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THE INSURANCE LAW SECTION OF THE STATE BAR OF TEXAS

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Journal of Texas Insurance Law

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

Anyone interested in submitting a manuscript for publication should contact Bill Chriss, Editor In Chief, at (361) 884-3330 or by email at wjchriss@gplawfirm.com. Manuscripts for publication must be typed double-spaced with endnotes (PC-compatible disks are appreciated). Replies to articles published in the ***Journal*** are welcome.

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Mission Statement

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

STATE BAR OF TEXAS
Created in 1939

Comments

FROM THE EDITOR

By William J. Chriss
Gravely & Pearson, LLP

In this issue of the Journal you will find articles on trucking insurance coverage by Wade Barrow and on the new Texas subrogation statute by Judy Kostura, as well as the first of a two-part series by Michael Quinn on the theory of insurance and how it is changing to meet the challenges of the cyber-world. And Shelley Glazer and David White continue their valuable column on recent Fifth Circuit and Texas Supreme Court insurance opinions. We also have a "Comments from the Chair" section by Chair Mark Ticer reaching out to each of you and inviting your participation in the Insurance Law Section. We sure would like to see more of all of you, whether at meetings, seminars, or in print. For my part, I am constantly impressed by the quality of the writing done by our members and would enjoy receiving a submission from you on any subject that has piqued your interest sufficiently for you to write about it.

Thanks go to all these authors and to Assistant Editor Pam Hopper, and Associate Editors Rebecca DiMasi and Mark Ticer whose help with this issue was, as usual, indispensable. The Journal would be happy to publish similar articles for the benefit of the bench and bar. Email articles to me at wjchriss@gplawfirm.com.

William J. Chriss
Publications Editor

William J. Chriss, of counsel to Gravely & Pearson, LLP, graduated from Harvard Law School, holds graduate degrees in Theology and Political Science, and is currently a doctoral candidate in legal history at the University of Texas. He has practiced insurance law for over thirty years and currently serves as editor in chief of *The Journal of Texas Insurance Law*.

Comments

FROM THE CHAIR

By Mark A. Ticer

Our section needs you.

One great myth or misconception of the Insurance Section is that we are primarily a group of coverage nerds or practitioners whose only focus or practice is insurance coverage and litigation. The truth is our section is mainly composed of lawyers who do not practice insurance law full time. Instead, our members are a great mix: general practitioners, small firms and solos, corporate counsel, civil litigation attorneys, construction lawyers and appellate practitioners. While coverage lawyers and insurance litigators are very much an important part of our membership, they are not the majority. Given this diversity of practices, our members depend on our section to provide resources, educational materials and opportunities, and communications on insurance law and related matters.

The significance and connection of insurance to almost every other area of practice cannot be underestimated. Insurance touches all areas of practice and is frequently the basis to fund or resolve litigation or claims. Insurance law is a common thread to all types of practices for the solo or general practitioner representing a consumer on a homeowner's claim, to corporate counsel in evaluating and protecting risks and corporate assets, to the appellate lawyer who seeks to enforce a trial court decision on coverage or damages covered by insurance, to the defense lawyer who is defending an insured in an auto accident, to the construction law practitioner on whether construction defect claims might be covered by insurance, and to the civil litigator who needs to have his recovery be paid by insurance.

Because of the composition of our section, we have an obligation to educate and provide resources for our diverse group. The Journal of Texas Insurance Law is one part of the tangible and substantive resources we provide to satisfy part of our mission. We have others: Right Off the Press, the Section's website, and continuing education opportunities. For $30.00 a year, it is undoubtedly the best bargain for a State Bar member or anyone else interested in insurance.

Our section depends on volunteers to satisfy our mission – lawyers who will write an article, help on a committee or project such as membership, updating our website to keep it current and informative, offering topics for a continuing education seminars, or just asking to help out wherever you are needed. You have something to offer and we seek your participation.

Will you volunteer and get involved?

Best,
Mark A. Ticer
Chair, Insurance Law Section

By Judy Kostura

Judge, Kostura & Putman, P.C.

A LEGISLATIVE SOLUTION TO FORTIS V. CANTU, 234 S.W.3D 642, 649 (TEX. 2007)

The Texas legislature instituted a significant reform of subrogation law by passing HB 1869, authored by Rep. Four Price, R. Amarillo, in May 2013. The new act took effect January 1, 2014, as Tex. Civ. Prac. & Rem. Code Chapter 140A. This legislation codifies the common fund doctrine and mandates that subrogated plans allow injured plaintiffs to share in the settlements or proceeds of tort actions. It protects Uninsured/Underinsured Motorist benefits if the injured person or his/her family member purchased that coverage and precludes subrogation to Personal Injury Protection benefits regardless of the purchaser. Chapter 140A is summarized in more detail:

§ **140.001** contains definitions which are essentially self-evident.

§ **140.002** says the new law applies to all medical and disability plans that Texas can regulate. More specifically, the law regulates any health or disability insurance contract purchased in Texas by individuals or furnished by employers, including any occupational benefit plan (bought as a substitute for worker's comp). The major players, Humana, Aetna, United, BCBS, CIGNA, etc. would all be included for any policies they sell or deliver in Texas. In addition to this broad category of all health and disability insurance plans, 140.002 specifically includes plans authorized by other statutes, including nonprofit hospital service plans authorized by Ins. Code 842; fraternal benefit societies which have a lodge system and a representative form of government (think Knights of Columbus) authorized by Ins. Code 885; stipulated premium insurance companies authorized by Ins. Code 884; reciprocal exchanges which provide indemnity among a group of subscribers for certain losses, such as USAA, authorized by Ins. Code 942; HMOs authorized by Ins. Code 843 or Ins. Code 844; a Multiple Employer Welfare Arrangement (MEWA) in which a group of unrelated employers form a larger pool to enable their small firms to spread the risk across a larger pool to lower premiums, (think plans offered by The Gasoline Retailers Association) as authorized by Ins. Code 846; local governmental employees such as firefighters, police officers, school cafeteria workers and custodians, city clerks, charter school employees, and other employees of local governments, whether covered by a risk pool or traditional health plan, which were formerly regulated by Chapter 172 of the Local Government Code, now repealed. Also included by name are employees of The State of Texas Employee Retirement System plan, whose plans used to be exempt from any regulation outside of § 1551 of the Ins. Code. Local community colleges are often included within the Teacher Retirement System and are covered by Ins. Code § 1551, so their plans are subject to this bill. Self-funded governmental plans (which are never ERISA) are expressly included, as are plans of religious organizations (churches, church schools, some church owned hospitals). As long as an ERISA plan is not self-funded, it is subject to state regulation. ERISA saves back to the states the right to regulate core business principles; see 29 U.S.C. § 1144(b)(2)(A), the "savings" clause of ERISA, and *UNUM v. Ward*, 536 U.S. 358 (1999). State laws such as Ch. 140 are not pre-empted by ERISA and will regulate insured ERISA plans.

\§ **140.002(f)** identifies those plans that are excluded from this bill: workers compensation, Medicare, Medicaid, CHIPS or Medical Assistance Programs (which currently have a safety net in place for injured people) and self-funded ERISA plans which the US Supreme Court says are exempt from state regulation because self-funded ERISA plans are deemed not to be insurance; see 29 U.S.C. § 1144(b)(2)(B), often called ERISA's "deemer" clause.

§ **140.005** allows subrogation whenever the injured person can seek a recovery for past medical expenses. Wrongful death beneficiaries and children typically cannot recover past medical bills, so regulated plans cannot subrogate to the recoveries of minors or wrongful death beneficiaries.

§ **140.005**(b) allows the plan to take up to 50% of a settlement or the actual amount they paid, whichever is less, when a personal injury claimant has not hired an attorney. Subsection (c) contains those same rules but imposes a fee-sharing rule on the plan when the claimant has hired an attorney. This provision codifies the common fund doctrine and forbids the health plans' attempt to obtain a free ride at the expense of the insured. Because an injured person may have multiple subrogation interests in the same claim, (b) and (c) also require the subrogated interests to divide their percentage of the recovery, capped at 50% less recovery costs, among themselves rather than encroach on the share set aside for the injured policyholder. The next subsection confirms that this bill does not restore the made whole doctrine, but at least neither the health insurer nor the injured person can get shut out of the settlement proceeds.

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§ **140.006** keeps either side from running up more attorney's fees if anyone files a declaratory judgment action to interpret this legislation.

§ **140.007** follows language similar to provisions in the worker's compensation act. A health plan can hire its own attorney to recover its subrogation interest to avoid having to pay the injured policy holder's attorney, or the plan can enter into a contract with the injured person's attorney, or the court can divide up the attorney fee if there is a dispute about which attorney did the work.

§ **140.008** limits when the health or disability plan can get paid back out of the injured person's first party recovery. If the injured person or his family bought Uninsured or Underinsured Motorist coverage, or Personal Injury Protection or Medical Payments coverage, then no regulated plan can take those first party benefits from the injured person. This provision is consistent with the Insurance Code mandates encouraging motorists to buy PIP (§ 1952.152) and UM/UIM (§ 1952.101: (b)) for their own protection. On the other hand, if someone else paid for the Uninsured Motorist coverage or Medical Payments coverage, then the health plans could subrogate to those benefits, up to the limits set in this bill, but Personal Injury Protection remains free of subrogation regardless of the purchaser.

§ **140.009** allows plans to be more generous if they want to waive or further reduce a subrogation interest.

The bill took effect January 1, 2014. The bill does not specify whether it covers claims for injuries that took place before the effective date but were not settled as of that date; *Liberty Mutual Ins. Co. v. Transit Mix Concrete & Materials Co.*, No. 06-12-00117-CV, (___ S.W.3d ___ June 28, 2013 pet. den.) suggests it applies only to new injuries after that date, but many health plans have applied it to cases still in the system as of the effective date. The trilogy of *Brainard*, *Nickerson* and *Norris* opinions from the Texas Supreme Court on Dec. 22, 2006 support an argument that all UM/UIM cases still pending as of January 1, 2014 are protected by Ch. 140A: The "UIM insurer is under no contractual duty to pay benefits until the insured obtains a judgment establishing the liability and underinsured status of the other motorist. *Henson,* 17 S.W.3d at 653-54. Neither requesting UIM benefits nor filing suit against the insurer triggers a contractual duty to pay. *Id.* Where there is no contractual duty to pay, there is no just amount owed. Thus, under Chapter 38, a claim for UIM benefits is not presented until the trial court signs a judgment establishing the negligence and underinsured status of the other motorist." *Brainard v. Trinity Universal Ins. Co.* (Tex. Dec. 22, 2006). If this language means the UM/UIM cause of action does not accrue until there is a judgment, then all UM/UIM cases still pending as of January 1, 2014 should be protected by Ch. 140A Tex. Civ. Prac. and Rem. Code.

by Michael Sean Quinn

INSURANCE UNIVERSALS & THE ARRIVAL OF THE CYBER-POLICY— PART ONE: PARTLY PROLEGOMENA

Here are two truths. First, insurance is insurance, always and in every way, regardless of type and irrespective of location. Second, all myths, like all fairy tales and all folk tales, are false. This two part essay will explore these truths.

Part One takes up general matters including both so called "real-world" insurance policies and so-called "cyber-world" insurance policies. Part Two focuses on some parts of a particular complex cyber policy, the Travelers **CyberRisk Policy**, CYB-3001 Ed. 07-10, copies of which are easily found on the Internet. Why "Prolegomena?" some might say. Well, here's the answer: Cyber Risk Insurance has only been with us for a couple of decades; compare that to century upon century, depending on the type of policy you want to talk about.

Of course, there is no such thing as a perfect insurance policy. How could there be, given that they must use language and all languages are incomplete, changing and constitutional systems. Equally obviously, some insurance policies are better done than others; indeed, some are really very well done, though I have not seen one that is magnificent. A truly magnificent insurance policy would be, so far as meeting its insurance purposes are concerned, one better than which cannot even be imagined—a Ninth Symphony of contracts of insurance. There is no such thing, and it might not last as that once language started to change. Still, the cyber policy to be discussed in Part Two is very well done, for the most part.

I. Mythology

Now that we have a very brief preface let us turn to substance. There is a myth about insurance and therefore about contracts of insurance; a myth created and propagated by some components of the insurance industry, an idea that includes customers, that there are two distinct insurances. On the one hand, there is insurance for the all of the distinct "contents" of the world as we know it—a world filled with people in various states of health, people performing all sorts of different activities, dwellings, other buildings, vehicles (some that float, some that drive, some that roll on tracks, and some that fly), assets, monies, stocks, bonds, yet other commercial assets that are not physical entities, information, and many, many types of "things."

But this before recently our only world, , is quite different, they say, radically distinct in comparison to, and in fact irreconcilably separated from, the hyper-innovative, magnificent, something like magical, and indeed dangerous world of cyber-reality. This other world a fair fraction of the general population thinks is a new reality, has become the center of our existence in many ways and the genuine solution of many of our heretofore unsolvable irresolvable problems.

That world, the newly discovered (or maybe invented) completely other world, now the center of all of our lives—the separate universe of *technologia supremissima,* home to Computer-Nerds, Cyber-Geeks, Really-New-Gurus aka Gooey-Ruzs, and Bo-Net-Zos, plus long cyberninsula of solutions to scientific, engineering, social, business, and personal-psychological problems, a place of new worship and revolutionary holiness, plus an entirely and revolutionary new ethics and in addition aesthetics, the latter replacing all of the "old" ones—needs a new, radically new, very special new, and completely different kind of insurance (and therefore contracts of insurance) that must match up with the newly invented, or discovered, entirely separate world. All of this is cyber-gunk, especially the part about insurance. Insurance is insurance.

This myth is asserted stridently, frequently, and loudly by those in some sectors of the insurance industry, especially those that do a lot of advertising. It does not matter how stridently this proposition is pleaded or screeched, as has already bluntly been asserted here, this view is anything but true.

Part One of this series of articles is about the myth, the industry, the essence of insurance contracts and hence insurance itself, and the inherent and un-dissolvable connectedness between all historic policies and all supposedly transformative cyber insurance. Part Two published in the next issue of the *Journal* will demonstrate the point by

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describing and analyzing some parts of one cyber insurance contract—the one already mentioned.

II. The "World(s)" of Insurance and Their Population

In the world(s) of insurance there are two large related families with—on the whole—different attitudes, when thought of across family lines. This is always true. It might be called a universally true statement when it comes to the history of insurance. Of course, it is also a universal truth that there are overlaps between large families. Some insurers are also insureds and some insureds area also insurers. This overlap applies to both entities and people.

As just indicated, one family consists of the Insurers; the other family is the Insureds. Sometimes their differences in attitude are striking; sometimes they are more similar, or—at least—less dramatically different. Differences may depend on the nature of the entities; they may depend on the type of relationship the two entities have and have had; they may depend on the size and nature of a given loss, and there are many more influential factors. This essay is about several universals in the law-based sector of the world of insurance, and how the so-called "New[Cyber]World" of cyber-insurance is absorbing them (or being absorbed by them).[1]

Paradigmatically, insurers tend to see their relationship with the insured as well articulated—not just sketched—in the contract of insurance between them. All duties, all rights, and all interests, flow from and are governed by its terms. Insurers do not think of the insurance policy as a mere outline of the relationship—something to which other duties and rights may be added or just understood to be present, except by sovereign powers (including state and territorial governments) in the U.S.

Insureds tend to view the relationship in terms of their having losses, and their insurers having a virtually automatic obligation to compensate them for the losses that are of a general type covered in the policy. An insurance policy is the basis and start of the relationship, but it does not exhaust the foundations of their relationship.

In addition, insurers tend to have rigid, mechanical attitudes toward how to think about contracts of insurance, whereas insureds tend to be just the opposite. Insureds tend to be skeptical about and/or suspicious of a positive attitude toward strict construction, at least when it comes to contracts of insurance. In a way, insurers are analogous to a Justice Scalia-type and insureds are analogous to a Justice Brennan-type.[2]

Finally, insurers tend to be mindful, at all times, that they are profit-making entities when it comes to selling insurance, even if they are not exactly that. Insureds tend to focus on their own interests, whether they are profit-making or not, with the outlook of someone who has had a loss. How could things be otherwise? Insureds are not, after all, in the business of buying insurance. Oddly enough, the differences tend to shrink, but never entirely evaporate, when the insured is larger, wealthier, and more of a business entity. Each family seems to have more appreciation of the complexities of the business of the other.

At bottom, insureds take the idea that insurance is risk transfer very seriously and quite literally. So far as the essence of the mind of the insured is concerned, the risk has literally been transferred—literally moved, in whatever sense of that terms makes sense. In other words, someone else now owns at least part of the risk. In the mind of a hypothetical, paradigmatic insured, the risk that was transferred is to be conceived both broadly and commonsensicallyand—in addition—it has become that of the insurer and no longer belongs to it. To put the matter again in a somewhat unorthodox way, the risk is now the property of the insurer.

Of course, paradigm cases are always limited exemplars for all member of an extensive set. There are constitutional differences amongst various insureds and amongst different insurers. And, of course, there can be screw-ups of different kinds and sizes on either side of an insurance contract, and sometimes on both sides at once—more or less—just as there can be in any business dealings. One or more errors might, among others, be found in types of products or services sought; in the contracts regarding the specifications of the type of service sought or offered; in the descriptions of the services sold and bought; or in the endorsement inclusions, pricing, administration, cancellations, renewals, claim receiving, claim process, coverage determination, formulas for determining compensation.

Contracts of insurance, relatively short and supposedly simple as they usually are in comparison with many other sophisticated business contracts, are actually quite complex from a conceptual point of view, though not so frequently from a pragmatic one. This truth is a consequence of the nature of insurance, the nature of society (especially the economic aspects of it), and the nature of persons.[3] The relevance of my general observations here will become clearer later on.

III. Insurance for Two "Worlds"

The word "world(s)," covers various sorts of supposedly contrasting worlds. It is clear that the term applies in different

ways to the two different huge metaphorical families in the general metaphorical "world" of insurance. The so-called "real-world" and the so-called "cyber-world" have actual separate and distinct realities.[4] Sometimes "cyber-space" is used to refer to part of the "cyber-world," and sometimes it is used instead of, but equivalent to, the other phrase. This metaphysical separation is at most merely false and moving-toward even fully nonsensical, and some might go even further and call it what it is, to wit: "bullshit."[5]

There is no such thing as "two worlds," and this fact is virtually self-evident to the rational modern mind. Even mathematics, whether invented or discovered, is part of *this* world; even dragons, if there were any, would be flying around in this world as there is no other world in which they might fly. There is one world—period . . . end of discussion! This proposition is true even if so-called "dualism,"[6] the doctrine that body is one thing and mind is quite another, is true as many, including myself, believe—the theory of our opponents being called either "materialism" or "physicalism."

At bottom, insureds take the idea that insurance is risk transfer very seriously and quite literally. So far as the essence of the mind of the insured is concerned, the risk has literally been transferred...the risk is now the property of the insurer.

It is a dreadful mistake to think the so-called cyber-world is not part of the physical world, although it may not be made of solid materials in the way that tangible physical objects are. Electricity is certainly physical, in that it is part of the physical world, but not material in a way that both turkey and dressing are. Some relationships are not physical, except insofar as they are part of the physical world, e.g., logic, truth, and mathematics.

In addition to there being no separate "cyber-world," and "separate-cyber space," there is no "virtual-world," where "virtual" means ontologically independent, conceptually separate and metaphysically distinct.[7] If "world" is a metaphorical word that means there are systems which are very complex and where human beings can do all sorts of new things which sometimes feel like the set of "Star Wars." If "virtual" means that this metaphorical world is very much like the actual and real world we deal with every day—so much so that it sometimes seems really-separate and actually-independent—then there is a virtual world.[8]

If "world" is a metaphorical word that implies there are systems which are very complex and where human beings can do all sorts of new things which sometimes feel like the set of "Star Wars" and dramas like it. If "virtual" means that this metaphorical world is very much like the actual and real world we deal with every day—so much so that it sometimes seems really-separate and actually-independent—then there is a virtual world. However, it is a mistake to think that the so-called cyber-world is not "physical," although it may not be made of solid materials in the way that tangible physical objects are. Electricity is physical, but not material in the way both turkey and dressing are. The term "world" is used in all sorts of metaphorical senses in our world, i.e., lots of human cultures. There was the "New World," there is the "Old World" (in several senses); there are "imaginary worlds"; some people are said to live in "different worlds"; and so forth. There is "my world," as Ralph Lauren, puts it; there is "my world, and welcome to it," said by others, though no doubt this world-champion narcissist would say it, if his minions had only thought of it. There is "the world of the *Enhyrdra*," something quite different from the "world of *Lutrasumatrana*," though both are types of otters; and, of course, there is "the world of Navy Seals," something vastly different from the world of *pinnipeds, that of computer SEALS,* and *different* from that of another type of cyber-seal, the *cryptographic algorithm.* As one might imagine, these list of contrasts might go on and on. The word or phrase cyber-world belongs on this list somewhere, I should think.

Taking the idea of two separate worlds seriously leads to brain-fog and mental-confusions in all sorts of areas of the law, including insurance.[9] Think of it this way. If there really were a separate world—a cyber-world that is not part of the real-world—then there could be insurance for just it, it alone, without inherent relationships with the real-world. This idea is entirely false, as can be demonstrated. It is a universally true statement that, so far as human activities are concerned, there is one real world—one reality—and no more than one.

IV. Universal Foundations of All Insurance

There are several ways in which contracts of insurance (a/k/a insurance policies) have universal foundations. One of them is the fundamental concepts involved; the second is the basic characteristics of such contracts. These are the focus here. The content—the substance—of universals appear to be well known, but the fact that they are universally true is not. Nor is it well understood how they must work.

A. Universal Concepts

The fundamental universal concepts to be found in all insurance contracts are these:

- **Peril,**
- **Risk,**
- **Causation,**
- **Injury,**
- **Loss,**
- **Moral Hazard, and**
- **Fortuity.**

These terms and the concepts expressed by them are used everywhere in the insurance industry. It is not the case, that they are all used, in the same way, by everyone, or—in fact—always defined in the same way. For example, sometimes "risk" is used in place of "peril," and "loss" can be used instead of "injury." These diversities are conceptually insignificant, though conflicting uses in conversation, discussion, argument, and the like can be confusing. What is significant is the concepts involved here, and they are quite distinct.

Since the concepts are universal, the terms may correspondingly be very roughly defined as follows:

A **fortuity** needs to be understood in terms of an event or state of affairs, that is **fortuitous** and is not planned, not deliberately performed or brought about, and/or not intentional. Often it is reasonable to think of a fortuitous event, as an **accident,** when viewed from the point of view of the insured. (One should remember that acts are types of events; omissions should be thought of as acts, and the effects or consequences of the event, whether acts or not, may be other events or simply states of affairs. Acts are not fortuitous; their consequences, however, may well be.)

A **peril** is a state of affairs that may injure an insured and cause it loss. The state of affairs may be a complex one with many parts, like the idea of a storm.

A **risk** is the probability that a peril may cause, or contribute to, an injury to an insured and thereby a loss.[10]

Causation is the rough idea pertaining to one empirical event—or a grouped together set of empirical events—inducing another subsequent event, substantially more probably than not. This idea can be more easily grasped at an intuitive, commonsense level if one thinks about A causes B if A makes B happen[11] (or brings it about that B happens), or is a necessary part of a group of events which do that, or is part of a chain of events that makes B happen. More than the last state of affairs in a chain can be a cause.

An **injury** is a state of affairs that is recognizably unacceptable to the insured. It is often referred to as **harm.** Some of those in the insurance industry associate injuries with the human body, damages with property of some sort (often tangible), and harm with property and more abstract insurable entities or processes, though the term "damages" is used in that area as well. I suggest that injuries hurt; they are setbacks; they damage a person; they make valued things less valuable than they were, for example, less functional, uglier, and more objectionable for some reason. Surveying the insurance industry, the three terms—"injury," "damage," and "harm"—are used in all sectors of the insurable as meaning the same thing, which they do, except that "harm" may have a broader sweep. (If I were choosing a universal system of insurance vocabulary, I would make "harm" the key general term, use injury for human bodies, and damage to everything else.)

A **loss** is how much dealing with an injury is going to cost or how much that of value must be "kissed goodbye" as a result of the injury. Usually this is measured by (or actually is) money. (There can be some confusion here, since what I am calling "loss" is also when necessary called "damages." After all, that is what plaintiffs see as their loss, their "damages." Q: "What were your client's damages?" A: "We said 1M." Q: "Did you get them." A: "We got more for it than its actual losses." And so forth.)

Finally, there are the problems of **moral hazards.** This is a complex concept with a number of meanings run together, some of them over time and some of them all at once.[12] Thus, the concept of **moral hazards** is both vague and ambiguous. (Of course, some think that all vague terms are ambiguous.)

(1) One of the usages is (or, was) that not all applicants for insurance should be insured since they are immoral individuals of poor character. Such people are unreliable and financially dangerous. It is not good for society that such people are "awarded" with the safety to be found in insurance. This was a traditional concept.

(2) That traditional concept went with another, and it went like this: since society regarded insurance as a species of gambling, or something close to it, and since gambling was regarded as filled with persons of poor character, no such person should ever be provided insurance. After all, the business of insurance should be kept far away from gambling in society. The insurance industry needed to adopt this view, assuming its members didn't believe it themselves, if they wanted to become a legal business.

(3) Another ancient view is that the term "moral"

in traditional theology, political theorizing, moral philosophizing, historically speaking; popular ethical thinking, and long ago in ordinary conversation referred simply to the *realm of human actions*. David Hume, the famous empiricist philosopher of the eighteenth century, used the phrase "moral science" in one of his famous works;[13] for him it meant a kind of what is today called sociology. Economists to this day call what they do "moral science." Thus, the phrase "moral sciences" might refer to considerations of immoral conduct, or it might not. Thus, the moral hazard would be any problems which arose out of the realm of human actions, activities, and interactions.

(4) The contemporary and prevailing view—in fact, now the only prevailing view, the explicit recognition and use of which has a history going back two centuries, or so—is that owning insurance has a tendency to encourage a deceptive increase in sloppiness and temptation for many insureds with respect to whatever is insured. This can easily be regarded as immoral, and so there is a "moral hazard." What is being described here is not necessarily a temptation with respect to which a decision much be made; instead, it is quite often a kind of slippage of commitment.

Fortunately, given the timing of the genesis of the cyber world, only "Moral Hazard # (4)" is applicable here. "What the hell, we've got insurance, so let's not worry about expensive network security protection."

B. Universal Characteristics

What then are essential characteristics of all types of insurance? The nature of insurance is revealed in what are commonly called insurance policies. All insurance policies are now and always have been contracts.[14] As with any other bona fide contract, one or both parties to it have tried to clearly set forth the applicable terms of the contract either explicitly or by the use of entailments. Like all other contracts, the vast majority of the duties and rights of the relationship formed by the contract are to be "found" in the contract document, though this is occasionally subject to disputes. There are at least ten of them. They are to be found at the foundation of conceiving insurance. They are very simple and can be listed this way:

1. All contracts of insurance explicitly involve the transfer of risks, though not using these words. (One party is receiving, usually buying, risks facing the other party. This is the nature of indemnification. To one degree, or another, indemnifications are future looking.)

2. All insurance contracts involve the transfer of the risk of dealing with having been beset by one or more **perils**, i.e., being beset by a particular peril that was named explicitly, something that still often (more or less) happens today,[15] though sometimes in the last couple of centuries, more general terms are used. (Indeed, "today," unlike "yesteryear" an insurance policy can transfer an insured's risk to the insurer who will have to deal with that insured's having been struck by one or more perils to be found in an abstract category set forth in the contract, where only the abstraction is set forth in the contract.[16])

3. All insurance contracts involve the transfer of the risk of dealing with direct, immediately connected **causes** or with **causal chains**, the nature of which are sometimes specified explicitly.[17]

4. All contracts of insurance are restricted to a determinable set of insureds, sometimes an explicit list; sometimes they are specified by name, and sometimes they are specified by category. There is always an attempt at complete specification. Usually this has been done, but sometimes not.

5. All contracts of insurance are for specified, understood, or nearly understood types of **injuries**.[18] Contracts of insurance do not insure against all possible injuries. Not every injury, however results in a loss; in fact, sometimes an injury can result in high benefits or profits.

6. All contracts of insurance exist to transfer risks of **losses**, and losses are tied to assets or money damages.

7. All contracts of insurance are based upon the idea of **fortuity**. The purpose of insurance is not to pay for people who deliberately perform acts that are intended to obtain compensation under the contract of insurance. Often these kinds of acts violate terms of the relevant insurance policy.

8. All contracts of insurance are designed to transfer risks only from persons who have a prudent or prudence-inducing[19] relationship with that which is insured.[20] This might be described as an insured's valuing positively that which is insured.

9. At the same time, all contracts of insurance entail the existence of **moral hazards**. Some ways of them are usually parts of the insurance contracts,[21] the applications for and of them, plus some

> of the conditions connected to the contract. They are there, as indicated to try to eliminate, minimize, mitigate, or control at least some of the insureds' susceptibility to moral hazard problems. The existence and power of moral hazards results from the nature of man in general. We are creatures of self-interest and temptation. Getting contracts of insurance to be clear about this point in general, i.e., in standardized and hence generalized policies, is anything but easy.[22]

Proposition #10, the Moral Hazard Problem(s), as already indicated, arises because when a person is characterized, at least in part, by the pursuit of self-interest, having insurance, or a relevant paid-for source of or right to money, at least tends to diminish the wish and the will of that person to make sure that it has no loss. It makes no difference whether a person is a human person or a corporate type person owned and/or run by human persons.

Given this characterization of moral hazards, there is moral hazard resting upon the shoulders of the insurer as well as those of all insureds. Insurers have received premiums in advance of having to pay any claim. Having already received money from its insureds and having put the receipt of it onto its books, an insurer is tempted (has a tendency) to keep the money to spend as little as possible paying claims.

Since insurers, or their hirelings, with few very narrow exceptions, are the only, or the only final, drafting entities doing the central features of all modern real-world insurance policies, the fact of the moral hazards inherent in the insurers is not explicitly acknowledged. Nor are clear rules of prevention, restraint, or other considerations deterring insurers from succumbing to that hazard—that peril—acknowledged, even impliedly, in insurance policies. One wonders whether the situation would be different if drafting was by "bi-party commissions" invented by both of what I have called the "families" in the insurance industry. (Nor are the moral hazards faced because they are afflictions of insurers generally acknowledged outside the policies either. Indeed, ads for insurers virtually deny any such thing or suggest that only other insurers are subject to them.)

It is important to keep in mind that every contract of insurance has all these characteristics, and that is true whether the contract is designed for the everyday—old, long established—world, for the cyber-world or both. It is also important to keep in mind that the idea of a loss is tied inextricably to the so-called real world. This is true because the idea of a loss is glued to the idea of money, and not just private currency like Bitcoin, a type of "virtual currency,"[23] since its value is determined by "coins of the realm."

C. Nearer to Being Universals

Although there are fixed, timeless, universals at the heart of insurance—indeed, at the heart of the very idea of insurance as we know it—not all well-known characteristics are like that. This is true, at least in part because insurance is an idea or set of ideas—that had an ancient start and then a long sporadic history.

One example is that there are many, many types of policies. Cyber insurance is just the latest in a long and now hugely diverse set. It all started with bottomry, commercial transport insurance—camels crossing deserts may have come first but soon thereafter, ocean marine insurance and "burial," and maybe a bit of life insurance (for Roman soldiers).[24]

Not only are there different kinds of policies insuring many different types of entities, actions and events, there are different types of jobs that policies perform and different ways that they do it. Thus, there is primary insurance, excess insurance, levels of excess insurance, umbrella policies, which are both excess and primary (as umbrella policies usually are) reinsurance policies for all of those, and then reinsurance for reinsurance and so forth. Moreover, there are different forms, e.g., so-called "cat bonds," bonds for various occupations, performance bonds, fidelity bonds, and there can be many sorts of different mixtures. Imagine a package policy that is primary with respect to one thing, excess to a different policy, excess to another excess policy, and reinsurance as to another.

Cyber insurance is simply the latest new substantive area, and it came into being toward the end of the most insurance-innovative century, or century and a half, of all times. Having come into being toward the end of the twentieth century, it has been multiplying in many different ways faster and faster.

At the same time, it must be remembered that all new types of insurance policies are built on the terms, definitions, general exclusions, and conditions of older policies, to one significant extent or another—though, of course, never completely. New types of policies must create or use some new terms and new understandings of what is covered, but there will be very strong continuity. A very good example of the reuse of traditional terminology coupled together with brand new terms is found in the history of aviation insurance. Property policies of the twenty-first century are built on policies from the twentieth century, which are in turn built upon those of the nineteenth century, and those of the nineteenth are linked to those of the eighteenth.[25] Maritime and fire policies of early in the last century are easily recognizable as connected to policies one hundred

years earlier. [26] This is probably true at least back to maritime policies of the Renaissance. [27]

As one might expect, as the centuries have gone by, the policies have gotten longer and longer. This is partly because fire policies of yesterday insured the peril of fires only, and what are often called fire policies today insure perils other than fire, as well as fire, but are developed from the original fire policies. In addition, some of the key language found in earlier policies, for example, "accident," dropped out of many policies as a defined term and therefore as a term of immediate and central focus. But it was followed by the word "occurrence"; it was more or less substituted for it, and it was then defined, in substantial part, by the word "accident"—the very term that has just dropped out. The same propositions are already true of cyber-insurance, whether it is for that realm only or for both realms. Perhaps standardization of the policies will cut down on this, but one doubts it.

It is also worth noting that all insurance involves the attempted preparation by at least one party to price the product (or service) in a rational or reasonable way. Insurers now lead the way on this, assuming that the insureds actively participate at all. Of course, highly-regulated markets have something to do with this as well, but there are vast efforts spent on in-advance preparation, and it spreads all over the respectable parts of the industry.

The reverse may have been true early on, twenty-five (or so) centuries ago. At that point, insureds may have done the original pricing, subject to negotiation, but that changed long, long ago. As insurance policy pricing has become more and more rationalistic or scientific or empirically based, and therefore economically and financially sophisticated, insurers have relied more and more on statistics, for example, actuarial methods and results. It became even more complicated the more perils a single policy covered, in parts the value of the perils interact in some cases. Insureds and many other participants in the various parts of the insurance industry do not understand how these processes work either, including many who call themselves "risk managers."

(Risk managers may not be particularly involved in underwriting. They may be engineers, security specialists, or project managers. Even if they have some actuarial knowledge, it must be remembered that some of them are in-house at insurers; some are in-house with insureds—where they might manage risk in various ways, e.g., insurance purchasing, collecting injury data, providing internal advice, and education; some are employees of insurance brokerage houses; and yet others have their own businesses.)

Naturally, it is more difficult for insureds to have a good command of all these pricing techniques, nor is it easy for them to find out. Insurers have an incentive for their pricing methods not to reach at least many insureds.

These methods are not easy to use in cyber insurance just yet because the relevant and relatively reliable data is still scarce.[28] In addition, new techniques are being placed in the underwriting tool boxes; this is especially true now that a great deal of the economics of insuring is now regarded as something to be found in the toolbox of international finance.[29]

V. Another Universal: Policy Typology

All contracts of insurance can be divided into exactly three categories. The first type can transfer to an insurer from an insured virtually any type of risk that can be somehow specified in (or somehow brought into) a contract of insurance, save one.

The category that is the exception is one in which the insured itself is the peril, where certain conduct of the insured is the peril against which there is insurance, that is, where the peril to the insured is its own liability to someone or some entity it has injured or is said to have injured. , Another way to put it is that there is a distinct type of insurance that transfers the insured's risk resulting from it (or an entity for which it is liable) having caused specified injuries to another.

The third type is an insurance contract that contains both the types of risk transfers found in the other two. Of course there are other ways to "typologize" insurance policies. For example, there is insurance for tangible physical objects, and there is insurance for rights to performances. There is insurance for autos; there is insurance for airplanes; and there is insurance for sea ships. That is not the point here, however.

The former type of the insurance contract is called a "First Party [Insurance] Policy" ("1PPs"), while the second is called a "Third Party Policy" ("3PPs"), and the third type is one type of that called a "package policy," or something of the sort. 1PPs are often called "property policies," while 3PPs are usually called "liability policies," though 3PPs often contain a 1PP component, namely, the carrier's duty to defend its insured, if sued or compelled to arbitrate.[30]

The presence of 1PP coverage inserted into a 3PP policy is extremely important to remember when we consider the cyber-policy—the Travelers **CyberRisk Policy** to be discussed later in Part II. There is an issue that will be seen to arise in a policy with both 1PP and 3PP parts, where one of the parts is entitled "Third Party Insuring Agreements"

while the other is entitled "First Party Insuring Agreement" but where one of the latter agreements (a 3PP) is—or appears to be—quite surprisingly incorporated, mixed, or blended, at least in part, into one of the former type (1PP) agreements, or vice versa, where a 1PP is incorporated into a 3PP, somehow. From the point of view of an insurance policy geek with proclivities toward cyber policies, this is an astounding and fascinating development.

In addition, there can be both cyber-policies and real-world policies in the same policy joined together, and be a sort of integrated packet of documents that is, the same "package policy." (It is a good idea to remember that a package policy can be "togethered," if that can be a word, as one might say, to various degrees. These can be real headaches when it comes to policy interpretation for lawyers and adjusters. The problems can be multiplied if both 1PPs and 3PPs of both worlds are packaged together.)

In any case, there are at least four ways to join different types of policies together. (i) Different policies are simply clipped/stabled together. (ii) Policies are shuffled together with substantive portions of two or more policies overlapping with more or less true fit. Of course, when creating package policies from the two worlds this can be difficult. One way to help is by stating explicitly which exclusions apply to which insuring agreements. (iii) The two or more policies can be genuinely integrated. And (iv) Packaging can be done by using endorsements.

...there can be both cyber-policies and real-world policies in the same policy joined together, and be a sort of integrated packet of documents that is, the same 'package policy.'

At the same time, having "integrated" policies—one policy with consecutively numbered pages, a Table of Contents that is clear and briefly descriptive, as few endorsements as possible, and no jumping around required—makes life easier for handlers, whether from the insurer, the agent-broker, or the risk manager from the insured. A policy can simply be this way right from the start without any shuffling or endorsements. A totally integrated policy also makes it easier for a coverage attorney to do the coverage analysis and the explanatory letter and lay it all out clearly. Too many different parts, section, and paragraph numbers make reporting by lawyers harder to follow, but it may be necessary to foster needed precisions. Lawyer prose is often inescapably opaque.

Of course, all insurance policies are contracts. The focus will be on a few parts of a single cyber-insurance contract; a package policy put out by Travelers that is illustrative of most of the whole array of cyber insurance policies. Before reaching that point, however, there needs to be a description of parts of cyber-world policies in general. It should surely come as no surprise that they closely resemble real-world policies. This typology applies to cyber-policies, with complication built into or upon it. The 1PPs may cover assets found only in the cyber world, or it may cover assets found in both worlds. Similarly, the 3PPs may cover injurious acts and omissions performed by the insured in not only the cyber world, but the real world as well. Defamation is like this.[31] Several perils covered in many 3PPs found in both worlds are such that they the peril can be correctly thought of as causing injuries in both worlds. Under those circumstances, it may be that there is coverage for the injury and loss under both the real-world and the cyber-world 3PPs. This leads to an interesting problem. Suppose both policies contain a clause that prescribes that if an insured peril is also insured by another policy, then the other policy goes first. Now for the question: Would the fact that one covers events in the real-world and the other covers events in the cyber-world make any difference to interpreting and dealing with the so-called "other insurance clauses"? What if each of them excluded injuries occurring in the other world?

For obvious reasons all cyber-insurance contracts of insurance are tied to losses that occur in the real-world, given what a loss is. This tie-relationship may be direct or indirect, but it will exist. Will this make any difference in answering the questions just asked? Surely, it is not the case that everything that happens in the cyber-world stays in the cyber-world.

VI. Some General Observations

Some 3PPs pertain only to the so-called real-world. However, all policies that pertain to the cyber-world also pertain to the real-world, if for no other reason that, ultimately, the insured loss is "in" the real-world, or connected to it in a significant way.[32] Sometimes there are some assets the insured owns (at least to some degree) that are not covered, and some not. Almost never are all the assets of the policyholder or a given set of them insured. Sometimes the assets have to be listed in the policy, sometimes not.

Sometimes the *assets* are tangible; sometimes they are not. Intangible assets can be owned and so are also considered the property of the insured, so all of these kinds of policies are the policies are to be called "property policies," although many people in the industry associate the name "property policy" with insurance that is principally for tangible property. (It is easy to keep in mind that there is no such thing as second party insurance. The PP1 refers to the entities insured and related property for their damages; PP3 refers to a

person alleging injury by referring to the person(s) injured; there is no "you." An insured is sometimes designated in a policy by the word "you," and the same can be true if there are several named insureds, and they may all be policyholders, although the term "policyholder" is—for no very good reason—sometimes defined by insurers differently, so that only one named insured can be *the* policyholder. In any case, when that is the case, the insurer is often referred to as "we," whether there is one insurer or more or whether the recognized name is, say, "State Farm," but the actual insurer is "State Farm Lloyds.")

In this regard, there are similarities between 1PPs in the so-called real-world and in the so-called cyber-world and some differences. First party coverage, purely in the cyber-world, could not insure physical/material bodies or any sort of tangible property (including the metal frames and wiring of and in desktops, etc.), but they can insure other entities that are similar in the sense they can be owned, serviced, valued, priced, auctioned off, valued, and even loved by insureds, such as people with physical bodies.

At the same time, 1PPs in the cyber world can be open to insuring losses that occur in the real-world as a result of events in the cyber-world. Thus, if a covered peril occurs in the cyber-world that physically injures a computer "here" in the real-world, as it were—say, causes it to catch fire—that could be covered. Similarly, if an occurrence in the cyber-world caused a physical, real-world computer to stop working at all, or stop doing its job correctly, that might be covered, since "property damage" in the real-world usually covers not only injurious physical impacts to tangible objects, other than human bodies, but also to the loss of use of those type of objects, even if there is no physical/material injury inflicted.

Of course, an insurance policy for the cyber-world could be written in such a way to make sure that what happens in that world stayed in that world for insurance purposes, and—in fact—that is becoming more common. At the same time, 3PPs in both worlds can provide insurance for the same sort of potentially injurious conduct. Defamation, copyright violations, trade-market infringement, etc. are like this.

Many types of 3PPs in both worlds provide defenses (or money to defend) to insureds when sued. In other words, in each of the different types of world, 3PPs impose upon the insurer a contract based duty to defend the insured, or--at least--a duty to pay for its defense. This is not a proposition of logical necessity, but the point of valuable risk transfer for both the insured and the insurer would be severely undermined if 3PPs did not take part in that transfer of risk. Not all types of defenses are covered, of course. In at least one type of case, unlike most 3PPs in the real-world, many 3PPs cyber policies cover defense costs in administrative litigation following government accusation against an insured.[33] Some of them even cover the liabilities for penalties imposed by courts sought by the government and thereafter imposed by a court at some level. Perhaps this is because exposures to regulatory problems have been conjectured to be a greater risk to cyber insureds than they are to real-world insured.

In the real-world and in the cyber-world, the duty to defend can be understood and analyzed in two quite separate ways. One type of duty to defend involves the insurer running the defense of the insured, more or less, and this duty carries with it a whole slew of duties and rights for both the insurer and the insured. When this is the duty to defend, the carrier pays the legal fees on behalf of the insured.

Another type of duty to defend involves the insurer paying for the defense, but the insured running it. The best known example of this type is the so-called "Directors and Officers" liability policy. The arrangement can, in theory, be made for any type of insurance and more commonly is for sophisticated forms of business insurance, for example, management liability insurance and lawyers errors and omissions liability policies. (The phrase "more common than" does not mean that something is commonly done.) In general these policies are called reimbursement policies.

Where a duty to defend involves the insurer not running the defense but only paying for it, the insurer invariably still has the right to review the litigation performance of the insured and its lawyers. And often the carrier has the right to specify a list of acceptable attorneys from which the insured must chose. In the alternative, sometimes the insured may choose whomever it wants with approval by the insurer.

Policies in which the duty to defend is paid by the insurer, but the insured runs the defense (the method of timing payments from the insurer vary) are uniformly called "reimbursement policies." In theory, the reimbursement could come in one sum at the end of the relationship. This is unusual, irrespective of the language of the policy. The more general pattern is that the insurer audits the legal expenses periodically and then pays them at various intervals. Sometimes these intervals are regular; sometimes not.

Another and separate way to analyze the duty to defend in both the real- and the cyber- worlds pertains to the duty and to the contract's "policy limits." In ordinary, real-world policies the insured's right to have its defense paid for by the insurer has no limit. Of course, the arrangement could be otherwise, and sometimes insurers have tried to get this changed, but the effort has never gone anywhere. In

professional malpractice policies and Directors and Officers policies, defense expenses being part of the amount included within policy limits is standard. In 3PPs for the cyber-world, all of them that I have seen or heard about have included defense expenses within policy limits.

Often, as a practical matter, and historically for many, many years, insurers in 3PPs ignored the relevant requirement in a reimbursement policy if the insurer was sure of coverage and amounts it will owe. In both types of PPs, for example, an insurer will pay settlement amounts but only if it approves the settlement. Of course, an insurer's approving a settlement amount is a non-issue if the insurer has completely determined that the amount, for example, by negotiation on behalf of the insured. Its negotiations constitute an approval.

In addition, there can be both cyber-policies and real-world policies in the same packet of documents that is, in the same package policy. There are three ways to do this. (i) Different policies are simply stapled together. (ii) It is also done by shuffling together substantive portions of two or more policies from the two worlds stating which exclusions apply to which insuring agreements. (iii) Using another alternative, this packaging can be done by using endorsements.

At the same time having one "integrated" policy—one policy with consecutively numbered pages and no jumping around—make life easier for some handlers, whether from the insurer, the agent-broker or the risk manager from the insured. A policy can simply be this way right from the start without any shuffling or endorsements. A completely integrated policy also makes it easier for a coverage attorney to do the coverage analysis and the explanatory letter and lay it all out clearly. Too many different parts, sections, and paragraph numbers make reporting and reading coverages more difficult and less easily read.

Contracts of Insurance in the Cyber World

As already spelled out, all insurance policies are contracts. The focus here will be on a complex package cyber insurance policy used in the cyber–world. Cyber-policies are not yet standardized, and some species of them never will be, but the policy to be discussed presently is typical in many ways. It will be the Travelers Indemnity Company's CYBERRISK policy, CYB-3001 007-10 ("Traveler's Policy" or "**CyberRisk Policy"** or "CYBERRISK Policy"[34]). It is easily locatable on the Internet. This is a complicated and sometimes subtle policy, but it is a good place to begin. This policy may a bit more complicated and subtle than others, but it is a good one to study.

Before turning to it specifically, however, a number of general points should be made first.

First, cyber-world policies are uniformly either "claims' made policies" or "claims' made and reported policies." I have never seen one with a policy period of longer than one year, but if the cyber-world is like the real-world, this can be arranged so that renewals can be virtually guaranteed. (In a sense these are virtual renewals, and they can be virtually guaranteed, even though they are part of the virtual world, the world of only virtual things. It must be remembered; of course, that none of the activities, the insurers, or the insureds is certain to be virtuous.)

Also like real-world policies, cyber-policies usually have a "Retrospective [Time] Period" "in which events that are insured during the policy period can be included within the coverage, so long as losses are reported in a timely basis in the policy period" or during an "Extended Reporting Period" that has been tied on. (Of course the additional periods involve additional expenses and can be purchased separately.) The two periods discussed here should probably be grouped together. As a general rule, the extension periods at both ends of the policy period are of one prescribed length or only a very few fixed lengths—the only one available from the insurer.

Second, the structures of cyber-policies are pretty much the same as that of real-world policies, and there are not systematic differences. This should come as a surprise to no one that since the twenty-first century, real-world policies are, relatively speaking, structurally similar to policies of 500 years ago, only now covering more different and more types of events and things, usually of the same sort, and so being much longer and also now being presented in many titled and subtitled, outline form. (The new policies are supposed to be, as a result of the last feature, easier to deal with in all respects—a comical idea if ever there was one.)

The structures of the cyber-policies can be the same without being in the same order. The order I like the best for all policies is:

- Title Page, e.g., naming the insurer or insures or stack of insurers, etc.,
- Introductions, e.g., with the abbreviations set forth,
- Declarations Sheet,
- Insuring Agreement(s),
- Exclusions,
- Definitions,
- Conditions,
- Miscellaneous, perhaps
- Endorsements, as well as, sometimes, the
- Application for the policy and whatever is included in it.

Leaving aside the Application, I prefer the order just set forth because that is how I "grew up"; however, other organizations are just as good, or better, once you get used to them. There are Chubb policies, for example that start with definitions, and makes a lot of sense: it makes the definitions very easy to find, and in highly complex policies, especially if there are newly-constructed terms with which to deal, that physical position impliedly suggests that the reader should begin with them, and that suggestion is correct. The orders of structures are just as varied in cyber-world policies as they are in real-world policies. Nevertheless, at this point in insurance history, by far, these sections need the most intense study.

It may seem odd to the reader to think of the insured's application for insurance in the list of parts of the policy. This is quite frequently done. However, the most important of the reasons why this is done, is to enable the insurer to justify such acts as policy cancellation, for example, in the middle of processing a claim, on the basis of some violations of the terms of the policy itself. Applications, of course, always contain requirements that the applicant disclose all relevant information in response to a question, and not assert any false propositions. The sentence including the application in the policy is sometimes to be found in the miscellany section, but it is sometimes elsewhere—sometimes right at the first of the policy. Under some circumstances counsel needs to determine if the clause is even present in the policy, and then if it is, study it.

Third, in cyber-policies different categories of covered perils may be listed in separate sections, but often conjoined together on lists. This might involve one set of insuring agreements for third-party coverages and one for first-party categories, or the covered categories may be shuffled together, sometimes in easily understood ways, sometimes not. In the CYBERRISK Policy, they are all in a single general group entitled "Insuring Agreements. It is divided into two subparts, one for 3PP agreements, of which there are three and one for 1PPs of which there are seven. The discussion here will consider one from each subpart.

Fourth, in real-world liability policies, the insurer's providing a defense to a lawsuit brought against the policyholder (or an insured) is one of the most important features of the policy. Defendants can win tort-type cases brought against them, and the more complicated the case, the more likely it is that the defendant will win it. This point includes cyber-suits especially, for now. But defenses can be expensive. Legal services are expensive in and of themselves; really good lawyers specializing in this are hard to find, unless they have lots of day-to-day experiences, suits can last a long time, and they take a lot of time to monitor.

Fifth, in contracts of cyber-insurance, there are usually a huge number of definitions, usually identified by letters and sometimes get to or close to "ZZZ,"—78 in number. As we shall see in Part Two, the Travelers Policy to be discussed goes to only to "GGG," and that's only 59. When there are a large number, as a rule, some of the definienda are so simple, one wonders why they are there at all. The definitions are often grouped together, and in two different senses. In general, in all cyber-policies, sometimes one definition depends on another definition, and that one depends on yet another, and so on; sometimes these stacks buildup to amazing levels.

In addition, as already stated in another context, definitions applying to 1PPs only, and others only to 3PPs can be shuffled into the same list. At the same time, not all important words are defined and sometimes in a definition involving several words, the last one is defined in terms of the others. For example, in the CYBERRISK Policy the term "wrongful act" is defined as a wrongful act occurring in the context of XYZ, and "XYZ" is—or should be—independently defined, but "wrongful act" itself is not. This means that the phrase "wrongful act" is not actually defined, but insurance industry folks do not seem to know this. This can make reading the lists a process

of cutting phrases up.

Sixth, all policies in the cyber-world contain exclusions—how could it be any other way given that insuring agreements use general terms—but often there are not so many as are usually to be found in real-world policies. Many of the definitions in policies of the cyber-world contain the same exclusionary language as is found in the actual exclusion sections of real-world policies. Here are several examples: no coverage for war, deliberate nuclear attacks, nuclear accidents, terrorism, various types of business losses, e.g., deriving from defective products and/or services, crimes performed by the insurer, and so forth. Naturally, many of the most interesting are "peculiar" to cyber-policies, conduct that has consequences that are "expected or intended," and the same is true with respect to the general themes of the insuring agreements, though either the specifics or what may appear to be details. (One wonders whether, in any insurance policy, there really are "details," in this sense of the word.)

Seventh, to a considerable extent, the Conditions in the policies of both the two worlds are very similar at general levels, though not completely. Some examples of the similarities are these: territories where applicable, counting and distinguishing claims, use of retained limits, policy limits, insured's duties to the insurer upon making a claim, e.g., cooperation. In addition, as with real-world policies, there may be miscellaneous sections; these contain an assortment of provisions, though often they are conditions, as it were, in disguise.

End of Part One

1 Evgeny Mrozov, To Save Everything, Click Here: The Folly of Technological Solutionism (2013).

2 Antonin Scalia & Bryan A. Garner, Reading the Law; The Interpretation of Legal Texts (2012). As the title makes clear, the authors are not just talking about the constitution or statutes. Opposing their "Originalism" and "Legalism" are, among many others, Oliver Wendall Holmes ("The life of the law has not been law, it has been experience), the advocates for Legal Realism, Legal Pragmatism, and their successors. *See* Richard A. Posner, Law, Pragmatism, and Democracy [, among other of his relevant writings], especially chapters Two and parts of Chapters Three and Nine (2003). Here is how Judge Posner describes one of the leaders of the pack: "Holmes's theory of contract is such a clear example of the pragmatic approach to law that I will pause to explain it. The traditional was that when you sign a contract you assume a legally enforceable duty to perform your contractual undertakings. But 'duty' is vague, abstract. Holmes pointed out that in a regime in which the sanction for breach of contract is merely an award of compensatory damages to the victim, the entirely effect of signing a contract is that by doing so one obtains an option to break it. The damages one must pay for breaking the contract are simply the price if the option is exercised." *See* Posner 58 & 56 n.4.

3 What used to be called the nature of man.

4 Mrozov, *supra.*

5 For readers unfamiliar with this word, or whose feel , as it were, for it, may wish to consult the learned monograph by Professor of Philosophy, Emeritus Harry G, Frankfurt, at Princeton University, On Bullshit (Princeton U. Press 2005).

6 In a different sense, if what philosophers and neuroscientists call "Cartesian"-dualism is true, which most of them these days think is not, human beings have an immaterial property, namely, their minds. (The word "Cartesian is an "adjectivization" of the name Rene Descartes.)

7 *See* Mrorzov, n.1, *supra,* at 153. For a neat illustration and a number of ambiguities built into the word "virtual," *see* Anand Giridharadas, *Museums See Virtue in Virtual Worlds*, N.Y. Times, Aug. 8, 2004, at C17, C24.

8 Here is the way Judge Eduardo C. Robreno described the "virtual world," not long ago. "The virtual world at issue is an interactive computer simulation which lets its participants see, hear, use, and even modify the simulated objects in the computer-generated environment. *Bragg v. Linden Research, Inc.*, 487 F. Supp. 2d 593, 595, nn.1, 2-3 (E.D. Pa. 2007). (Notice the use of the term "simulation," noun referring to state of affairs involving nothing more than resemblance, and "simulated," a transitive verb.) Those of the readers who tire of voluminous case cites from all sorts of sites, may now whisper a prayer of thanksgiving, for there will be very few more. (It is not the case that many more are actually needed. The terminology has not been an issue in cyber-insurance reported cases, of which there are not that many anyway. There is a literature, however; occasionally I am asked in depositions "Do you have any authority for what you have just said?" Sometimes I say, "Yes, me." I suppose that sounds arrogant.)

9 This may have happened recently in a decision of the Texas Supreme Court, in which liability insurance may have been in the shadows, since some cyber-likability-policies, as well as some real-world liability policies, cover allegations of defamation. *See In re John DOE a/k/a "Trooper,"* No. 13-0073, 2014 WL 4783574 (Tex. Aug. 29, 2014). Under Texas law of procedure, like that of other states, one can file what might be called a pre-suit suit to "'prevent a failure or delay of justice in an anticipated suit.'" *Id.* at *2. The question was whether one could use such a suit to find out the identity of an anonymous blogger who called "itself" "Trooper" and who may have defamed a Texas resident by a blog that was published over the Internet. *Id.* at *3. In a 5-4 opinion, the court said "No," on the basis of the fact that the plaintiff, the allegedly defamed, could not establish personal jurisdiction over the blogger, even though personal jurisdiction was easily established over Google, the service provider, and the blogger "sent" the blog to Texas, and most everywhere else. *Id.* at *5. What may have happened here is that the majority of the court confused or conflated

the idea actual space, upon which personal jurisdiction may depend, with the idea of cyber-space and tied personal jurisdiction based on cyber-space (in part) to the former. This case involves two very interesting opinions with sharply different outlooks. I myself am tempted to say that if you publish a blog in a given U.S. jurisdiction, then the courts of that jurisdiction have personal jurisdiction over the blogger. Bloggery may establish "minimum contacts" for something that was caused to happen in a given state, e.g., Texas.

10 The nature of risk and dealing with it in the twentieth century is discussed in an interesting manner in ARWEN P. MOHUN, RISK: NEGOTIATING SAFETY IN AMERICAN SOCIETY (2013). A large number of more general discussions are referenced in her endnotes for the introductory chapter and in the discussion of insurance in the next chapter.

11 From a philosophical point of view, the idea of *to make happen* may itself be obscure. But we don't practice insurance law at a philosophical level.

12 *See* Tom Baker, *On the Genealogy of Moral Hazard*, 75 Tex. L. Rev. 237 (1996). Professor Baker studies the history of this idea, and discusses all of the phases, except for #(3).

13 DAVID HUME, AN ENQUIRY CONCERNING THE PRINCIPLES OF MORALS (1751).

14 Quite frequently, I will refer to both parties to contracts of insurance as entities. Thus, I am treating real persons—people—as entities, which they actually are.

15 Here are some actual examples of "named perils": fire, flood, hail, collision, terrorist attack, hackery, embezzlement by an employee, trademark infringement, breach of security, lock out of network system, and extortion as to lock out. Here is an example of an unnamed, general peril: an accident, a disease, health of an animal, business interruption, computer malfunction, default on a note, specified defects in a bond, and so forth.

16 As a matter of semantics and logic, of course, all risks listed have some level of generality. This is true even if the risk is "hail stones no larger than a dime width sphere blown into a tin roof from the west." Semantically speaking this risk still has elements of generality built into it. Of course, taking recognition of this fact makes the idea of ambiguity much broader than it is usually perceived, and that has potentially profound implications for insurance in the cyber world, since much of the terminality invented for it is relatively new and therefore not fixed in stone.

17 Here is an example of different types of causation: insurance for direct causation, but none for indirect.

18 Sometimes the term "injury" is used explicitly, e.g., with respect to the human body ("bodily injury"). Sometimes the term "damage" is used instead of "injury" to mean the same thing ("property damage"). That useless distinction can be confusing and the concept of "damages" goes well with the concept of "loss." (If asked "What were your damages?" most people would know the question was, "How much?")

19 From what point in time the prudence is measured, for how long it's measured, and how much there need be, varies.

20 Where tangible property has been involved ownership, something related to ownership (like a mortgage), or something like ownership, are used as one of the ways to limit who may be an insured. The same more or less holds for intangible property. For example, in trade credit insurance and its near relationships a right is covered, in particular, the right to be paid. The same propositions are true in the cyber realm.

21 Often some of these pieces of the design are built into or around the application for insurance. For example, an insurer might require that the insured have and know how to use fire extinguishers. Some of these may be for real world policies (for example, having tires checked); others may be for cyber-world policies (having using encryption codes of some sort or a specified sort; and yet other may pertain to both worlds (like fire extinguishers).

22 *See* KENNETH S. WOLLNER, HOW TO DRAFT AND INTERPRET INSURANCE POLICIES (2d ed. 2007), a mildly interesting book that actually portrays nothing an average lawyer would not know about how to draft an insurance policy correctly. The point to the citation being that there is little helpful literature about how to actually to draft; this is now and perhaps always has been and esoteric art.

23 The phrase or term "virtual currency" is just another name for "private currency" devised for the "virtual world." One wonders whether this use of "virtually" is like usage of "worlds" and "spaces" in talking about the so-called "real-world" and the so-called "cyber-world." Historically, the latter lead to the former, bit semantically, they are distinct. The world "virtually" usually means "very much alike," "can perform the same function though different in nature," "almost alike," or "near substitute." The term "world" has not such meaning except, maybe referring to video games. The terminology around "virtual currency" is just another phraseology for a kind of currency devised for the one world that there is. There is a nice example of fog and confusion arising out of the idea of there being plural worlds.

24 C.F. TRENERRY, THE ORIGIN AND EARLY HISTORY OF INSURANCE: INCLUDING THE CONTRACT OF BOTTOMRY (1926) though written a while before that. (Actually, bottomry is an obvious case of what is actually insurance, and why people have resisted recognizing this is beyond me.)

25 *See* H.A.L. COCKERELL & EDWIN GREEN, THE BRITISH INSURANCE BUSINESS: HISTORY AND ARCHIVES 1547-1970 (1976), HAROLD E. RAYNES, A HISTORY OF BRITISH INSURANCE (2d ed. 1964), and ROBIN PEARSON, INSURING THE INDUSTRIAL REVOLUTION: FIRE INSURANCE IN GREAT BRITAIN, 1700-1850 (2004)), and a few others for UK.

26 SAMUEL MARSHALL, A TREATISE ON THE LAW OF INSURANCE: IN FOUR BOOKS (1802). Most of the sections and pages by far are about maritime insurance. The others are an Introduction, Life Insurance, and Fire Insurance. The U.S. version was apparently published in 1805, though the British version was used in the U.S. before that. The currently available volume is a "hugely" thick one volume paperback. It is not recommendation that you drop it on your foot or on the head of your baby or grand-baby in residence or elsewhere.

27 *See* GIUSEPPE STEFANI, INSURANCE IN VENICE FROM THE ORIGINS TO THE END OF THE SERENISSIMA (Arturo Dawson Amuroso trans., 1958) Chapters V entitled "The Insurance Contract" pp. 57-65, including picture. (It is distressing to observe that there was

a brisk trade in slave insurance. It is encouraging to note that there were strict laws against at least some forms of trading in them. Unfortunately, the business was too lucrative (literally in ducats) to resist. *See* pp. 52-54.)

28 *See Quinn's Commentaries on Insurance Law, Underwriting and Cyber Insurance Coming of Age*, http://quinninsurancelaw.blogspot.com (June 24, 2014).

29 Eric Briys & Francois de Varenne, Insurance: From Underwriting to Derivatives: Asset Liability Management in Insurance Companies (2001).

30 For reasons of saving space, I will use 1PP to refer to a first party insuring agreement where there are other insuring agreements, and 3PP to refer to a liability insuring agreement where there are other insuring agreements in the policy. This is done, of all things, in the interest of minimizing abbreviations and hence clarity.

31 Defamation may be an incident in the real-world and/or it may be an episode in the cyber-world. Sometimes it starts in one of them and then laps over to the other; sometimes it might start in both worlds at once. In addition, a defamation event might be covered under a 1PP and a 3PP at the same time. (When I use the terms "incident," "episode," "event," and perhaps others, I am not drawing a distinction or using them in some specialized way, although at least one of them does have a special meaning in some areas of insurance, e.g., petroleum industry. An exception to that will be the phrase "wrongful act."

32 Thus, usually it is a real-world person who is the policyholder. But suppose eventually robots are insureds. Most robots are to be found in the real world. But suppose further there was an electronic robot found only in the cyber world. A person in the real world will own the robot or own cyber entities that own the cyber-robot. Thus eventually the insured loss or derivative loss is to be found in the real-world.

33 An exception to their being no duty to defend insureds in administrative cases is the lawyer malpractice policy. Bar committees working on "ethics" complaints about lawyers are nothing like actual administrative proceedings.

34 CYBERRISK is what it is called in the overall title on the first page. **CyberRisk Policy** is the phrase used in the definition section and throughout the rest of the policy. This variation is somewhat uncommon.

By Wade A. Barrow

SURETY ENDORSEMENTS IN COMMERCIAL TRUCKING AUTO POLICIES

The MCS-90 endorsement to interstate commercial vehicle insurance policies is required to ensure that vehicles have a minimum level of insurance while operating on public roadways. Over the last three (3) decades, courts have begun to examine the breadth of coverage of the MCS-90 endorsement. The goal here is to discuss the MCS-90 endorsement generally, the case law, and the implications for both plaintiff and defense practice.

History

Prior to 1980, the Interstate Commerce Commission regulated commercial vehicles. However, the trucking industry implemented various business arrangements with its fleet (*e.g.* leased trucks or independent contractor drivers) to avoid regulation. *American Trucking Ass'ns. v. U.S.*, 344 U.S. 298, 305 (1953). Under these business practices, motor carriers were allowed to avoid liability for negligent drivers who were "independent contractors." *See e.g. Eagle Trucking Co. v. Texas Bitulithic Co.,* 612 S.W.2d 503, 508 (Tex. 1981). The practical effect of a driver being deemed an independent contractor was that there frequently was inadequate or non-existent insurance coverage for a collision.

This is the background in which the Motor Carrier Act of 1980 was passed. Within that bill was a requirement that every motor carrier operating pursuant to United States Department of Transportation ("U.S.D.O.T.") authority have an insurance policy that contained an MCS-90 endorsement. The legislative intent of this provision was to "protect members of the public from motor carriers' attempts to escape liability for the negligence of drivers by claiming their drivers were independent contractors." *Perry v. Harco Nat'l. Ins. Co.*, 129 F.3d 1072, 1074 (9th Cir. 1997). More broadly, the purpose of the MCS-90 and its intrastate counterpart Form F is "to ensure that liability insurance is always available for the protection of motorists injured by commercial motor carriers." *Nat'l. Cas. Co. v. Lane Express, Inc.*, 998 S.W.2d 256, 263 (Tex. App. – Dallas 1999, pet. denied). "In effect, the endorsement shifts the risk of loss for accidents occurring in the course of interstate commerce away from the public by guaranteeing that an injured party will be compensated even if the insurance carrier has a valid defense based on a condition in the policy." *Pierre v. Providence Washington Ins. Co.,* 784 N.E.2d 52, 53-54 (N.Y. App. 2002)

What is an MCS-90 ?

The MCS-90 is not insurance. It is akin to a surety bond. The MCS-90 endorsement ensures payment to the public for the negligence of a motor carrier, regardless of coverage under the policy, on the condition that the motor carrier is obligated to reimburse the insurer for any payments made for which no coverage existed under the commercial motor vehicle policy. *T.H.E. Ins. Co. v. Larsen Intermodal Servs., Inc.*, 242 F.3d 667, 671 (5th Cir. 2001).

The actual MCS-90 endorsement is a two page document that states in part:

> "In consideration of the premium stated in the policy in which this endorsement is attached, the insurer (the company) agrees to pay, within the limits of liability described herein, any final judgment recovered against the insured for public liability resulting from negligence in the operation, maintenance or use of motor vehicles subject to…. the Motor Carrier Act of 1980 regardless of whether or not each motor vehicle is specifically described in the policy . . .Such insurance as is afforded, for public liability, does not apply to injury to or death of the insured's employees . . .The insured agrees to reimburse the company for any payment made by the company on account of any accident, claim, or suit involving a breach of the terms of the policy, and for any payment that the company would not have been obligated to make under the provisions of the policy except for the agreement contained in this endorsement . . ."[1]

The second page of the MCS-90 describes the limits of liability: $750,000 for non-hazardous carriers; $1,000,000 for transporters of certain oil products; and $5,000,000 for motor carriers transporting hazardous materials. 49 C.F.R. § 387.9.

The MCS-90 endorsement creates a suretyship covering the motor carrier up to $750,000 in a collision or accident. *Canal Ins. Co. v. Carolina Cas. Ins. Co.* 59 F.3d 281, 283 (1st Cir. 1995). One can usually ascertain whether a commercial vehicle policy contains a MCS-90 endorsement. If a motor carrier is operating under U.S.D.O.T. authority, it must

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submit valid proof of a MCS-90 to receive its operating authority. 49 C.F.R. § 387.7. The MCS-90 endorsement continues until terminated. An insurer must give thirty-five (35) days notice to the motor carrier of cancellation of the MCS-90 endorsement. 49 C.F.R. § 387.7(b)(1), Further, the insurer must give the Federal Motor Carrier Safety Administration thirty (30) days notice of the cancellation of the MCS-90 endorsement. 49 C.F.R. § 387.313(d). When a motor carrier's MCS-90 endorsement is cancelled, the Federal Motor Carrier Safety Administration ("F.M.C.S.A.") will also revoke the carrier's operating authority. Therefore, in a bit of *ipso facto*, if a motor carrier is operating pursuant to unrevoked U.S.D.O.T. authority, its insurance policy contains an MCS-90. Even in cases where the policy does not actually include an MCS-90 endorsement, where the insurer has filed the applicable form with a regulatory agency stating the policy includes an MCS-90 endorsement, the "motor carrier's liability insurance policy has been amended by the addition of . . . a Form MCS 90 ." *Northland Ins. Co. v. New Hampshire Ins. Co.*, 63 F.Supp.2d 128, 139 (D.N.H. 1999). The MCS-90 becomes a part of the policy by operation of law upon, the insurer submitting verification (Form BMC-91) of its insurance meeting the minimum requirements to the F.M.C.S.A. to gain operating authority for the motor carrier. The F.M.C.S.A. maintains an active database of motor carriers on its website (www.safersys.org) and states whether a motor carrier's operating authority is active or has been revoked.

Intrastate Motor Carriers - Form F

For purely intrastate carriers, there is a Texas equivalent of the MCS-90 endorsement called "Form F." This coverage endorsement is based on model language adopted by many states throughout the U.S. and says in part:

> "The certification of the policy … under the provisions of any State motor carrier law or regulations promulgated by any State commission … amends the policy to provide insurance for automobile bodily injury and property damage liability in accordance with the provisions of such law or regulation to the extent of the coverage and limits of liability required thereby … provided only that the insured agrees to reimburse the company for any payment made by the company which it would not have been obligated to make under the policy except by reason of the obligation assumed in making such certification."

Nat'l. Cas. Co., 998 S.W.2d at 263.

While the Texas Department of Public Safety has incorporated by reference the majority of the Federal Motor Carrier Safety Regulations ("FMCSR"), Texas has devised its own regulatory scheme for ensuring the financial responsibility of intrastate motor carriers. 37 T.A.C. § 4.11 (2014). Each motor carrier must file a Form E with the Texas Department of Motor Vehicles when making an application for motor carrier operating authority. The Form E simply notifies the State of Texas of the identity of the insurer who issued the Form F. *Nat'l. Cas. Co.*, 998 S.W.2d at 263.

One difference between the Form F and the MCS-90 is that the minimum insurance requirement for intrastate motor carriers in Texas is $500,000, and not $750,000. 43 T.A.C. § 218.16(a) (2014). There is a dearth of Texas case law interpreting Form F because there are few exclusively intrastate motor carriers. *Progressive County Mut. Ins. Co. v. Carway,* 951 S.W.2d 108, 111-14 (Tex. App. – Houston [14th Dist.] 1999, pet. denied) ("driver" is not a "motor carrier" for purposes of Form F endorsement); *Nat'l. Cas. Co.*, 998 S.W.2d at 263 (insurer may obtain reimbursement from named insured for settlement paid pursuant to Form F endorsement); *Truck Ins. Exchange v. E. H. Martin, Inc.* 876 S.W.2d 200, 203 (Tex. App. – Waco 1994, writ denied) (insurer not required to meet cancellation requirements of Form F when insured is covered by a separate policy that meets minimum insurance requirements).

Yet another reason for the lack of case law on Form F is that most transportation activities meet the test for interstate commerce and thus require a MCS-90 endorsement. The test to determine whether a motor carrier is engaged in *inter*state commerce versus *intra*state commerce does not turn on what route the driver took but on what cargo the motor carrier was hauling. *See State of Tex. v. U.S.*, 866 F.2d 1546 (5th Cir. 1989); *Merchants Fast Motor Lines, Inc. v. I.C.C.,* 528 F.2d 1042, 1044 (5th Cir. 1976 ("It is elemental that a carrier is engaged in interstate commerce when transporting goods either originating in transit from beyond Texas or ultimately bound for destinations beyond Texas, even though the route of the particular carrier is wholly within one state. Traffic need not physically cross state lines . . ."). Under the Fifth Circuit's analysis, even if the motor carrier only transports goods one (1) block, if those goods are set for delivery out of state, the motor carrier is engaged in interstate commerce.

Coverage Disputes

Often the business auto policies that cover commercial motor vehicles contain several standard coverage exclusions that vary depending on the type of policy. Courts will disregard these exclusions if they preclude recovery by the injured party. *Adams v. Royal Indem. Co.*, 99 F.3d 964, 968-972 (10th Cir. 1996) (though the policy excluded coverage for unscheduled vehicles, Plaintiff could recover under the MCS-90); *Pierre,* 784 N.E.2d at 59-61 (failure of insureds to give insurer notice of suit did not relieve insurers duty to pay default judgment under MCS-90 endorsement); *Campbell v. Bartlett*, 975 F.2d 1569, 1580-81 (10th Cir. 1992) (insured's failure to cooperate does not negate insurers duty to indemnify under MCS-90); *Republic W. Ins. Co. v. Rockmore*, No. 3-02-CV-1569-K, 2005 U.S. Dist. LEXIS 327,

2005 WL 57284, at *10-11 (N.D. Tex. Jan. 10, 2005) (insurer that cancelled policy for failure to complete underwriting documents 32 days before occurrence must still provide coverage pursuant to the MCS-90 endorsement because federal law requires 35 days notice to cancel the policy).

An interesting illustration of the breadth of the application of the MCS-90 endorsement is contained in *John Deere Ins. Co. v. Nueva*. There, the driver and tractor owner were uninsured. But, the trailer owner, a separate motor carrier from the tractor owner, had an insurance policy that contained an MCS-90 endorsement. *John Deere Ins. Co. v. Nueva*, 229 F.3d 853, 854 (9th Cir. 2000). The Plaintiffs sought recovery from the trailer owner's policy pursuant to the MCS-90 endorsement of the trailer policy. *Id.* Though not expressly stated, there is no indication that the Plaintiffs in *Nueva* alleged that the trailer owner committed some negligent act. They merely argued its policy covered the occurrence. The District Court found that the MCS-90 did not come into play because it only created an obligation to indemnify the named insured (trailer owner), and not the driver or tractor owner. *Id.* On appeal, the Ninth Circuit found that a MCS-90 endorsement negated the entire portion of the policy which attempted to limit who is an "insured." *Nueva*, 229 F.3d at 859. The motor carrier who owned the tractor and its driver became "insureds" under the policy of the motor carrier who owned the trailer, via application of the MCS-90 endorsement, despite an exclusion in the policy. *Id*. at 860. The Plaintiff was not required to show an independent negligent act of the trailer owner to trigger the policy, but merely that the negligent motor carrier was a permissive user of the trailer. *Id.*

Exceptions to MCS-90 payment

There are some limited exceptions to coverage under a MCS-90 endorsement. The rule in Texas, simply stated, is: an insurer must indemnify a motor carrier specifically named in a MCS-90 endorsement for a judgment taken by an injured person against that motor carrier, regardless of the coverage defenses that may be available under the policy.

> It is one thing to hold that a motor carrier is absolutely liable–based on the Interstate Commerce Act–for injuries resulting from the negligent operation of vehicles leased to it, but it seems an unjustified and illogical leap to hold that an insurance company–whose sole obligation rests on contract–should be bound to pay a judgment for others who are not mentioned in the ICC insurance regulation [citation omitted], and who are specifically excluded by the language of the policy.

Carway, 951 S.W.2d at 114.

Thus, it is important to note that MCS-90 coverage is only invoked when a judgment is taken against the *motor carrier,* as opposed to the *driver*. *John Deere Ins. Co. v. Truckin' U.S.A.,* 122 F.3d 270 (5th Cir. 1997); *Carway,* 951 S.W.2d 108; *But see Nueva*, 229 F.3d 853 (distinguishing *Truckin' U.S.A.* as a dispute between insurers and holding that "motor carrier" includes permissive users who are not named insureds). It is more difficult to reconcile the analysis in *Nueva* and *Carway*, which unlike *Truckin' U.S.A.,* involved a dispute between the injured public and a motor carrier. The Ohio Supreme Court analyzed the competing views of whether the MCS-90 applies only to the motor carrier or named insureds. *Lynch v. Yob*, 768 N.E.2d 1158 (Ohio 2002). The Court followed *Nueva* finding that the public is best served when injured persons are "protected by insurance and ultimate responsibility rests on the truckers . . ." *Id.* at 1165.

Conversely, since *Nueva* and *Carway* were decided, the F.M.C.S.R. has weighed in specifically on this issue. The official interpretation to 49 C.F.R. § 387.15 states:

> ****Question 5*:** Does the term "insured" as used on Form MCS-90, Endorsement for Motor Carrier Policies of Insurance for Public Liability, or "Principal," as used in Form MCS-82, Motor Carrier Liability Surety Bond, mean the motor carrier named in the endorsement or surety bond?
>
> *Guidance:* Yes. Under 49 CFR 387.5, "insured and principal" is defined as "the motor carrier named in the policy of insurance, surety bond, endorsement, or notice of cancellation, and also the fiduciary of such motor carrier." Form MCS-90 and Form MCS-82 are not intended, and do not purport, to require a motor carrier's insurer or surety to satisfy a judgment against any party other than the carrier named in the endorsement or surety bond or its fiduciary.

49 C.F.R. § 387.15, Official Interpretations, Question 5 (J.J. Keller & Associates, November 2013); *see also* F.M.C.S.A. Regulatory Guidance, 70 FedF.R. 58065, 58066 (Oct. 5, 2005).

While arguments exist supporting both positions on whether a MCS-90 endorsement will satisfy a judgment against the motor carrier, in Texas, this issue appears resolved. Thus, Plaintiffs must pursue judgment against the motor carrier if they hope to avail themselves of the benefits of the MCS-90 endorsement.

Additionally, a MCS-90 endorsement provides coverage for the public, not for employees of the motor carrier. *Consumers County Mut. Ins. Co. v. P.W. & Sons Trucking, Inc.*, 307 F.3d 362, 366-67 (5th Cir. 2002) (co-driver asleep

in the sleeper's bunk was an employee under 390.5 and thus was not a member of the public).

Notwithstanding the Fifth Circuit's broad definition of interstate commerce in *State of Texas v. U.S.*, *supra*, other jurisdictions have found that if the load is intrastate, the MCS-90 endorsement does not apply. *See e.g., General Sec. Ins. Co. v. Barrentine,* 829 So.2d 980, 983-84 (Fla. 1st. DCA 2002). Therefore, an exclusion may exist for purely intrastate commerce.

Finally, an important exclusion exists when more than one policy covers a collision. In *Carolina Cas. Ins. Co. v. Yeates*, the Tenth Circuit was presented with a catastrophic collision where the motor carrier had two (2) different insurance policies. The first insurance policy specifically covered the vehicle operated by the motor carrier involved in the accident, and tendered its $750,000 policy in the matter. *Carolina Cas. Ins. Co. v. Yeates*, 584 F.3d 868, 871 (10th Cir. 2009) (en banc). The second policy (Carolina Casualty) was a "general liability policy" that contained a MCS-90 endorsement. *Id.* Carolina Casualty argued that because the injured party had already been compensated up to the statutory minimum coverage ($750,000), the public policy rationale for the MCS-90 had been satisfied and thus should not apply to the Carolina Casualty policy. *Id.* at 872. Previous to this case, the Tenth Circuit had held that when one or more policies that contained MCS-90 endorsements were available, the exclusions were disregarded and the allocation of liability among the insurance policies should be made according to controlling state law. *Id.* at 877. But in *Yeates,* the MCS-90 endorsement only applies when the underlying policy does not provide coverage *and* there are no other insurance policies providing coverage up to the minimum financial responsibility limits. *Id.* at 878. This decision is in harmony with the majority of circuits, including the Fifth Circuit. *See T.H.E. Ins. Co.*, 242 F.3d at 672 (the MCS-90 endorsement only applies when "other coverage is lacking.").

Because the Plaintiff had already recovered $750,000, the MCS-90 endorsement contained within the Carolina Casualty policy did not apply. *Yeates*, 584 F.3dat 886. Thus, one of the more important limitations to the MCS-90 endorsement is that it is not implicated in a case where the injured party receives payment up to the minimum insurance requirements by, or on behalf of, a motor carrier.

Additionally, in *Yeates,* the Tenth Circuit found that the MCS-90 endorsement does not create any priority or allocation among multiple insurers for the same loss. *Id.* at 878-79; *see also T.H.E. Ins. Co.*, 242 F.3d at 673. This is a critical point for insurers because it prevents a Plaintiff from first recovering from a MCS-90 endorsement where the policy does not otherwise provide coverage, and then pursuing a second policy, which does not contest coverage. The conclusion is clear. The MCS-90 endorsement ensures that a Plaintiff can receive up to $750,000, but cannot be used as a method to invalidate coverage exclusions to recover in excess of $750,000.

Practical Implications:

The MCS-90 poses unusual problems for the practitioner. For the Plaintiff, it is imperative that a judgment be taken against the motor carrier, not just the driver, to invoke the MCS-90 endorsement. That is the lesson of *Carway*: a judgment solely against the driver will not invoke the MCS-90 endorsement, and the insurance carrier will be able to avail itself of all defenses to coverage. The requirement to obtain a judgment against the motor carrier is not as onerous as it may seem. The MCS-90 was written with an eye towards the FMCSR. In those regulations, the term "employer" is defined as ". . . any person engaged in a business affecting interstate commerce who owns or leases a commercial motor vehicle in connection with that business, or assigns employees to operate it . . ." 49 C.F.R. § 390.5. And, the term "employee" is defined 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 motor vehicle (including an independent contractor while in the course of operating a commercial motor vehicle), a mechanic, and a freight handler . . ." *Id.* The employer/employee relationship is so broadly defined under the FMCSR that any permissive user of the vehicle is highly likely to be deemed an employee of the motor carrier. Therefore, a Plaintiff may take a judgment against a motor carrier pursuant to the common law doctrine of *respondeat superior* without regard to the actual employment relationship between the motor carrier and the driver (independent contractor, etc.) because, pursuant to the FMCSR, the driver is the statutory employee of the motor carrier.

Insurance adjusters may feel the insurer is insulated from negative consequences if a default judgment is taken against their insured. *See e.g., Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. Crocker,* 246 S.W.3d 603, 609 (Tex. 2008) (insurer not liable for default even though it had notice of suit because insured did not forward suit papers). However, within the MCS-90 context, it is likely that a Court would find that an insurer would be obligated to pay a default judgment against a motor carrier even if the motor carrier failed to request a defense or the insurer did not have notice of the suit. *See e.g., Pierre,* 784 N.E.2d 52. Where a default is taken against a motor carrier whose policy contains a MCS-90 endorsement, the insurer is likely left with two (2) options: (1) attacking the default judgment via traditional methods (*e.g.,* motion for new trial, restricted appeal or bill of review), or (2) paying the default judgment and seeking reimbursement for payments made by the insurer from the motor carrier. Neither option is particularly desirable for the insurer and differ from the rights and remedies an

insurer would have outside the MCS-90 context.

Conclusion

The overall lesson of the case law is that a judgment against a motor carrier is going to be paid by the insurer regardless of coverage provisions contained within the policy. Practitioners representing Plaintiffs should ensure that their pleadings and litigation strategy are geared towards a judgment against the motor carrier. Conversely, due to the effect of the MCS-90 endorsement, insurers should be vigilant in making sure motor carriers they insure do not allow a default judgment to be granted against them.

1 Exemplars of the forms discussed in this paper, including MCS-90, Form F, are available at www.texlawyers.com/forms

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RECENT FIFTH CIRCUIT AND TEXAS SUPREME COURT INSURANCE DECISIONS

Texas Supreme Court Upholds Vacancy Clause in Homeowners Policy Despite No Prejudice to Insurer, Arguably Creating What a Justice Calls "Illogical Uncertainty."

Greene v. Farmers Ins. Exch., 2014 Tex. LEXIS 757 (Tex. Aug. 29, 2014, Boyd and Willett JJ. concurring).

In his concurring opinion, Justice Boyd argues that the High Court has departed over the last thirty years from the certainty of condition-precedent doctrine by requiring insurers to prove prejudice or "materiality" for some conditions but not others. The majority holds that this case is distinguishable from five precedents raised by the insured, *Puckett, Hernandez, PAJ, Prodigy, and Lennar*, all requiring an insurer to show prejudice or causation before denying coverage.[1] Justices Boyd and Willett counter that these cases are indistinguishable and urge adoption of a middle ground between *stare decisis* and the certainty of old-fashioned contract principles by confining these precedents strictly to their facts.[2]

LaWayne Greene insured her residence under a state-approved Texas Homeowners-A Policy (form "HOA") that contained a standard "vacancy clause," providing that coverage will be suspended effective 60 days after the dwelling becomes vacant. During the policy period, the insured moved into a retirement community and notified Farmers of her intent to sell the property. More than 60 days after moving, but still during the policy period, a neighbor's house caught fire, damaging the insured's house. Farmers denied coverage, and this action ensued.[3]

The insured relied on both the Texas cases cited above and an "anti-technicality statute"[4] to argue that because her vacancy did not cause or contribute to the damage or otherwise prejudice the insurer's rights, which Farmers stipulated was true, the vacancy clause did not excuse Farmers from its coverage obligation. The trial court granted summary judgment for the insured. The court of appeals reversed, a ruling affirmed here by the Supreme Court.

The majority basically followed the reasoning of the appellate court by holding first that the "anti-technicality" statute in Section 862.054 applied only to an insured's breach of a warranty, condition, or provision in a policy, and Ms. Greene did not breach any of these when she vacated the premises. The Court stated:

> [T]he vacancy clause does not contain a promise by or obligation on behalf of Greene to occupy her house, thus her vacating the house was neither a breach nor a violation of the clause.[5]

The insured argued that her "triggering" the vacancy clause was sufficiently similar to violating or breaching a warranty or condition to fall within the statute. The Court disagreed.[6]

Second, the Court held that the clause did not require proof of prejudice due to the vacancy because, unlike in *Hernandez, PAJ, Prodigy, and Lennar,* Ms Greene did not breach a policy condition when she vacated the premises. Rather, the scope of coverage simply did not encompass a vacated dwelling beyond the 60 day extension of coverage afforded by the vacancy clause. In other words, reasoned the Court, the vacancy clause actually expanded coverage because the policy covered only an occupied dwelling, but the clause afforded an extra grace period of 60 days.[7]

In *Hernandez* and *Lennar*, the insured breached consent-to-settle provisions. Applying general contract-law principles in those cases, the Court held that the breaches were not material without some showing of actual prejudice to the insurer. *PAJ* and *Prodigy* involved notification requirements that had been breached, yet without prejudice to the insurers' defense duties.

> In all four cases we concluded either that the insurers received the benefit they expected from the contracts, or that the policy terms at issue were not a part of the bargained-for exchanges between insurers and insureds.[8]

Third, unlike in *Puckett*, the Court found that there was no public policy reason for requiring that the vacancy cause the loss, primarily because the HOA form was approved by the Texas Department of Insurance, to which the Legislature had expressly delegated authority to make decisions about provisions in that form.[9] Therefore, the Court affirmed holding of the court of appeals.

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Whatever the merits of the concurring justices' opinion and its proposed correction to fence-off the "flawed logic" of the deviant precedents by confining them to their facts, their points were made forcefully after a thorough discussion of the history of the High Court's treatment of conditions precedent. This remedy may seem to many to be either unnecessary or unsatisfactory. Indeed, the concurrence ends with a plea to the Legislature to weigh in on the future of the prejudice requirement.[10]

After Rehearing, Fifth Circuit Holds That An Express Warranty Does Not Trigger Assumed-Contract Exclusion, Expanding *Ewing*.

Crownover v. Mid-Continent Cas. Co., 2014 U.S. App. LEXIS 20737 (5th Cir. Oct. 29, 2014).[11]

In January 2014, the Texas Supreme Court issued its long-awaited *Ewing* decision, holding that insurance coverage for faulty-construction litigation was not excluded as an "assumption of liability in a contract," based simply upon an alleged breach of a contractor's implied warranty to perform work in a good and workmanship manner.[12] Interest in the *Ewing* case among both the insurers and building contractors was quite high. Had the case gone the other way, arguably, CGL insurers would likely have no obligation to cover most construction litigation, but builders, accordingly, would have little incentive to purchase the insurance in the first place. Now, the Fifth Circuit's *Crownover* decision arguably solidifies, or even broadens, *Ewing*, holding that an express warranty to repair also fails to trigger the assumed-contract exclusion.

The Crownovers hired a builder to construct their home. Soon after completion, cracks appeared in the walls and foundation, and other defects required replacement of the air conditioning system. The construction contract contained an express warranty to repair, which the Crownovers alleged in litigation that the builder breached after repair attempts failed. The builder then went bankrupt, which automatically stayed the lawsuit, but the bankruptcy judge lifted the stay to allow the Crownovers to purse the builder's CGL insurer for coverage in arbitration. The arbitrator held that the builder breached its express warranty. The Crownovers then sued Mid-Continent for coverage.

The insurer asserted that the homeowners' claim fell within certain policy exclusions, including liability that the insured assumes in a contract.[13] The lower court granted the insurer summary judgment based on the assumed-contract exclusion. This ruling, however, was issued before the Texas Supreme Court's *Ewing* decision. In its initial ruling, the *Crownover* appellate panel affirmed and distinguished *Ewing* based on the distinction between an implied warranty, which did not extend an insured's liability under common law, and an express warranty. However, after rehearing, the panel determined that the express warranty to repair did not extend liability beyond obligations to repair under general law.

The panel first held that the insureds met their burden of establishing coverage. The foundation cracks and air conditioning defects were the result of an occurrence that caused physical damage to the foundation and to the air conditioning units themselves. The burden shifted to the insurer to show that coverage was excluded. Regarding the assumed-contract exclusion, the panel followed the reasoning in *Ewing* that the exclusion applied only if the insured agreed in a contract to assume an extra duty that it would not have under general law principles. "The key question, therefore, becomes whether the source of adjudicated liability —the express duty to repair —expanded [the insured's] obligations. We hold that it did not."[14] Thus, the distinction between express and implied warranties is irrelevant because, held the *Crownover* panel, "general law provides a duty to repair."[15]

Because Mid-Continent had also asserted the business-risk exclusions, which the lower court did not address, the panel determined that it should consider those exclusions as well. The policy excluded damage to (1) the insured's "work"; and (2) that particular part of real property that the insured or any subcontractors worked on or any property that had to be restored, repaired or replaced because the insured's "work" was incorrectly performed on it. The panel found that neither exclusion applied. Damage to the insured's work is not excluded if the work is performed by a subcontractor, which it was. The second exclusion applied only to property damage that occurred while work was ongoing, which was not the case. Therefore, the panel reversed and remanded the case solely to calculate the insured's attorneys' fees.

Arguably, this decision restricts the *Gilbert* holding strictly to its "unique" facts.[16] Defective-workmanship cases almost always allege both tort and contract liability. Moreover, in those cases like *Crownover* and *Ewing* that claim only under the insured's contractual obligations, the allegations are usually "general" enough to avoid the contract exclusion. As in *Ewing*, the Fifth Circuit's initial decision drew a number of amici briefs. Insurers and builders will continue to watch.

Umbrella Liability Policies May be Written to Step In Even If the Underlying Limits Are Exhausted By Claims Not Covered By the Umbrella Policies.

Indemnity Ins. Co. of N. Am. v. W&T Offshore, Inc., 756 F.3d 347 (5th Cir. 2014).

This is one of those knotty cases that requires close and careful reading of multiple policy provisions to get the right answer. The trial court decided one way. The Fifth Circuit delved a little deeper into the policy language and reversed. As this goes to press, the parties are still fighting. Simply stated, do four umbrella/excess liability insurers have to pick up coverage for various hurricane losses and liabilities when the underlying policy limits have been exhausted, but the umbrella policies do not cover and did not pay the same risks as covered by the underlying policies? The underlying policies paid first-party losses for Ike-related property damage and debris cleanup. The umbrella policies cover only third-party liability. If you

think the answer is easy, think again.

W&T purchased multiple layers of insurance that cover hurricane risks. For simplicity, there are two layered groups: (1) the first layer consists of a primary general liability policy and five energy package policies that cover various first-party losses; and (2) four umbrella policies that cover in ascending order only W&T's legal liability.[17] However, by endorsement, all the umbrella polices also cover debris removal. In 2008, Hurricane Ike damaged over 150 offshore platforms owned in part by W&T.

The energy package policies were expected to exhaust their limits by payment of W&T's operators' extra expense and property damage to the platforms, losses not covered by the umbrella policies. Because the adjuster notified the umbrella insurers that W&T would be submitting to them some $50 million of debris removal, the insurers brought a declaratory judgment action challenging their obligation to pay, arguing that the umbrella policies take effect only if the primary insurance is exhausted by claims that would be covered by the umbrella policies.

The district court granted summary judgment to the umbrella insurers, relying in part on *Westchester Fire Ins. Co. v. Stewart & Stevenson Serv., Inc.*[18] However, the Fifth Circuit panel distinguished *Westchester* based on differing policy language. The umbrella policies cover "those sums in excess of the Retained limit" that the insured becomes liable to pay and that are covered under the umbrella policy.[19] Because debris removal is explicitly covered, the pertinent issue is whether the sums are in excess of the "Retained Limit," which is defined as the greater of (1) the amount of underlying insurance or (2) the amount of the SIR that is not covered by the underlying insurance. At this point the panel notes:

> Nothing in the text of the Coverage provision or the definition of the Retained Limit specifies how the "[limits] of the underlying policies" must be reached or states that the Retained Limit refers exclusively to sums covered by the Umbrella Policy.[20]

The insurers nonetheless relied on a different provision in the policy that they argue required the Retained Limit to be paid for claims also covered by the umbrella policies. This section stated:

> If the applicable limits of insurance of the [underlying policies] . . . are reduced or exhausted by payment of one or more claims *that would be insured by our Policy* we will:
>
> 1. In the event of reduction, pay in excess of the reduced underlying limits of insurance; or
> 2. In the event of exhaustion of the underlying limits, continue in force as underlying insurance.[21]

The panel rejected the insurers' argument. The quoted language that the insurers rely on does not, holds the panel, require that the Retained Limit be paid toward claims covered by the umbrella policies, rather it states what happens if it is so paid.[22]

Moreover, the panel looked at other provisions of the umbrella policies, indicating that the there are enhanced duties if the underlying payments are also covered by the umbrella policies, not least of which is that the umbrella insurers agree to step in and defend as well as indemnify.[23] The policies are complicated, but the panel summarized that umbrella coverage may result in four ways:

> First, if the Retained Limit is met, Underwriters pay sums for covered damages in excess to that limit. Second, if the underlying policies are reduced by claims covered under the policy, Underwriters pay sums ~~n~~not in excess of the Retained Limit ~~b~~but in excess of the reduced limit of the underlying policies. Third, if the underlying policies are exhausted by covered claims, Underwriters act as the underlying insurers and are obligated to defend against covered claims. And finally, if Underwriters provide the only coverage, they again must act as the underlying insurers and defend against covered claims.[24]

The lesson here is that coverage issues, unfortunately, are rarely determined by bright-line rules or doctrine, such as, "excess insurers never cover unless underlying polices are first exhausted by payment of covered claims." The specific terms of the policies must govern. Moreover, considering the structure of W&T's insurance program as a whole, if the umbrella policies cover only legal liability, yet they overlie both liability and first-party policies, it is reasonable that the excess/umbrella coverage should be written to take effect should the Retained Limit be exhausted only by the first-party policies.

"And" Can Mean "Or" If the Context Requires, Holds the Fifth Circuit.

Trammel Crow Residential Co. v. American Protection Ins. Co., 2014 U.S. App. LEXIS 12785 (5th Cir. July 7, 2014).

The two issues in this rather unusual case are: (1) whether the conjunction "and" may be used disjunctively to mean "or" (and if so, does that render the phrase in question ambiguous, and if so, must the phrase be interpreted in favor of the insured); and (2) whether the insured is collaterally estopped from asserting that the policy deductible has been met. The Fifth Circuit holds that "and" can mean "or" when the context requires, and Trammel Crow is not estopped from showing that it met the deductible because the deductible issue at stake in an earlier action was not identical to the one involved in this action.

The background is somewhat complex. The insured, Trammel Crow, was sued by residents for mold problems.

Several insurers covered Trammel, including American Protection ("APIC"), but apparently none stepped up to the plate to defend the insured. So Trammel Crow sued one of them, Virginia Surety, who filed a third-party action for contribution against APIC. The panel refers to this coverage suit as the "Insurance Litigation."[25] APIC was found to have no duty to defend the insured and was dismissed from the Insurance Litigation. The mold litigation was eventually settled. APIC then billed the insured for the costs APIC incurred in the Insurance Litigation, and the insured filed this action, called the "Current Litigation," seeking return of what was paid to APIC.[26]

Under the policy, APIC is entitled to recover "claim expenses" below a $250,000 deductible. "Claim expense" is defined as:

> [a]ll reasonable expenses incurred by the insured *and* by us in . . . investigating, defending and settling any coverage dispute under this policy.[27]

The insured did not contest that the Insurance Litigation was a "coverage dispute," but it did assert that APIC's costs in defending that action did not constitute "claims expenses," which by definition had to be incurred by both the insured and APIC, not one or the other. Trammel Crow did not incur any part of APIC's costs defending the Insurance Litigation. Alternatively, the insured argued that it had met the deductible and, therefore, would not liable to reimburse even legitimate claims expenses. The district court held that APIC was entitled to reimbursement of its defense expenses up to the amount of the deductible, and the insured was barred under the doctrine of collateral estoppel from arguing that the deductible had been met.

On appeal, the panel held that the word "and" was ambiguous because the term is primarily used conjunctively, but courts applying Texas law had often interpreted "and" as disjunctive, meaning "or," when the context requires.[28] For example, in *Aerospatiale Helicopter Corp. v. Universal Health Serv., Inc*., the helicopter lessee agreed to indemnify the manufacture against claims arising from (1) the use of the helicopter by lessee *and* (2) the installation or removal of any part of the equipment.[29] The lessee refused to indemnify the manufacturer against claims resulting from a fatal crash while lessee was operating the helicopter, arguing that both its use of craft and a change of equipment parts were necessary conditions to indemnity.

The Texas appellate court rejected this argument on a "common sense" reading of the agreement.[30] Accordingly, the *Trammel Crow* panel found that certain provisions of the policy would be rendered meaningless if both APIC and the insured had to incur an expense before it could be recovered.[31] Therefore, APIC could recover its defense expenses within the deductible. However, the panel reversed and remanded the case on the issue of collateral estoppel.[32] The Insurance Litigation had established that the deductible was not exhausted, but subsequent to that finding, the insured had paid additional damages and claims expense. Therefore, the panel held that the issue in the Current Litigation was not the same as in the Insurance Litigation, and collateral estoppel did not apply.

Could this grammatical (and legal) dispute have been avoided with more careful drafting? Certainly the policy could have said, "incurred by the insured *or* by us," but in the right context, someone might object, if both parties incurred expenses, that the "or" was to be understood as exclusively disjunctive (i.e., "incurred by the insured or us but not both"). Nor would the nimble "and/or" appeal to many careful writers.[33] Perhaps the simplest solution would be, "incurred by the insured or us, or both."

Tort Claimant May Seek Recovery of Insurance Proceeds Directly From Insurer in a Compulsory Counterclaim.

National Liab. & Fire Ins. Co. v. R&R Marine, Inc., 756 F.3d 825 (5th Cir. 2014).

This decision marches through some of the strictures of marine insurance, a conflict between state law and the Federal Rules, and the Court's Erie-guess that, under Texas law, a tort claimant can recover attorneys' fees as a potential third-party beneficiary from a liability insurer. Hornbeck Offshore Services, L.L.C. brought its vessel to R&R's shipyard for repairs. On September 12, 2007, Tropical Storm Humberto gathered force and, despite a hurricane warning, R&R's employees left the shipyard without taking any precautions to secure property in R&R's custody. By the next morning, the ship had sunk. Hornbeck hired a salvage company to raise the vessel, electing a cheaper (but unlimited) time-and-material bid, which turned out costing twice as much as the fixed price it could have paid. Hornbeck demanded that R&R pay damages. National, R&R's marine insurer, filed a declaratory judgment action against both R&R and Hornbeck, seeking a determination of no liability for coverage. Hornbeck counterclaimed against National and filed a cross-claim against R&R. The district court held, and the Fifth Circuit affirmed, that R&R was liable for negligence, and National's policy covered the damage and Hornbeck's attorneys' fees.

Addressing R&R's negligence first, the lower court found that Hornbeck's delivery of the vessel afloat to R&R and R&R's full custody created a bailment and thus a presumption of negligence that R&R had the burden to rebut.[34] R&R countered that only a limited bailment was created because Hornbeck's agents had unlimited access to the vessel while in the shipyard. Also, R&R argued that a bailee was not liable for force majeure events, such as hurricanes.[35]

However, the stubborn facts of the case were against R&R. Its employees had moored the vessel, were aware of the deteriorating weather conditions, and had reassured Hornbeck's agents that measures would be taken to secure the vessel during the storm. Full custody was thus established.[36] Moreover, the lower court reasonably found that the weather did not rise to the level of a force majeure

because the sustained winds never reached hurricane force. R&R could have and should have handled it.[37] Therefore, R&R was liable.

Next to bat, National challenged coverage primarily on grounds that Hornbeck was not an insured under the policy and so had no standing to assert a counterclaim for insurance proceeds. It should have waited until it had a final judgment against R&R. The panel acknowledged that Texas was not a direct action state, and a tort claimant could not sue a liability insurer until the insured-tortfeasor was adjudged liable to the claimant.[38]

Hornbeck countered, however, that when National joined it in the coverage lawsuit in federal court, its counterclaim for insurance was "compulsory" under Federal Rule 13(a), "forcing" it to bring the coverage counterclaim. The reviewing Court observed that, if a direct collision exists, "we must apply the Federal Rule as long as it does not violate either the Constitution or the Rules Enabling Act."[39] Applying the "logical relation test" under Rule 13, the Court held that the counterclaim was compulsory, neither the Constitution nor the Rules Enabling Act applied, and Hornbeck had standing when it filed its counterclaim.[40]

National then challenged the damages award on three grounds: (1) the salvage was above the policy limit; (2) the 18% interest rate was not allowed under the Texas Insurance Code; and (3) Hornbeck was not entitled to recover attorneys' fees under the Texas Civil Practice & Remedies Code. The panel agreed with National on the first two points. National was responsible only for its $1 million policy limit.[41] Also, the 18% delay penalty under Section 542 of the Insurance Code was explicitly excepted for a marine insurance policy.[42] However, the attorneys' fee analysis was a little more difficult.

Although the panel found that attorneys' fees are recoverable under the Civil Practice & Remedies Code against an admitted carrier such as National,[43] Hornbeck's right to recovery as a tort claimant, not a party to the insurance contract, was not so clear. The parties apparently failed to cite a Texas decision squarely addressing the issue.[44] One Texas court had held in *dicta* and without reliable authority that a party injured by an insured is considered a third-party beneficiary of the liability insurance policy.[45] Nevertheless, the panel found a workers' compensation case in which the carrier was permitted to recover settlement benefits from the covered employee's widow through subrogation, but the widow was permitted to recover her attorneys' fees incurred against the tortfeasor.[46] Based on the *Iscay* case, the panel made an Erie-guess that Texas law permitted Hornbeck's recovery of attorneys' fees.

Although Horneck's recovery of its attorneys' fees does follow the *Iscay* case (because neither claimant was in privity with the insurer), the panel does not explain how the recovery is properly characterized as one for breach of contract, the remedy provided under Section 38.001 of the Civil Practice & Remedies Code. That may be a question for the Texas courts to sort out.

After "Assumed-Contract" Attack Failed, Insurer Prevailed on "Business Risk" Exclusions To Bar Coverage for Defective Engine Repairs.

Blanton v. Continental Ins. Co., 565 Fed. Appx. 330 (5th Cir. 2014).

Having determined that this defective repair case did not entail an excluded "assumption of liability" under *Ewing Contr. Co. v. Amerisure Ins. Co.*,[47] the Fifth Circuit panel here denied coverage under other so-called "business-risk" exclusions in two liability policies. Field Service Industries ("FSI"), owned by sole-proprietor Misty Blanton, installed and later repaired two engines in a vessel owned by J.A.M. Marine Services. J.A.M. sued FSI for defective work and loss of use of the vessel. FSI, in turn, sought defense and indemnification from Continental under both commercial general liability and "Ship Repairer's Liability" ("SLR") coverage. Continental denied coverage.

Continental asserted that J.A.M alleged: (1) loss of use of the vessel due to negligent installation; (2) loss of use of the vessel due to negligent repairs and diagnohstics; (3) damage to the engines due to negligent installation; and (4) damage to the engines due to negligent repairs and diagnostics. Each of these, asserted Continental, falls within one or more of the policies' exclusions to the insured's own work or products or "impaired property." The panel agreed.

First Exclusion "m" in the CGL policy excluded property damage (including loss of use) to:

> "impaired property,"[48] or property that has not been physically injured, arising out of: . . . a defect, deficiency, inadequacy or dangerous condition in 'your product' or 'your work'… .

But this exclusion does not apply to loss of use of other property arising out of "sudden and accidental physical injury to 'your product' or 'your work' after it has been put to its intended use." The panel found that, even construing the provision liberally in favor of coverage, the damage to the engines was not sudden and accidental, and the exclusion applied.[49]

Moreover, the SLR policy contained an exclusion (e) for "demurrage, loss of time, loss of freight, . . . and/or similar . . . expenses." FSI argued that exclusion (e) failed to list "loss of use damages" or "property damage," and so did not apply.[50] The Court disagreed, holding that the alleged loss of use of the vessel fell within the definition of "demurrage."[51] Other exclusions in the SLR policy, similar to those in the CGL policy, also applied to the faulty installation claim.

As seen in many cases of this sort, the challenge to the insured is to show an allegation of physical damage to some part of the property, in this case a vessel, that was not part of the insured's "work" or "products." The underlying allegations,

however, were only of loss of use of the vessel and subpar engine performance.

1 Puckett v. U.S. Fire Ins. Co., 678 S.W.2d 936, 937 (Tex. 1984) (requiring as a matter of public policy that insurer show that lack of airworthiness certificate, a condition of coverage, contributed to the accident); Hernandez v. Gulf Group Lloyds, 875 S.W.2d 691, 694 (Tex. 1994) (insured's breach of consent-to-settle condition in UM portion of auto policy must be material); PAJ, Inc. v. Hanover Ins. Co., 243 S.W.3d 630, 636-37 (Tex. 2008) (untimely notice under CGL policy does not permit denial of coverage absent proof of prejudice); Prodigy Commc'ns Corp. v. Agricultural Excess & Surplus Ins. Co., 288 S.W.3d 374, 382 (Tex. 2009) (untimely notice within policy period under claims-made policy does not justify denial of coverage absent proof of prejudice); Lennar Corp. v. Markel Am. Ins. Co., 413 S.W.3d 750, 755 (Tex. 2013) (insured's breach of consent-to-settle condition in CGL policy must be material to justify denial).

2 *Greene*, 2014 Tex. LEXIS 757 at *27 (Boyd J. concurring) ("While illogical certainty is admittedly undesirable, it is at least better than the illogical uncertainty that will result from the Court's decision in this case.")

3 Suit was brought on behalf of the insured, LaWayne Greene, by Bob Greene as her next friend. *Id.* at *2.

4 Texas Ins. Code Ann. §862.054 (Vernon 2009) (providing that a breach or violation of a policy provision that does not cause the loss does not void the policy or the claim).

5 *Greene*, 2014 Tex. LEXIS 757 at *8.

6 *Id.* at *13.

7 *Id.* at **8 and 17-18.

8 *Id.* at *16.

9 *Id.* at *19. Also, the insured could have purchased an endorsement extending vacancy coverage indefinitely. *Id.* at *20.

10 *Id.* at *65.

11 This opinion grants appellants' motion for rehearing and vacates its earlier decision in Crownover v. Mid-Continent Cas. Co., 757 F.3d 200 (5th Cir. 2014).

12 Ewing Constr. Co. v. Amerisure Ins. Co., 420 S.W.3d 30 (Tex. 2014). *Ewing* distinguished the earlier Supreme Court decision, Gilbert Texas Constr., L.P. v. Underwriters at Lloyd's London, 327 S.W.3d 118 (Tex. 2010), holding that the assumed-contract exclusion was not restricted to the liability of another assumed in an indemnity agreement and so applied to any liability that an insured expressly assumed beyond those burdens imposed by common law.

13 The insurer also asserted the usual business-risk exclusions for damage to or restoration of "your work."

14 *Crownover*, 2014 U.S. App. LEXIS 20737 at *25.

15 *Id.* at *27.

16 *See Id.* at 33 ("Gilbert was a unique case because governmental immunity foreclosed all relief except relief sounding in contract … [and] Gilbert's contractual obligation that triggered the liability exclusion was its obligation to repair or pay for damage of property of 'third parties'.")

17 The primary policies overlay a $10 million self-insured retention ("SIR").

18 Westchester Fire Ins. Co. v. Stewart & Stevenson Serv., Inc., 31 S.W.3d 654, 659 (Tex. App.—Houston [1st Dist.] 2000, pet. denied) (holding that an excess insurer had no duty to provide coverage if the underlying policy is exhausted by claims not covered by the excess policy).

19 *W&T Offshore*, 756 F.3d at 352.

20 *Id.* at 353. For purposes of this decision, the four umbrella policies are treated as substantively identical and so are sometimes referred to in the singular.

21 *Id.* at 351 [Emphasis added].

22 *Id.* at 352 n. 1.

23 *Id.* at 354.

24 *Id.* at 355.

25 *Trammel Crow*, 2014 U.S. App. LEXIS 12785 at *3.

26 *Id.* at *4. Apparently Trammel Crow maintained an account managed by a third-party administrator to pay its various insurers for what must be assumed to be considerable ongoing litigation.

27 *Id.* at *5 [Emphasis added].

28 *Id.* at *10-11 (citing In re Velazquez, 660 F.3d 893, 895-96 (5th Cir. 2011) (holding that the word "and" in a deed of trust meant both "and" and "or.") and Board of Ins. Comm'rs of Texas v. Guardian Life Ins. Co., 180 S.W.2d 906, 908 (Tex. 1944) (holding that "and" is sometimes construed to mean "or" when the context clearly indicates)).

29 *Id.* at *15-16 (citing Aerospatiale Helicopter Corp. v. Universal Health Serv., Inc., 778 S.W.2d 492, 502 (Tex. App.—Dallas 1989, pet. denied)).

30 *Id.*at *16 (noting that even though indemnity agreements should be construed against the indemnitee, terms and phrases nonetheless are to be read in a common sense manner).

31 *Id.* at *20-22 (finding the provision ambiguous but in light of all provisions of the policy, must mean either party may incur the expense).

32 *Id.* at *27.

33 *See, e.g.*, *Chicago Manual of Style*, Rule 5.220 at 266 (16th ed. University of Chicago Press 2010) ("Avoid this Janus-faced term") and William Strunk Jr. & EB White, *Elements of Style,* at 40 (4th ed. New York: Longman, 1999) ("A device or shortcut that damages a sentence and often leads to confusion or ambiguity").

34 *R&R Marine*, 756 F.3d at 830.

35 *Id.* at 831.

36 *Id.* at 832.

37 *Id.* R&R also challenged Hornbeck's election of the more expensive time-and-material salvage contract, but under the clear error standard of review, the Fifth Circuit upheld the lower court's finding that Hornbeck's choice was not unreasonable. *Id.* at 833.

38 *Id.* at 834 (observing that Texas courts have considered this a rule of standing and determine if a final liability judgment existed at the time a claim is filed, citing Owens v. Allstate Ins. Co.. 996 S.W.2d 207, 208-09 (Tex. App.—Dallas 1998, pet. denied)).

39 *Id.*at 835.

40 *Id.* at 835-36.

41 *Id.* at 836.

42 *Id.* at 837 (citing Tex. Ins. Code Ann. §542.053 (5) (Vernon 2009).

43 *Id.* (citing Tex. Civ. Prac. & Rem. Code §38.001 (Vernon 2008)).

44 *Id.*

45 *Id.* at 838, n. 55 (citing Rust v. Texas Farmers Ins. Co., 341 S.W.3d 541, 547 (Tex. App.—El Paso 2011, pet. denied)).

46 *Id.* at 838, n. 58 (citing Iscay v. Twin City Fire Ins. Co., 718 S.W.2d 885, 888 (Tex. App.—Austin 1986, writ ref'd n.r.e.)).

47 Ewing Contr. Co. v. Amerisure Ins. Co., 420 S.W.3d 30, 36 (Tex. 2014) (holding that an express agree to perform in a good and workmanship manner was not an "assumption of liability" within the meaning of the contractual liability exclusion).

48 *Blanton*, 565 Fed. Appx. at 335 ("Impaired property "is defined as "tangible property, other that 'your product' or 'your work' that cannot be used or is less useful because . . . it incorporates 'your products' or 'your work' that is known to be defective, deficient, inadequate or dangerous.")

49 *Id.*

50 *Id.* at 336.

51 *Id.* at 337 (citing The Conqueror, 166 U.S. 110, 125 (1897)).

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