to refund premiums collected from aggrieved insureds. Then, in 1987, S.B. 403 dramatically expanded the Commissioner's traditional enforcement powers by adding restitution as a new remedy. This time, it was specifically called "restitution." In 1999, through the enactment of H.B. 610 (the "Prompt Pay Act"), the Commissioner's enforcement powers, including the power of restitution, were implicitly extended to violations of the Prompt Pay Act.

Shortly thereafter, in 2000 and 2001, the Commissioner's power of restitution took center stage as the Commissioner ordered 47 insurers to pay $36 million in "restitution" to medical providers for violations of the Prompt Pay Act.[2] This action was so swift and of such magnitude that TDI referred to it as the "Prompt Pay Blitz."[3] But several questions remain about the Commissioner's unprecedented exercise of the power of restitution for prompt pay violations: (1) was it beyond the scope of the Legislature's original intent; (2) was it really restitution; and (3) was it constitutional under the separation of powers clause of the Texas Constitution?

B. Some Background on the Commissioner's Power of Restitution

Prior to the enactment of H.B. 417 in 1973, the Commissioner had no statutory authority to order restitution. But the Commissioner, nevertheless, had significant power over authorized insurers. Since as early as 1876, the Commissioner had been charged with seeing that all laws respecting insurance were faithfully executed.[4] If a company did not comply with the insurance laws, the Commissioner could suspend the company's entire business in the state.[5] The Commissioner also could revoke any certificate of authority when any conditions prescribed by law for granting it no longer existed.[6]

These powers are sometimes referred to as "agency muscle" or the Commissioner's "power of life and death" over an insurer, and could be used as an informal basis to order restitution. This use of the those powers was explained in the following exchange that took place in 1973 between industry expert Mr. Will Davis[7] and Rep. Arthur Temple (D-Diboll) during the legislative hearings on H. B. 417:[8]

> DAVIS: But they [the Department of Insurance] can and do by power of fiat, let's say, have thousands of dollars of money returned to people every year at the administrative agency. **Now, let me say, that I think that is beyond, beyond their authority, but is it not beyond their muscle because they hold the power of life and death over these people who are doing business under their authority, and that is the license that I mentioned earlier.** And if you tell them, if you don't return the premiums, we think that you have engaged in a practice which brings into our thinking your credibility for holding that license, they are going to return the premiums or the money, and they do.
>
> TEMPLE: **The insurance commission does not really have the authority to order any restitution?**

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DAVIS: **No sir, no sir. They do not.**

TEMPLE: What about the—what procedure does an individual have without legislation such as this, what remedy does a private citizen have if he feels that he presently—if he presently feels that he has been defrauded by an insurance company as it relates to the insurance commission, disregarding any other remedies he might have under civil procedure or whatever?

DAVIS: As it relates to the insurance commission?

TEMPLE: Yeah what-

DAVIS: Report the matter to the insurance commission for two purposes: one to see if the commission can help him recover his money that he feels he has been deceived out of-

TEMPLE: **Which they cannot do, right?**

DAVIS*:* **Legally, which they cannot do, but which they do all the time;** and secondly, to have that person or company subject to the sanctions as the Texas Insurance Code now vests in them. But then, he also has his private remedy of recovery, cancellation of policy, return of premiums, whatever it may be, and under Rule 42, I think a class action.[9]

At the time of Mr. Davis' testimony, the Commissioner's ability to cancel or revoke an insurance carrier's certificate of authority required notice and an opportunity for a hearing.[10] Still, this was, no doubt, the "power of life and death" referred to above by Mr. Davis. In addition to cancelling or revoking a certificate of authority, the Commissioner had other sanctions available, such as administrative penalties.[11] As if the prospect of those kinds of sanctions were not deterrent enough, if the Commissioner took any of those enumerated actions, he was required to give notice of that action to the insurance commissioner of each state.[12]

These weapons in the Commissioner's arsenal constitute an impressive array of "agency muscle." But as the exchange above makes clear, in spite of all the informal "agency muscle," industry experts such as Mr. Davis understood and recognized that the Commissioner, up to 1973, did not have the formal power to order an insurer to pay restitution.

C. The Initial Grant of the Power of Restitution to the Board

The need to rely on informal "agency muscle" for restitution ended in 1973 with the enactment of H.B. 417.[13] With that bill, the Legislature for the first time formally gave the State Board of Insurance the statutory authority to order restitution,[14] but the power was very limited. It only allowed the Board to order a refund of premiums collected by an insurer from aggrieved persons.[15] Further, the refund of premiums had to result from an insurer violating article 21.21, its rules or regulations, or the Deceptive Trade Practices Act ("DTPA").[16] Finally, the premiums refunded had to be net of policy benefits actually paid by the insurer while the policy of insurance was in force.[17]

Interestingly, the enactment did not use the word "restitution," although clearly the legal remedy of restitution would encompass the return of premiums to an insured by the insurer.[18] Also, this power could only be exercised through the procedural device of an administrative class action.[19]

D. The Expansion of the Power of Restitution By S.B. 403

Although the restitution provision in H.B. 417 was very narrowly targeted, S.B. 403's, in 1987, was not.[20] Instead, it dramatically expanded the Commissioner's power of restitution by adding the new power of restitution to article 1.10 of the Insurance Code, which, among other things, contained the Commissioner's "life or death power" to cancel or revoke a carrier's license.[21] This time, the enactment specifically used the word "restitution." As originally enacted, it provided that, if the Commissioner determined that it would be "more fair, reasonable or equitable" than cancellation or revocation, the Commissioner could "[d]irect the holder of such authorization to make complete restitution to all Texas residents, Texas insureds, and entities operating in Texas harmed by the violation or failure to comply."[22]

The restitution provision of S.B. 403 was recodified in 1999, with slight changes, as section 82.053(a) of the Insurance Code, and provides as follows:

> The commissioner may direct the holder of an authorization to make complete restitution to each Texas resident, each Texas insured, and each entity operating in the state that is harmed by a violation of, or failure to comply with, this code or a rule of the commissioner.[23]

A closer analysis of the new power reveals how much it expanded the Commissioner's power of restitution. Unlike H.B. 417, this new power applied not just to an insurer, but

to the "holder of an authorization." Thus, this new power conceivably could apply to the entire list of "authorized persons" in section 83.002.[24]

Further, the ability to order restitution not only "to each Texas insured," but to "each Texas resident," was an expansion from H.B. 417's authority to return premiums only to an insured. But the further ability to order restitution to be paid to "each entity operating in the state" conceivably would extend beyond Texas insureds and Texas residents to any entity—foreign or domestic—operating in the state.

The new power also expanded the kind of harm that could be remedied by restitution. In H.B. 417, the refund of premiums had to result from an insurer's violation of article 21.21, its rules or regulations, or the DTPA.[25] But in S.B. 403, restitution could be awarded to someone "that is harmed by a violation of, or failure to comply with, this code or a rule of the commissioner." Thus, this new power applied to a violation of any provision of the entire Insurance Code, or any rule of the Commissioner.

As this analysis demonstrates, S.B. 403 was a quantum leap from H.B. 417. Based on this new language of S.B. 403, it is difficult to imagine a situation in which the Commissioner could not order an "authorized person" to pay restitution for any violation of the Insurance Code or any rule of the Commissioner.

E. The Legislative Record about the Scope of Restitution in S.B. 403

Even though S.B. 403 dramatically expanded the Commissioner's power of restitution, there is no hint of that in the legislative record leading up to the enactment of the bill. The legislative history of S.B. 403 indicates the power of restitution was represented to have a far narrower scope. Admittedly, the scope of the power is determined primarily from the language of the statute, as enacted, rather than from representations made in legislative hearings.[26] Still, it is illuminating to see what the legislators were told about the extent of the power they were being asked to confer upon the Commissioner, as compared to the actual enactment.

The House Bill Analysis on S.B. 403 indicates the power of restitution was to be limited to requiring a carrier to give back premiums to a harmed policyholder. Specifically, the House Bill Analysis states that the bill "would allow [TDI] to require total restitution to harmed policyholders from companies, agents, and licensees".[27] But when compared to the phrase "each Texas resident" in the actual bill, there is no requirement that the Texas resident be a policyholder. Nor does the actual bill's phrase "each entity operating in the state" contain any such limitation. So while S.B. 403 definitely would allow restitution to a harmed policyholder, it certainly was not limited to policyholders.

When S.B. 403 was laid out for floor debate in the Senate, Sen. Bob Glasgow (D-Stephenville), the author of the bill, likewise affirmed the limited purpose for the power of restitution:

> Members, S.B. 403 is one of the State Board bills. Uh, what happens right now, the State Board of Insurance has the authority to enter sanctions for violations of the Insurance Code up to $10,000 against an insurance company. **But the State Board has no authority to require an insurance company to reimburse an insurer [sic] for premium payments that were not authorized to be collected. The only thing this bill does is authorize the State Board to order reimbursement to insurers [sic].**[28]

The House sponsor of S.B. 403, Rep. Al Price (D-Beaumont), made similar statements during the House floor debate.[29] Further, the following exchange between Sen. Glasgow (D-Stephenville) and members of the Senate Economic Development Committee, which held hearings on the bill prior to recommending its passage to the full Senate, also indicates the very limited purpose for the restitutionary power:

SEN. GLASGOW: Mr. Chairman and members, Senate Bill 403 is, uh, a bill that will give the Insurance Commission a little more authority. What they do is they have the authority now to revoke licenses and revoke charters. **[The] only thing this bill would do is also give them the authority to compel restitution to an insured if an insurer does something that would deprive him of his rights under the Insurance Code.**

QUESTION: They can't do that now?

SEN. GLASGOW: **They can not order restitution.**

QUESTION: ... What, what ground rules, what, **what constitutes restitution?**

SEN. GLASGOW: **Restitution under the law would be something that the insured has lost payment or lost**. . . . **It's a loss to the insured.**[30]

After making the foregoing remarks, Sen. Glasgow presented TDI Deputy Commissioner Michael Broll to the committee as a resource witness. In the following exchange between

Deputy Commissioner Broll and committee chairman Sen. O.H. ("Ike") Harris (R-Dallas), Mr. Broll likewise made it clear the intent of the bill from the Department's perspective was to give the Commissioner the power to order insurance companies to reimburse insureds for overpaid premiums:

MR. BROLL: Mr. Chairman, my name is Michael Broll. I'm deputy insurance commissioner for the State Board of Insurance. **Our intention with this bill is to require, uh, repayment of premiums. We do not wish to get into the loss adjustment procedure**, ah, [the] insured would have the courthouse remedy available to him. What this would concern is an insured is overcharged premium by an insurance company or by an agent. Uh, on an automobile policy he's charged 300 dollars when the state rates are 200 dollars.

CHAIRMAN HARRIS: I see.

MR. BROLL: **We are trying to get the insured back to paying only what he is required to pay under the law in that case. That is, that is restitution.**

CHAIRMAN HARRIS: One of the classics that I've seen over the years, or used to be the classic way, is on not having an insurance policy for a year. It would be cancelled, removed, or whatever for whatever reason halfway through the year. I'm entitled to half that premium back and a lot of those agents don't bother to ever get around to paying it; or used to not get around to paying it back. Is that the same kind of thing you're after?

MR. BROLL: Yes, sir; yes sir. **We're, trying to just, uh, require [the] insured to pay for proper coverage**, to pay what's owed under the statute **and nothing more.**[31]

Despite all these statements to the contrary in the legislative record, S.B. 403 clearly expanded the scope of the Commissioner's power of restitution far beyond the repayment of premiums to an insured.

This bit of legislative history illustrates several key points about the respective legislators' state of knowledge in passing S.B. 403. First, the legislators were told the Commissioner did not have the power of restitution. Obviously, H.B. 417 had given him that power, albeit through the procedural mechanism of an administrative class action. Second, legislators were told, repeatedly, that the power of restitution was to be used only to remedy the overpayment of premiums by an insured to an insurer**.** As Mr. Broll specifically stated, TDI did not want to get into the "loss adjustment procedure," as the insured would have the courthouse available for that. As will be seen below, that is exactly how the power was later used. Finally, the representations made to the legislators about restitution were consistent with the traditional meaning of the term at common law. However, that was not how the enactment was actually worded. That also was not how the power was ultimately used by the Commissioner in the context of the Prompt Pay Act.

While legislators asked *whether* the Commissioner had the power of restitution, none of them asked *why* the Commissioner did not have the power of restitution. To understand why the Commissioner did not have the power of restitution for so many years, a discussion of restitution and the Texas Constitution may be helpful.

F. What is Restitution?

Restitution is a remedy invented by the chancery and awarded in equity in various circumstances, including cases of unjust enrichment.[32] Restitution quickly became recognized at law as a tort remedy,[33] as a quasi-contractual remedy,[34] and as an alternative to benefit-of-the-bargain damages for breach of contract.[35]

Black's Law Dictionary defines restitution as restoring something to a person that has been wrongfully deprived of it:

> Act of restoring; restoration; restoration of anything to its rightful owner; the act of making good or giving equivalent for any loss, damage or injury; and indemnification. … Restoration of status quo and in an amount which would put plaintiff in as good a position as he would have been if no contract had been made and restores to plaintiff value of what he parted with in performing contract. … A person who has been unjustly enriched at the expense of another is required to make restitution to the other.[36]

The legislative testimony and representations about S.B. 403 were consistent with this commonly understood definition of restitution--to allow the Commissioner to order an insurer to restore to an insured the amount of premium that the insurer had improperly caused the insured to pay. Still, a question not asked by the legislators remains: Why did the Commissioner not have the power of restitution prior to 1973?

G. The Commissioner's Power of Restitution and the Separation of Powers Clause

Separation of the powers of government is a fundamental principle of constitutional jurisprudence.[37] It was incorporated into the constitution of the Republic of Texas,[38] and it has remained a part of every Texas constitution,[39] including the current one.[40] The current Texas Constitution expressly provides for the creation of three distinct and separate branches of government, each with its own powers, but none with the authority to intrude on the power of the others:

> The powers of the Government of the State of Texas shall be divided into three distinct departments, each of which shall be confided to a separate body of magistracy, to-wit: Those which are Legislative to one; those which are Executive to another; and those which are Judicial to another; and no person or collection of persons, being of one of these departments, shall exercise any power properly attached to either of the others, except in the instances herein expressly permitted.[41]

The separation of powers provision is violated when one governmental department (such as the legislative) assumes and delegates to another department (for example, the executive) a power that belongs exclusively to the third department (the judicial).[42] One of the principal purposes of separation of powers is to prevent excessive concentrations of power in the hands of any governmental official who might then abuse that power by acting arbitrarily.[43]

Within the three branches of government, the power to adjudicate private disputes is the fundamental characteristic that distinguishes the judiciary from the executive and legislative branches. As the Texas Supreme Court has noted on a number of occasions, "no power is more properly or certainly attached to the judicial department than that which determines controverted rights to property by means of binding judgments."[44] This means that, with very few exceptions, only the courts are empowered to determine controverted property rights.[45]

As discussed above, restitution is founded upon facts, such as the existence and amount of loss; damage or injury; the value of any performance rendered; the existence and extent of any enrichment; and whether, under the circumstances, the enrichment was unjust. If the Commissioner orders an insurer to pay restitution to an insured, the Commissioner is making some or all of these factual determinations, any or all of which may be disputed. In other words, the Commissioner's power of restitution presumes the Commissioner has the constitutional power to make every factual determination necessary to determine both the propriety *and* amount of restitution. Since most insurance policies are contracts between the insurance company and its insured, the Commissioner is adjudicating a contractual dispute between two private parties: the insurer and its insured. Thus, in H.B. 417 and S.B. 403, the legislature has given an appointed member of the executive department a power that is quintessentially a judicial function.[46]

The Commissioner's power of restitution should not be confused with the Commissioner's power to impose a fine on a holder of an authorization. It is one thing to require a holder of an authorization, such as an insurer, to pay a fine to the Department; it is quite another, from a constitutional standpoint, to have the power to order an insurer to pay money to another private party.[47] The Texas courts have been keenly aware of this distinction and have closely scrutinized whether a legislative grant of power to a governmental agency purportedly includes the power to order that money be paid by one private party to another.[48] Historically, Texas courts have paid particularly close attention when the governmental agency is the Department of Insurance.[49] As explained by the Austin Court of Appeals in 1962 in *McDonel v. Agan*:

> It is our opinion that the State Board of Insurance has no jurisdiction of a suit on a sworn account, be the account for insurance premiums or for butter and eggs. If it has, then the fall and decline of the judicial branch of the Government is well on its way.[50]

As a basis for its holding, the *McDonel* court cited to another court of appeals, which had come to the same conclusion:

> [T]he Legislature cannot deprive the courts of their judicial function to determine the legal rights of insurance companies and policy holders, consequent upon a correction being made in rate-application by such legislative agency, and vest such purely judicial function in such agency.[51]

The logic of the Austin Court of Appeals in *McDonel v. Agan* was compelling: If the legislature could delegate to agencies the power to decide common law disputes and require one private party to pay money to another, then the legislature, if it so chose, could completely circumvent the judicial branch of government. In spite of the holding in *McDonel v. Agan* and similar cases, S.B. 403 gave the Commissioner, an appointed member of the executive branch, the power to take money out of the pocket of one private party and place it in the pocket of another.

One can only speculate, but perhaps the holding in *McDonel v. Agan* was the very reason why the Department did not have the power to order restitution until 1973. When Will Davis testified to the House Business & Industry Committee in 1973 that the Department could not legally make a carrier give money back to an insured, perhaps he meant this would violate the separation of powers clause of the Texas Constitution. It is interesting that the legislative hearings on S.B. 403 contain no discussion whatsoever of its constitutionality.

All this is not to say that an agency can never decide factual disputes and cause one private entity to pay money to another. Exceptions exist where the Legislature creates rights and obligations that are "(1) unknown in the common law or (2) reasonable substitutes for common-law rights and obligations that are abolished by the Legislature."[52] In either of those exceptional cases, the Legislature may prescribe the conditions for recovery, including adjudication before an administrative agency.[53] Other than certain limited situations, however, the Texas courts have scrupulously guarded against usurpation of judicial power by the legislative and executive branches.[54]

At the present time, there is no reported case challenging the constitutionality of the Commissioner's power of restitution. So at least for now, the constitutionality of that power remains an open question. But if S.B. 403 indeed gave the Commissioner an unconstitutional power, the scope of the power was expanded with the enactment of H.B. 610.

H. Prompt Pay Legislation

In 1999, the legislature enacted H.B. 610, commonly known as the Prompt Pay Act.[55] Very generally, the Act requires payors, such as insurance companies and health maintenance organizations ("HMOs"), to pay or deny the bills of medical providers within forty-five (45) days after receipt, provided the claim was "clean," as defined by the Act.[56] If a payor violates the Act, the payor is subject to the various penalties provided for in the Act itself.[57] In addition, certain violations might subject a payor to administrative penalties under former article 1.10E of the Insurance Code.[58] However, these penalties are not the exclusive penalties for violating the Prompt Pay Act. The Act contains a "dragnet" provision clearly reading, "[i]n addition to any other penalty or remedy authorized by this code or another insurance law of this state".[59]

The language in the dragnet provision indicates the Commissioner can resort to the power of restitution for violations of the Prompt Pay Act, since restitution is an "other remedy" authorized by the Insurance Code in section 82.053. As discussed above, S.B. 403 allowed the Commissioner to order restitution to "each entity operating in the state that is harmed by a violation of, or failure to comply with, this code or a rule of the commissioner."[60] Since a medical provider would be an "entity operating in this state," the Commissioner could order an HMO, for example, to pay "restitution" to any medical provider that was harmed by a violation of the Prompt Pay Act.

That is exactly what the Commissioner did. TDI clearly adopted this construction of the interplay between the Prompt Pay Act and the power of restitution. On the TDI website, TDI listed the ability to "[o]rder Restitution within a specified period to any person or entity harmed" as one of the sanctions that could be imposed for Prompt Pay violations.[61]

This extension of the Commissioner's power of restitution to Prompt Pay violations certainly was beyond the original intent of S.B. 403. At the time S.B. 403 was enacted in 1987, it would be another twelve years before the Prompt Pay Act was passed. So logically, the Legislature could not possibly have intended for restitution to apply to violations of an act that had not yet been enacted. By including the dragnet provision—permitting any other penalty or remedy authorized by the Insurance Code—that is exactly what the Prompt Pay Act authorized.

I. Is Restitution Appropriate for Prompt Pay Violations?

Even though the Commissioner invoked his power of restitution to order insurers to pay money to medical providers, the question remains whether this is really restitution. In the typical "prompt pay" scenario, the insured (or, in most cases, the insured's employer) has paid a premium to the insurer in exchange for the insurer's promise to provide or arrange for covered medical care for the insured. To arrange for this medical care, the insurer then contracts with medical providers. Those contracts provide the conditions and terms of payment for the medical services to be provided. The insured then receives medical treatment from the contracted medical provider, and the medical provider, pursuant to the contract, sends its bill to the insurer.

From the standpoint of restitution, the critical fact is that the medical providers have not paid any money or premiums to the insurer. Also, they are not insureds of the insurer. In the typical "prompt pay" dispute, there are usually one or more disputed issues between the insurer and the medical provider. Frequently, these disputes concern contractual compliance by the medical provider. For example, the medical provider may be seeking payment for two days in the hospital, while

the insurer may claim there was authorization, as required by the contract, for only one day. But even if the medical provider's claim is properly payable, there is no money for the insurer to "restore" to the medical provider as restitution because the medical provider has not paid any premiums or other money to the insurer. The medical provider simply has a claim for payment. Hence, there arguably is no basis for restitution in the common law sense of the term. Instead, it is a run-of-the-mill contract dispute, albeit in the healthcare context.[62] If the medical provider were to sue the insurer and obtain a judgment, the judgment would be a judgment for damages, not a judgment for restitution of money previously paid to the insurer.[63] Analytically, since the medical providers in a prompt pay dispute have not paid any money to the insurers, there is nothing for the insurer to "restore." This analytical obstacle did not stop the Commissioner from ordering the insurers to pay "restitution" during the Prompt Pay Blitz.[64]

As noted previously, the amount of ordered restitution totaled $36 million.[65] To oversee the monumental task of requiring insurers to pay "restitution," the Commissioner appointed Audrey Selden as the "Provider Ombudsman" for prompt pay. Ms. Selden, in sworn testimony as the designated representative of TDI, explained the numerous factual issues that necessarily must be made, as to each claim, in order to calculate the amount of "restitution" owed:

QUESTION: Do you agree with Commissioner Montemayor's description . . . as to what would be entailed to go through that entire process of calculating the exact amount of restitution . . . ? And I'll just read to you. It says, "Consequently, a calculation of owed amounts would entail review of each claim, the contract between the health carrier and a particular physician or provider, review of the claim receipt documents, the payment made, the date of payment, amounts previously paid, usual and customary payments, and contract penalty or billed charges payment records."

MS. SELDEN: And what is the question?

QUESTION: Do you agree with Commissioner Montemayor that that's what you would have to do with respect to each claim in order to determine compliance with 20A.18B [the Prompt Pay Act] and hence, the amount of restitution?

MS. SELDEN: Yes, I do.[66]

According to Ms. Selden, in the event of a disagreement between a carrier and the Commissioner about those factual issues, the Commissioner makes the final determination:

QUESTION: Well, this Section A of Section 82.053 says that the commissioner may direct the holder of an authorization to make complete restitution to each Texas resident, each Texas insured and each entity operating in this state that is harmed by a violation of or failure to comply with this code or a rule of the commissioner. And Subsection B says, "The holder of the authorization shall make the restitution in the form and amount and within the period determined by the commissioner." So what I'm asking you is, if there's a disagreement between the HMO and the commissioner as to the amount of restitution to be paid, doesn't Subsection B of Section 82.053 give the commissioner the final say on determining the amount of restitution to be paid?

MS. SELDEN: Under provision B, yes.[67]

As this testimony illustrates, the Commissioner, in ordering restitution, was making the kinds of factual determinations about controverted property rights that Texas courts have held to be a function of the judiciary. Simply stated, section 82.053 of the Insurance Code enables the Commissioner to be both "prosecutor and jury." First, much like a prosecutor, the Commissioner is charged with enforcing the provisions of the Insurance Code.[68] Then, section 82.053 gives the Commissioner the power to order restitution, which, as shown in the testimony of Ms. Seldon, necessarily requires him to function as a fact finder, by deciding all factual disputes regarding entitlement to restitution and all facts necessary to its calculation.

J. The Commissioner is Lawmaker, Prosecutor, Fact Finder, and Judge

The concentration of governmental power in TDI and the Commissioner did not end with the dragnet provision in the Prompt Pay Act. In the Act, the Commissioner also was charged with adopting rules defining a "clean claim."[69] To discharge its task of formulating regulations about "clean claims," the TDI accepted multitudes of written comments, held a public hearing, and responded to comments.[70] The TDI initially issued proposed regulations for comment on December 17, 1999.[71] Among other things, TDI issued proposed, and later adopted, definitions relating to the general claim process, the required elements of a "clean claim," and the effect of filing a "clean claim."[72] Written comments on the proposed rules were due on January

17, 2000, and the public hearing was held on January 25, 2000. [73] After receiving and responding to the numerous comments, the TDI finalized the proposed regulations and the regulations were adopted on May 23, 2000.[74] In doing so, TDI, a member of the executive branch, had now taken on the role of "rule maker," or legislator. Simply stated, TDI and the Commissioner now had the power to create the rules, prosecute violations of those rules, make factual decisions about how much money to transfer from one private party to another, and then order that money to be paid.

Conclusion

The fear of power concentrated in the hands of a single person, class or group has, among other things, influenced the doctrine of the separation of powers. James Madison wrote in *The Federalist Papers* that the accumulation of the legislative, executive and judicial powers in the same hands may justly be pronounced the very definition of tyranny.[75] As discussed above, a fundamental principle of American constitutional jurisprudence, as expressed in article II of the Texas Constitution, is that the exercise of executive, legislative and judicial powers are to be vested in separate and independent organs of government.[76]

As discussed above, the same appointed member of the executive branch of Texas government writes the rules, enforces them, decides all factual disputes about their alleged violation, and orders payment. With this judicial authority vested in a member of the executive branch, is the "fall and decline of the judicial branch of Government . . . well on its way," as the court in *McDonel v. Agan* forewarned? This judicial authority in the executive branch would seem to be the very combination that Madison feared and that the authors of the Texas Constitution tried to prohibit. As the history of H.B. 417, S.B. 403, and the Prompt Pay Act demonstrates, that is almost certainly what has happened.

1. Since its creation, the agency currently known as the Texas Department of Insurance has undergone numerous name changes. During some of the periods covered in this article, it was known as the State Board of Insurance, or simply "the Board." The history of those name changes is beyond the scope of this article, but is documented on the agency's website at www.tdi.texas.gov/general/history/html. For a comprehensive and detailed history of the Texas Department of Insurance, *see,* Bruce McCandless, III, "You Can Take That, or Worse: A Brief History of the Texas Department of Insurance," published in two parts in the Spring 2002 and Winter 2003 issues of the *Journal of Texas Insurance Law.*

2. House Research Organization, Focus Report, "The Prompt Payment Dispute," No. 77-22, July 17, 2002, p. 4: "As of July 2002, TDI's efforts had resulted in consent orders requiring 47 HMOs in Texas to pay about $36 million in restitution to providers and $15 million in fines for failing to comply with prompt-payment regulations." In this article, the term "insurers" will be used to refer collectively to insurance carriers and health maintenance organizations, unless the context indicates otherwise. The terms "medical providers" and "providers" will be used interchangeably to refer to physicians and other providers of medical services.

3. In 2002 the TDI website contained the following headline and link: "Prompt Pay Blitz Nets Restitution, Fines from 47 Carriers." www.tdi.state.tx.us/inter/asprout/commish/news/clips2002.asp. The link is no longer on the TDI website. However, the current TDI website has the shortened headline, "Prompt Pay Blitz Nets Restitution." Physician/Provider Information & Advice for Physicians and Providers, www.tdi.texas.gov/hprovider/drnews.html#payments (last visited March 9, 2013).

4. Act approved Aug. 21, 1876, 14th Leg., R.S., ch. 133, 1876 Tex. Gen. Laws 219, 220, *reprinted in* 8 H.P.N. Gammel, The Laws of Texas 1822-1897, at 1056 (Austin, Gammel Book Co. 1989). Originally enacted as art. 3050, sec. 1.

5. Act approved Aug. 21, 1876, 14th Leg., R.S., ch. 133, 1876 Tex. Gen. Laws 219, 222, *reprinted in* 8 H.P.N. Gammel, The Laws of Texas 1822-1897, at 1058 (Austin, Gammel Book Co. 1989). Originally enacted as art. 3050, sec. 15.

6. Act approved Aug. 21, 1876, 14th Leg., R.S., ch. 133, 1876 Tex. Gen. Laws 219, 222, *reprinted in* 8 H.P.N. Gammel, The Laws of Texas 1822-1897, at 1058 (Austin, Gammel Book Co. 1989). Originally enacted as art. 3051, sec. 4; *also, see* Glens Falls Ins. Co. v. Hawkins, 126 S.W. 1114, 1115 (Tex. 1910) ("The Commissioner is empowered to revoke an existing permit when an insurance company violates the law, and may refuse to grant a permit for the same reason.").

7. Mr. Will Davis previously had been an assistant attorney general for the State of Texas. As assistant attorney general, he was the head of the Insurance, Banking, Savings & Loan and State Affairs Division and the Appellate Division of the Attorney General's Office. He also served as the general counsel for the State Board of Insurance for three years.

8. House Bill 417 created what is more commonly known as the Texas Deceptive Trade Practices-Consumer Protection Act ("DTPA"). *See* TEX. BUS. & COM. CODE § 17.41.

9. The Texas Deceptive Trade Practice-Consumer Protection Act: Hearings on Tex. H.B. 417 Before the House Comm. on Bus. & Indus., 63rd Leg., R.S. (February 27, 1973) (transcript available from House Video & Audio Services Office) (emphasis added).

10. *See* Tex. Ins. Code § 82.051 ("After notice and opportunity for a hearing, the commissioner may cancel or revoke an authorization if the holder of the authorization is found to be in violation of, or to have failed to comply with, this code or a rule of the commissioner."). This provision was previously contained in Tex. Ins. Code Art. 1.10, §7(a), and was recodified to its current location by Acts, 1999, 76th Leg., ch. 101, §1, eff. Sept. 1, 1999.

11. *See* Tex. Ins. Code § 82.052: "In addition to the cancellation or revocation of an authorization under section

82.051, the commissioner may:

(1) suspend the authorization for a specified time not to exceed one year;

(2) order the holder of the authorization to cease and desist from:

(A) the activity determined to be in violation of this code or a rule of the commissioner; or

(B) the failure to comply with this code or a rule of the commissioner;

(3) direct the holder of the authorization to pay an administrative penalty under Chapter 84;

(4) direct the holder of the authorization to make restitution under Section 82.053; or

(5) take any combination of those actions."

This provision was previously contained in Tex. Ins. Code Art. 1.10, §7(a), and was recodified to its current location by Acts, 1999, 76th Leg., ch. 101, §1, eff. Sept. 1, 1999.

12. *See* Tex. Ins. Code § 82.056 ("The commissioner shall give notice of an action taken under this subchapter to the insurance commissioner or other similar officer of each state."). This provision was previously contained in Tex. Ins. Code art. 1.10 § 7(e) and was recodified by Acts, 1999, 76th Leg., ch. 101, §1, eff. Sept. 1, 1999.

13. Act of May 21, 1973, 63rd Leg. R.S., ch.143, 1973 Tex. Gen. Laws 322 (to be codified as an amendment to Tex. Bus. & Com. Code § 17.41 *et seq.*).

14. *Id.* at 336-37.

15. H.B. 417 added a new section 14 to then Tex. Ins. Code Art. 21.21, entitled "Administrative Class Action," which provided as follows:

> (a) In connection with the issuance of a cease and desist order as provided in Section 7 of this Article or upon application of any aggrieved person, the Board may, after notice and hearing as provided in Section 6 of Article, in connection with the issuance of a cease and desist order resulting from a finding that an insurer has engaged in a method of competition, act or practice in violation of this Article, rules or regulations issued under this Article, or Section 17.46, Business & Commerce Code, as amended, or upon finding by the Board that the aggrieved person and persons similarly situated were induced to purchase a policy of insurance as a result of the insurer engaging in a method of competition, act or practice in violation of this Article, rules or regulations issued under this Article, or Section 17.46, Business & Commerce Code, as amended, the Board may require the insurer to account for all premiums collected for policies issued during the immediately preceding two years in connection with such acts in violation of this Article and require: (i) such insurer to give notice to all persons from whom such premiums were collected, and (ii) to refund the total of all premiums collected from each such person, electing to accept a premium refund in exchange for cancellation of the policy of insurance issued. Premiums so refunded shall be net of policy benefits actually paid by such insurer while the policy of insurance was in force. The Board shall specify a reasonable time within which the insurer shall be required to make such premium refunds.

See Act of May 21, 1973, 63rd Leg. R.S., ch.143, § 2 (c), 1973 Tex. Gen. Laws at 336-7 (to be codified as an amendment to Tex. Bus. & Com. Code § 17.41 *et seq*).

16. *Id.*

17. *Id.* at 337.

18. *See* Part F ("What is Restitution?"), *supra.*

19. The "Administrative Class Action" section was recodified in 2003 to its current location as Tex. Ins. Code § 541.301-4. Act effective date April 1, 2005, 78th Leg. R.S., ch. 1274, § 2, Tex. Gen. Laws 3671-2. In the recodification process, the phrase "Administrative Class Action" was deleted.

20. *See* Act of June 17, 1987, 70th Leg., R.S., ch. 416 § 1, Tex. Gen Laws 1987 (codified as an amendment to Texas Ins. Code art. 1.10 § 7(a)(4) (This provision has been altered slightly since its original enactment in 1987. *See* Tex. Ins. Code § 82.053.

21. *Id.*

22. Act of June 17, 1987, 70th Leg., R.S., ch. 416 § 1, Tex. Gen Laws 1987 (codified as an amendment to Texas Ins. Code art. 1.10 § 7(a)(4)).

23. Tex. Ins. Code § 82.053(a).

24. Tex. Ins. Code § 83.001 provides as follows: "In this chapter: (1) 'Authorized person' means an individual or entity described by Section 83.002." Tex. Ins. Code § 83.002, in turn, provides as follows:

> (a) This chapter applies to each company regulated by the commissioner, including:
>
> (1) a domestic or foreign, stock or mutual, life, health, or accident insurance company;
>
> (2) a domestic or foreign, stock or mutual, fire or casualty insurance company;
>
> (3) a Mexican casualty company;
>
> (4) a domestic or foreign Lloyd's plan insurer;
>
> (5) a domestic or foreign reciprocal or interinsurance exchange;
>
> (6) a domestic or foreign fraternal benefit society;
>
> (7) a domestic or foreign title insurance company;
>
> (8) an attorney's title insurance company;
>
> (9) a stipulated premium insurance company;
>
> (10) a nonprofit legal service corporation;

(11) a statewide mutual assessment company;

(12) a local mutual aid association;

(13) a local mutual burial association;

(14) an association exempt under Section 887.102;

(15) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 842;

(16) a county mutual insurance company; and

(17) a farm mutual insurance company.

(b) This chapter also applies to:

(1) an agent of an entity described by Subsection (a); and

(2) an individual or a corporation, association, partnership, or other artificial person who:

(A) is engaged in the business of insurance;

(B) holds a permit, certificate, registration, license, or other authority under this code; or

(C) is regulated by the commissioner.

(c) This chapter also applies to:

(1) a person appointed as a qualified inspector under Section 2210.254 or 2210.255; and

(2) a person acting as a qualified inspector under Section 2210.254 or 2210.255 without being appointed as a qualified inspector under either of those sections.

25. In 1973, the "Rules and Regulations" related to Article 21.21 were limited to what is referred to as "Board Order 18663." *See*, Rules and Regulations of The State Board of Insurance of Texas On Unfair Competition and Unfair Practices of Insurers and On Misrepresentations Of Policies, and Including Regulation of Insurance Trade Practices In Respect of Advertising and Solicitations, Board Order 18663, Dec. 3, 1971 (current version at 28 Tex. Admin. Code §§ 21.1-21.5).

26. Fitzgerald v. Advanced Spine Fixation, 996 S.W.2d 864, 865-66 (Tex. 1999), citing Liberty Mut. Ins. Co. v. Garrison Contractors, 996 S.W.2d 482, 484 (Tex. 1998).

27. House Comm. on Ins., Bill Analysis, Tex. S.B. 403, 70th Leg., R.S. (1987) (emphasis added).

28. Debate on S.B. 403 on the Floor of the Senate, 70th Leg., R.S. (Mar. 31, 1987) (transcript available from Senate Staff Services Office) (emphasis added). Although Sen. Glasgow refers to reimbursement to "insurers," he almost certainly meant "insureds."

29. *See* Debate on S.B. 403 on the Floor of the House of Representatives, 70th Leg. R.S. (May 28, 1987) (transcript available from the Office of the Chief Clerk of the House).

30. Hearing on Tex. S.B. 403 Before the Senate Econ. Dev. Comm., 70th Leg. R.S. (March 23, 1987) (tape of hearing available from Secretary of the Senate) (emphasis added).

31. *Id.* (emphasis added).

32. *See generally* Restatement (Third) of Restitution §§ 4-10 (2011).

33. *See, e.g.*, Heldenfels Bros., Inc. v. City of Corpus Christi, 832 S.W.2d 39, 41 (Tex. 1992).

34. *See, e.g.,* Breaux v. Allied Bank of Texas, 699 S.W.2d 599, 604 (Tex. App. — Houston [14th Dist.] 1985, writ ref'd n.r.e.).

35. *See, e.g.,* Coon v. Schoeneman, 476 S.W.2d 439, 441 (Tex. Civ. App.—Dallas 1972, writ ref'd n.r.e.).

36. Black's Law Dictionary, 1180 (8th ed. 2004) (internal citations omitted).

37. "A fundamental principle of American constitutional jurisprudence, here expressed in Article II [of the Texas Constitution], is that the exercise of executive, legislative and judicial powers are to be vested in separate and independent organs of government." Tex. Const. art. II, § 1 interp. Commentary (Vernon 2007).

38. Repub. Tex. Const. of 1836, art. I, § 1, *reprinted in* 1 *H.P.N. Gammel, The Laws of Texas 1822-1897*, at 1069, 1073 (Austin, Gammel Book Co. 1898).

39. Tex. Const. of 1845, 1861, 1866 and 1869.

40. Tex Const. art. II, § 1.

41. Tex Const. art. II, § 1. The Republic of Texas Constitution of 1836 contained a shorter version of the same principle: "[t]he powers of this government shall be divided into three departments, viz: legislative, executive, and judicial, which shall remain forever separate and distinct." Tex Const. art. I, § 1 (1836) *reprinted in* 1 *H.P.N. Gammel, The Laws of Texas 1822-1897*, at 1069, 1073 (Austin, Gammel Book Co. 1898).

42. State v. Montgomery, 957 S.W.2d 581, 583 (Tex. App.—Houston [14th Dist.] 1997, pet. ref'd).

43. "Were the power of judging joined with the legislative, the life and liberty of the subject would be exposed to arbitrary control, for *the judge* would then be *the legislator*. Were it joined to the executive power, *the judge* might behave with all the violence of *an oppressor*." The Federalist No. 47, at 303 (J. Madison) (C. Rossiter ed., 1961) (quoting Montesquieu, The Spirit of the Laws, Book XI, ch. 6).

44. *See* State v. Flag-Redfern Oil Co., 852 S.W.2d 480, 484 (Tex. 1993) (quoting Bd. of Water Eng v. McKnight, 229 S.W. 301, 304 (Tex. 1921)).

45. Gen. Land Office v. Rutherford Oil Corp., 802 S.W.2d 65, 68 (Tex. App.—Austin 1990), *aff'd sub nom., Flag-Redfern Oil Co.,* 852 S.W.2d 480.

46. The Insurance Commissioner is appointed by the governor, with the advice and consent of the senate, for a two-year term that expires on February 1 of each odd-numbered year. Tex. Ins Code § 31.022(a).

47. *See generally*, Tex. Ins. Code Chapter 84, "Administrative Penalties."

48. *See, e.g.,* Subaru of America v. David McDavid Nissan, Inc., 84 S.W.3d 212, 220 (Tex. 2002); Sportscoach Corp. of Am., Inc. v. Eastex Camper Sales, Inc., 31 S.W.3d 730, 735 (Tex. App.—Austin 2000, no writ); Westland Film Indus. v. State Bd. of Ins., 697 S.W.2d 621, 623-24 (Tex. App.—Austin 1985), *rev'd on other grounds,* 705 S.W.2d 695 (Tex. 1986).

49. *See, e.g.,* McDonel v. Agan, 353 S.W.2d 485 (Tex. Civ. App.—Austin 1962, writ dism'd).

50. *McDonel,* 353 S.W.2d 485 at 488.

51. Brown & Root, Inc. v. Traders & Gen'l Ins. Co., 135 S.W.2d 534, 542 (Tex. Civ. App.—Galveston 1939) (writ dism'd judgm't cor.); *also, see generally,* Perry v. Del Rio, 67 S.W.3d 85, 93 (Tex. 2001) (holding that a branch of government shall not exercise any power properly attached to either of the two others, unless expressly permitted by the Constitution.)

52. Council of Co-Owners of Saida II Condominium Ass'n v. Tex. Catastrophe Prop. Ins. Ass'n, 696 S.W.2d 60, 65 (Tex. App.—Austin 1985), *rev'd on other grounds,* 706 S.W.2d 644 (Tex. 1986).

53. Tex. Catastrophe Prop. Ins. Ass'n v. Council of Co-Owners of Saida II Condominium Ass'n, 706 S.W.2d 644, 646 (Tex. 1986).

54. *E.g., McKnight,* 229 S.W. at 305 (holding statute improperly authorized State Board to adjudicate title to water rights); *Rutherford Oil Co.,* 802 S.W.2d at 69 (holding statute did not empower GLO to adjudicate property rights); Bd. of Trustees v. Briggs, 486 S.W.2d 829, 835 (Tex. Civ. App.—Beaumont 1972, writ ref'd n.r.e.) (Commissioner of Education has no judicial power to determine legality of contract or rights of parties thereto); *McDonel,* 353 S.W.2d at 488 (State Board of Insurance has no jurisdiction to adjudicate rights on sworn account).

55. Act of September 1, 1999, 76th Leg., R.S., ch. 1343, § 1, 1999 Tex. Gen. Laws 4556 (codified as an amendment to Tex. Ins. Code art. 20A.). Hereinafter referred to sometimes as "the Act."

56. Former Tex. Ins. Code art. 20A.18B (c); currently at Tex. Ins. Code § 843.338.

57. Tex. Ins. Code § 843.342.

58. Former Tex. Ins. Code art. 20A.18B(h). Although subsection (h) of Art. 20A.18B referred to art. 1.10E, that article was repealed by Act of September 1, 1999, 76th Leg., ch. 101, § 5, 1999 Tex. Gen. Laws 538, and recodified generally as Chapter 84 by Act of September 1, 1999, 76th Leg., ch. 101, § 5, 1999 Tex. Gen. Laws 486. The current provision is Tex. Ins. Code § 843.342(k).

59. Tex. Ins. Code § 843.342(k).

60. Tex. Ins. Code § 82.053(a).

61. *See* "Enforcement Strategies," Aug. 8, 2001 at www.tdi.texas.gov/hprovider/workshophd1a.html.

62. *See e.g.,* RenCare, Ltd. v. Humana Health Plan of Texas, Inc., 395 F.3d 555, 559 (5th Cir. 2004) ("At bottom, RenCare's claims are claims for payment pursuant to a contract between private parties.).

63. *See, e.g.,* Christus Health Gulf Coast v. Aetna, Inc., 237 S.W.3d 338 (Tex. 2007) (holding that the provider's only interest was in receiving payment from the insurer for the medical services provided).

64. Virtually all of these orders were by consent decrees that were agreed to and signed by both the Commissioner and the alleged violator. *See* TDI website at www.tdi.texas.gov/hprovider/drnews.html#payments.

65. *See supra* footnote 5,. For a detailed listing of the amounts of fines and "restitution" paid by each HMO, go to the TDI website at www.tdi.texas.gov/hprovider/drnews.html#payments.

66. Deposition transcript of Audrey Selden ("Selden Depo"), taken in PacifiCare of Texas, Inc. v. Texas Department of Insurance, et al, Cause No. GN-103,906, 53rd Judicial District Court of Travis County, Texas, on October 2 & 3, 2001, at p. 162, line 18 through p. 163, line 12.

67. *Id,* at p. 157, line 21 through p. 158, line 12.

68. *See* Tex. Ins. Code § 31.021(a) (reading, "The commissioner is the department's chief executive and administrative officer. The commissioner shall administer and enforce this code, other insurance laws of this state, and other laws granting jurisdiction or applicable to the department or the commissioner.") *See also* Tex. Ins. Code § 31.002 (reading, "In addition to the other duties required of the Texas Department of Insurance, the department shall: (3) ensure that this code and other laws regarding insurance and insurance companies are executed.")

69. Tex. Ins. Code §843.336(a)(Vernon 2009)).

70. *See* 24 Tex. Reg. 11219-11228 (1999) (codified at 28 Tex. Admin. Code §§ 21.2801-21.2816) (proposed December 17, 1999); 25 Tex. Reg. 4543-4578 (2000) (codified at 28 Tex. Admin. Code §§ 21.2801-21.2816) (adopted May 19, 2000).

71. 24 Tex. Reg. at 11228 (1999).

72. *Id.* at 11219-11228.

73. *Id.* at 11221-22.

74. 25 Tex. Reg. at 4543 (2000).

75. The Federalist No. 47, at 303 (J. Madison).

76. Tex. Const. art. II, § 1 (interp. commentary)(Vernon 2007).

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TWOMBLY/IQBAL MEET THE EIGHT CORNERS RULE—A LOVE STORY?

Within the past six years, a sea of change has occurred in the federal standard of review for motions to dismiss. No longer do federal courts follow the broad notice pleading standard that does not require pleading of actual facts. Now, federal courts must carefully scrutinize complaints to determine whether they allege facts rather than conclusory labels.

So why place a paper about the new federal pleading standard in the *Journal of Texas Insurance Law*? This story starts with a Supreme Court of Texas opinion that predates these federal changes by nearly a decade.[1] The Court's decision in *Griffin* held that a paramount feature of the "Eight Corners Rule" is the focus on factual allegations rather than legal labels.[2] Thus, the Eight Corners Rule and new federal pleading standard share a mutual love for facts above all. Conclusory labels hold no attraction.

The new federal pleading standard has led to a near doubling of the number of motions to dismiss in federal courts, forcing them to devote more time searching complaints for factual allegations. Naturally, this heightened pleading standard affects other areas of law, including insurance coverage actions. Indeed, in applying the new pleading standard, more and more federal courts are emboldened to ignore conclusory allegations when analyzing a carrier's duty to defend.

Understandably, policyholders are not thrilled by this budding influence of the new heightened pleading standard in federal courts on the Eight Corners Rule. After all, this emerging trend threatens to silence the mantra that policyholders have been repeating when urging coverage under the Eight Corners Rule: "When in doubt, defend."[3]

Moreover, policyholders point out the unfairness of using a fact-based standard in applying the Eight Corners Rule to underlying petitions filed in Texas. Underlying petitions are subject to the fair notice standard governing Texas pleading practice, which does not require the pleading of facts with meticulous particularity. As a result, insureds contend that the Eight Corners Rule should be liberally and broadly construed in keeping with Texas's fair notice standards. However, policyholders have unsuccessfully raised similar arguments in the past before the Supreme Court of Texas.

Accordingly, this paper will examine the history of these two pleading standards, and analyze the current trend that might be a match made in heaven (for carriers).

1. Forget About *Conley;* Meet *Twombly.*

This story starts with two landmark United States Supreme Court decisions that caused a seismic shift in federal court pleading standards: *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007), and more recently, *Ashcroft v. Iqbal*, 129 S.Ct. 1937 (2009). In combination, these two decisions (collectively "*Twombly/Iqbal*") jettisoned the broad notice pleading standard that had previously governed ever since *Conley v. Gibson*, 355 U.S. 41 (1957). In *Conley's* wake, *Twombly/Iqbal* established a much more rigorous standard for whether a complaint is sufficient to withstand a 12(b)(6) or 12(c) motion to dismiss on the pleadings—a standard requiring the utmost reliance on facts rather than mere labels and conclusions.

A. The First Move: Twombly Gets Rid Of Conley And Its Reliance Upon Conclusory Allegations.

The language of Federal Rule of Civil Procedure 8, which governs the standard for pleadings in federal court, appears plain enough. It requires that complaints contain "a short and plain statement of the claim showing that the pleader is entitled to relief," in order to "give the defendant fair notice of what the . . . claim is and the grounds upon which it rests."[4] Prior to *Twombly*, Rule 8 was not interpreted to "require a claimant to set out in detail the facts upon which he bases his claim."[5] Instead, as recognized in 1957 by the Supreme Court in *Conley,* "a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief."[6] This standard set forth in *Conley* was known as the "notice pleading" standard, and federal courts would not typically dismiss an action if a complaint was devoid of facts.[7]

And for nearly fifty years, federal courts faithfully followed *Conley's* notice pleading standard. As lower courts noted regarding *Conley's* notice pleading requirement, "its operation [was] broad and its standard liberal."[8] Over time, however, disagreements about the *Conley's* scope began to surface. Some courts suggested that Rule 8 mandated a fact pleading standard, not the notice pleading that *Conley's* progeny adopted.[9]

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In the face of this emerging discord, along came *Twombly*. In 2007, the Supreme Court addressed whether a complaint alleging an antitrust conspiracy under the Sherman Act met the pleading requirements of Rule 8.[10] The Court swiftly excised the main pillar of *Conley's* notice pleading standard—the notion that Rule 8 "dispensed with the pleading of facts altogether."[11] Not holding anything back, the Court candidly explained that *Conley's* "'no set of facts' language has been questioned, criticized, and explained away long enough by courts and commentators. . . . The phrase is best forgotten as an incomplete, negative gloss on an accepted pleading standard."[12]

In *Conley's* place, the Supreme Court adopted the "plausibility" standard. According to the Supreme Court, Rule 8 "requires more than labels and conclusions [in a complaint], and a formulaic recitation of a cause of action's elements will not do."[13] Instead, the factual allegations are of paramount importance, as they "must be enough to raise a right to relief above the speculative level . . . on the assumption that all of the complaint's allegations are true."[14] "[N]aked assertion[s]" without any "further factual enhancement," will fail to suffice.[15] Therefore, under the *Twombly* Court's "plausibility" standard, the recitation of a cause of action supported by conclusory statements is insufficient; the alleged cause of action must be supported by enough factual matter to demonstrate that the plaintiff is *plausibly* entitled to relief.[16]

The Court was careful to note that "plausibility" under this new standard "does not impose a *probability* requirement at the pleading stage; it simply calls for enough fact to raise a reasonable expectation that discovery will reveal evidence [to support the cause of action]."[17] Further, "a well-pleaded complaint may proceed even if it strikes a savvy judge that actual proof of those facts is improbable, and 'that a recovery is very remote and unlikely.'"[18]

Justice Stevens, joined by Justice Ginsburg, authored a blistering dissent in *Twombly*. Arguing that the majority should have stayed faithful to *Conley's* notice pleading standard, Justice Stevens called into doubt the majority's purported whitewashing of *Conley,* as follows:

> This is not and cannot be what the *Conley* Court meant. First, as I have explained, and as the *Conley* Court well knew, the pleading standard the Federal Rules meant to codify does not require, or even invite, the pleading of facts.[19]

Further, the dissent raised the practical reality that the necessary facts to support the cause of action are often in the hands of the defendant.[20] However, these pleas to stay true to *Conley* were futile.

Nonetheless, like any long relationship, the actual divorce with *Conley* required more time. Some courts viewed *Twombly* as limited to antitrust claims, with no application to other types of civil cases.[21] However, two years after the arrival of *Twombly,* all memories of *Conley* would be erased by the Supreme Court's decision in *Ashcroft v. Iqbal*, a case alleging civil rights violations.[22]

Iqbal categorically rejected the notion that the "plausibility standard" was limited to the antitrust context.[23] Instead, the Court recognized that this standard applied to all civil actions in federal court. Further, the Supreme Court further expounded on the *Twombly* pleading standard, as follows:

> Two working principles underlie *Twombly.* First, the tenet that a court must accept a complaint's allegations as true is inapplicable to threadbare recitals of a cause of action's elements, supported by mere conclusory statements. Second, determining whether a complaint states a plausible claim is context-specific, requiring the reviewing court to draw on its experience and common sense. A court considering a motion to dismiss may begin by identifying allegations that, because they are mere conclusions, are not entitled to the assumption of truth. ***While legal conclusions can provide the complaint's framework, they must be supported by factual allegations.*** When there are well-pleaded factual allegations, a court should assume their veracity and then determine whether they plausibly give rise to an entitlement to relief.[24]

Thus, as recognized in *Twombly,* legal labels and conclusory allegations are insufficient to withstand a motion to dismiss under the *Twombly/Iqbal* plausibility standard.[25]

B. Double The Fun

With the *Twombly/Iqbal* standard well established, federal courts have seen a marked increase in the number of 12(b)(6) motions to dismiss in federal courts.[26] Indeed, they have nearly doubled:

> After *Iqbal*, a plaintiff was twice as likely to face a motion to dismiss as compared with the period before *Twombly*, a marked increase in the rate of Rule 12(b)(6) motion activity from the steady filing rate observed over the last several decades. As for dismissal orders, the FJC found that in every case category that was examined there were more orders granting dismissal after *Iqbal* than there were before *Twombly*, both with and without prejudice. Most importantly, in every case category examined it was more likely that a motion

to dismiss would be granted.[27]

As a result, more and more of federal courts' time is consumed with analyzing and applying the *Twombly/Iqbal* plausibility standard, requiring a focus on substantive over conclusory allegations.

Moreover, like all other types of litigation, insurance coverage litigation in federal courts has been impacted by the plausibility standard post-*Iqbal*. Now, coverage actions must be pleaded in compliance with *Twombly/Iqbal*'s strict pleading standards.[28] Practitioners would be wise to plead specific references to the relevant portions of the policy, and the reasons why coverage is triggered or does not exist. The facts relevant to a carrier's duty to defend under the Eight Corners Rule will largely be those alleged in the underlying lawsuit against the insured, which should also pled in the coverage action.

2. Twombly/Iqbal Amplifies Courts' Willingness To Ignore Legal Labels And Focus On The Facts In Determining A Duty To Defend.

Moreover, like all other types of litigation, insurance coverage litigation in federal courts has been impacted by the plausibility standard post-Iqbal. Now, coverage actions must be pleaded in compliance with Twombly/Iqbal's strict pleading standards.[28]

Due to this more than doubling of motion to dismiss actions that federal courts are required to decide, the plausibility standard appears to be moving into other substantive areas of law. Indeed, *Twombly/Iqbal* appears to have turned its gaze toward the Eight Corners Rule, which governs a liability carrier's duty to defend. However, before considering *Twombly/Iqbal*'s effect on the Eight Corners Rule, we should first see what these two substantive standards have in common.

A. So Much In Common, Especially Their Love Of Facts

Although it is often said that opposites attract, the standard in *Twombly/Iqbal* has much in common with the Eight Corners Rule. Both are based on the interpretation of the pleadings alone, without resort to extrinsic evidence.[29] Further, under both standards, the allegations must be taken as true, and all doubts must be resolved in favor of the insured/plaintiff.[30] And, both are determined as a matter of law.[31]

Beyond these basic similarities, the two standards share a common love above all others—the fondness for facts over conclusory allegations. In particular, the Supreme Court of Texas has recognized on multiple occasions that the courts should focus on the factual allegations rather than conclusory labels in determining the duty to defend under the Eight Corners Rule. For example, in *Farmers Texas Cnty. Mut. Ins. Co. v. Griffin*, the Court analyzed an underlying lawsuit containing a conclusory allegation of negligence.[32] Instead of reliance upon conclusory labels, the Court recognized that the factual allegations control.[33] Applying this "focus on the facts" standard, the Court refused to find that a conclusory label of negligence in the underlying petition was sufficient to trigger the duty to defend where the alleged facts demonstrated an intentional shooting.[34] Thus, like the *Twombly/Iqbal* standard, facts are paramount in determining the duty to defend under the Eight Corners Rule, not conclusory statements.

Further, the tests governing the Eight Corners Rule and the plausibility standard under *Iqbal/Twombly* provide courts a certain amount of subjectivity when reaching their decision. With regard to the plausibility pleading standard, "the majority opinion and Justice Souter's dissent in *Iqbal* [demonstrates that] 'plausibility' lies largely in the eye of the beholder, and in general, plaintiffs do not know what a judge will find plausible."[35] Similarly, subjectivity is introduced into the Eight Corners Rule via tug-of-war between two competing principles governing the duty to defend: courts must liberally construe the pleadings in favor of coverage, but at the same time, they cannot "imagine factual scenarios which might trigger coverage."[36] The line between these two competing principles is often unclear, and gives courts latitude in going either direction.[37]

B. A Secret Relationship Between The Eight Corners Rule And Twombly/Iqbal?

With so much in common, the Eight Corners Rule and *Twombly/Iqbal* were destined to meet. Indeed, their chance encounters initially occurred when the underlying lawsuit against the insured was filed in federal court. The pleadings in these underlying federal lawsuits had to comply with *Twombly/Iqbal*'s heightened standard or face dismissal. Therefore, the underlying lawsuits have provided much needed factual allegations (from the carrier's standpoint) in determining the duty to defend under the Eight Corners Rule.

However, the question remains whether the relationship between *Twombly/Iqbal* and the Eight Corners Rule goes deeper than this limited situation in which the underlying lawsuit is filed in federal court. Based on a number of recent decisions in federal court, it appears that the doubling of motions to dismiss filed after *Twombly/Iqbal* is ushering in a renaissance of the rule announced a decade earlier in *Griffin*, requiring courts to focus on the factual allegations, and not the conclusory statements in applying the Eight Corners Rule. However, neither the name *Iqbal* nor *Twombly* ever appears in these federal court decisions.

An example of the hidden confluence between the Eight Corners Rule and *Twombly/Iqbal* is demonstrated by the Fifth Circuit's recent decision in *PPI Tech. Servs., L.P. v. Liberty Mut. Ins. Co*.[38] There, the underlying lawsuit

expressly alleged the literal definition of property damage found in the CGL policy, as follows: "Royal alleges that PPI caused 'property damage to Royal as an owner in the property where the well was being drilled' including 'physical injury to tangible property, including all resulting loss of use of the property.'"[39] The insured argued that this allegation, construed broadly, triggered the policy because covered "property damage," as literally defined by the policy, was alleged. In contrast, the carrier argued that this copy-and-paste allegation was a naked legal conclusion that could not be considered in determining its duty to defend under the Eight Corners Rule.[40]

In determining the duty to defend, the Fifth Circuit employed an Eight Corners analysis that would make *Twombly/Iqbal* blush. In particular, the court first cited the insured-friendly standard under the Eight Corners Rule that, "[i]f there is a 'doubt as to whether or not the allegations of a complaint against the insured state a cause of action within the coverage of a liability policy sufficient to compel the insurer to defend the action, such doubt will be resolved in the insured's favor.'"[41] However, the court circled back and cited *Griffin* for the *Twombly/Iqbal*-inspired standard that "[A] court must focus on the factual allegations rather than the legal theories asserted in reviewing the underlying petition."[42]

Returning to the allegations that literally tracked the definition of "property damage" from the CGL policy, the Fifth Circuit found that these allegations of "property damage" in the underlying lawsuits "***are either for economic damages, and thus are not covered, or are legal conclusions, rather than factual allegations as required*** [under the Eight Corners Rule]."[43] According to the *PPI* Court, the underlying petitions "did not allege facts supporting" this bare assertion of property damage.[44] As a result, the court found that the insured was not entitled to a defense.

Although the *PPI* Court did not reveal the relationship between *Twombly/Iqbal* and the Eight Corners Rule to the world at large, the opinion in *PPI* employs virtually similar language as federal courts deciding motions to dismiss under the plausibility standard. For example, *Twombly/Iqbal* progeny has also found that "[W]here the existence of a conspiracy is based only on **legal conclusions, rather than factual allegations,** a plaintiff's complaint fails to meet the pleading standard announced in *Twombly* and *Ashcroft v. Iqbal*."[45] In fact, the Fifth Circuit's finding in *PPI* that the underlying petitions "did not allege facts supporting" the conclusory allegations echoes similar language by the Fifth Circuit in deciding a motion to dismiss under *Twombly/Iqbal*, which found dismissal warranted where the plaintiff "did not allege facts supporting his claims . . . ."[46] Thus, even if the Fifth Circuit is not prepared to expressly state that *Twombly/Iqbal* is infecting the Eight Corners analysis, the court's focus on factual allegations over conclusory labels in determining the duty to defend is certainly being supported by the same standards set forth in *Twombly/Iqbal.*

Indeed, in a portion of the decision that was later withdrawn, the *PPI* Court noted, as a policy matter, that holding otherwise "would permit plaintiffs to trigger coverage in almost any case by making general assertions that copy the language of the Policy statement. That consequence should be avoided."[47] This concern is similar to the public policy animating the Supreme Court's decision in *Twombly* that prompted adoption of the plausibility standard, viz., preventing a plaintiff with "'a largely groundless claim' from 'tak[ing] up the time of a number of other people, with the right to do so representing an *in terrorem* increment of the settlement value.'"[48]

The Fifth Circuit's *PPI* decision is the only case to apply a standard similar to *Twombly/Iqbal* to the Eight Corners analysis without expressly disclosing this relationship.[49] Indeed, the Fifth Circuit appears to be following the lead of its district courts, which have long shown a willingness under the Eight Corners Rule to ignore conclusory labels and apply a "focus on the facts" pleading standard to the duty to defend.[50] For example, in *Chang,* the district court for the Southern District of Texas ignored a conclusory allegation of negligence to find that an allegation that an employee "discharged his gun numerous times" negated coverage under the assault and battery exclusion because "no reasonable jury could find [that discharging a gun numerous times] was a negligent act."[51] Indeed, the court found that "it is not determinative that [the underlying lawsuits] assert that [the insureds] acted negligently; rather the court must consider the specific facts alleged."[52] Similarly, in *House of Yahweh,* the district court for the Northern District of Texas looked past allegations of negligence to find that no coverage existed because, "it is evident that the conduct of the [insureds] is alleged to have been intentional."[53] Therefore, this rash of *Twombly/Iqbal*-inspired opinions involving the Eight Corners Rule appear to be the emerging trend rather than the exception.

C. A Doomed Relationship?

Is this seemingly strong relationship between *Iqbal/Twombly* and the Eight Corners Rule destined to last in federal court? That is certainly the hope of carriers in Texas, as they are the primary beneficiaries of this heightened pleading standard in the duty to defend context. After all, and hinted at by the opinion in *PPI*, carriers pine for the day when they are no longer forced to defend groundless and fraudulent claims.

Of course, policyholders are rooting for this budding relationship to fail. In fact, they have already attempted to break up the Eight Corner's secret relationship with this "focus on the facts" pleading requirement. For example, the insured in *PPI* filed a petition for an en banc rehearing pointing out that the pleading standards for plaintiffs when they file underlying lawsuits is a "fair notice" standard.[54] The fair notice standard is the virtual antithesis of the plausibility pleading standard of *Twombly/Iqbal*, as it requires very little in the way of facts.[55] Instead, "[t]he 'fair notice' standard for pleading looks to whether the opposing party can ascertain from the pleading the nature

and basic issues of the controversy and what testimony will be relevant."[56] Significantly, "it also relieves the pleader of the burden of pleading evidentiary matters with meticulous particularity."[57]

It is precisely this seeming incongruence between Texas' fair notice pleading standard and the federal court's plausibility standard that the insured in *PPI* seized upon to argue that the Fifth Circuit erred. According to the insured, the "[underlying] pleadings in Texas cases are often not drafted with specificity" due to the fair notice standards.[58] As a result, the insured argued that the Eight Corners Rule should be liberally construed to reflect this reality that the underlying petitions are often fact-deprived.[59] After all, the insured does not draft these underlying petitions, the claimant suing the insured does.

Despite these well-reasoned arguments, the insured's petition for rehearing in *PPI* was unsuccessful in reversing the court's decision.[60] However, the insured in *PPI* raised an important issue that Fifth Circuit failed to address in its revised opinion. In particular, employing a *Twombly/Iqbal*-like standard to the Eight Corners Rule creates tension between the fair notice pleading standards required to maintain the underlying lawsuit against an insured in Texas, and the "focus on the facts" Eight Corners standard that the court in *PPI* applied.

Although the Fifth Circuit did not address this disparity, a similar argument involving the fair notice standard and its application to the Eight Corners Rule was addressed by the Supreme Court of Texas a decade before *Twombly* was even decided. In *Trinity Universal Ins. Co. v. Cowan*,[61] the Supreme Court rejected the notion that the fair notice standard was the proper test for the Eight Corners Rule. Specifically, the issue before the Court was whether an underlying lawsuit alleged "bodily injury" under the Eight Corners Rule. The underlying petition alleged only mental anguish – there was no allegation of any physical manifestations (*i.e.,* headaches, stomachaches, and sleeplessness).[62]

The insured in *Cowan* made a similar argument that the insured in *PPI* made. He contended that an allegation of mental anguish should be liberally construed under the Eight Corners Rule, especially in light of the fact that Texas follows the fair notice standard. Indeed, the insured argued that not only was the underlying claimant free to introduce evidence of what would constitute bodily injury (headaches, stomachaches, etc.) under the fair notice standard, the claimant actually testified at trial that "she had experienced headaches, stomachaches, and sleeplessness."[63]

Overlooking these forceful arguments, the *Cowan* Court implicitly rejected the notion that the fair notice standards influenced the Eight Corners Rule by recognizing the claimant's right "to introduce evidence [at trial] of physical manifestations of mental anguish against a tortfeasor under the 'fair notice' rule."[64] Nonetheless, the Court rejected the notion that the fair notice standard modified the Eight Corners Rule, holding that, "in the context of determining an insurer's duty to defend we will not presume a claim for physical manifestations when none is pleaded."[65]

Accordingly, *Cowan* demonstrates that the relationship between the Eight Corners Rule and *Twombly/Iqbal* is likely to continue to be strong, and that it will prosper to the benefit of carriers. The biggest roadblock to this continuing relationship—the tension created by Texas' fair notice pleading standards—did not persuade the Texas Supreme Court in a similar situation. Further hurting policyholders' efforts is the similarity of *Twombly/Iqbal* to the Texas Supreme Court's edict to "focus [their] review on the pleading's factual allegations, not on the legal theories asserted" when determining the duty to defend under the Eight Corners Rule.[66] As a result, the trend of federal courts applying a *Twombly/Iqbal* inspired standard to the Eight Corners Rule appears likely to proceed largely unabated.

However, the same cannot be said about state appellate courts in Texas. They have not acted as fast in dumping their reliance upon conclusory labels as their federal court partners.[67] Indeed, as the policyholders in *PPI* pointed out in seeking rehearing, the Fifth Circuit's "decision could dictate that the duty to defend cases may be decided differently in federal court than they would have been decided in Texas state court."[68]

The state courts' reticence to join the trend of their federal brethren makes some sense. Texas appellate courts and district courts operate under the fair notice pleading standard. Unlike in federal courts, an ever-increasing amount of Texas state courts' workload is not spent deciding motions to dismiss under the *Twombly/Iqbal* plausibility standard. Thus, *Twombly/Iqbal*'s plausibility standard has yet to take root in state court. Perhaps, over time, with the development of Texas' new motion to dismiss practice, state courts' hesitation to forcefully apply the Supreme Court of Texas's holding in *Griffin* will dissipate.

D. Will the Honeymoon Last?

In the ultimate of ironies, some insurers may be planting the seed that dooms this carrier-friendly relationship between *Twombly/Iqbal* and the Eight Corners Rule. Although the Fifth Circuit has recently rejected attempts to completely abolish the Eight Corners Rule, it has reaffirmed its prior precedent that "[t]he eight-corners rule is a judge-made rule, and . . . parties can agree to contract around the rule."[69] Attempting to make good on this invitation, some insurers in Texas have issued endorsements in their policies that expressly allow for the inclusion of extrinsic evidence to determine the duty to defend.[70] Carriers' desire for an "Unlimited Corners" Rule in determining a duty to defend largely mirrors the concerns of *Twombly/Iqbal* – to weed out those cases that are based on groundless or fraudulent allegations.

Interpreting policies that contain these extrinsic evidence endorsements, courts are no longer limited to the allegations in the pleadings. This stands in stark contrast to motions to dismiss employing the *Twombly/Iqbal* standard because federal courts typically do not consider extrinsic evidence in deciding motions to dismiss.[71]

In fact, the use of extrinsic evidence could wholly undercut the *Twombly/Iqbal* inspired Eight Corners Rule. Specifically, the use of extrinsic evidence in determining the duty to defend is a two-way street, because insureds would be able to introduce their own extrinsic evidence to trigger coverage. For example, the insured in the *PPI* case could have introduced actual evidence of "property damage" to support the bare-bone allegations found to be insufficient to trigger a duty to defend in the underlying petition. Had the insured come forward with such factual evidence of "property damage," the court would have no need to focus on the fact that the underlying petition only contained irrelevant conclusory allegations. The insurer's duty to defend would have been triggered based on the actual evidence supporting the insured's liability for potentially covered "property damage." Therefore, some insurers may, unwittingly, be adopting a pro-insured approach by seeking the use of extrinsic evidence. As the old adage goes, "be careful what you ask for, because you might just get it."

1. See discussion, *infra* Part II.A, regarding Farmers Texas Cnty. Mut. Ins. Co. v. Griffin, 955 S.W.2d 81, 82-83 (Tex. 1997).

2. *Id.* at 82. The Eight Corners Rule is the applicable standard in Texas for determining a carrier's duty to defend an insured from covered claims asserted in an underlying lawsuit, based exclusively on consideration of the eight corners of the pleading and the policy. Under the Eight Corners Rule, the duty to defend arises "when the facts alleged in the [underlying lawsuit], if taken as true, would *potentially* state a cause of action falling within the terms of the policy." Northfield Ins. Co. v. Loving Home Care, Inc., 363 F.3d 523, 528 (5th Cir.2004) (emphasis added).

3. *See* Gore Design Completions, Ltd. v. Hartford Fire Ins. Co., 538 F.3d 365, 369 (5th Cir. 2008) (holding that under the Eight Corners Rule, all doubts must be resolved in the insured's favor).

4. Fed. R. Civ. P. 8.; Conley v. Gibson, 355 U.S. 41, 47 (1957).

5. *Conley*, 355 U.S. at 47.

6. *Id.* at 45-46.

7. *See Id.* at 48 (citing the last section of Rule 8 that "all pleadings shall be so construed as to do substantial justice," and noting that "[T]he Federal Rules reject the approach that pleading is a game of skill in which one misstep by counsel may be decisive to the outcome and accept the principle that the purpose of pleading is to facilitate a proper decision on the merits.").

8. *See* Gray v. Derderian, 365 F. Supp. 2d 218, 226 (D.R.I. 2005).

9. *See* Bell Atlantic Corp. v. Twombly, 550 U.S. 544, 562 (2007) (citing Geoffrey C. Hazard, *From Whom No Secrets Are Hid*, 76 Tex. L. Rev. 1665, 1685 (1998) (describing *Conley* as having "turned Rule 8 on its head"); and Richard L. Marcus, *The Revival of Fact Pleading Under the Federal Rules of Civil Procedure*, 86 Colum. L. Rev. 433, 463-465 (1986) (noting tension between *Conley* and subsequent understandings of Rule 8)).

10. *Twombly*, 550 U.S. at 550-551.

11. *Id.* at 555 n.3.

12. *Id.* at 562-563.

13. *Id.* at 555.

14. *Id.* (citations omitted).

15. *Id.* at 557.

16. *Id.* at 557-558.

17. *Id.* at 556.

18. *Id.* (quoting Scheuer v. Rhodes, 416 U.S. 232, 236 (1974)).

19. *Id.* at 580 (Stevens, J. dissenting).

20. *Id.* at 586-87.

21. *See, e.g.,* Gunasekera v. Irwin, 551 F.3d 461, 466 (6th Cir. 2009) ("Courts in and out of the Sixth Circuit have identified uncertainty regarding the scope of *Twombly* and have indicated that its holding is likely limited to expensive, complicated litigation like [the antitrust litigation] considered in *Twombly.").*

22. Ashcroft v. Iqbal , 556 U.S. 662 (2009).

23. *See Gunasekera*, 551 F.3d at 466.

24. *Iqbal*, 556 U.S. at 663-64 (citations omitted, emphasis added).

25. Indeed, in applying this two-part analysis to the complaint at issue in *Iqbal,* the Supreme Court concluded that the complaint failed to cross "the line from conceivable to plausible." *Id.* at 680. Specifically, the Court found that the complaint's "bare assertions, much like the pleading of conspiracy in *Twombly* amount to nothing more than a 'formulaic recitation of the elements' of a constitutional discrimination claim." *Id.* at 681 (quoting *Twombly*, 550 U.S. at 555). Thus, the Court found that dismissal of the complaint was warranted under Rule 8.

26. Of course, the standard announced by the Court in *Twombly/Iqbal* has its critics. Some legislators in Congress are opposed to the changes to the pleading standard caused by *Twombly/Iqbal.* Legislation, such as the "Notice Pleading Restoration Act," has been introduced, but failed to pass. Notice Pleading Restoration Act of 2009, S. 1504, 111th Cong. (2009); Open Access to Courts Act of 2009, H.R. 4115, 111th Cong. (2009).

27. *See* Lonny Hoffman, *Twombly and Iqbal's Measure: An Assessment of the Federal Judicial Center's Study of Motions to Dismiss*, 6 Fed. Cts. L.Rev. 1, 7 (2012).

28. *See, e.g.,* D.R. Horton, Inc. v. American Guar. & Liab. Ins. Co., 864 F. Supp. 2d 541, 556 (N.D. Tex. 2012) ("The conclusory allegations of Horton's complaint fail to satisfy the pleading standards articulated by the Supreme Court in [*Twombly/Iqbal*]."); Basalite Concrete Products, LLC v. National Union Fire Ins. Co., 2013 WL 587077, at *2 (E.D. Cal. Feb. 13, 2013) ("Judged by the standard of *Ashcroft v. Iqbal* . . . the Complaint does not allege

a plausible basis to conclude that defendants had a duty to defend based on a potential claim for personal or advertising injury."); David Lerner Associates, Inc. v. Philadelphia Indem. Ins. Co., __ F. Supp.2d __, 2013 WL 1277882, at *3-4 (E.D.N.Y. Mar. 29, 2013); National Cas. Co. v. Franklin County, Miss., 718 F. Supp.2d 785, 793 (S.D. Miss. 2010) (dismissing claim that insurer had no duty to defend due to a prior knowledge exclusion because the insurer's complaint failed to plead facts showing that the insured had subjective knowledge before the purchase of the policy); Baiden and Associates, Inc. v. Crum & Forster Specialty Ins. Co., 2012 WL 591752, at *5 (D.S.C. Feb. 23, 2012) ("Baiden's amended complaint plainly does more than offer 'labels and conclusions, or a formulaic recitation of the elements of a cause of action.' It identifies the circumstances that triggered Lloyds' alleged duty to defend Baiden under the policy, offers specific references to the Lloyds Policy, and provides a near-verbatim recitation of a critical provision of the Lloyds Policy that governs when Lloyds would have a duty to defend." (quoting *Iqbal*, 556 U.S. at 681, citations omitted)).

29. *Compare* GuideOne Elite Ins. Co. v. Fielder Rd. Baptist Church, 197 S.W.3d 305, 308 (Tex. 2006) (refusing to recognize an exception to the Eight Corners Rule), *with* Carson v. Kelly, 2011 WL 3331801, at *4 (N.D. Tex. June 24, 2011) *report and recommendation adopted,* 2011 WL 3348102 (N.D. Tex. July 29, 2011) ("Further, the Court cannot consider the articles that Plaintiff attached to his Rule 12(b)(6) response as supporting evidence in his behalf."); Whiteman v. El Paso Criminal Justice Ctr., 2011 WL 2610202, at *5 (D. Colo. July 1, 2011) ("I first reiterate that I have not considered Mr. Whiteman's affidavit or other evidence attached to the response, as I find that this portion of the motion to dismiss seeking dismissal under Rule 12(b)(6) should be decided by reference to the allegations of the complaint."); *see also* Alie v. NYNEX Corp., 158 F.R.D. 239, 243 (E.D.N.Y. 1994) ("When a party submits evidence outside the pleadings in response to a motion to dismiss, the court has discretion to 'exclude the additional material and decide the motion on the complaint alone.'" (quoting Kopec v. Coughlin, 922 F.2d 152, 154 (2d Cir. 1991)).

30. *Compare* Papasan v. Allain, 478 U.S. 265, 286 (1986) ("[F]or the purposes of this motion to dismiss we must take all the factual allegations in the complaint as true, ..."), *and* Fernandez-Montes v. Allied Pilots Ass'n, 987 F.2d 278, 284 (5th Cir. 1993) ("When considering a motion to dismiss for failure to state a claim, the district court must take the factual allegations of the complaint as true and resolve any ambiguities or doubts regarding the sufficiency of the claim in favor of the plaintiff."), *with* Gehan Homes, Ltd. v. Employers Mut. Cas. Co., 146 S.W.3d 833, 838 (Tex. App.—Dallas 2004, pet. denied) ("The insurer's duty to defend arises when a third party sues the insured on allegations that, if taken as true, potentially state a cause of action within the terms of the policy.").

31. *Compare* Continental Cas. Co. v. American Safety Cas. Ins. Co., 365 S.W.3d 165, 169 (Tex. App.—Houston [14th Dist.] 2012, pet. denied) ("Whether an insurer owes its insured a duty to defend is a question of law, ..."), *with* Fernandez-Montes v. Allied Pilots Ass'n, 987 F.2d 278, 284 n.9 (5th Cir. 1993) ("The dismissal of a complaint under Fed.R.Civ.P. 12(b)(6) is a question of law, and is not entitled to the same deference as determinations involving fact questions.").

32. Farmers Texas Cnty. Mut. Ins. Co. v. Griffin, 955 S.W.2d 81, 82-83 (Tex. 1997); *see also* Gilbert Tex. Constr., L.P. v. Underwriters at Lloyd's London, 327 S.W.3d 118, 135 (Tex. 2010); Zurich Am. Ins. Co. v. Nokia, Inc., 268 S.W.3d 487, 495 (Tex. 2008) (holding that factual allegations rather than legal theories alleged determine the duty to defend (quoting 14 Couch on Insurance § 200:19)), *and* National Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc., 939 S.W.2d 139, 142 (Tex. 1997) ("Although the pleadings allege that Hart negligently discharged the firearm, we must focus our review on the pleading's factual allegations, not on the legal theories asserted.").

33. *Griffin*, 955 S.W.2d at 82.

34. *Id.* at 82-83 ("Thus, although Griffin seeks relief on legal theories of negligence and gross negligence, he alleged facts indicating that the **origin of his damages** was intentional behavior. He made no factual contention that could constitute negligent behavior by Royal." (emphasis added, citations omitted)).

35. Dodson v. Munirs Co., 2013 WL 3146818, at *4 n.4 (E.D. Cal. June 18, 2013).

36. *Merchants*, 939 S.W.2d at 142.

37. Specifically, these competing principles give the court room to operate in coverage actions—if a court is inclined to find coverage, the court will state that it is interpreting the allegations liberally. In contrast, where a court does not feel coverage is owed, the court can hold that the insured's position would require the court to "imagine factual scenarios," which it may not do.

38. PPI Tech. Servs., L.P. v. Liberty Mut. Ins. Co., 2013 WL 829040 (5th Cir. Mar. 1, 2013) (not selected for publication).

39. *Id.* at *1.

40. *Id.* at *2.

41. *Id.* at *3 (quoting National Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc., 939 S.W.2d 139, 141 (Tex. 1997)).

42. *Id.* at *4 (quoting Farmers Texas Cnty. Mut. Ins. Co. v. Griffin, 955 S.W.2d 81, 82 (Tex. 1997)).

43. *Id.* (emphasis added).

44. *Id.*

45. Humphrey v. John Doe Officer One, 2010 WL 1576464, at *4 (M.D. Pa. April 20, 2010); *see also* Mamani v. Berzain, 654 F.3d 1148, 1153 (11th Cir. 2011) ("These allegations sound much like those found insufficient by the Supreme Court in *Iqbal:* statements of legal conclusions rather than true factual allegations."); Murdock v. East Coast Mortg. Corp., 2012 WL 2344515, at *7 (D. N.J. June 20, 2012) ("These are merely legal conclusions, rather than factual allegations, that are not entitled to an assumption of truthfulness when ruling on a Rule 12(b)(6) motion to dismiss"); Thomas v. City of Chicago, 2013 WL 1345396, at *3 (N.D. Ill. Mar. 29, 2013) ("Significantly, the only allegations that are entitled to the assumption of truth are those that are *factual* allegations, rather than mere legal conclusions or formulaic assertions of elements of the asserted claim."); Blomquist v. Washington Mut., 2008 WL 5233864, at *4 n.8 (N.D. Cal. Dec. 15, 2008); Tovey v. Nike, Inc., 2012 WL 7017821, at *13 (N.D. Ohio July 3, 2012) ("They are, instead, mere legal conclusions rather than factual allegations. Consequently, they fail to meet the *Twombly*

standard."); *and* Brigliadora v. Wells Fargo Bank, N.A., 2011 WL 940317, at *2 (M.D. Fla. Mar. 17, 2011) ("In order to overcome Defendant's Motion to Dismiss. Plaintiff's Complaint must allege factual allegations rather than mere legal conclusions.").

46. Greenhill v. U.S., ex rel. Fed. Bureau of Prisons, 275 Fed. Appx. 315, 316 (5th Cir. 2008).

47. PPI Tech. Services, L.P. v. Liberty Mut. Ins. Co., 701 F.3d 1070, 1078 (5th Cir. 2012) *opinion withdrawn and superseded on reh'g*, 2013 WL 829040 (5th Cir. Mar. 1, 2013).

48. *Twombly*, 550 U.S. at 558 (quoting Dura Pharms., Inc. v. Broudo, 544 U.S. 336, 347 (2005)).

49. At least one federal district court in the Fifth Circuit came close to outing this secret relationship. In particular, the court came close to answering this question as to "whether there is a heightened pleading standard in duty to defend cases filed in federal court." United Nat. Ins. Co. v. Paul & Mark's Inc., 2011 WL 2690615, at *1 (E.D. La. July 11, 2011). However, the court did not reach the issue because it found that the duty to defend was triggered under either standard. *Id.*

50. *See, e.g.,* Atain Specialty Ins. Co. v. Chang, 2012 WL 2194116, *4-5 (S.D. Tex. June 14, 2012) (Miller, J.); GuideOne Ins. Co. v. House of Yahweh, 828 F. Supp.2d 859, 861-62 (N.D. Tex. 2011) (Means, J.) (despite acknowledging that the "allegations in the underlying lawsuit are less than precise," the court focused on factual allegation to find intentional conduct.); David Lewis Builders, Inc. v. Mid-Continent Cas. Co., 720 F. Supp.2d 781, 786 (N.D. Tex. 2010) (McBryde, J.) (disregarding conclusory allegation of negligence against the homebuilder, and finding no coverage because "[T]he [homeowner's] state court pleading make[s] clear that the only loss or damage suffered by the [homeowner] was the subject matter of their contract with the [builder] . . . ."); Mid-Continent Cas. Co., v. Camaley Energy Co., 364 F. Supp.2d 600, 605 (N.D. Tex. 2005) (Buchmeyer, J.) (deciding on other grounds but finding that the underlying lawsuit, despite its inclusion of the phrase property damage, "clearly does not allege physical injury to tangible property.").

51. *Chang*, 2012 WL 2194116, at *4.

52. *Id.*

53. *House of Yahweh,* 828 F. Supp.2d at 862.

54. Appellant's Pet. for En Banc Reh'g and Mot. To Certify Question, at PPI Tech. Services, L.P. v. Liberty Mut. Ins. Co., No. 12-40189, at 7-8 (5th Cir. Dec. 13, 2012) (citing Horizon/CMS Healthcare Corp. v. Auld, 34 S.W.3d 887, 896 (Tex. 2000) (citing Broom v. Brookshire Bros., Inc., 923 S.W.2d 57, 60 (Tex. App.—Tyler 1995, writ denied) (recognizing that the Texas rules only require "a short statement of the cause of action sufficient to give fair notice of the claim involved") (quoting Tex. R. Civ. P. 47)); *see also* State Fidelity Mortgage Co. v. Varner, 740 S.W.2d 477, 480 (Tex.App.—Houston [1st Dist.] 1987, writ denied) (recognizing that the "fair notice" requirement of Tex.R. Civ.P. 45(c) relieves the pleader of the burden of pleading evidentiary matters with meticulous particularity).

55. *See* Malcolm v. Spring Lake Associates Ltd. P'ship, 1998 WL 713667, at *3 (Tex. App.—Houston [1st Dist.] Aug. 20, 1998, pet. denied) (affirming trial court's denial of defendant's special exception despite fact that plaintiff's pleading "contain[ed] no facts concerning the alleged fraud," where defendant had fair notice of fraud allegation.); *see also* Paramount Pipe & Supply Co., Inc. v. Muhr, 749 S.W.2d 491, 494-95 (Tex. 1988) ("Rule 45 does not require that the plaintiff set out in his pleadings the evidence upon which he relies to establish his asserted cause of action.").

56. Elite Door & Trim, Inc. v. Tapia, 355 S.W.3d 757, 766 (Tex. App.—Dallas 2011, no pet.).

57. *Id.*

58. *PPI Tech. Services, supra* note 54, at 8.

59. *Id.* at 6, 8.

60. Although the *PPI* Court withdrew their original decision, the court replaced it with a revised decision that again found no coverage on the same grounds that there were no facts supporting the "conclusory" allegation of property damage in the underlying petition. However, the court did remove some of the more carrier-friendly passages from the decision. *See, supra,* note 47.

61. Trinity Universal Ins. Co. v. Cowan, 945 S.W.2d 819 (Tex. 1997).

62. *Id.* at 825.

63. *Id.*

64. *Id.* n.4.

65. *Id.* at 825.

66. National Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc., 939 S.W.2d 139, 142 (Tex. 1997).

67. *See, e.g.,* Gehan Homes, Ltd. v. Employers Mut. Cas. Co., 146 S.W.3d 833, 838 (Tex. App.—Dallas 2004, pet. denied) (broadly construing the Eight Corners Rule).

68. *PPI Tech. Services, supra* note 54, at 8.

69. GuideOne Specialty Mut. Ins. Co. v. Missionary Church of Disciples of Jesus Christ, 687 F.3d 676, 683 (5th Cir. 2012) (citing Pendergest–Holt v. Certain Underwriters at Lloyd's of London, 600 F.3d 562, 574 (5th Cir. 2010)).

70. Specifically, the Insurance Services Office, or "ISO," has issued a "Texas Amended Coverage A Insuring Agreement Endorsement," which seeks to upend the Eight Corners Rule. This endorsement modifies the insurer's defense agreement in the standard CGL Policy as follows: "Our duty to defend the insured is based on the factual allegations contained in the 'suit' and our knowledge of additional facts that are material to determining coverage but were not alleged in the 'suit'." (emphasis added).

71. *See, supra,* note 27.

By Michael Sean Quinn

THE CYBER-WORLD AND INSURANCE: AN INTRODUCTION TO A NEW INSURANCE[1]

I. Preface: Our Times

The worlds of the "nets"-internet, intranet, extranet, and so forth, have spawned considerable litigation over the last 20 or so years. Almost none of it has involved cyber-insurance, although there are two interesting federal government reports that miss the instructional mark for lawyers but are nevertheless informative.[2] But, there are virtually no reported cases involving[3] cyber-law; the leading financial press contains next to nothing[4] and—oddly enough—the magazine WIRED is similarly lacking. Moreover, there is a mere smattering in relevant encyclopedias,[5] books,[6] how-to manuals,[7] law review articles[8], and lawyerly magazines.[9] There are short "Dangerous and Irrational-Not-To-Have-It" articles and market stories[10] here and there in business magazines but very little in publications like Bloomberg, Business Week, Forbes, Fortune and similar publications.

There are also some helpful observations available in actual independent blogs, and quasi-blogs, the purpose of which is to hawk some service, e.g., that of law firms.[11] Of course, there are slews of ads, mostly by insurance agents, but some from law firms, about the importance of cyber-insurance. The ads are universally shallow and, for the most part, not worth reading. Insurers themselves don't do this much.

Of course the insurers have such ads, but they are usually a little more detailed. The most important sources of information that can be obtained from insurers are specimens of potentially helpful policies. Only a few insurers make these available, and they can be obtained only off the internet, usually.

Interestingly, there is now a growing literature concerning ethics governing cyber conduct.[12] Except for Electronic Storage of Information (ESI), not much has been set forth and debated regarding lawyer ethics (understood in a broad sense) in the cyberworld. Similarly, there has been little, if any, discourse and debate regarding insurance ethics in that domain. I expect this to change.

Of course, there may be other sources of authoritative information helpful to lawyers, e.g., unreported decisions and opinions and they are usually accessible; there are briefs, but they are designed to advocate, not inform; there may have been "secret" settlements but nothing is generally known about them and none have leaked to the general readers; and there might be cases where insurance was on a far periphery, but these rarely involve sources of legal information about cyber insurance.

II. Our Context

Since not much interesting has happened in coverage litigation lately, coverage lawyers will, for a while, analyze the new cyber policies mostly based on how the language of insurance policies looked in the past and still look now. They will start with the proposition that insurance of the future, e.g., cyber insurance policies (CIPs), will mostly resemble the insurance contracts of the past, and so, as insurance organizational documents become more standardized not much will change. Insureds will still have to cooperate with insurers in a variety of ways, and applications will require disclosure, truthfulness and be incorporated into the policy. Nevertheless, they will ask many of the same or contextually equivalent questions.

Thus, anyone who says that cyber-policies are really just existing policies, just as inland marine policies are really just maritime policies that cover something else, are right to some degree; but it will be only to some degree. Fire insurance policies from Eighteenth Century England work somewhat like those of the present; at the same time, they are also quite different, for example as to structure, including definitions, exclusions, conditions and various common meanings.[13]

With the coming of the cyber-world and its extensive commercial use and its numerous perils, there is not only a whole new lingo with new descriptive and technical language, there are also long lists of new concepts, new risks, new perils and new analyses of the financial and social functions of insurance and its relation to public policy. Some of these analyses will be subject to serious and prolonged debate (meaning what is now being erroneously called societal "conversation").

This will not change many formalistic features of cyber insurance, but it is obvious that it will change serious legal reasoning, when it comes to CIPs. Here are three examples among the many and the more to come: (1) The new cyber based languages, most of which are not rigorously defined or agreed upon in cyber industries and practices, will impact how the so called ambiguity rules will be applied

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to coverage, and insureds may, at least for a while, get more sympathy from the judicial system than they now enjoy. Then again, some policies contain explicit agreements that disagreements will be resolved on an "even playing field." Of course, such policy provisions probably undermine the foundation of the ambiguity rule in those policies; (2) As will be discussed presently, the first-party component of some liability policies has begun to contain more distinct provisions than simply the duty to defend; (3) Finally, for now at least, business income, losses of it and its triggers will be characterized and applied quite differently. This change (and others like it) will create a host of new coverage work, and most of that will be found in innovative large firms, where the work is usually done for sophisticated and large commercial insureds.

With respect to what has typically been called "business interruption coverage," example (3) is especially true for at least three reasons. First, there must be new foundations because damage to tangible property (at least, usually) will no longer be the trigger for this coverage. Second, loss of business income will have to be reevaluated in several ways: how will the triggers be reconceived; how will measuring claims be conducted in a manner that is fair for everybody; and how will BI claims be handled, e.g., with respect to investigation, auditing, negotiations, and so forth. As a result, the training and previous experience requirements for all sorts of adjusting will change radically.

Adjusters will have to not only work with them, but come to understand, the new lingo and the technical vocabulary, the relevant concepts and much more. Some independent adjusting firms might create special international departments to handle cyber cases only. Of course, insurers, or coalitions of insurers, may create joint "independent" agencies, and some may take the work in house just as they are beginning to bring coverage opinion and coverage litigators into in-house counsel departments.[14]

Some of the new policies will be extremely difficult to understand. There are a number of different policies already being designed and sold, and although there are similar cyber-perils that are already insurable, there will be more, and there are already a huge number of different ways to word policies. There are no standard policies and there does not appear to be an organized effort yet to create even a few.

There's already a whole range of new types of errors and omissions policies for cyber-professionals: architecture designers, code construction contractors, platform engineers, digital asset monitors, security risk inspectors and analysts, and many more, some with strange, some with witty, and some with informative descriptions. Several of the already established professional liability policies, such as lawyer and accounting error and omissions policies, will work somewhat the same way they do now. Reasonable performances within the scope of contracted work are at their essence. But it is likely that there will be long lists of new things which insured lawyers must place in their applications, if they are doing cyber-related professional work. Of course, applications are usually part of the policy, but more directly, the number and nature of exclusions will change. Possibly even new technicalities in applicable standards of care will change, and certainly those activities to which the standards apply are already changed in revolutionary ways.

Oddly enough, the actual language used in CIPs has not been analyzed in publications for underwriters, innovative brokers or lawyers. There are many advertisements, some involving more than one page or more than one click, but they are mostly from insurance companies, firms of insurance intermediaries looking for business, and vendors of cyber related services, e.g., from those trying to make sure that their systems will perform and protect their customers from various difficulties and disasters. Curiously, none seem to be from so-called independent adjusters or public adjusters.

It is important that there be some analyses of different kinds of policies within each category. The forms of the policies have changed little (at least on the surface); there are still declaration pages, insuring agreements, exclusions, definitions, and endorsements, but the terms of many of these have changed immensely. At the same time, some have not. A widespread and easily understandable absence of change is found within the "personal injury" section of the CGL policy. The new and virtually identical section has remained intact because defamation and other sections have remained problematic and, in some case, have become more of a central concern. At the same time--and this should come as no surprise--coverage for "bodily injury" and "property damage" is pretty much gone.

Experienced coverage lawyers do not need to read each policy thoroughly before starting to work; they know the policies backwards and forwards. This is at present not true for CIPs. For a coverage lawyer, not to mention other kinds of lawyers, CIPs must not only be read but studied in considerable detail. The reader may even need to consult appropriate technical dictionaries, engineering textbooks, relevant cyber-magazines and journals, and other sources. Wikipedia, as helpful as it can be, is not enough.

Few cyber-policies are the same, and there are no standardized policies yet, although insurance groups like members of the AIG group may interchange these policies to some degree. Further, none of the writings on the cyber-policies available for the last couple of decades contain anything like linguistic analyses of policy language. For example, none of them discuss the diverse definitions used across the market, how complex definitions fit with insuring agreements and exclusions in given policies, or how to deal with policies which contain 50 or more separate definitions. Nor are definitions the only problem. Insuring agreements often

appear to be short, but they are often the opposite since they really depend on several definitions, some of which depend on other definitions.

Additionally, problems may also arise from the fact that the exclusion lists can also be quite lengthy, and since they often depend on the definitions, these exclusions, too, can be quite difficult to understand. Oddly enough, there are sometimes undefined terms to be found in the insuring agreement and/or in the exclusions, which cry out for definition, but have none. Even stranger is the fact that endorsements have heretofore, not been used much to fix those problems.

III. Some Overlapping Generalities

There are a variety of ways in which "real world" contracts of insurance and CIPs are very much alike. It has already been mentioned that their physical structures are identical. However, there are more important overlaps.

It is well known that there are two types of insurances coverages. As one might expect, (1) there are contracts of liability (or, third-party) insurance CLPs, indemnifying the insured for what he may have to pay if he has, or is said to have, injured some third party; and, (2) there are (CFPs) where the value of the insured's assets, at least some dimensions of health, reputation, some mental states, and so forth, are protected by an insurance policy to some degree of other. Sometimes, in what might be called the "over arching policy," the two types of polices are integrated together; sometimes they are "blanket" policies; and on other occasions they are "package" policies.

There are a variety of ways in which "real world" contracts of insurance and CIPs are very much alike. It has already been mentioned that their physical structures are identical. However, there are more important overlaps.

Some of the contracts of the cyber-insurance contracts are primary policies; others are umbrella policies; some are excess polices. And, as one would expect, often, the layers going up follow the form of at least one policy below it, often the primary.

Of course, there is some reinsurance retrocession available, but in terms of pricing for those policies, facultative or treaty, it is difficult for underwriting departments to price policies or establish reasonable reserves since there is so little statistically reliable risk data from which to calculate either.

IV. Insured Perils and Covered Compensation

There is a whole list of new perils that are insured in most cyber-policies. They will be listed shortly. There is one which can be said to be a "meta-peril." (The idea of an insurable "meta-peril" is about as logical as the locution "meta-information inquiry," etc.) As already mentioned, most liability (3rd-party) policies contain a 1st-party component. At its most basic level, the insurer has a duty to defend its insured when he is sued and there is arguably coverage. The cost of the defense is usually the only 1st-party component. In some cyber-liability-policies, the insurer has a duty to provide (so the insured has a right to receive) more 1st-party coverage. One should think these additions are either mitigation expenses or something like them. Ultimately, paying such expenses could save the insurer substantial amounts of money.

Now, as promised, here is a list of some of the perils that may be insured in a cyber policy. At least one insurer lists them in such a way that the insured can treat them as something of a smorgasbord in constructing a new policy. One way to portray this is to divide coverages into "modules," and the insurance customer can "pick and choose."

> In any case, here is a rough list of some 3rd-party liability insurance coverages dealing with suits or claims of liability against an insured from:

• Directly obtaining, distributing, disseminating, etc., private information of another. (The private information may be of different sorts: credit, financial, conduct, misconduct, medical, client-lawyer, lawyer-client, and so forth.)

• Indirectly causing the same sort of "privacy-injuries." (A cyber-defendant "permits" an invasion of its system, which allows another to cause a "privacy injury," e.g., a cyber server permits a hacker to get to a bank and the hacker makes off with credit information of the bank's customers. Privacy injuries may include "identity theft," a broad concept.)[15]

• Causing the theft of valuable information from a customer, e-vandalism, and so forth. (Of course, this could also involve the same kind of attacks on a customer of the insured's customer.)

• Causing, whether directly or indirectly, claims resulting from alleged injury causing intellectual property infringement, e.g., copyright, trademark infringement, and so forth. (This is a cyber conflict area, which is extensively discussed, if not heavily litigated.)

• Causing product disparagement, defamation, invasion of privacy, or injury to reputation, and so forth.

• Insured's security failures that have injured a 3rd-party (and the third party's injury may result from an injury it caused to yet more parties, running up to whole classes.)

• The opposite of the last one (the insured's system fails and as a result the system of another is unavailable to its customers).

• Insured's technical errors or system defects that cause injury to the systems of another or others.

• Insured causing the destruction of or injury to the information of another.

• Insured causes cyber-BI to another or to others.

• Insured is somehow negligently causally involved in a cyber-extortion[16]

• And so forth.

Those for which damages will be paid are quite different from commercial policies in the so-called "real world." Of course, 1st-party policies are also quite different when it comes to that which is covered and the perils for which there can be coverage. Perhaps an important adaption when real world insurance and cyber-world insurance are both potentially involved in a property damage claim is going to be corresponding anti-coinsurance clauses. For real world insurance involving property losses, there will be an exclusion if the cyber-world is also involved, whereas for cyber-world insurance, there is no coverage for property damage if real world property insurance is involved. It could even be that both real world and cyber-world policies will contain exclusions of property when the cyber-world is involved.

V. Partial Policy Analyses

The author's experience so far is that there are a number of ways to analyze insurance policies. They range from shallow to advanced text-book detail. The first of the two analyses here is medium-detailed and the second one is somewhat less so. The only way to do a worthy, really detailed coverage analysis of new and somewhat innovative policies like these, is to focus on the contract clause-by-clause, but even interested readers cannot stay awake for that, not even passionate insurance geeks like the author.[17]

Parts of two policies will now be discussed briefly. Some propositions in these will be merely summarized, and much will be skipped. Here are some of the to-be-omitted parts: declaration sheets, applications, deductibles, retentions, policy limits, self-insurance, duties to defend, retroactive periods, extension periods, damage calculations, conditions, and more. (In passing, it should be pointed out that defense expenses reduce policy limits, as is the case in most claims-made policies.)

A. Policy No. 1: Some Language

THE INSURING AGREEMENT

> **We** shall pay on your behalf those amounts, in excess of the applicable Retention,* **you** are legally obligated to pay, including **content based liability** and liability **assumed under contract** as **damages**, resulting from any **claim(s)** made against **you** for **your wrongful act(s)** in connection with **Internet media** in the conduct of your business. Such **wrongful act(s)** must occur during the **policy period.**

[IMPORTANT[18]] DEFINITIONS[19]

> **Assumed under contract** means liability assumed by you in the form of hold harmless or indemnity agreements executed with any party, **but** only as respects material provided or disseminated by you.
>
> **Content-based liability** means **your** liability arising from a third party acting upon **your Internet media or Internet media services**, provided the third party has no common ownership interest or other affiliation with **you.**
>
> **Internet media** means **advertising**, webcasting, electronic publishing, transmission, republication, re-transmission utterance, dissemination, distribution, serialization, creation, production, origination, exhibition or displaying of material on **your Internet site.**
>
> **[AN] EXCLUSION** [There are dozens. This one is included to illustrate the scope of this policy. Not all cyber-policies contain this exclusion, but some do, to one degree or another.]
>
> [Any action] against **you** [is excluded] that is brought by or on behalf of the Federal Trade Commission ("FTC"), Federal Communications Commission ("FCC") or any other federal, state or local government agency or ASCAP, SESAC, BMI or other licensing organizations in such entity's regulatory, quasi-regulatory or official capacity, functions or duties.

B. Policy No. 1: Some Analysis

The language of the Insuring Agreement is laid out like that in most insuring agreements, but it means nothing, if the definitions are not understood. In order for the insurer to have a legal obligation to do anything, the insured must perform a "wrongful act", as defined in the policy, and that definition is long and multidimensional. One of its typical conditions is that the insured's act(s) or omissions must be negligent or something like it. Wrongful acts can be found in a variety of different areas of human conduct. These include the following and those closely related to them:

- defamation [of a person, a business, or a product]
- outrage or outrageous conduct
- copyright (etc.) violations, and
- invasions of privacy (etc.)

So now we know what kind of conduct is covered. Notice it all comes from the definition, a very complex list filled with vague terms, some of which have been explored for decades and more, by reported cases.

We do not yet know what kinds of things are actually covered. It all has to do with happenings connected to **Internet Media.** The first thing to do is give up the idea that internet media corresponds to the ordinary use of the term ''media." In ordinary usage, that term applies to and differentiates among such things as radio, TV, movies, and maybe phones, iPads, etc. There has been a contemporary change in the use of the word; now we have things like "social media," which is a use of the internet. The phrase does not apply, however to specific activities. Here the term "media" includes different substantive activities (e.g., advertising, a form of publishing) and different ways to perform those activities (e.g., webcasting). Obviously, the use of the term "media" is simply more complex; at least in the area of the cyber-world, the term has several different uses. One thing it does not mean is "portal." Of course, this complexity in usage may create problems for coverage.

In any case, the Wrongful Acts specified in the definitions must be performed in connection with some kind of media. Thus negligent false advertising made on the Internet appears to be covered, at least within the insuring agreement. Now, who must perform the activity in order for there to be coverage? Obviously, if the insured performs the act at issue wrongfully, it is covered by the insuring agreement. Now, what about others; what about people who the insured has permitted to enter through a site he controls or has a right to control. Prima facie coverage pursuant to contracts probably does not apply.

What about someone who just entered with permission (i.e., snuck through, perhaps)? This scenario would fit, I think, into the insuring agreement. This start toward coverage would happen if the insured committed a wrongful act in permitting the "interloper" to use his site or if the insured permitted it but failed to regulate it.

There are a very large number of definitions in this policy and nearly as many exclusions as there are definitions. Some of the exclusions are hangers-on from real-world liability policies; some are designed to separate cyber-world policies from those of the real world; and some are unknown, obscure, and/or confusing all on their own, e.g. the exclusion of **Public Key Infrastructure.**

It should be noted that the definitions exclude amounts of money that the insured must spend in curing or altering its own problems that lead to the injuries inflicted upon others. Those might include: "cyber-fixing," "cyber-redesign,""new architecture," and so forth. It might also include closing a form of media, preventing someone from using it, creating new agreements, demanding bonding, and so forth. The language extracted from the policy and the commentary on it gives the reader a simplified and partial exposition of some parts of this policy. (Please remember the contents of Note #1.) Let us therefore turn to quite a different policy.

C. Policy No. 2: Orientation

Another policy, this one designated PI-CY-001 (05/10), is quite different. It is entitled CYBER SECURITY LIABILITY COVERAGE FORM, though it can be conceived as a smorgasbord type of policy. Some of its components are genuinely "liability" (3rd person) policies, while other parts are 1st-party policies. The **INSURING AGREEMENTS** list contains 8 separate sections, 3 of which are liability sections and 5 of which are first party coverage. Here is the whole list, with the 3rd party coverage titles containing the word "liability:"

A. Loss of Digital Assets

B. Non-Physical Business Interruption and Extra Expenses

C. Cyber Extortion

D. Security Event Costs

E. Network Security and Privacy Liability Coverage

F. Employee Privacy Liability Coverage

G. Electronic Media Liability Coverage[20]

H. Cyber Terrorism Coverage

There are very little truly informed discussions these days about cyber-problems. It is easy to conclude (or semi-guess) how these coverages fit into that discussion. This can be done without much text. I shall discuss only one of them. Naturally, it is the longest one, so I will have to avoid many quotations.

D. Policy No. 2: Some Language

The analysis here will focus on the **Security Event Costs** coverage of the above-referenced policy. The whole policy includes over 50 definitions, nearly 1/5th of which are used in this part of the **COVERED CAUSE OF LOSS** section (§II).

> The introductory section of the "D" coverage states:
>
> We will reimburse you for **security event costs** and **special expenses**, in excess of the applicable deductible shown in the Declarations, up to the Limit of Liability for Insuring Agreement **D** shown in the Declarations, when you incur **security event costs** or **special expenses**

during the **period of recovery** from a **security breach, privacy breach**, or breach of **privacy regulations** that first occurs and is reported to us during the **policy period** and such costs directly result from either:

1. [a] Complying with "any statute, rule or regulation, or [b] with respect to a judgment, approved settlement, consent decree or other legal obligation, the cost of notifying "the affected individuals of such **security breach**.[21]

2. "Minimizing harm to your brand or reputation from an **adverse media report.**"[22] [Apparently, the adverse media report must arise from the report of a **newsworthy event**.]

Obviously, a good number of definitions are used here. Some of them can be sketched; some need to be quoted; some are obvious enough that they can be ignored.

- **Privacy breach** means a common law or statutory breach of confidence or violation of any common law or statutory rights to privacy, including but not limited to breach of your privacy policy, breach of a person's right of publicity, false light, intrusion upon a person's seclusion, or public disclosure of a person's private information.

- **Security breach** means:

1. **Unauthorized access** of your **computer system** or **unauthorized use** of **computer systems** including **unauthorized access** or **unauthorized use** resulting from the theft of a password from your **computer system**;

2. A **denial of service** attack against your **computer systems**; or

3. Infection of your **computer systems** by **malicious code** or transmission of **malicious code** from your **computer systems**, whether any of the foregoing is a specifically targeted attack or a generally distributed attack.

- **Malicious code** means unauthorized and corrupting computer code, including but not limited to computer viruses, spy ware, Trojan horses, worms, logic bombs, and mutations of any of the preceding.

- **Security event costs** means all reasonable and necessary fees, costs, and outside expenses you incur with our prior written consent in connection with a security breach, privacy breach or breach of privacy regulations, as described below:

1. Notification costs and related expenses that you incur to comply with requirements of governmental statutes, rules or regulations, or which you incur as a result of a judgment, settlement, consent decree, or other legal obligation, including the services of an outside legal firm to determine the applicability of and actions necessary to comply with governmental statutes, rules or regulations;

2. Computer forensic costs of outside experts retained to determine the scope, cause, or extent of any theft or unauthorized disclosure of information, but such expenses will not include your compensation, fees, benefits, or expenses of those of any of your **employees**;

3. Credit protection services for the affected individual.

- **Special expenses** shall not include interruption expenses and shall mean the reasonable and necessary costs in excess of the applicable deductible or co-insurance percentage you incur to:

1. Prevent, preserve, minimize, or mitigate any further damage to your digital assets, including the reasonable and necessary fees and expenses of specialists, outside consultants or forensic experts you retain;

2. Preserve critical evidence of any criminal or malicious wrongdoing;

3. Purchase replacement licenses for programs because the copy protection system and/or access control software was damaged or destroyed by a covered cause of loss;

4. Customer notification expenses, but only if an amount is shown in ITEM 4 in the Declarations for the Customer Notification Expenses Aggregate Sublimit or provided by endorsement to this policy; and

5. Public relations expenses, but only if an amount is shown in ITEM 4 in the Declarations for the Customer Notification Expenses Aggregate Sublimit or provided by endorsement to this policy.[23]

- **Professional service** means those acts or services requiring specialized knowledge, which you render, or for which any person or entity renders on your behalf, to others pursuant

to a written agreement and for a fee or other consideration.

These definitions are not terribly difficult to grasp, at least in so far as they are clear. This topic will be discussed later.

There are also, of course, exclusions. This policy contains an absolutely enormous number, and they appear intended, to apply to all of the different coverages in the policy, just as many of the definitions do. [24] All sorts of acts and events are excluded from coverage: governmental action such as seizure, destruction, etc, power outages, fire, acts of God, various design failures, acts of terrorism, pollution, wear and tear of the **computer system** and **digital asset**, failure to render professional services, warranties, fee disputes, and many more. Many of these are similar to exclusions to be found in real world policies, like the **Pollutants** exclusion, exclusions for promotional game or other game of chance contests, and the like. [25]

E. Policy No. 2: Some Analysis

The coverage in this second section of the policy pertains to various "invasions" of the insured's cyberdomain. That area may be conceived of as a fort, the wall of which can be crashed through. This is an intuitive way to think about a **security breach**, which is one of the fundamental ideas built into this section. That phrase and, hence the coverage, can also be thought of as unauthorized entries, uses, denials of services, and computer infections by **malicious codes**.[26]

Once the fort-computer system has been invaded, the insured's privacy can be adversely affected in a variety of ways. The very concept of privacy has many dimensions, some of which are already recognized in common law, some of which are internal privacy policies (that can themselves be invaded), and governmental regulations of many kinds.

Such invasions can cost large amounts of money to cure, fix, improve, restore, recreate, subject to forensic analysis, and provide **credit protection services**. These costs constitute the **security event costs**. Parts of these are the insured losses subject to policy limits, time restrictions, substantive exclusions that pretty much run (or at least are intended to run) throughout the policy.

Some **special event costs** are also covered. These include costs to "[p]revent, preserve, minimize, or mitigate any further damage to [the insured's] **digital assets**[.]" These include both data and various tangible objects. They also include costs of preserving significant evidence, replacing licenses, customer notification expenses, and public relation expenses.

VI. Conclusion

All the details set forth above seem relatively straightforward. Once coverage litigation begins, however, all sorts of questions will emerge and a good number will also be constructed. Policies this huge are the stuff new coverage advice, disputes, and litigation are made. Obscure passages, meant to be protective of insurers, will be acknowledged for what they are; processes of adjustment will remain the same, except for the extraordinary complexity of those "things" and states of affairs that, along with perils, are at the roots of insurance itself and insurance controversies. One can boo this state of affairs-and it will inevitably come—one can be stoical and acknowledge the world of insurance coverage disputes for what it has always been and what it will always be.

1. New insurance policies with previously unthought of coverage provisions is a phenomenon which has not happened in as much as a thousand years (or two). There have been no wild and rapid scientific, industrial, and social radical changes. None has ever generated a new set of concepts and new nomenclature as quickly as cyber insurance policy. The new language used in these new (yet old) contracts-the contracts of insurance-will be subject to an enormous amount of legal controversy. *See* C. F. Trenerry, The Origin And Early History of Insurance: Including the Contract of Bottomry (Ethel L. Grover & Agnes S. Paul eds., 1926). This only looks like it is contradicting me.

The reader should keep in mind that this is (or nearly is) the first among what will become a widespread archive of essays, probably written by coverage lawyers, regular lawyers, and (on rare occasions) interested geeks. First ''whacks" at virtually anything are, by definition-to some (hopefully small and/or on the fringes) extent-subject to innovative speculation that can lead to original error. Such essays will probably be helpful in (almost) starting the process of relevant learning, but they are also prone to (limited) error. Some skepticism is therefore appropriate.

2. *See* Nat'l Prot. & Programs Directorate U.S. Dep't of Homeland Sec., *Cybersecurity Insurance Workshop Readout Report* (November 2012), http://www.dhs.gov/sites/default/files/publications/cybersecurity-insurance-read-out-report.pdf. *See also* Nat'l Prot. & Programs Directorate U.S. Dep't of Homeland Sec., *Cyber Risk Culture Roundtable Readout Report* (May 2013), https://www.dhs.gov/sites/default/files/publications/cyber-risk-culture-roundtable-readout_0.pdf

3. Here is a significant exception: Retain Ventures, Inc. v. Nat'l Union Fire Ins. Co., 691 F.3d 821 (6th Cir. 2012). *See also* Netscape Commc'ns Corp. v. Fed. Ins. Co., 2007 WL 2972924 (N.D. Cal. 2007), *rev'd* 343 F. App'x. 271 (9th Cir. 2009).

4. For a recent indictment involving a man cyberstalking his own family following murder, in a state courthouse, and related conspiracies see Martha Neil, *Son of Courthouse Shooter is Held Without Bail After 'Unique' Cyberstalking Indictment*, A.B.A. J., Aug. 12, 2013. http://www.

abajournal.com/news/article/son_of_courthouse_shooter_is_held_without_bail_after_unique_cyberstalking/ An indictment was issued on about August 11 , 201 3 against several alleged participants. The defendant was denied bail. See also Bert Rankin, *Five Strategies for Reducing Cybercrime Risk*, Property Casualty 360, June 6, 2013, http://www.propertycasualty360.com/2013/06/06/five-strategies-for-reducing-cybercrime-risk. Cyber crime is not a one way street. *See Cyber Theft Victims Itchy to Retaliate*, Wall St. J. (June 3, 2013). There is an interesting insurance problem inherent in this area. What if there is deliberate retaliation , and the retaliator "hits" the wrong cyber-citizen? One would hypothesize that there would not be liability coverage for that. Incidentally, the ABA has formed a "Cybersecurity Legal TaskForce." One of its present focuses is on "beaconing," a process which enables networks to fix their own problems. The American Bar Association House of Delegates has now stepped into the breach. At its August 2013 Annual Meeting, it adopted a resolution urging governments of the United States by themselves and in contact with foreign powers to amend and approve all sorts of new laws regarding cyber attacks. Obviously, the idea of beaconing is important to insurance contracts since insurers should require insureds to have such devices, in at least some cases.

5. Bert Wells, et al., *Cyber-Risk Insurance, New Appleman on Insurance Law Library Edition, Chapter 29*, LexisNexis Legal Newsroom Insurance Law, (March 4, 2011). http://www.lexisnexis.com/legalnewsroom/insurance/b/applemaninsurance/archive/2011/03/04/cyber-risk-insurance-new-appleman-on-insurance-law-library-edition-chapter-29-covington-burling-llp-.aspx.

(An encyclopedia of "early-ish" cyber cases, analyses of cyber policies, and of the few existing cases.) If they are not there to be found, one cannot expect a truly extraordinary group of authors to find them.

6. *See* Lawrence Lessig, Code version 2.0 (2006). (This book is as much about political theory, jurisprudence, and philosophic ethics as applied to the cyber-world as anything else). A lot of this book pertains to codes as a source of cyber-regulation. However, insurance as regulation is implied in his discussion of markets, along with three other factors (law, norm, and architecture, see pg. 178 for an explicit mention). His sense of the term "code" has some role already to play in cyber-insurance policies.

7. George Sutcliffe, E-Commerce Insurance And Risk Management (Second Edition 2001). There are no further editions. This book is valuable for its introductory level but topically diverse lengthy introduction, a glossary, and several policies too briefly summarized (one page a piece).

8. One of the few law review applicable articles focuses mainly on how cyber-problems are dealt with under standard, "real world" policies. *See* David Cohen & Roberta D. Anderson, *Insurance Coverage for "Cyber Losses,"* 35 TORT & INS. L.J. 891 (2000). The most concrete component of this piece concerns controversies regarding insurance coverage for accidental damages to some cyber-"creature" and covered "property damage" under CGL-type policies. *See also* Amy R.Willis, *Note: Business Insurance: First Party Commercial Property Insurance and the Physical Damage Required in a Computer Dominated World,* 37 Fla. St. U. L. Rev. 1003 (2010).

9. *See* Spencer M. Taylor & Sean W. Shirley, *Insurance and Cyber-Losses: Coverage for Downloading Disaster,* 62

Ala. Law. 193 (2001).

10. Siobhan Gorman, *Annual U.S. Cybercrime Costs Estimated at $100 Billion*, Wall St. J. (July 23, 2013); Mark Greisiger, *Cyber Liability & Data Breach Insurance Claims: A Study of Actual Payouts for Covered Data Breaches*, NetDiligence (June 2011); Caron Carlson, *Why Cyber Insurance Isn't Booming*, (April14, 2013), www.fiercecio.com; Patricia-Anne Tom, *How to Find Cyber Insurance for the Uninsurable*, Ins. J. (May 2, 2011); Ed Silverstein, *Insurance Technology-Cyber-Liability Insurance Market Could See More Business in Europe*, (June 21, 2013), www.tmcnet.com; Anya Khalamayzer, *Cyber Insurance Take-Up Rate Among Fortune 500 Very Low*, Property Casualty 360 (June 10, 2013); Richard Bortnick, *Cyber Liability Insurance: Ensuring Adequate Coverage in the Age of E-Commerce*, Cyber Inquirer (July 27, 2013); Adam Courtenay, *Cover for a Growing Business*, The Age (July 29, 2013); *Zurich Tapping into Cyber Attack Insurance*, The Economic Times (July 16, 2013).

11. These are the essays of Roberta D. Anderson, *Spotlight on Cyber "Cloud Insurance Coverage,"* Legal Cloud Central Blog (July 1, 2003) perhaps a firm source), *Insurance Coverage for Cyber Attacks, A Two Part Essay,* 12#5 The Insurance Coverage Law Bulletin (May & June 2013). Most of these articles are about the relationship between cyber activities with contemporary policies or contemporary new-cyber restrictions. However, there are brief discussions of a small number of reported cyber cases. (Pages 4-7 in Part 2), which contain explicit discussions of cyber policies and cyber attacks. Those three pages are informative. The two articles can be found on the Internet or under the authors name at K & L GATES. THE BULLETIN indicates that is an ALM product, and the subscription rate is $500± annually.

12. For some sources on cyber ethics see Richard A.Spinello's Cyberethics: Morality and Morality and Law in Cyberspace (4m Ed. 2011) (a college textbook). *See also Ten Commandments of Cyber Ethics*, The Cyber Citizenship Partnership, http://cybercitizenship.org/ethics/commandments.html; *Computer and Information Ethics*, Stanford Encyclopedia of Philosophy (Aug. 14, 2001), http://plato.stanford.edu/entries/ethics-computer; *Internet Research Ethics*, Stanford Encyclopedia of Philosophy (June 22, 2012), http://plato.stanford.edu/entries/ethics-internet-research; *Code of Ethics*, ACM Code of Ethics and Professional Conduct (Oct. 16, 1992), http://www.acm.org/about/code-of-ethics; Donald Gotterbarn, *Computer Ethics: Responsibility Regained,* http://csciwww.etsu.edu/gotterbarn/artpp1.htm; Kenneth Himma & Herman Tavani, The Handbook of Information and Computer Ethics (May 27, 2008); Lee Gillam & Anna Vartapetiance, *Cyber Law*, Cyber Ethics and Online Gambling (Ch. 5), (2012); Seyed Farjami, *Is There a Place for Cyberethics? A Con-*

ceptual Look at the Effects of Cybertechnology on Ethics and Communications in Cyberspace, Asian Social Science, Vol. 8, No.4, April 2012; *Case 3: Whose Fault is it Anyway?*, Univ. of Ala. (April 16, 2009), www.bamaed.us.edu/edtechcases/case3.html#case.

13. *See* Robin Pearson, Insuring The Industrial Revolution: Fire Insurance In Great Britain, 1700-1850, (April 2004). See also Cornelius Walford's discussion of the history and nature of fire insurance. The Insurance Cyclopedia, Volume IV, pp. 5-171 (1876). There is a discussion of the lawyerauthor in Wikipedia under his name at http://en.wikipedia.org/wiki/Cornelius_Walford.

14. Of course, there will also be a whole new breed of expert witnesses, along with the existing herds.

15. Consider what is described here as one form of "indirectly" causing injury.

16. Here's one: "Pay us $X or we will destroy your computer system [or whatever]. It will never work again. It is your company's baby [life line, family, essence, etc.]" Here is another: "Pay us big time, or we will set up a situation in which you will have to spend millions to dig yourself out of a muddy business trench."

17. For verification of this proposition, try reading early policy analyses found on the sporadically "published" Blog, Quinn on Insurance (2013).

18. A number of definitions set forth in each policy are crucially important to understanding each cyber-policy as a whole. (Of course, this is commonly said about all sorts of insurance policies, and maybe so, but it is even more so for cyber-policies, and not just a little-bit more-so.) In any case, the following definition is very complex and not for novitiates. Consider this one: Public Key Infrastructure (PKI) means the policies, methods, equipment and procedures, including associated software, hardware and firmware, for establishing and managing a secure method for exchanging electronic information involving the use of certification authorities, digital certificates, digital signatures, public and/or private keys or any other similar type of technology however labeled. (Ex-U) ["Digital Signature." Any chance of linguistic controversies over this?]

19. The definitions set forth here are not in the same order as in the policy.

20. This coverage is similar to that found in the other policies.

21. This is mostly a paraphrase.

22. It seems obvious that the use of the term "media" is, at its core, much more similar to traditional usages, maybe with internet communications thrown in.

23. It is worth noting in passing, although this is not part of the analysis, that many of the definitions in cyber-world involve definitions built upon definitions. This is not "redefinition" since that means changing the definition, this simply means that one definition must be understood in terms of another. It of course can involve layers, definitions within definitions, within definitions. It really gets complicated when the highest layer is redefined in the traditional way.

24. Obviously not all of the definitions do this. Some of them, like the definition of **Professional Service** is directed to liability policy situations. Some parts of the policy don't work very well. The definition of **Professional Service**: First, it is so diverse that it could be ambiguous. Second, in the cyber-world, a cyber-insured may count a whole raft of activities as professional. Third, the definition appears to include the scenario where a written contract requires a written contract. Unless that requirement is buried somewhere else in the policy, its presence here distorts the idea of professional services.

25. The "gambling exclusion" is an obvious case of an exclusion that spreads over both 1st and 3rd party coverages, as do a number of others.

26. Curiously, this section also pertains to the insureds computer system transmitting malicious codes. One would think that this part of the definition of the phrase security breach would pertain to 3rd party liability coverage, but that is unlikely, for example, because there is no definition of the phrase wrongful act and neither the term "negligence" nor any of its sibling or cousins is present. Whether it involves potential third party liability, the real focus is on an insured notifying its own customers.

By David S. White and Rachelle H. Glazer

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

The Scope of Coverage for Additional Insureds Is Determined by the Terms of the Policy Without Regard to Limitations in the Underlying Indemnity Agreement.

***In re Deepwater Horizon.*, 710 F.3d 338 (5th Cir. 2013).**

In one of many cases arising from the infamous April 2010 explosion and pollution release from a Gulf of Mexico well owned by BP and operated by Transocean Holdings, Inc., BP seeks pollution liability insurance coverage as an additional insured under several of Transocean's primary and umbrella policies for numerous lawsuits. All the parties agree that BP qualified as an additional insured, but the insurers assert that they have no obligation to cover BP for pollution-related liabilities because the underlying Drilling Contract allocates responsibility for subsea pollution risks to BP, not Transocean, and Transocean agreed to provide BP insurance only for liabilities that Transocean assumed in the Contract. The Fifth Circuit, however, held that the scope of coverage available to an additional insured must be determined solely with reference to the terms of the policy. Any limitation on the scope of Transocean's insurance-procurement obligations may not limit the scope of coverage in the policies, unless the policies explicitly state such a limitation, and the policies do not exclude an additional insured's pollution-related liability. Reversed and remanded for entry of judgment in favor of BP.

The Drilling Contract required Transocean to procure liability insurance naming BP as an additional insured "for liabilities assumed by [Transocean] under the terms of this Contract." Responsibility for pollution-related claims and liabilities was allocated in the Contract in two indemnification clauses, one of which assigned responsibility to Transocean for pollution liabilities "originating on or above the surface of land or water;" the other, to BP for pollution liabilities not assumed by Transocean. Accordingly, the Contract allocated responsibility for the subsea pollution to BP, excusing Transocean from any obligation to procure insurance covering BP for that liability.

All of the applicable policies contained materially identical additional-insured provisions. The definition of "Insured" included anyone for whom Transocean is obligated by any oral or written contract to procure insurance, if Transocean is also obligated by contract to assume that party's tort liability to pay for, among other things, "bodily injury" or "property damage." Tort liability is broadly defined to include any liability imposed by law in the absence of a contract or agreement.

All the insurers denied coverage for pollution-related claims against BP, and coverage litigation ensued. The insurers argued that the scope of coverage available to BP as additional insured was limited by the scope of insurance coverage Transocean agreed to provide, i.e., only for liabilities that Transocean assumed under the terms of the Drilling Contract. BP countered that, under two recent cases, the scope of coverage available to an additional insured must be determined exclusively with reference to the terms of the additional-insured provisions of the insurance policy, to the exclusion of any limitations in the underlying contract.[2] The lower court held that these cases were distinguishable and denied BP's motion for judgment. BP appealed.

The Fifth Circuit panel agreed with BP that *ATOFINA* and *Aubris* controlled the scope-of-coverage issue, stating:

> [T]o discern "whether a [liability] insurance policy that was purchased to secure the insured's indemnity obligation in a service contract with a third party also provides direct liability coverage for the third party," we look to the "terms of the [policy] itself," instead of looking to the indemnity agreement in the underlying service contract.[3] We apply this analysis so long as the indemnity agreement and the insurance coverage provision are separate and

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independent.[4]

The *Deepwater* panel found that the *ATOFINA* case closely matched the present case. In both cases, the additional-insured provision in the insurance policy afforded direct liability coverage with no limitations on scope other than the terms and conditions of the policy itself. The underlying contracts in both cases contained severe limitations on the scope of coverage that would exclude coverage for the additional insured if applied to the policy. The Texas Supreme Court in *ATOFINA* refused to import into the policy any of the restrictions on scope of coverage in the underlying contract.[5]

The panel then determined whether the additional-insured provision was separate from and additional to the indemnity provisions, a requirement first imposed by the Texas Supreme Court in the *Getty Oil* case.[6] The panel again returned to the *ATOFINA* case that concluded that if the additional-insured provision in the insurance policy afforded "*direct* insured status to *ATOFINA* as an additional insured," then the provision establishes a separate and independent obligation for insuring liability.[7] Accordingly, because the policies themselves do not impose any relevant limitations on coverage for BP's pollution-related liabilities, and the additional-insured provisions in the Drilling Contract are separate from and additional to the indemnity provisions, the panel reversed the lower court's denial of judgment for BP and remanded with instructions to enter an appropriate judgment consistent with the panel's decision.

It is likely that insurers will take heed and begin to incorporate into their additional-insured endorsements all limitations on scope of coverage found in the underlying contract. It will probably be enough for the endorsement to state, "The scope of coverage provided under this endorsement shall be no broader than is required in your written or oral contract."

Post-Judgment Notice of Claim to Insurer Voids Duty to Defend Even Though Judgment Was Appealable at the Time.

***Jamestown Ins. Co. v. Reeder,* No. 12-20437, 508 Fed. Appx. 306 (5th Cir. 2013).**

Texas law governing untimely notice of a claim under a general liability policy is fairly well settled. The insurer may not refuse to defend unless it can show that late notice caused prejudice.[8] Failure to notify an insurer of a claim until after a judgment has become final and non-appealable prejudices the insurer as a matter of law.[9] In the present case, the Fifth Circuit holds that notice 56 months after the insured was first counter-sued and 31 months after the trial court had entered final judgment against the insured prejudices the insurer, even though the judgment was appealable at the time of notice and was, in fact, ultimately reversed in the insured's favor.

In 2004, Jamestown's insured brought a number of claims against his business partners in Wood County state court. In March 2006 the defendants filed the first of several counterclaims against the insured alleging a variety of causes of action. In March 2008, the trial court entered an amended final judgment against the insured, which was unsuccessfully appealed to the Texas Court of Appeals. While the Wood County case was pending, Reeder-affiliated entities sued several of the Wood County defendants in Red River County, and these defendants counter-sued Reeder for fraudulently transferring property to avoid paying the Wood County judgment.

Reeder did not send written notice of these lawsuits until November 2010, more than two years after judgment against Reeder. Jamestown refused to defend or pay the judgment because notice had not been delivered as required under the policy, "as soon as practicable," and the coverage lawsuit followed. The lower court granted summary judgment for Jamestown. The Texas Supreme Court reversed the Wood County judgment and rendered a take nothing judgment in the insured's favor in August 2012.

Observing that the Texas Supreme Court had not directly addressed the question of whether an insured's failure to notify an insurer of an appealable judgment is prejudicial as a matter of law, the Fifth Circuit panel made an *Erie* guess and stated that "one of the purposes of a notice provision is to allow an insurer to form an intelligent estimate of its rights and liabilities before it is obliged to pay."[10] The court concluded:

> Reeder's choice to litigate the Wood County matter unilaterally for more than four years before notifying Jamestown prevented it from making such an estimate, from helping Reeder prevail in the trial court, or from exercising its option to settle with the Wood county defendants—perhaps for less than the cost of Reeder's attorney's fee.

Accordingly, the panel held that Jamestown was actually prejudiced as a matter of law and so had no duty to defend or indemnify Reeder. The Fifth Circuit panel also affirmed the lower court's summary judgment that the insurer had no duty to indemnify the insured in the more recent Red River County suit because the only allegation in that action was intentionally initiating a fraudulent transfer, which is excluded under the policy.

The Fifth Circuit Upholds Insurer's *Soriano* Right to Exhaust Limits by Settling One Insured, Thereby Leaving Another Insured Without Further Defense or Indemnity.

***Pride Trans. v. Continental Cas.Co.*, No. 11-10892, 511 Fed.Appx. 347 (5th Cir. 2013).**

Krystal Harbin, a driver for Pride Transportation, rear-ended another vehicle, causing crippling injuries to the other driver. Pride, a large-fleet motor carrier, carried $1 million primary and $4 million excess auto liability insurance. The injured driver sued Harbin and Pride, and Pride's primary insurer agreed to defend them both. Defense counsel estimated the reasonable value of Harbin's liability at between $8 million and $10 million, with a real possibility of damages against Pride in excess of $5 million. Moreover, during discovery, it became clear that Harbin had falsified her driver logs to avoid work restrictions, a fact that probably increased her exposure to liability. Also, the plaintiff's attorney had recently won a $25 million verdict in a similar case in the county.

The plaintiff sent a settlement demand to Harbin for $5 million, policy limits, in exchange for a release of Harbin from liability. The primary carrier tendered its limits to the excess carrier. Pride asked the excess carrier to seek a counter-offer of $5 million to settle liability against both defendants, which the excess carrier refused to do unless both insureds agreed to it. Harbin rejected that proposal and demanded that the carrier accept the plaintiff's initial offer, which it did. Pride then filed a cross-claim for indemnity against Harbin in the underlying suit.

Both insurers notified Pride that because the policies were exhausted, they would withdraw their defense. The excess carrier then brought a coverage action, seeking declaratory judgment that it had no further liability for Pride's defense or indemnity. Pride brought a separate declaratory action alleging breach of contract, fiduciary duty, good faith and fair dealing, and violation of the Texas Insurance Code. The two actions were consolidated in the Northern District of Texas, which granted summary judgment in favor of the insurance companies.

The appellate court noted a line of cases, beginning with *Farmers Ins. Co. v. Soriano*,[11] holding that an insurance company, when faced with a settlement demand arising out of multiple claims and inadequate proceeds, may enter into a reasonable settlement with one of several claimants, even though the settlement exhausts or diminishes the proceeds available to satisfy other claims. Specifically, under *Soriano*, an insurer cannot be liable for failing to settle remaining claims "unless there is evidence that either (1) [the insurer] negligently rejected a demand from the [claimant] within policy limits; or (2) the [initial settlement demand] was itself unreasonable."[12] All parties agreed that the insurers did not reject any demand made to Pride or Harbin, that the policies explicitly absolved the insurers of their duty to defend once the policy had been exhausted by judgments or settlements, and the policies gave insurers the contractual right to settle claims as they deemed appropriate.

Pride argued that summary judgment was improper because the reasonableness of the insurer's acceptance of Harbin's settlement presented an issue of material fact. If a jury found that the settlement was unreasonable, the insurers would not be dismissed from their contractual duty to defend Pride. The Fifth Circuit panel found, however, that Pride had not pointed to any evidence tending to show that the settlement was unreasonable. Pride's only argument for unreasonableness rested on the residual liability Harbin faced in its indemnity claim by Pride. That argument failed, held the court, because the policies exclude claims or suits brought by one insured against another insured. "An insurer has no duty to settle a claim that is not covered under its policy."[13] Rather, in view of the likelihood and degree of potential exposure to excess judgment for Harbin, the panel found the settlement to be reasonable as a matter of law. Therefore, the court affirmed the district court's ruling that the insurers had acted reasonably in accepting the plaintiff's demand despite the fact that Pride remained in the case.

Insurer's Unfair Settlement Practices During Investigation Were Not The Producing Cause of Increased Damages Against The Insured.

***Mid-Continent Cas. Co. v. Eland Energy, Inc.*, 709 F.3d 515 (5th Cir. 2013).**

In this bad-faith action, Mid-Continent tendered its full $6 million limits to pay pollution clean-up costs that would likely be more than the limits, thereby avoiding further costs in defending Eland against a class action property damage lawsuit by nearby landowners. Eland asserted that Mid-Continent breached multiple extracontractual duties by making an unauthorized and undisclosed settlement offer to one of the landowners, thereby increasing the settlement cost. The Fifth Circuit found that any bad-faith conduct was not the producing cause of any damage to Eland.

Eland owns an oil and gas production facility in Louisiana that was hit first by Hurricane Katrina, destroying the facility, and then by Hurricane Rita, releasing large amounts of crude oil onto neighboring land. Property owners brought a number of lawsuits against the insured, which it tendered to Mid-Continent under a $1 million primary policy and a $5 million umbrella. These policies apparently

covered both pollution clean-up costs, as well as liability for bodily injury and property damage.

Mid-Continent agreed to defend Eland subject to a reservation of rights, which the insured asserted created a conflict of interest, justifying the insured's selection of independent counsel. Mid-Continent agreed to the insured's selection of counsel but kept its own adjuster and two other attorneys involved to associate in the defense. In October 2005, at a very early stage of the underlying litigation, one of Mid-Continent's attorneys inspected the property of an owner named Leopold, who claimed that Eland's oil had damaged his property. Eland had not yet joined the class action. Based on this inspection and other information, Mid-Continent apparently made a settlement offer to Leopold, which he rejected. Mid-Continent did not inform Eland or Eland's selected attorney of this offer.

Mid-Continent determined that the clean-up costs would exceed the combined limits of both policies and tendered the combined limits to Eland in August of 2006. When the insured insisted that Mid-Continent had a continuing duty to defend the underlying litigation, Mid-Continent filed suit for declaratory judgment. Eland cross-claimed asserting breach of contract, as well as breach of the duty of good faith and fair dealing and other theories of extracontractual liability. Eland later settled the underlying litigation for $2 million but believed that the amount would have been less had Mid-Continent not made the settlement offer to Leopold. Although the lower court granted summary judgment to Mid-Continent, holding that it properly could tender policy limits and avoid any further duty to defend or indemnify, the court submitted the extracontractual causes of action to the jury, which awarded $8.5 million in compensatory, penalty, and punitive damages. However, the district court granted Mid-Continent's motion overturning the jury verdict. Eland appealed.

The Fifth Circuit panel first determined that Texas law did not recognize an action for breach of a common law duty of good faith and fair dealing arising from mishandling claims. Eland had argued that the Texas Supreme Court had at least implied that common law bad faith might be actionable in certain circumstances, but the panel found that no Texas court had accepted this argument. The insured also argued that its bad faith claim should be determined under Louisiana rather than Texas law. After engaging in a choice-of-law analysis under the "significant relationship" test from Section 6 of the Restatement (Second) Conflict of Laws, the court determined that the significant contacts were primarily with Texas, not Louisiana. Accordingly, even if Louisiana allowed a claim for the breach of duty of good faith and fair dealing, Texas law would govern that issue.

The jury had found that Mid-Continent violated several provisions of Chapter 541.060 of the Texas Insurance Code, including making a settlement offer to Leopold who was thereby induced to join the litigation and disclose information hurtful to Eland to other plaintiffs, misstating the law when it denied that a conflict of interest was created by its reservation of rights, stating that it would not pay more than $200 an hour for a Louisiana attorney, and misstating the law when the insurer maintained that it had an unavoidable duty to investigate the Leopold claim. The District Court overturned the jury's verdict on the basis that none of these unfair settlement practices was a producing cause of the insured's injury in the amount of the underlying settlement.

The panel found that the insured had not produced any evidence that Leopold would not have been persuaded to join the underlying lawsuit or to discuss his claim with the other property owners had Mid-Continent not made the settlement offer. Nor did the insured put forth any explanation for how lack of acknowledgment by Mid-Continent of a conflict of interest could lead to a more costly settlement. Similarly, any misrepresentation about the choice of attorneys or their fee rates was not shown to have any direct connection with the amount of settlement in the underlying suit. The court concluded that, even though the insured needed to successfully tie only one misrepresentation by the insurer to the increased settlement amount to establish that it was a producing cause, nevertheless, the evidence did not establish that any of the misrepresentations was a producing cause of an increased settlement for the underlying litigation.

The Definition of "Employee" Could Include an Independent Contractor Under a Motor Carrier's Public-Liability Insurance Policy by Virtue of Applicable Federal Regulations, Rather Than Texas Common Law.

***Canal Indemn. Co. v. Rapid Logistics, Inc.,* 12-40209, 514 Fed.Appx. 474 (5th Cir. February 2013).**

Rapid Logistics ("RL") is a licensed motor carrier in the interstate trucking industry, governed in large part by federal regulation.[14] RL enters independent contractor operating agreements with individuals who provide the trucks and drivers used in RL's business. Rafael Olivas was driving a tractor trailer truck owned by Oralia Sanchez, who had an operating agreement with RL. During the operations, the truck began to jack-knife and struck another truck, seriously injuring Olivas who sued RL and Sanchez for negligence. Canal had issued a commercial automobile liability policy to RL in effect at the time of the accident. RL tendered the lawsuit to Canal, which denied coverage, arguing that the policy excluded coverage for Olivas because he was RL's employee. This coverage action followed. The district court

granted summary judgment for Canal.

On appeal, the Fifth Circuit panel described the regulatory scheme that mandates that the carrier purchase a certain amount of public-liability insurance to ensure financial responsibility to compensate members of the public who are injured in a collision with a commercial motor vehicle. However, the regulations expressly provide that the public liability insurance "does not apply to injury or death of the insured's employees while engaged in the course of their employment."[15] More significantly, The Transportation Code defines "employee" as:

> "Any individual other than an employer, who is employed by an employer and who in the course of his or her employment directly affects commercial motor vehicle safety … such term includes a driver of a commercial vehicle (including an independent contractor while in the course of operating the commercial motor vehicle)."[16]

RL argued that Olivas was not its employee but was rather the employee of the independent contractor that owned the truck and that Texas common law, rather than federal regulations, should apply to determine the definition of "employee" in the policy. However, the panel relied on an earlier Fifth Circuit case that held that the federal regulation eliminated the traditional common law distinction between employees and independent contractors.[17] The *Consumers County* court had also held that "absent an indication in the policy," it would not assume that the parties intended to use a different definition than the one set forth in the applicable federal regulations. In RL's policy, the term "employee" includes a "leased worker," and RL had failed to explain how this definition would not include Olivas.

Further, even assuming that Olivas was not RL's "employee," the panel found that RL had admitted certain facts under another provision of the policy that excluded coverage. Specifically, the policy states that it provides coverage for:

> Anyone else while using with your permission a covered "auto" you own, hire or borrower except: (1) the owner, or any "employee," agent or driver of the owner, or anyone else from whom you hire or borrower a covered "auto."

Since Olivas was the driver of the owner, coverage was not available.

RL also argued failure to cover Olivas was a violation of public policy because a motor carrier would never be able to insure itself against the risk of injury or death of an independent contractor or its employee in the course or scope of its statutory employment. However, the Fifth Circuit held that Texas courts will not void a law or statute as against public policy unless the law in question contravened some other positive statute or some well-established rule of law.[18] Here, RL had failed to cite a statute or case in support of its argument that the district court's holding violated public policy.

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

2. Evanston Ins. Co. v. ATOFINA Petrochem., Inc., 256 S.W.3d 660 (Tex. 2008), and Aubris Resources LP v. St. Paul Fire & Marine Ins. Co., 566 F.3d 483 (5th Cir. 2009).

3. *ATOFINA*, 256 S.W.3d at 662, 664; *see also Aubris*, 566 F.3d at 488–89.

4. *ATOFINA*, 256 S.W.3d at 664 n. 5 (citing Getty Oil Co. v. Insurance of N. Am., 845 S.W.2d 794, 804 (Tex. 1992)); *Aubris*, 566 F.3d at 489.

5. *ATOFINA*, 256 S.W.3d at 667. The *Deepwater* panel reached a similar conclusion after reviewing the *Aubris* case.

6. Getty Oil Co. v. Insurance of N. Am., 845 S.W.2d 794, 804 (Tex. 1992).

7. *Id.* at 670. [Emphasis in original].

8. PAJ v. Hanover Ins. Co., 243 S.W.3d 630, 632 (Tex. 2008).

9. Harwell v. State Farm Mut. Auto Ins. Co., 896 S.W.2d 170, 174 (Tex. 1995).

10. Quoting, 13 Couch on Insurance § 186:22 (2003).

11. Farmers Ins. Co. v. Soriano, 881 S.W.2d 312, 315 (Tex. 1994).

12. *Id.*

13. American Physicians Ins. Exch. v. Garcia, 876 S.W.2d 842, 848 (Tex. 1994).

14. *See* Motor Carrier Safety Act of 1984, 49 U.S.C. § 13906 (2000); 49. C.F.R. § 387.1 (*et seq.*)

15. 49 C.F.R. § 387.15.

16. 49 C.F.R. § 390.5

17. Consumers County Mut. Ins. v. P. W. & Sons Trucking, 307 F.3d 362, 366 (5th Cir. 2002).

18. Quoting, Lawrence v. CDB Servs., Inc. 44 S.W. 3d 544, 553 (Tex. 2001), *superseded by* Tex. Lab. Code Ann. § 406.033(e) (Vernon Supp. 2005).

Comments

FROM THE CHAIR

By Stephen E. Walraven
Langley & Banack, Inc.

Your Insurance Law Section is successful and thriving, and all of the credit goes to its past leadership. I want to thank the past leadership, in particular the past Chair, Vince Morgan, for all of the hard work that has gone into making the Section what it has become.

I would also like to thank the outgoing Editor of the Section's Journal, The Journal of Texas Insurance Law. Kimberly Steele has done a magnificent job as Editor, and she is to be congratulated for her hard work, as she turns the reigns over to the new Editor-in-Chief, Bill Chriss.

I was particularly pleased to learn the other day how the efforts of the Section, and the Journal, really do make a difference. I received a call from a lawyer who was upset about an article in the Journal. He complained that the article was regularly being used against him in Court. (I told him that to balance the scales, he should write an article of his own.) I was pleased to see that the Journal does make a difference. I would encourage all of you to think about contributing to the Journal.

The Section is co-sponsoring, along with the University of Texas School of Law, the 18th Annual Insurance Law Institute on November 7-8, 2013 in Houston. I would not only encourage those of you who are interested to attend this seminar, but also to let me, or anyone else on the Council know how future seminars might be better tailored to be of use to you in your practice.

I hope that we can continue to make this Section valuable to you, through the Journal, the website, the CLE offerings, and in other ways. Please let me, or one of the other officers or council members know how we can improve the Section, and/or if you would like to help us do so.

Stephen E. Walraven
Chair

Comments

FROM THE EDITOR

By L. Kimberly Steele
Sedgwick, LLP

While I have enjoyed serving as the Publications Editor for the Insurance Law Section these past three years (almost), the time has come to pass the torch. The Section has elected Bill Chriss of Gravely & Pearson as the new Editor-in-Chief of the Journal. Assisting Bill will be Managing Editors Rachelle (Shelley) H. Glazer and David S. White of Thompson & Knight and Doug Skelley of the Shidlofsky Law Firm. Serving as Associate Editors are Pamella A. Hopper of McGuire Woods, Mark Ticer of the Law Office of Mark A. Ticer, John Tollefson of Tollefson Bradley Mitchell & Melendi and Meloney Perry of Perry Law, P.C. The Journal will be in good hands with all of these fine folks involved.

Steve Walraven of Langley & Banack is the new Chair of the Insurance Law Section and is already hard at work continuing the efforts of his predecessors to improve the Section and make it even more valuable to its membership. As part of this effort, Steve and the other members of the Council for the Section are working to ensure that the Section continues to provide meaningful, timely and substantive information and benefits to its members. If any of you have specific ideas, requests or suggestions for improving the utility of the Section, its publications, CLE offerings, scholarships or any other of its benefits, Steve would love to hear from you. He can be reached at swalraven@langleybanack.com. In the meantime, thank you for your continued membership and support of the Insurance Law Section.

Special thanks to Kishwer M. Lakhani with the Dallas County District Attorney's Office, David S. White of Thompson & Knight and Richard G. Wilson of Kerr Wilson, P.C. for their assistance in editing the articles included in this issue of the Journal. Editing for the Journal is a volunteer position, and often a somewhat time-consuming, yet thankless, one.

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 Bill Chriss at wjchriss@gplawfirm.com.

L. Kimberly Steele
Publications Editor

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