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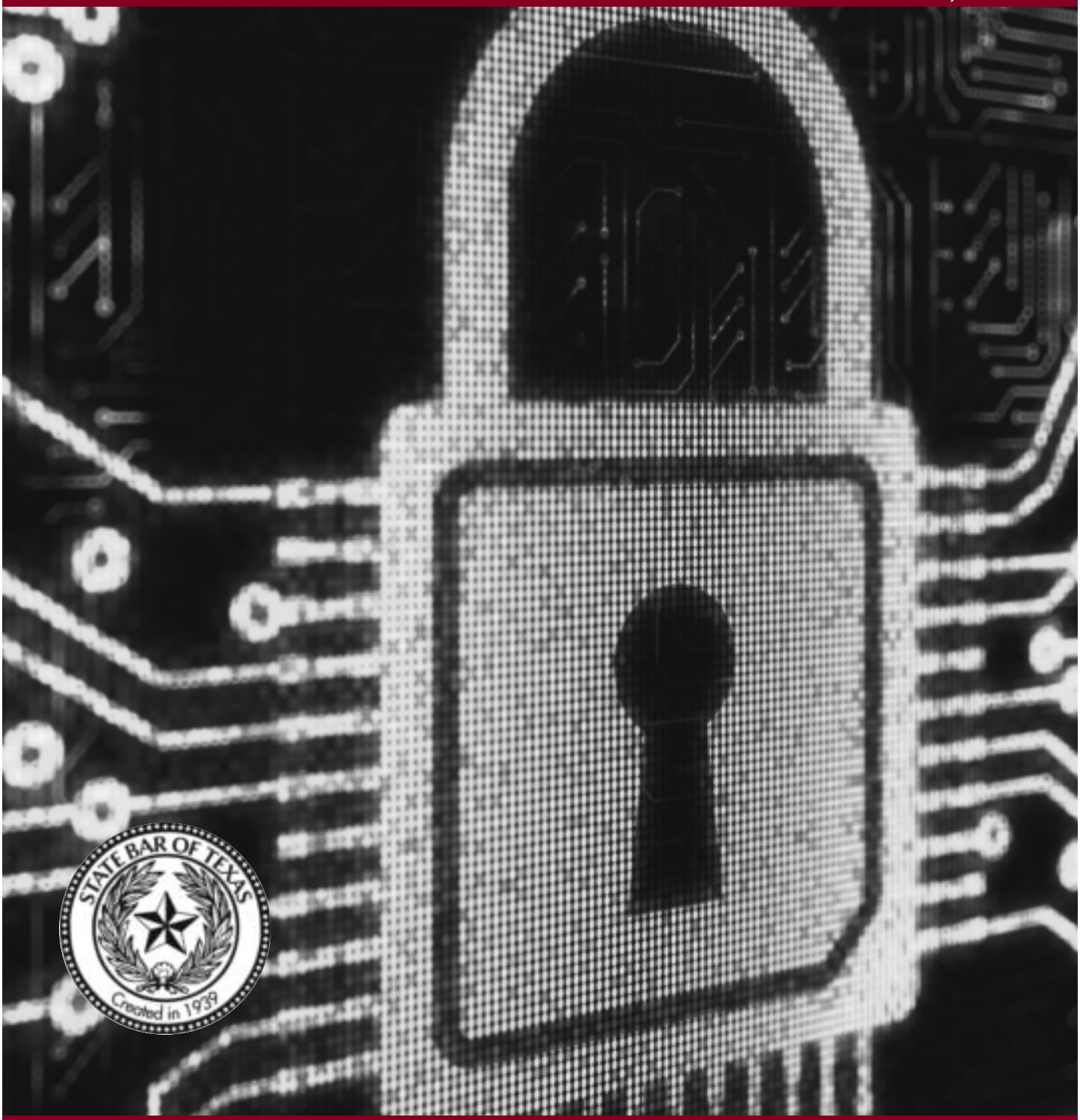

Official publication of the Insurance Law Section of the State Bar of Texas

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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 a trilogy of articles on "cyber-insurance," i.e., the types of insurance now available to protect individuals and businesses from the risks of mishap in the use of artificial intelligence and internet communications. Jes Alexander's article explains the nature of these risks and how they often occur. This is followed by part two of Michael Quinn's dissertation on the theory and structure of policies that protect insureds from losses arising from hacking and other cyber-dangers. And then Micah Skidmore gives us practical guidance on how to negotiate for this coverage and how to litigate disputes arising under it.

Shelley Glazer and David White continue their valuable column on recent Fifth Circuit and Texas Supreme Court insurance opinions, and in this issue you will also find the 2014 annual survey of Texas insurance opinions from Mark Kincaid, Suzzette Selden, and Elizabeth von Kreisler.

Please pay particular interest to this month's "Comments from the Chair" by Chair Mark Ticer explaining how you can become a member of the Insurance Law Section's governing council. The council is now receiving nominations for available positions.

In any event, we would like to see more of all of you, whether at meetings, seminars, in print, or as officeholders or members of the council. 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, to Jennifer Johnson, to my Assistant Editor Pam Hopper, and to Associate Editors Rebecca DiMasi and Candace Ourso, 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 master's degrees in Theology and Political Science, and was recently awarded a Ph.D. in History by 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

Your Insurance Section is operated and governed by the Insurance Council ("Council"). The Council consists of the Chair, Chair Elect, Secretary, Publications Editor, Technology Officer and Treasurer (all elected by the Council itself) and fourteen (14) at-large members. The at-large members in the past have been selected from those who have expressed an interest in joining the Council and who are then approved by the Section at its annual meeting. Terms for at-large members are for two (2) years.

This year, we are initiating a formal process for those interested in being members of the Council. Specifically, anyone, including those seeking reappointment to the Council, must fill out a short one (1) page form that will be made available on the Section's website, in an email blast sent to Section members, included in this edition of our Journal, and also sent through the Section's weekly, Right Off The Press.

Our main purpose of this short application process is to directly and broadly reach out to our Section members and seek their participation. Anyone wanting to become or stay a Council member will be required to complete the form. If a person does not fill out this short form, they will not be considered. Deadline for submission is March 30, 2015.

Once the application deadline has passed, the Council's Nominating Committee will review the applications and make recommendations on who should be considered by the Council. The Council will in turn decide on whom to recommend for appointment to the Section at its annual meeting. The Section will decide and vote on who should be chosen for Council membership.

For those that want to have hands-on involvement with their Section, this process provides an opportunity to participate and contribute. The Council, by using this process, is aggressively and actively seeking participation from anyone who has a desire to serve.

As Chair, I hope you will seize this opportunity to share your talents and efforts with this—your Section.

Best,
Mark A. Ticer
Chair, Insurance Law Section

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INSURANCE SECTION OF THE STATE BAR OF TEXAS
Application for Position on Council of the Section – Term Expiring 2017

Minimum criteria:

1. Have practiced law for 5 years.
2. Have been in the Section for 2 years.
3. Devote at least 30% of practice to insurance matters or have otherwise demonstrated a significant commitment to the practice area.
4. Can commit to four or five in person Council meetings and phone conferences a year.

Considerations, but not requirements:

1. Have demonstrated a willingness to make the time commitment involved by other similar type involvements, in the section or otherwise.
2. Have demonstrated leadership in other similar activities, in the section or otherwise. Consideration may also be given to the applicant having shown interest by applying in the past.
3. Contributes to the diversity of the council, as to practice area (policy holder v. carrier practice), regional diversity, in addition to the traditional diversity considerations.
4. It is preferred that no more than one member of a firm be on the council at the same time.

Name _____ Law Firm or Company Name: _____

Address _____ Phone _____

_____ E-Mail _____

Do You Meet the Minimum Criteria Listed, Above? _____

Describe How In The Past You Have Demonstrated A Willingness To Make The Necessary Time Commitments Involved To Productively Serve In The Section Or Other Extracurricular Commitments. _____

_____

_____

Describe How You Have Demonstrated Leadership In The Section Or Other Activities.

_____

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_____

Why Are You Applying For A Position On The Council And How Do You Plan To Serve?

_____

_____

_____

Is There Anything Else You Think The Nomination Committee Should Consider About Your Application?

_____

_____

Deadline for Submission: March 30, 2015. Send to: Stephen E. Walraven, swalraven@langleybanack.com

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12th Annual Advanced Insurance Law Course

San Antonio – June 11-12, 2015

Hilton San Antonio Hill Country Resort

14 hours / 2 ethics

Highlights:

The New Restatement of the Law of Liability Insurance presented by ALI associate reporter Kyle Logue

Discovery in Insurance Cases with Paul Gold

A Review of the Recent Supreme Court Opinion in BP-Deepwater Horizon

And Supreme Court Insurance Update with Justice Paul Green

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By Jes Alexander

Dickey's Barbecue Restaurants, Inc.

ANATOMY OF A DATA BREACH— WHAT CYBER POLICIES SHOULD COVER

In the early eighties, Hollywood depicted hackers as benevolent characters that allowed curiosity to get the better of them. For example, in WarGames, a curious teenager played by a young Matthew Broderick unwittingly stumbled into a military supercomputer and almost triggered a nuclear war with the former U.S.S.R. At the time, the notion of a hacker doing that much harm was laughable to security experts and hackers alike.

Nobody laughs anymore about the exploits of these cyber black hats intending to steal information and to disrupt a company's operations. Upon opening a newspaper on virtually any day of the week, you will be bombarded with horror stories of yet another company falling victim to a cyber security data breach. Most often, these stories are accompanied by a headline of "largest and most costly data breach ever."

What is responsible for this trend? Combined with steadily falling costs to store and process data, businesses of all stripes realize that information is an invaluable resource. Now, more digital information is collected and stored by companies than ever before. As a result, strict information control is vital to any company's ability to protect trade secrets and store confidential customer, client and payment information. Undoubtedly, we are living and working in the Information Age.

But properly securing a company is like trying to plug a dam with thousands of holes. With so many potential vulnerabilitie—hardware, software, and human error—perfection is a nearly impossible goal even for the largest and most sophisticated companies. As recent data breaches illustrate, attackers need only find a small vulnerability to infiltrate a company's system and wreak havoc.

Digital pirates possess great power to terrorize a company on many different fronts: blackmail a small business by holding its computer system hostage, post employees' confidential information on websites, steal payment information, and espionage. Unfortunately, these digital thieves turned away from Spider Man's sage advice, "With great power, comes great responsibility."

As data breaches affect businesses with increasingly greater cost and consequences, the need for cyber liability insurance becomes crucial. Very little coverage under a standard commercial general liability ("CGL") policy exists for liabilities resulting from data breaches, as demonstrated by new decisions from courts and the introduction of restrictive data liability endorsements.[1] Those companies that rely solely upon CGL or other general policies do so at great peril.

Unfortunately, the procurement of cyber insurance presents two significant problems:

1. Massive data breaches are a relatively new phenomena. As a result, case law is scarce and courts are currently struggling to define the parameters of liability faced by a breached company. The current trend is to allow increasingly creative claims to be filed against a company after a data breach; and

2. The cyber insurance market is relatively new, and no standard policy form exists. Thus, the risks covered under cyber liability policies often vary amongst insurers.

To properly address these concerns, coverage afforded under a manuscript cyber policy must be compared to the individual risks faced by a particular company.

Although the risks encountered from company to company will vary, recent data breaches involving Target, Sony and healthcare companies illustrate many of the risks shared by all companies, regardless of size. Likewise, these three digital canaries in the coal mine highlight some of the major areas that a cyber policy should address.

A. An Easy Target—Why Companies Accepting Payment Cards Are Major Targets.

What do retailers like Target, Michaels, Neiman Marcus, and Staples have in common with restaurants like P.F. Chang's and Jimmy John's? No, they are not hoping to create

The author of this paper, Jes Alexander, is deputy general counsel at Dickey's Barbecue Restaurants, Inc. Prior to joining Dickey's, Mr. Alexander spent nearly a decade successfully handling high-profile insurance coverage cases and civil appeals. The author would like to give a special thanks to Jamie Strickler for her invaluable help in editing this paper. She has lived up to her nickname of the "Sticklerrr." The views reflected in this article are not necessarily the views of the author's organization.

the newest taste sensation with a General Tso's chicken sandwich. Instead, each of these retailers recently suffered massive payment card breaches.

These breaches create a virtual goldmine for thieves, a trove of payment information. Using stolen payment-card information, thieves can quickly make fraudulent charges. Payment-card thieves are creative when earning an ill-gotten buck, and underground markets exist to buy and sell stolen payment-card data.

Theft of customer information, including names and addresses, may be equally valuable to some digital pirates. Customer information can be used to commit identity theft and forgery. Moreover, the wholesale theft of customers' email addresses allows thieves to create highly convincing phony emails designed to obtain sensitive personal information, such as an email that appears to be sent from your own bank.

The trend of data breaches began in earnest when T.J. Maxx was breached in 2005. At least 45 million credit and debit card numbers were stolen during an 18-month period.[2] The breach resulted from an intrusion into the company's wireless network through a relatively insecure form of encryption.[3] The breach resulted in a loss of about a quarter of a billion dollars. At the time, this was the largest retail data breach.

Even ignominious records are meant to be broken. The 2013 Target data breach compromised 40 million credit card numbers in about three weeks, and the information of over 70 million customers.[4] The source? Thieves stole the network password from a third-party HVAC subcontractor working at a few Target locations.[5] The three-week breach resulted in losses exceeding $148 million, and costs continue to rise.[6]

In 2014, The Home Depot also fell victim to a data breach that exposed 56 million credit card accounts and 53 million customer email addresses.[7] The digital thieves breached The Home Depot's security in the same manner as Target's — by targeting a small outside vendor in possession of The Home Depot's network passwords.[8] Although final figures will not be known for some time, The Home Depot lost approximately $43 million in one fiscal quarter.[9]

While data breaches involving massive retailers grab all the headlines, smaller companies are increasingly targeted because they have less sophisticated security safeguards. Most small businesses do not have an in-house security team or the resources to hire an outside vendor. For example, Mel's Diner in Louisiana used weak password protection in its network that resulted in the theft of nearly 700 credit cards.[10] The cost to Mel's was over $50,000, a sum that would likely bankrupt a small business without proper cyber liability insurance.

Additionally, these data breaches are not limited to traditional retail stores like Target or small mom-and-pop restaurants. Any company that accepts payments via credit card or that digitally stores client data, such as law firms, is a target. Thus, the universe of companies at risk for encountering a data breach is vast.

What accounts for these eye-popping losses after a breach? A portion is a loss in sales due to erosion of customer goodwill, like Target suffered during the holiday season. But the lion's share of these huge losses is due to the liability encountered post-breach. Businesses face liability exposure on all fronts: the government, financial institutions, and customers. These are the three worst enemies of any company attempting to make a profit.

1. The Regulators Impose Costly Notification Requirements & Penalties.

a. You Have Mail—Notification Requirements After A Breach

Maybe the initial data breach is a headache, but the nightmare truly begins when the regulators show up. One of the more onerous liabilities faced by a breached company is data-notification law, currently found in 47 states.[11] Common among these notification laws is the requirement that companies notify all individuals if any personal identifiable information is lost, stolen, or compromised.[12] For example, Texas' Identity Theft Enforcement and Protection Act statute includes a Breach Notification Requirement.

> Any person or business that owns or licenses computerized data that includes [personal identifiable information] shall, upon a discovery of a breach, notify any resident of [Texas] whose [personal identifiable information] may be included in the breach.[13]

The costs to comply with consumer-notification laws can be staggering. Notification costs vary based on the number of records involved in a data breach. These expenses can range from $.50 to $5.00 per individual notice.[14] Therefore, businesses must ensure that their cyber liability policies include coverage for the full range of cost caused by a breach.

Fortunately, most cyber liability policies on the market today provide coverage for costs related to notification laws in the form of "privacy" liability coverage.[15] This form of coverage typically insures against the unauthorized disclosure of personal identifiable information. Significantly, the privacy-related portions of cyber liability policies provide coverage even where no computer-related data breach is involved.

Privacy liability coverage is typically paired with an insuring agreement for a secondary "privacy breach response services"

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that provides a range of ancillary coverages. This coverage protects insureds from potentially ruinous expenses created by these omnipresent breach-notification requirements.

But the devil is in the details with regard to this form of coverage. Many cyber liability polices contain a maximum number of notifications that are covered. Depending on potential exposure, an insured can elect to purchase 1,000 notifications or millions of notifications. Thus, when purchasing a cyber liability policy, it is important to forecast the worst-case scenario for the necessary number of notifications. As data breaches often go undetected for long periods of time, the more notifications covered, the better.

A breached insured will immediately face other expenses when complying with data-notification laws. These costs typically include a forensics investigation to determine the extent of the breach, along with certification from computer experts confirming that the system is secure.

Data breaches may severely damage the company's brand. For example, Target's sales plummeted when news of its breach became public. In an effort to minimize damage to customer goodwill and preserve the brand, many companies will incur significant costs by engaging crisis-management and public-relations firms. And although not required, companies typically provide additional services to affected individuals, such as call centers and identity monitoring services. Many cyber liability policies provide coverage for these expenses under separate insuring agreements. Significantly, these ancillary costs often erode the policy's aggregate limits should be carefully monitored.

b. Post Breach, All Is Not Fine.

In addition to the costs associated with notifying affected consumers, many breach-notification laws also allow states to impose penalties and recover damages. Should a business ignore the requirements to report a breach to the state under data-notification statutes, the hammer will drop.[16] For example, Texas law penalizes companies $100 per individual, per day of failed or delayed notification, up to $250,000 for a single breach.[17] Fortunately, cyber liability policies provide coverage designed for an insured's "failure to timely disclose an incident described…in violation of any Breach Notice Law."[18] This coverage is typically subject to its own independent sublimit.

Penalties are often levied against companies for the data breach itself. Texas' Identity Theft Enforcement and Protection Act authorizes the Attorney General to bring an action against a company seeking "a civil penalty of at least $2,000 but not more than $50,000 for each violation."[19] Other states impose similar fines.

On the federal level, no statute expressly regulates corporate data security practices of businesses with regard to data breaches. Despite this statutory void, the Federal Trade Commission ("FTC") asserts that it is authorized to fine companies after a data breach. To support its power to issue penalties against companies, the FTC relies upon an archaic law dated 1914 that was designed to protect consumers from companies that engage in "unfair or deceptive acts or practices in or affecting commerce."[20] Penalties under this law can exceed hundreds of thousands of dollars.[21]

Cyber liability policies have evolved to provide coverage for regulatory penalties. For example, the Beazley Cyber Policy contains a separate insuring agreement subject to a specific sublimit for claims and expenses related to regulatory proceedings.[22] As the coverage for regulatory penalties is subject to a lesser sublimit, it is necessary for the insured to determine whether the penalty sublimit is adequate.

It is an open question in many jurisdictions whether penalties are insurable under the particular state's public policy.[23] Although Texas courts have not addressed whether civil penalties for a data breach are insurable, the Texas Supreme Court's *Stephens Martin* decision is instructive.[24] There, the Court found it was not against public policy to allow coverage for punitive damages, which are similar in nature to civil penalties. The Court found punitive damages insurable because a company was being sued for the conduct of its employees, and the company's upper management was unaware of its employee's wrongful acts.[25] But the Court advised that punitive damages based "extreme circumstances," such as intentional misconduct, would not be insurable.[26]

The similarities between civil penalties and punitive damages make it likely that a similar *Stephens Martin* analysis would be applied to the question of whether civil penalties for data breaches are insurable under Texas' public policy. If a company negligently or unintentionally failed to prevent a data breach based on its employees' wrongful acts, coverage would likely exist for civil penalties. But if a business acted willfully or intentionally relating to a data breach, coverage for civil penalties may not be owed for these "extreme circumstances." In fact, coverage litigation involving whether civil penalties under the Telephone Consumer Protection Act[27] for unsolicited telemarketing calls or faxes reflect the same dichotomy: penalties for negligent and unintentional conduct are insurable, but penalties for malicious conduct (triggering treble damages) are uninsurable under the particular state's public policy.[28]

2. The Game Is Rigged—The Banks Always Win.

a. Merchant Services Agreements

Claims from financial institutions present another serious liability for any business accepting payment cards, such as

retailers, medical providers, or law firms. These companies must enter into "merchant services agreements" with acquiring banks. In turn, acquiring banks maintain separate contracts with payment card companies, such as MasterCard and Visa.

To protect payment card data from digital theft, merchant services agreements typically require companies to implement strict security measures. These security measures are known as PCI Data Security Standards ("PCI-DSS") and were developed by the five major payment card companies.[29] The PCI-DSS standards include 12 main requirements for security management and procedures that the company must implement. [30]

Significantly, the standard merchant agreement also mandates that businesses pay fines and indemnify the acquiring bank when a data breach occurs. These fines stem from the fact that payment card companies may penalize an acquiring bank $5,000 to $100,000 per month for PCI compliance violations.[31] In turn, acquiring banks pass any penalties downstream to the non-compliant merchant.

Thus, it is important to evaluate whether the victimized company's cyber liability policy provides coverage for the acquiring bank's indemnity claim. Many cyber liability policies, such as the Beazley policy, expressly provide coverage to the insured "for PCI Fines and Costs." This coverage for PCI penalties is typically subject to a separate sublimit.

Furthermore, merchant services agreements typically impose a host of additional requirements in the event of a breach. Specifically, businesses are required to determine the cause of the breach and to minimize the likelihood of a future breach. Complying with these additional requirements does not come cheap. Fortunately, many cyber liability policies cover these steep additional costs under the insuring agreement for "privacy breach response services." In particular, a cyber liability policy might cover the following costs:

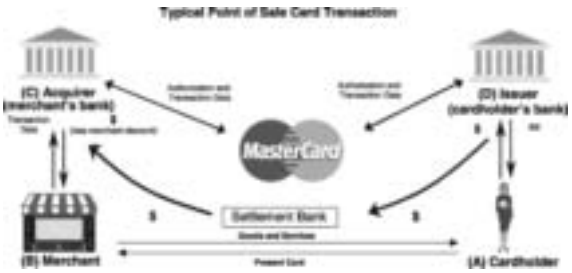
- "a PCI Forensic Investigator that is approved by the PCI Security Standards Council and is retained by the Insured Organization in order to comply with the terms of a Merchant Services Agreement to investigate the existence and extent of an actual or suspected compromise of credit card data;"
- "a computer security expert to demonstrate the Insured's ability to prevent a future electronic data breach as required by a Merchant Services Agreement;" and
- "fees charged by an attorney…to advise the Insured Organization in responding to credit card system operating regulation requirements for any actual or suspected compromise of credit card data that is required to be reported to the Insured Organization's merchant bank under the terms of a Merchant Services Agreement."[32]

Companies must scrutinize any contractual liability exclusions that could exclude coverage for these contractual PCI penalties found in merchant agreements. Although most cyber liability policies have some form of contractual liability exclusion, they typically have an exception for PCI-related penalties.[33]

b. Issuing Banks & The Unsettling Trend For Companies

Liability to financial institutions may not end with acquiring banks. Individual cardholders, like you and me, receive payment cards from financial institutions (an "issuing bank") that have a relationship with payment card companies, such as MasterCard or Visa. For example, consumers apply to an issuing bank for a credit card, such as Chase for their Southwest Visa credit card or, if you are George Clooney, the invitation-only "Black Card" issued by American Express.[34]

The relationships underlying a typical consumer transaction at a retail outlet are depicted in the following graphic.



[35]

Significantly, no direct relationship exists between merchants, like Target, and issuing banks, like Chase or Citibank.

But issuing banks suffer great expense after a business is breached. When a data breach occurs at a company that processes payment cards, issuing banks must cancel accounts, deal with fraudulent charges, and reissue cards. The administrative costs to replace a card average $10 to $22 per card—this does not include the cost of fraudulent charges that result.[36] This $22 per-card sum can rapidly get out of hand when a data breach involves the exposure of millions of credit cards. It is estimated that issuing banks will incur about $400 million dollars in administrative expenses related to the Target data breach.[37]

Since no contract exists between the issuing bank and the breached company, issuing banks are often left holding the bag for these huge expenses. Issuing banks are not wallflowers in litigation, and many are attempting to forge new precedents to hold businesses liable for these costs. In fact, litigation involving Target has given issuing banks new hope that the costs of data breaches can be passed on to the

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negligent business.

> After Target was breached, a group of issuing banks initiated a class-action lawsuit.[38] The issuing banks alleged that Target's negligent acts and omissions resulted in the data breach. In a standard tactic that has been successful in data-breach litigation involving issuing banks, Target moved to dismiss the class's negligence claim. Target's motion pointed to the lack of a contractual relationship with the banks and argued that Target "had no duty to [the issuing banks] because there is no special relationship… and in any event, 'a person has no duty under [state] law to protect another from the harmful conduct, including criminal conduct, of a third person.'"[39] The federal district court surprised many and rejected Target's no-duty argument, holding as follows: Although the third-party hackers' activities caused harm, Target played a key role in allowing the harm to occur. Indeed, Plaintiffs' allegation that Target purposely disabled one of the security features that would have prevented the harm is itself sufficient to plead a direct negligence case: Plaintiffs allege that Target's 'own conduct create[d] a foreseeable risk of injury to a foreseeable plaintiff.'[40]

With this ruling, issuing banks have a new weapon in their arsenal in the form of pure negligence claims against companies for employing lax security systems. Breached companies have another massive headache to worry about.

In addition, issuing banks are lobbying Congress to pass federal legislation that would hold companies statutorily liable for negligent breaches.[41] In fact, some states, such as Minnesota, have already passed legislation making the security standard PCI-DSS a statutory requirement; the failure to comply would result in liability to the company.[42] Texas came very close to passing a similar statute, but the proposed legislation ultimately failed.[43]

Fortunately, the emerging class-action lawsuits are typically covered under the privacy-liability portion of the cyber liability policy. A common privacy liability insuring agreement provides:

> [Insurer agrees to] pay on behalf of the Insured [Damages and Claims Expenses for]:
>
> theft, loss, or Unauthorized Disclosure of Personally Identifiable Non-Public Information or Third Party Corporate Information that is in the care, custody or control of the Insured Organization, or a third party for whose theft, loss or Unauthorized Disclosure of Personally Identifiable Non-Public Information or Third Party Corporate Information the Insured Organization is legally liable.[44]

Given the *Target* decision's potential for contagion, the significant legal costs dealing with class-action lawsuits by issuing banks attempting to recoup their damages must be considered when determining the adequacy of a cyber liability policy's limits. Old damage models for cyber liability claims will no longer suffice, as they do not include losses relating to issuing banks. As the bullseye on companies' backs gets bigger, limits of cyber liability policy should be adjusted upwards.

Issuing banks have a new weapon in their arsenal in the form of pure negligence claims against companies for employing lax security systems.

3. Companies Are Clapping That Consumers May Not Have Much Of A Leg To Stand On.

Not to be left out, consumers also target businesses after a breach. Consumers often file class-action lawsuits against businesses asserting claims of negligence, breach of warranty, and unfair or deceptive trade practices. To date, a big impediment to these consumer lawsuits has been the fact that the financial institutions (the issuing banks and acquiring banks) bear the brunt of the blame. The issuing banks (not the consumers) absorb the costs of fraudulent charges and administrative costs to reissue payment cards. Accordingly, most of the complaints brought by consumers involve the threat of future harm, such as consumers' fear that they will be victims of future identity theft. Thus, the major issue is typically whether the consumer has suffered a legally cognizable injury that will support standing to bring suit, an issue that can be addressed early by a 12(b)(6) motion to dismiss in federal courts.

To date, the U.S. Courts of Appeals for the First and Third Circuits hold that consumers lack standing because consumers have only a generalized notion of a threat of future identity theft or fraudulent charges.[45] The Seventh and Ninth Circuits stand on the opposite side of this debate, finding standing for consumers to proceed with lawsuits despite any actual loss.[46] But the Seventh and Ninth Circuits' broad interpretation of standing may not stand the test of time based on a recent U.S. Supreme Court decision, *Clapper v. Amnesty International USA*.[47]

Clapper involved human rights organizations and media groups challenging the Foreign Intelligence Surveillance Act's authority regarding wiretaps on intelligence targets.

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In a 5-4 decision, the Court found these groups had no standing despite their fears of imminent harm in being the subject of a wiretap. Relevant to consumer claims in a cyber liability context, the Court found that, although the plaintiffs' concerns were not "fanciful, paranoid, or otherwise unreasonable," the harm complained about was not "certainly impending." The court also held that standing cannot be created "based on their fears of hypothetical future harm that is not certainly impending."[48] Indeed, all but a few courts have dismissed data breach lawsuits in early stages of litigation based on *Clapper's* narrow view of standing.[49]

When consumers can establish that they have been injured, standing should not be an impediment. For example, a proposed class action filed by 114 consumers with regard to the Target data breach has been allowed to proceed despite Target's argument that they did not have *enough* standing to establish injury.[50] But the consumers alleged injuries for unlawful charges, restricted or blocked access to bank accounts, inability to pay other bills, and late-payment charges. Target argued that it was unclear from the face of the consumers' complaints whether the expenses were reimbursed by the issuing banks. In rejecting Target's argument, the federal district court in Minnesota held that the consumers' "allegations plausibly allege that they suffered injuries that are 'fairly traceable' to Target's conduct."[51]

Given that the Target consumers' main claim was a general negligence claim under Minnesota law – a negligence standard that is virtually the same in all other states – we can expect more consumer lawsuits in the future. Savvy plaintiffs' attorneys will likely follow the rationale of the decision by the Minnesota court in *Target* and bring lawsuits alleging actual damages sufficient to establish legal standing. As a result, defense costs will be an ever-increasing issue that must be considered in a cyber liability policy.

Unlike CGL polices where the payment of defense costs by the insurer does not decrease the amount of indemnity dollars available, cyber liability policies are typically "wasting" or "cannibalizing" polices. Each dollar paid for defense costs erodes the available indemnity limits. Thus, if an insurer that issued a $1 million cyber liability policy pays $250,000 in defense, policy limits erode such that only $750,000 remains to pay any judgments or settlements. When determining the amount of cyber liability coverage that should be purchased, an insured must take into account defense costs for the highly specialized attorneys that may be necessary in the event of a breach.

4. Passing The Buck—Who Can Companies Target?

The breach involving Target and The Home Depot arose from a common source—their vendors' negligence. Accordingly, companies must proactively ensure that vendor contracts provide protection in the event of a data breach. Companies should adopt an approach similar to the standard in the construction industry. Specifically, vendor contracts should contain a belt-and-suspender approach of additional insured coverage and contractual indemnification for data breach claims.

It is usually possible for a vendor to add a hiring company as an additional insured under its cyber liability policy. Many cyber liability policies allow for the insured to provide additional insured coverage that is similar to those found in other types of liability policies, such as CGL policies.

> [An entity qualifies as an Additional Insured when]:
>
> 1. any natural person or entity that the Insured Organization has expressly agreed in writing to add as an Additional Insured under this policy prior to the commission of any act for which such person or entity would be provided coverage for under this Policy, but only to the extent the Insured Organization would have been liable and coverage would have been afforded under the terms and conditions of this Policy had such Claim been made against the Insured Organization.[52]

Companies should ensure that contracts with outside vendors potentially posing a cyber-security risk include written requirements requiring the company to be added as an additional insured. It is good practice to verify that the vendor's cyber liability policy actually provides additional insured coverage.

Enforceable indemnification agreements from vendors are necessary to provide another layer of protection. Should the additional insured obligation of the vendor fail for lack of coverage or the limits prove inadequate, an enforceable indemnity agreement will provide the company an alternate source of recovery. A contractual indemnity suit can be brought directly against the insured, and may trigger coverage under the cyber liability policy subject to any contractual liability exclusions.

Also, when additional insured coverage is in play, there is often a dispute between which policy should pay first – the additional insured policy or the company's own policy. These disputes often center on both policies' "Other Insurance" clauses. But an enforceable indemnification agreement will trump the application of Other Insurance clauses and require that the additional insurer act in primary manner and pay before the businesses' own policy.[53]

Careful attention should be given to the language of the indemnity agreement to ensure that it is enforceable. A number of Texas courts hold that in order to be enforceable, the exact harm to be indemnified against must be expressly

referenced in the indemnification agreement. These courts have extended the express-negligence rule to causes of action beyond negligence, such as warranty claims or strict liability claims.[54] Thus, indemnity for penalties, warranties, and any other claims related to a cyber breach should be included in the language of the agreement.

B. Like Father, Not Like Sony

In the past, making a satirical movie lampooning a dictator came with little risk. Perhaps the offended country issued a strongly worded denunciation, which provided the side-benefit of free advertising for the movie. For example, the film "Team America: World Police" depicted the then-leader of North Korea, Kim Jong Il, as an outlandish and petulant villain. Eventually, he is impaled on a spiked German helmet (although he did not die but morphed into an alien cockroach). The North Korean leader's only response was to ask the Czech Republic to ban the film—a request that was swiftly rejected.

So when Sony Pictures Entertainment ("Sony") decided to greenlight a comedy with a similar plot-line involving the assassination of current North Korean dictator, Kim Jong-un, Sony's risk managers did not bat an eyelash. Unfortunately for Sony, the axiom "like father, like son" did not hold true with regard to the movie "The Interview." In the most destructive data breach in history (for now), this electronic Pearl Harbor left Sony debilitated.

The aim of the data breach was not only to steal data, but to send a clear message to Sony. And send a message they did. First, Sony's crown jewels—unreleased films—were uploaded online by the perpetrators of the breach. Next came confidential and highly embarrassing emails from executives and employees, including an email exchange calling Angelina Jolie a "spoiled brat."[55] In addition, confidential information of over 47,000 former employees was released, including some social security numbers and medical information. As a result of this breach, Sony has been forced to suspend its current film projects.

Unlike the relatively simplistic data breaches involving Target or The Home Depot, security experts describe the Sony attack as "unprecedented in nature."[56] The techniques used were "undetectable by industry standard antivirus software."[57] Before analyzing the legal pain that is just beginning for Sony, it is significant to understand how this slow-moving disaster began.

1."I'm Gonna Make Him An Offer He Can't Refuse"—Coverage For Digital Extortions

Three days prior to the initial wave of destruction that has gripped Sony, two Sony executives received the following cryptic and hilariously translated ransom demand:

> We've got great damage by Sony Pictures.
>
> **The compensation for it, monetary compensation we want.**
>
> Pay the damage, or Sony Pictures will be bombarded as a whole.
>
> You know us very well. We never wait long.
>
> You'd better behave wisely.
>
> From God's Apstls[58]

It is unclear whether Sony executives thought it was a serious demand or ever tendered it to Sony's cyber liability insurer.

Sony is just one of many companies targeted for cyber extortion. The acceleration of this cyber extortion trend is caused partially by the rise of readily available software programs (such as CryptoLocker) digital thieves use to lock companies out from their own data.[59] With this readily available software, a ransom-oriented cyber thief "can take in $30 million in only a few months" according to cyber security experts.[60] As a result, cyber ransoms are not limited to large companies like Sony—small businesses are now falling victim to cyber ransoms at an alarming rate.[61]

Imagine showing up for work at your law firm on Monday morning. Instead of being confronted by the familiar Windows desktop on your computer, an ominous message greets you demanding payment of $20,000 or the deletion of the firm's electronic files. Then the extortionists make it impossible to access any of the files on your system, or to send emails to anyone other than the perpetrator of the cyber threat. Now imagine the amount of money lost as the result of business interruption and the ethical quandaries that would follow if this ransom demand was ignored like it was with Sony. Would you subject your firm to such a risk on the prayer that it was a giant bluff?

Fortunately, a number of cyber liability policies provide cyber-extortion coverage via endorsements that can be purchased. For example, one cyber liability insurer provides coverage for "Cyber Extortion Loss…incurred by the Insured Organization as a direct result of an Extortion Threat first made against the Insured Organization during the Policy Period…."[62] Given the time-sensitive nature of these cyber-extortion situations, cyber policies require that ransom demands are immediately reported to the insurer. Typically, the insurer will have a special extortion-related phone number to provide notice.

The question of late notice may prove to be very interesting. Will insurers that receive notice of the extortion demand after a payment is made by an insured be successful in establishing that that they were sufficiently prejudiced by late notice to avoid coverage? For example, a shareholder at a law firm might receive an extortion demand threatening

the destruction of the firm's electronic files within 24 hours unless $10,000 is wired to a bank account. The shareholder ignores the demand because it is badly worded and he is two days into a month-long trial. The next day, the cyber extortionist makes good on his threat, and deletes the firm's data. Absent any late-notice argument, the resulting damages of $60,000 would normally be covered under the cyber liability policy. Can the insurer assert that it was materially prejudiced by the law firm's late notice? After all, had the $10,000 extortion demand been paid, the law firm would not have suffered $60,000 in subsequent losses. Given the rise in data breaches, the answer to this question may come sooner rather than later.

2. Sony, Interrupted —Business Interruption Coverage For Data Breaches

Sony's main loss will ultimately be the business interruption that it suffered. The cyber attack has crippled Sony, disrupting all of the company's operations. Sony halted the filming of movies—its bread and butter—because it could not pay vendors through compromised computer systems.[63] The breach has left Sony as a movie company that cannot make movies.

The business-interruption coverage found in property policies typically excludes interruptions caused by cyber thieves. Enter cyber liability coverage. A typical cyber policy provides first-party coverage to cover business-interruptions losses (*i.e.,* net profit) caused by a cyber breach. Cyber business-interruption coverage reimburses the insured, to the particular limits in that insuring agreement, for its business losses until the company's computer systems are restored (or would have been restored if the insured had exercised due diligence). And like other business-interruption coverages, cyber business-interruption coverage does not reimburse the insured for losses related to "unfavorable business conditions, loss of market or any other consequential loss; or costs or expenses."[64]

Business-interruption coverage is not just for large companies like Sony. Small companies have small or non-existent cash reserves to weather a long period with operations shut down due to a data breach. Thus, cyber business interruption coverage may be even more vital to small companies than it is to a company like Sony.

3. The Employee Strikes Back (And First)

Although no one knows if Sony would have suffered the same harm had the ransom been paid, Sony has already been sued as a result of the breach. The breach exposed confidential information of numerous employees and ex-employees, including social security numbers. After receiving notification from Sony regarding the breach, a number of ex-employees filed a class-action lawsuit against Sony, faulting its lax security practices and inadequate notifications.

These types of lawsuits will typically be covered by the privacy liability portion of a cyber liability policy. With regard to the breach notifications that Sony has been required to send employees and ex-employees who have had their personal identifiable information stolen, these expenses are covered by the privacy services insuring agreement found in typical cyber policies. The fact that fundamentally different companies face similar expenses when a data breach occurs underscores the need for any company storing personal identifiable information, such as law firms, to purchase cyber liability coverage.

4. Not War Of The Worlds

Further, the breach raises questions of terrorism. Although denying official blame, the American government indicates that North Korea ordered the attack.[65] And in response, the United States announced further sanctions against North Korea. Although the President of the United States stated that the data breach was not an act of war, he stated that it could land North Korea back on the administration's terror list.[66] North Korea railed against the new sanctions and referred to the United States as an "inveterate repugnancy."[67]

Unfortunately, cyber liability policies are written like most other liability policies to exclude coverage for acts of war. And cyber liability policies are not uniform and require extra scrutiny to determine the precise wording of the insured's particular exclusion for war. For example, a policy's exclusion may only preclude coverage for declared acts of war. If this narrow exclusionary language is found in Sony's cyber liability policy, coverage would still exist because the United States did not classify North Korea's alleged actions as acts of war.

But broader exclusions may exclude coverage for a much larger category of foreign aggressions than officially declared wars. For example, some cyber liability polices exclude losses arising out of "acts of foreign enemies, [or] hostilities (whether war be declared or not)."[68] If this exclusion were present in Sony's $60 million cyber liability policy, it would have been an uphill argument to avoid this broader exclusion. Therefore, it is crucial for companies to evaluate their potential exposure to cyber terrorism when obtaining cyber coverage.

It appears that Sony chose its cyber policy wisely, and deleted or modified a broad war exclusion. Indeed, Sony's chief executive stated that "the costs from the devastating cyber attack on the Hollywood studio will be *completely covered* by insurance and will not lead to further cost-cutting."[69]

C. The Correct Cyber Liability Insurance Policy, Not Laughter, Is The Best Medicine.

If the outlook for data breaches appeared bleak for businesses that store customer information and process payments, healthcare companies are on life support. Since 2009, about

29 million patient health records have been compromised, with a shocking 138% increase between from 2012 to 2013 alone.[70] Accounting for this rapid increase in data breaches is the widespread adoption of electronic health records in order to reduce medical errors. Unlike its traditional paper-file counterpart, electronic records can be stored in massive quantities, millions of files on a single laptop hard drive.

At the same time that electronic records began taking off, new regulations with ramped-up penalties for the disclosure of health records made an appearance. First, in 1996, the Health Insurance Portability and Accountability Act ("HIPAA") was passed, requiring healthcare providers to maintain security standards for protected health information. A breach of this statute results in civil penalties and potentially criminal fines.

As part of the stimulus bill in 2009, Congress enacted the Health Information Technology for Economic and Clinical Health ("HITECH") Act, which strengthens penalties for HIPAA violations. It includes rules for the healthcare industry regarding notifications after a breach, and gave the United States Department of Health and Human Services ("HHS") enforcement powers.[71] Penalties levied by the HHS under the HITECH Act can cost as much as $1.5 million dollars per year.

In addition, HITECH extends HIPAA violation liability to healthcare vendors to whom protected health information is disclosed. This expansion of entities that must comply with HIPPA and HITECH includes third-party administrators or accounting firms.[72] Thus, the world of companies that must comply with HIPPA has expanded exponentially.

Individual states have enacted laws expanding protection mandated by HIPPA and HITECH in several areas. For example, Texas' "Medical Records Act" does not allow a patient's health information to be marketed, or to be used in marketing, without the patient's consent or authorization.[73] Also, the Texas Act imposes its own penalties ranging from $5,000 to $1.5 million per year.[74]

Additionally, patient lawsuits, including class action suits, are a concern. However, patients that have had their medical history exposed have not generally been successful in courts.[75] Patients typically see their cases dismissed under the constitutional doctrine of federal preemption. Healthcare providers argue that because HIPPA did not include a private cause of action, patients attempting to bring state law claims are preempted.

But the tide may be turning. With some success, patients sidestep this preemption argument by contending that HIPPA is not the basis of their cause of action; rather, probative evidence that the healthcare provide violated the appropriate standard of care under state law.[76] Recently, the Supreme Court of Connecticut rejected the federal preemption argument and ruled in favor of the patients in an eagerly anticipated decision that has given a shot in the arm to patient claims.[77]

The cyber-related claims faced by healthcare companies are like the claims faced by other merchants but also involve sensitive health information. Like other merchants, these notifications expenses and fines are covered by the privacy liability, privacy services, and fine-insuring agreements found in typical cyber policies. But healthcare companies must be careful to ensure that the sublimit of their cyber liability policy covering HIPPA/HITECH and state law penalties is sufficient to cover potential penalties that may be imposed for a catastrophic breach.

Conclusion—If You Build It, They Will Breach It

For many companies, it is not a matter of if, but when they will fall victim to a debilitating cyber theft. After a breach, companies' ears will be ringing with the familiar phrase, "Show me the money." Breached businesses may face class-action lawsuits from consumers and banks, expensive notification requirements, civil penalties from regulators, and significant business interruption from a crippled or destroyed computer network. Ensuring that the proper cyber coverage is in place may be the difference between closing the doors or keeping the lights on.

1 One recent case found that no coverage exists for data breaches. *See, e.g., Zurich Am. Ins. Co. v. Sony Corp. of Am.*, Index No. 651982-2011, transcript of proceedings rec'd Mar. 3, 2014(N.Y. Supp. Ct., Feb.21, 2014)(the court did not issue a written opinion)(finding that class action lawsuits stemming from the data breach of Sony's PlayStation Network—where personal details from approximately 77 million accounts were stolen—did not constitute an alleged "oral or written publication in any manner of material that violates a person's right of privacy" under a CGL policy because Sony did not publish the material the stolen information); *and see Travelers Indem. Co. of Conn. v. P.F. Chang's China Bistro Inc.*, case number 2:14-cv-01458, (D. Conn. filed Oct. 2, 2014), *available at* http://www.privacyriskreport.com/wp-content/uploads/2014/10/Travelers-v.-PF-Changs-Complaint.pdf (contending in its complaint that "The lawsuits fail to trigger coverage under the policies because they do not allege 'bodily injury' or 'property damage' caused by an 'occurrence,' nor do they allege 'advertising injury' or 'personal injury' as the policies expressly and unambiguously define those terms.").

Moreover, coming to your client's CGL policy soon are new cyber exclusion ISO endorsements approved by regulators in most states that leave little room for doubt that most data breach claims are not covered. Insurance Journal, *ISO Comments on CGL Endorsements for Data Breach Liability Exclusions,* (Jul. 18, 2014), http://www.insurancejournal.com/news/east/2014/07/18/332655.htm.

2 Larry Greenemeier, *T.J. Maxx Parent Company Data Theft Is The Worst Ever*, (Mar. 29, 2007), http://www.informationweek.com/tj-maxx-parent-company-data-theft-is-the-worst-ever/d/d-id/1053522?.

3 Tom Espiner, *Wi-Fi hack caused TK Maxx security breach*, (May 8, 2007), http://www.zdnet.com/article/wi-fi-hack-caused-tk-maxx-security-breach/.

4 Kelli B. Grant, *Why did Target take so long to report the breach?*, (Dec. 20, 2013), http://www.cnbc.com/id/101287567#.

5 Brian Krebs, *Target Hackers Broke in Via HVAC Company*, (Feb. 5, 2014), http://krebsonsecurity.com/2014/02/target-hackers-broke-in-via-hvac-company/.

6 Rachel Abrams, *Target Puts Data Breach Costs at $148 Million, and Forecasts Profit Drop*, (Aug. 5, 2014), http://www.nytimes.com/2014/08/06/business/target-puts-data-breach-costs-at-148-million.html?_r=0.

7 Shelly Banjo, *Home Depot Hackers Exposed 53 Million Email Addresses*, (Nov. 6, 2014), http://www.wsj.com/articles/home-depot-hackers-used-password-stolen-from-vendor-1415309282.

8 *Id.*

9 Jeremy Kirk, *Home Depot spent $43 million on data breach in just one quarter*, (Nov. 25, 2014), http://www.pcworld.com/article/2852472/home-depot-spent-43-million-on-data-breach-in-just-one-quarter.html.

10 Robert McMillan, *Restaurants sue vendors after point-of-sale hack*, (Dec. 1, 2009), http://www.computerworld.com/article/2521259/security0/restaurants-sue-vendors-after-point-of-sale-hack.html.

11 As of January 1, 2015, the only states without similar breach notification laws are Alabama, New Mexico and South Dakota. But a one-size-fits-all approach may be coming soon. The Obama administration proposed federal legislation that would supersede these varying state regulations. Rachael King, *30 Days Not Enough Time in Obama's Proposed Breach Notification Law: Retail Group*, (Jan. 12, 2015), http://blogs.wsj.com/cio/2015/01/12/30-days-not-enough-time-in-obamas-proposed-breach-notification-law-retail-group/.

12 For example, the Texas statute defines "sensitive personal information" as "an individual's first name or first initial and last name in combination with any one or more of the following items, if the name in the items are not encrypted: social security number, driver's license number or government-issued identification number; or account number or credit or debit card numbers in combination with any required security code, access code, or password…." Tex. Bus. & Comm. Code § 521.002(a)(2).

13 *Id.* at § 521.052-053.

14 Tim Stapelton, *Data Breach Cost*, (July 2012), http://www.zurichna.com/internet/zna/sitecollectiondocuments/en/products/securityandprivacy/data%20breach%20costs%20wp%20part%201%20%28risks,%20costs%20and%20mitigation%20strategies%29.pdf.

15 Privacy liability insurance is often paired in the same insuring agreement with "network security liability" coverage. Network security coverage is designed to protect policyholders when there is an unauthorized access to the insured's computer network.

16 Furthermore, the fact that a company's discovery of a data breach must be reported dovetails with the "claims-made" nature of typical cyber liability policies. For coverage to be triggered, an insured company must discover and report the data breach during the applicable policy period. Failure to tender the data breach to the insurer within the policy period is likely fatal to coverage under the policy. *See Prodigy Commc'ns Corp. v. Agric. Excess & Surplus Ins. Co.*, 288 S.W.3d 374, 378-79 (Tex. 2009).

17 Tex. Bus. & Com. Code Ann. § 521.151(a-1).

18 *See*, *e.g.*, Beazley Breach Response Select, form F00340, at p. 2, §3 (Dec. 2013 ed.), *available at* https://ociaccess.oci.wi.gov/Companyfilings/document?docid=196328&filid=211797.

19 Tex. Bus. & Com. Code Ann. § 521.151.

20 *See* Section 5 of the FTC Act, 15 U.S.C. § 45.

21 Given the limited authority upon which the FTC relies, a number of companies have challenged the FTC's authority. This litigation produced no ruling, as each of these challenges settled by consent orders. But a case involving the Wyndham hotel chain is currently pending before the U.S. Court of Appeals for the Third Circuit.

In particular, on April 7, 2014, the U.S. District Court for the District of New Jersey ruled in favor of the FTC, holding that it had authority under the "unfairness" prong of the FTC Act to bring an enforcement action against Wyndham for its alleged unreasonable data security practices. *F.T.C. v. Wyndham Worldwide Corp.*, 10 F.Supp.3d 602 (D.N.J. 2014), *motion to certify appeal granted* (June 23, 2014), *available at* http://www.kslaw.com/library/newsletters/dataprivacysecurity/2014/1215/dps121514_Wyndham.pdf. Wyndham filed an interlocutory appeal to the Third Circuit, which has been granted. Although a decision may be issued soon on this significant issue governing the scope of the FTC's power, the district court recently ordered the FTC and Wyndham to mediate on the basis that mediation "of this civil action would conserve the resources, and be in the best interests, of the Court and the parties." *F.T.C. v. Wyndham Worldwide Corp.*, No. 2:13-cv-1887 (D.N.J. Nov. 17 2014). Thus, it is unclear whether a decision from the Third Circuit will be reached in this case.

22 Beazley Breach Response Select, form F00340, at p. 7 (Dec. 2013 ed.), *available at* https://ociaccess.oci.wi.gov/Companyfilings/document?docid=196328&filid=211797.

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23 Compare *Bullock v. Md. Cas. Co.*, 85 Cal.App.4th 1435, 1448 (2001) (reasoning that civil penalties for violation of city ordinance did not trigger duty to defend because "public policy would not permit defendants to insure those sums") with *Wilson v. Chem–Solv, Inc.*, 1988 WL 109375, *1 (Del.Super.Ct. 1988) (concluding that public policy did not bar insurance coverage for civil penalties assessed for pollution).

24 *Fairfield Ins. Co. v. Stephens Martin Paving, LP*, 246 S.W.3d 653 (Tex. 2008).

25 *Id.* at 670.

26 *Id.*

27 47 U.S.C. § 227.

28 *Columbia Cas. Co. v. HIAR Holding, L.L.C.*, 411 S.W.3d 258, 274 (Mo. 2013) (finding that penalties were insurable because the insured's "conduct…was not willful and malicious, but rather it was negligent and unintentionally resulted in violations of the TCPA."); *Standard Mut. Ins. Co. v. Lay*, 989 N.E.2d 591, 600 (Ill. 2013) (same); *Motorists Mut. Ins. Co. v. Dandy-Jim, Inc.*, 912 N.E.2d 659 (Ohio Ct. App. 2009) (same); *but see Terra Nova Ins. Co. v. Fray-Witzer*, 869 N.E.2d 565, 576 (Mass. 2007)(holding that TCPA damages are insurable, but if penalties above $500 were awarded pursuant to the treble damages provision, "such an increase would amount to punitive damages and would not be covered under Terra Nova's policy.").

29 In 2006, five major credit card brands (Visa, MasterCard, American Express, Discover Financial Services and JCB International) created the Payment Card Industry Security Standards Council to address issues of payment security.

30 Software vendors of POS systems are governed by a similar standard developed by the major payment card brands, PCA-DSS.

31 *PCI Faqs*, (), https://www.pcicomplianceguide.org/pci-faqs-2/.

32 *See* Beazley Breach Response Select, form F00340, at p. 1 (Dec. 2013 ed.), *available at* https://ociaccess.oci.wi.gov/Companyfilings/document?docid=196328&filid=211797.

33 Beyond notification laws, only a few states have laws that impose fines on companies that are not PCI-DSS compliant. In these states, like Nevada, regulatory fines can be levied against companies that are not PCI-DSS compliant. *See* Nev. Rev. Stat. § 603A.215. But at present, Texas does not have a similar statute mandating PCI-DSS compliance. Should a company find itself governed by one of these statutes, coverage under a cyber liability policy would likely exist under "PCI Fines and Costs" coverage provision.

34 The Black Card was popularized by the movie "Up in the Air" starring George Clooney.

35 MasterCard Incorporated, 10-K Annual Report, at 7 (Dec. 31, 2007).

36 *US banks have re-issued 17.2 million cards following Target data breach*, (Feb. 7, 2014), http://www.finextra.com/news/fullstory.aspx?newsitemid=25702.

37 Jonathon Randles, *Target Data Breach Ruling Raises Stakes For Retailers*, (Dec. 4, 2014), http://www.law360.com/articles/600931/target-data-breach-ruling-raises-stakes-for-retailers.

38 Prior to the consolidation into the multi-district litigation (MDL), Target faced over 100 lawsuits related to the data breach in federal district courts across the nation..

39 *See In re Target Corp. Customer Data Security Breach Lit.*, MDL No. 14-2522(PAM/JJK), 2014 WL 6775314 (D. Minn. Dec. 2, 2014).

40 *Id.*

41 B. Dan Berger, *Congress Must Make Retailers Responsible for Data Breaches*, (Jan. 15, 2014), http://www.americanbanker.com/bankthink/congress-must-make-retailers-responsible-for-data-breaches-1064921-1.html.

42 For example, Minnesota's Plastic Card Security Act provides:

> No person or entity conducting business in Minnesota that accepts a[] [credit
>
> or debit card] in connection with a transaction shall retain the card security
>
> code data, the PIN verification code number, or the full contents of any track
>
> of magnetic stripe data, subsequent to the authorization of the transaction or
>
> in the case of a PIN debit transaction, subsequent to 48 hours after
>
> authorization of the transaction.
>
> * * * *
>
> Whenever there is a breach of the security of the system of a person or entity
>
> that has violated this section... that person or entity shall reimburse the
>
> financial institution that issued any [credit or debit cards] affected by the
>
> breach for the costs of reasonable actions undertaken by the financial
>
> institution as a result of the breach in order to protect the information of its
>
> cardholders or to continue to provide services to cardholders....

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Minn. Stat. § 325E.64, subd. 2, 3.

43 Specifically, the proposed Texas bill, H.B. No. 3222, provided:

> A business that, in the regular course of business, collects, maintains, or stores sensitive personal information in connection with an access device must comply with payment card industry ["PCI"] data security standards ["DSS"].
>
> …[and]…
>
> A financial institution may bring an action against a business that is subject to a breach of system security if, at the time of the breach, the business is [not in compliance with PCI DSS].

44 Beazley Breach Response Select, form F00340, at p. 1 (Dec. 2013 ed.), *available at* https://ociaccess.oci.wi.gov/Companyfilings/document?docid=196328&filid=211797.

45 *See Katz v. Pershing, LLC*, 672 F.3d 64 (1st Cir. 2012); *Reilly v. Ceridian Corp.*, 664 F.3d 38 (3d Cir. 2011).

46 *See Krottner v. Starbucks Corp*., 628 F.3d 1139 (9th Cir. 2010); *Pisciotta v. Old Nat'l Bancorp*, 499 F.3d 629 (7th Cir. 2007).

47 133 S. Ct. 1138 (2013).

48 *Id.* at 1151.

49 *See Lewert v. P.F. Chang's China Bistro, Inc.,* Case No. 14-cv-4787, 2014 WL 7005097, at *3 (N.D. Ill. Dec. 10, 2014) (dismissing lawsuit for lack of standing under *Clapper* and holding that "[s]peculation of future harm does not constitute actual injury."); *In re Science Applications Int'l Corp. (SAIC) Backup Tape Data Theft Litig.*, MDL No. 2360, 2014 WL 1858458 (D.D.C. May 9, 2014) (same); *Strautins v. Trustwave Holdings, Inc*., No. 12 C 09115, 2014 WL 960816 (N.D. Ill. Mar. 12, 2014) (same); *Galaria v. Nationwide Mut. Ins. Co*., Case Nos. 2:13-cv-118, 2:13-cv-257, 2014 WL 689703 (S.D. Ohio Feb. 10, 2014) (same); *Polanco v. Omnicell, Inc*., Civ. No. 13-1417 (NLH/KMW), 2013 WL 6823265 (D.N.J. Dec. 26, 2013) (same); *In re Barnes & Noble Pin Pad Litig.*, No. 12-cv-8617, 2013 WL 4759588 (N.D. Ill. Sept. 3, 2013) (same); *but see In re Sony Gaming Networks & Customer Data Sec. Breach Litig.*, MDL No. 11md2258 AJB(MDD), 2014 WL 223677 (S.D. Cal. Jan. 21, 2014) (finding standing in the face of *Clapper*); *In re Adobe Sys., Inc. Privacy Litig.*, Case No.: 13-CV-05226-LHK, 2014 WL 4379916 (N.D. Cal. Sept. 4, 2014) (same); *Moyer v. Michaels Stores, Inc.*, No. 14 C 561, 2014 WL 3511500, at *5 (N.D. Ill. July 14, 2014).

50 *See In re Target Corp. Customer Data Security Breach Lit.*, MDL No. 14-2522-PAM, Doc #281 (D. Minn., Dec. 18, 2014).

51 *Id.*

52 Beazley Amendatory Endorsement, form E04418 (Dec. 2013 ed.), *available at* https://ociaccess.oci.wi.gov/Companyfilings/document?docid=196328&filid=211797.

53 *See American Indem. Lloyds v. Travelers Prop. & Cas. Ins. Co.*, 335 F.3d 429, 436 (5th Cir. 2003) ("[T]he clear majority of jurisdictions recognizes the foregoing exception and gives controlling effect to the indemnity obligation of one insured to the other insured over 'other insurance' or similar clauses in the policies of the insurers, particularly where one of the policies covers the indemnity obligation."); *Northfield Ins. Co. v. Lexington Ins. Co*., 2003 WL 22138440 at *7 (S.D. Tex. Sep. 16, 2003) ("The court concludes that Lexington's [CGL and Umbrella] policies are the primary policies and that Lexington may not seek contribution from Northfield."); *Wal-Mart Stores, Inc. v. RLI Ins. Co.*, 292 F.3d 583, 593-94 (8th Cir. 2002) (same).

54 *See Houston Lighting & Power Co. v. Atchison, Topeka & Santa Fe Ry. Co.*, 890 S.W.2d 455, 458–59 (Tex.1994) (extending express negligence test to strict liability claims); *and Staton Holdings, Inc. v. Tatum, L.L.C.,* 345 S.W.3d 729, 734 (Tex. App.—Dallas 2011, pet. denied) (same regarding warranty claims).

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By Michael Sean Quinn, Ph.D., J.D., C.P.C.U.

INSURANCE UNIVERSALS & THE ARRIVAL OF THE CYBER-POLICY—PART TWO: SOME SPECIFICS ON LIABILITY INSURANCE

Part One of this three-part essay outlined the background for "cyber-insurance," its nature, its fundamental characteristics, and its policy structures, and made some additional observations about cyber insurance. That discussion included some "insurance universals" that apply to all types of insurance. Part Two, this part, takes up far more specific matters with a sharper focus on cyber policies. This is done by focusing on the liability section of one policy that is characteristic of many more blanket policies and thereby on many more narrow policies, though these are "rare birds," indeed—much more so than many narrowed so-called "real-world policies." The principal focus of this discussion concerns parts of the Travelers ***CYBERRISK***[1] **Policy** ("CRP").

Part Three to appear in a later issue of the *Journal* will concern First-Party insurance, often called "property insurance," though it would more accurately be called "asset insurance." Even that is not really accurate since that form of insurance may cover debt, health, or it may be life insurance. After all, it is first-party, or at least very much like first-party insurance. Therefore, it can be placed there, if there are only two forms of insurance.

I. Brief Typology of Cyber policies

All groupings of insurance policies have what might be called generic titles or general names."Commercial General Liability" is a generic title used, as are "D & O," "Builders Risk Policies," "Boiler & Machinery," "Engineering E & O," and dozens of others. Cyber policies are like that too, except that the titles tend to be longer and less familiar. Real-world policies have titles for various parts, for example: "Insuring Agreements." Cyber policies are similar to real-world policies in this regard.

Cyber policies have a large number of differing foci, whether First-Party Policies (1PPs); Third-Party Policies (3PPs); or coverages mixed together, for example auto and homeowners insurance. Each policy has its own insuring agreement, though the definitions appear all together in a separate section, while the exclusions are partly together and partly separated.

To a considerable extent at least, all of these provisions are different from real-world policies, so it is a good idea for counsel to study "cyber-titles" carefully. They may help interpret the language of the actual individual insuring agreement.[2] This is true even though most insurance policies—whether real- or cyber-world—explicitly assert, usually in the Conditions section, that the titles in the policy cannot be used to do this.

Along the same lines, counsel should remember that cyber policies almost always contain multiple agreements, usually many more than real-world policies. Counsel should consider using the language of each of them to help understand and interpret at least some of the others. As a general rule, insureds can pick which one or more specified agreements it wants, but often only within general ranges and sometimes only with the insurance carrier's consent. Sometimes there are separate policies that can easily be put together. Obtaining supplementary insuring agreements by way of endorsement can also be very helpful, for purposes of understanding and interpretation. Many of these are easier to obtain than special, as opposed to general, endorsements in real-world policies.

Significantly, different wordings are common in cyber policies, since there are no established, standardized cyber policies. But there are many common categories of coverages found in cyber policies, for example:

- Network Security Protection Liability
- Network Security and Information [or "Data"] Violation Liability[3]
- Communication and Media Liability
- Regulatory Defense Expenses
- Crisis Management Event Expenses

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- Security Breach and Remediation Expenses
- Computer Fraud
- Funds Transfer Fraud
- E-Commerce Extortion
- Business Interruption and Additional Expenses
- Extortion
- Breach of Insured's Privacy
- Breach of the Privacy of Others by the Insured
- Professional and Technology Based Services Liability
- Professional and Technology Based Services Injury
- Professional Liability Arising from Software Design
- Professional Liability Resulting from Network Design and Installation
- Cyber Crimes Against the Insured.[4]

Notice that some of the covered events *take place in cyber-space*, and some of them are *done to cyber space*, particularly the professional malpractice coverages.

As an example, the crisis management type coverages are for losses an insured sustains when it suffers an injury that it needs to conceptualize, explore, investigate, trace, determine, correct, fix, revise, undo, redo, guard against for the future, and deal with damage it has sustained to its brand reputation, its entity reputation, or, more generally, its public persona of any kind. This coverage also helps an insured to clarify, limit or somehow delete the injury it caused from public attention and, to the extent possible, from public consciousness.

As will be obvious very quickly, this coverage is designed to result from the Wrongful Acts of others. Why this coverage is restricted to the Wrongful Acts of others can be regarded as a mystery. One can burn down one's house or any other building of one's own and still have coverage.

Crisis management coverage may include the costs of notification—often statutorily required—of those who have lost or may lose something. For example, what is often called "personal identity," though in this context, whether or not such a person has or will sustain economic or financial injury is a phrase not to be found in this policy. Obviously, this can be an expense of gargantuan size if millions of people have "lost" their personal identity, even though they still have all of its components, except for its secrecy, if—indeed—it was secret. Some credit card information is like this.

II. The Travelers "CYBERRISK" Policy

The Travelers "***CYBERRISK***" **Policy**, part of which will be discussed below, has at least thirty-three (33) exclusions. Most of the exclusions contain several other exclusions. Fourteen (14) of the numbered exclusions apply exactly and only to the parts of the policy to be discussed, while eight (8) of the exclusions are identified as general and apply to all the insuring agreements. Another eleven (11) exclusions apply to other parts of the policy. Some of the exclusions are difficult to understand. This results partly because they utilize the high-tech vocabulary of the cyber world. But some of the prose is simply so opaque that even some experienced coverage counsel have difficulty understanding it. This problem is not uncommon for sophisticated cyber policies.

Often, but not always, the insurer pays defense lawyers directly so that the insured does not have a month-to-month or other periodic cost assessment. When the insurer pays the lawyers as the case develops, it is called "pay on behalf of" coverage. When the insurer is providing a defense, the insurer typically picks defense counsel, supervises counsel, and gives direction. This is not always true, however, e.g., in Directors and Officers policies. Often in more advanced policies, *e.g.,* lawyer's E & O policies, the insured is invited to participate in the selection of counsel. All of these same points apply to cyber-liability insurance.

But insurers have little idea how to supervise defense counsel in the context of administrative proceedings for real-world policies; for one thing they do not want to learn about them, and for another, they do not know how to reliably price it the insurance for the relatively narrow markets in which it could be sold. However, the problems regarding providing a duty to defend in administrative proceedings are much easier for the cyber-world than the real-world. The prevalence and possible preeminence of administrative tribunals are already well-established in the cyber world. How could it be otherwise given the role of government regulation in the cyber world, *ab initio*?

Some substantive details on this coverage are to be found in the ***CYBERRISK* Policy**. It has provided more than a few of the titles for coverage agreements listed above. The ***CYBERRISK* Policy** contains ten (10) insuring agreements, "only" fifty-nine (59) definitions, and a larger than usual number of exclusions—but only eight (8) of the exclusions apply to all the insurance agreements, while another fourteen (14) of them apply to crisis management coverage only.

The ***CYBERRISK* Policy** is an elaborate and complex commercial cyber-policy. Whatever its flaws, the drafting of this policy is an embodiment of truly extraordinary

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underwriting work. One might even be tempted to call it a "magnificent" piece of work if it were not for certain semantic flaws. (That problem will be discussed *infra*.) Still, even beautiful objects are not perfect, and one cannot work with real -world practical language without imperfections. The flaws may be in the language itself and not in a linguistic design.

The phrase "CyberRisk Policy" is explicitly defined in the policy as:

> **CyberRisk Policy** means, collectively, the **Declarations**, the **Application**, each purchased **Third Party Liability Insuring Agreement** and **First Party Insuring Agreement**, and endorsements attached thereto.

This definition makes it clear that an insured can only buy parts of the coverages set forth in the policies. Note that this definition explicitly makes the application for insurance part of the policy. If nothing else, this creates the obligations of the insured-to-be by the explicit requirements of the application, as well as its obligations under the contract of insurance—the policy. This could enhance Travelers' contract rights and make the obligations of the insured-to-be easier for Travelers to enforce. Additionally, this is a "claim made and reported" policy, meaning the claims against the insured must occur within the policy period (and any relevant extensions) and the claim must be reported to the insurer within the claim period (subject to relevant extensions).

A. Liability Insurance in the CRP

The 3PP consists of three (3) different insuring agreements:

- Network and Information Security Wrongful Act ["NISWA"];
- Communications and Media Wrongful Act ["CMWA"]; and
- Regulatory Defense Expenses ["RDE"].

A good way to consider these coverages is to start with some definitions. Here are a few general definitions. We begin with a discussion of the *definiendum* "**Related Wrongful Acts,"** which technically relies on the phrase "**Cyber Risk Policy,**" the definition of which was just set forth.

In any case, the coverage for liability portions of this policy concern claims against the insured. The term "**Claim**" means, among other things, a written demand by a third party (or group of third parties) for compensation as the result of an alleged "**Wrongful Act**" by the insured. There are an array of such demands, each of which may be a "**Claim**"; all of which have to be in writing. There is also a specification as to how a "**Claim**" is to be dated.

Not all other policies, whether real-world or cyber-world policies, work exactly like this, but they are very similar. The "claim-handling process," the "process of adjusting," or "the process of settling," is thought of and sometimes described as beginning when an insured makes a "claim" against its company (in third-party insurance situations), and there is certainly nothing conceptually or language-usage wrong with this. The different ways of talking certainly bare a "family resemblance" to one another, though it is not really the absolutely correct vocabulary. In the case of this policy, the duty of the insured, if it wants coverage, is to "report" a claim to the insurer. In other policies, the insured must "notify" the carrier or give it "notice." (If it doesn't seek coverage, of course, it has no duty to report the claim against it, until the time of the next application, probably.)

So much for general observations and orientation. Let us turn to the actual provisions of the policy.

1. The Network and Information Security Wrongful Act ["NISWA"] Coverage

The insuring agreement for NISWA portion of the policy provides as follows:

> The Company will pay on behalf of the **Insured**, **Loss** for any **Claim**, other than a **Regulatory Claim**, first made during the **Policy Period** or, if exercised, during the **Extended Reporting Period** or Run-Off Extended Reporting Period,[5] for a **Network and Information Security Wrongful Act [NISWA].**

Not all these definitions, as is true with almost all insurance policies, need expository consideration. Some of them are minor, and others are reasonably understandable, or already understood. The agreement under discussion contains three definitions that need immediate discussion, though one of them is not really important, although it looks it, and isn't really a definition at all. The most important definition is that of **NISWA** itself. In turn, **NISWA** contains more defined terms, only two (2) of which warrant discussion: **"Network,"** and **"Wrongful Act."**

The term **Loss** is the second really central defined term. Most significantly, and perhaps unexpectedly, it renders the insurer responsible for paying proved punitive and similar types of damages, in addition to actual damages, so long

as such damages are insurable under applicable law. Such damages are not often—almost never— awarded in the end, even though they are often sought, but when they are awarded, the amounts can be astronomical. In addition, it is worth noting that including punitive damages in the coverage suspends the principle of fortuity, as the reader knows, one of the universal tenets of "real, unadulterated" contracts of insurance. The definition of **Loss** also contains a slew of what are, in effect, definitions of loss and also contains a slew of what are, in effect, exclusions.[6]

This definition also contains a subordinate definition of "**Defense Expenses"**; it is not substantially different from the usual sort of these definitions. Here it is:

> **Defense Expenses** means reasonable and necessary legal expenses incurred by the Company or the **Insured**, with the Company's prior written consent, in the investigation, defense, settlement and appeal of a **Claim,** including costs of the expert consultants and witnesses, premiums for appeal, injunction, attachment or supersedeas bonds (without the obligation to furnish such bonds) regarding such **Claim;** provided, that **Defense Expenses** will not include the salaries, wages, benefits or overhead of, or paid to, any **Insured** or any employee of such **Insured**.

This is a fairly standard definition of "**Defense Expenses**." Often that term is not defined in real-world policies, particularly those at a lower level of sophistication. When the phrase or its equivalent is defined, it closely resembles this one. Although the definition in the ***CYBERRISK*** **Policy** itself does make it clear that Travelers will direct the legal defense and pay for the defense on behalf of its insured, the definition of **Loss** makes that clear. This definition does make clear that the amounts spent by the insured in preparing its defense are to be paid on its behalf, so long as certain exclusionary language of limitation is met—*e.g.,* having obtained written consent to the expenditure in advance of undertaking it.[7]

"Network," is defined as

> any and all services provided by or through the facilities of electronic or computer communication system... and automated teller machines, point of sale terminals, and other system operating systems, including any shared networks, internet access facilities, or other similar facilities for such systems in which the **Insured Organization** participates, allowing the input, output, examination or transfer of data or programs from one computer to a **Computer System.**

While "**Network"** is defined, "information**"** is not. Significantly, it is not distinguished from data, as is often done.

Computer System is defined as:

> any computer system, and any input, output, processing, storage or communication device, or any related network, operating system or application software, that is connected to, or used in connection with, such computer, which is rented by, or owned by, leased by, licensed to, or under the direct operational control of, the **Insured Organization**.

"**Wrongful Act** means any **NISWA** or **Communications and Media Wrongful Act [CMWA]**." In other words: one or the other or both. The phrase "wrongful act" is restricted to two (2) different contexts, and it is defined for each of those contexts in another, more complex phrase.

So at best the definition works like this:

The general phrase **Wrongful Act** does not have one meaning; it has two, each for a different context. Those "definitions" are really just lists of actions and other states of affairs that are consequences of one or more of many different acts.

Obviously, this is not really a definition, even though it does give the following direction, unusual for a definition:

"If you want to know what the phrase "wrongful act" means in this insurance policy, it is restricted to two different contexts, and it is defined for each of those contexts in another more complex phrase, so you have a look elsewhere."

What we get for defining the idea of **Wrongful Act** listed as a separate phrase is a list of failures for a **Wrongful Act** in the context of **NISWA**-type situations. A list of failures, however, obviously, is not a definition; it is a list of consequences of acts. What we have then is a statement to the effect that any act which causes one or more of the listed states of affairs is to be considered a **Wrongful Act.**

Or maybe it's this:

> Any act which results in any one or more of the listed states of affairs are to be considered a **Wrongful Act**, however many different acts may cause each of the different states of affairs.

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To repeat: this is a very unusual—indeed, unreal—way to carry out a defining term, whether a word or a phrase.

Thus, we forget about a real definition and turn to the list, and what the policy considers the definition of **NISWA** can be sketched. It means any actual or alleged:

1. failure to prevent unauthorized access to or use of electronic or non-electronic data containing **Identity Information**;

2. failure to prevent the transmission of **Computer Virus** through the **Computer System** into a computer network, any application of software, or a computer operated system or related network, that is not rented, owned, leased by, licensed to, or under the direct operational control, of the **Insured Organization;**

3. failure to provide any authorized user of the **Insured Organization** website or **Computer Systems** with access to such website or **Computer System**; or

4. failure to provide notification of any actual or potential unauthorized access to, or use of, data containing private or confidential information of others if such notification is required by any **Security Breach Notification Law** by, or asserted against, an **Insured Person,** in his or her capacity as such**,** or the **Insured Organization.**

Is it really the case that there cannot be a **Wrongful Act** unless it causes a state of affairs that constitutes an injury? After all, one can try to murder someone without causing a death. In addition, one wonders how many different **Wrongful Acts** can dance on the head of each of these pins. I shall return to the second of these questions in a moment for important information.

Of the many points that can be made or suggested by this "definition," two (2) points can be suggested immediately. First, notice the presence of the word "or" but not "and," which is there in some definitions, such as the one of **Computer System**; "or" always, as opposed to "and," has very significant implications. It means "one of these," "both of these," or "all of these," unlike "and." Second, and just as important, notice that the word "failure" is present. This is an ambiguous term. On the one hand, it is a term of criticism, as in "Pat failed Advanced Calculus, flibbertigibbet that s/he is." On the other, it is a term of reporting, as in "Patty failed Advanced Calculus; she was too sick to show up—what with having brain surgery and all—for the exam. Professor Prick wouldn't listen—rigid, ill-informed, intolerant bastard that he is." Or it's hard to tell which one is being used."The Supreme Court failed to consider the 5th point of the brief." Often in lawyer discourse, that locution is an instant of the second meaning—the court just didn't do it, but one is often unclear as to which one is being used.

One odd feature of this method of defining "**Wrongful Act**" is that the phrase "Network and Information Security" is also not defined. One would expect that if one term got no definition but it was specified that its meaning would be understood as it is used in another phrase which is not commonly understood, that the phrase describing where the supposedly define term is placed would itself be defined. This is a defect in the policy. All is not lost, however; the policy provides a flawed method for more or less determining what the phrase "Network and Information Security" means, as we shall see in moment.

Nevertheless, we can find out a good deal about what constitutes a "Network and Information" state of affair that is secured might be and which is damaged by the act which is a **Wrongful Act**, remembering that an omission is a **Wrongful Act.**

Consider #1 on the list. The state of affairs specified there is unauthorized access to, or use of electronic or non-electronic data (information) containing many different kinds of information about natural persons; the phrase **Identity Information** is defined. Of course, the access may be harmless; the use may be trivial; and the data may be found non-electronic, such as that found on a piece of paper, and may be obtained by means not utilized in cyber-space, such as breaking into a building.

It is not necessary to go further and analyze the other components of the definition of **Identity Information**. They are even more complex and equally absurd, or have equally absurd instances. These **Wrongful Acts** are not restricted to the failure to prevent hacking and similar external and internal acts, which is what one would expect.

2. CMWA Insurance

Now for the second insuring agreement in the liability part of the policy considered here. It reads this way:

> The Company will pay on behalf of the **Insured**, **Loss** for any **Claim**, other than a **Regulatory Claim**, first made during the **Policy Period** or, if exercised, during the **Extended Reporting Period** or Run-Off Extended Reporting Period, for a **Communications and Media Wrongful Act.**

In all significant and relevant respects, the specification of this insuring agreement works like the **NISWA** insuring agreement. The only difference between these two (2) insuring agreements worth discussion is its definition of the phrase **CMWA** as applied in the 1PP section. Here it is:

any actual or alleged

1. unauthorized use of, or infringement of, copyright, title, slogan, trademark, trade, service mark, domain name, logo or service name in the **Insured Organization's Covered Material**;

2. plagiarism or unauthorized use of a literary or artistic format, character, or performance in the **Insured Organization's Covered Material;**

3. invasion or interference with an individual's right of publicity, including commercial appropriation of name, voice or likeness in the **Insured Organization's Covered Material**;

4. defamation, libel, slander, trade libel, or other tort related to disparagement or harm to the reputation or character of any person or organization in the **Insured Organization's Covered Material**, by, or asserted against, an **Insured Person**, in his or her capacity as such, or the **Insured Organization**.

It should be fairly obvious that this so-called definition is structurally similar to the definition found in **NISWA**, and it suffers from the same problems. But at the same time, each of these definitions, both central to the content of two of the insuring agreements, exemplifies one of the key features of the coverage found in the insuring agreement and so they both contain a complex list of perils covered by the insuring agreement. At the same time, both say nothing about risk or about causation or injury. Those are matters to be found in the agreement itself. Also significantly, this definition is reminiscent of some of the definitions found in various commercial liability policies formerly and/or now used in the real-world.

An important feature of NISWA is that the concept is also used in 3PP. The context there is quite different from that here. NISWA and CMWA appear in both the Liability part (3PP) of the policy and in the First Party section (1PP). The principal difference is that in one section, the terms refer to what is done *by* the insured to someone else, while in the First Party section, it refers to something that *is* done to it, not necessarily by someone else.

B. First-Party Insurance Coverage

Two (2) first-party coverages will be discussed here. The first one is for "**Crisis Management Event Expenses ["CMEE"],**" and the second is for "**Security Breach Remediation and Notification Expenses ["SBFRNE"].**"

These coverages are being described as 1PPs. The reader should take a careful look and ask him/herself whether there could be coverage for injury the insured inflicts upon itself for liability to a different person or entity.

1. CMEE Insurance

One of the most important things to know about **CMEE** is that it can be connected to cyber liability insurance. If an insured injured one of its customers, **CMEE** can be conceptualized as attached to liability insurance. The same is true for **NISWA**. The substantive part of this insuring agreement reads, in part, as follows:

> The Company will pay the **Insured Organization** [which may be several companies] for [**CMEE**] incurred by the **Insured Organization**... as a result of any [**NISWA**] or [**CMWA**] taking place prior to... [Time periods have been omitted.]

The definition of **CMEE** is:

> reasonable fees, costs, and expenses incurred and paid by the **Insured Organization** with the Company's prior written consent, for *public relations services,* recommended and provided by an **Approved Service Manager** to the **Insured Organization** to mitigate any actual or potential negative publicity resulting from any **Wrongful Act.**

[Italics added.]

Notice that the insured's expenses must have been "incurred and paid." Notice that the insured's expenses must also be originally authorized by the insurer and audited in detail by the insured.

The essence of this coverage is to deal with injury to reputation. This definition sets forth what the insurer will pay for—namely, public relations expenses caused by one (1) of two (2) types of events. Many policies contain this sort of definition.

This coverage can, at least in theory, be mixed together with the 3PP. How the blending works—something that is not spelled out explicitly in the policy and which could easily be missed—is that this clause contains the unexplained and ambiguous term "any." The perils here are NISWAs the CMWAs and some others, although not all of them, as is explicitly specified in the language of the policy. But there are two (2) types of each of these **Wrongful Acts**—one of them occurs when it is the insured that performs the **Wrongful Acts**, and the other one occurs when someone else—someone other than an insured—performs the **Wrongful Acts**.

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Thus, some entity other than the insured might perform one or both of the types of **Wrongful Acts** and thereby injure the insured, but that event might cause a blow to the insured's reputation. This could happen, for example, if the insured's security was breached and the event was highly publicized. What happened to the insured might lead to losses for its customers. In the alternative, however, the insured might engage in **Wrongful Acts** directed toward another entity, be involved in or implicated in such **Wrongful Acts**. If the insured's activities were discovered, or if the insured was closely connected to its victim, the reputation of the company and its senior management would be harmed. This is not a pure case of first-party insurance—it is a blend of both first-party coverage and third-party coverage. In other words, it is being used like the duty to defend.

In any case, this clause of the insuring agreement contains all of the essential, fundamental ideas outlined in §III.A above. The two specified perils, **NISWA** and **CMWA,** are certain types of wrongful acts, and an occurrence of either of them can make substantially more probable (cause) injuries to an insured, one species of which is a (probably substantial and sudden) decline or undermining of the reputation, as a result of which the insured sustains a loss when its revenues and profits decline, and the insured is required to spend money to restore its reputation as best it can be afforded.

So far as risk is concerned, network breaches can lead to disasters, so there is a high risk involved here, especially if it comes from the hackorama, obviously, something insureds need to study carefully when identifying and evaluating the risks they face.

In analyzing **CMEE** in the light of the fundamental concepts of insurance, it is important to remember that risk is being transferred. The phrase **CMEE** refers to expenses that will be charged to the insured as it tries to repair itself, and the point of the insuring agreement is to transfer them to the insurer. For the purposes of this transfer, it does not matter who is responsible for the insured's harm and loss. This fact can be recognized from the definition of **CMEE**.

Notably, there are no reported cases that embody disputes arising under this category of definition, whether in cyber-world policies or in real-world policies. But these types of disputes will eventually come. Here are some examples of what sorts of disputes between insurers and insureds regarding expenses are almost certain to arise:

2. The policy makes all but "potential negative publicity" a reimbursement obligation, but coverage for a potential event cannot be reimbursed.

1. It insures only "reasonable fees, costs and expenses." There is always controversy about this sort of conflicting right, and there is an added complication here: to what must the insurer consent? The reasonableness of the amounts paid or paying them at all. (Consider the following: the insured consents to the payment of the fees, but says nothing about approving their reasonableness and then denies coverage based on the grounds that it had not approved the fees as being reasonable. This is absurd, of course, but consistent with the language of the contract literally construed.)

2. It makes the approval by the "**Approved Service Provider"** [ASP], which must both approve and conduct the covered activity. Does the insured have no say in the matter? Also, the reasonableness of the insurer's choice will sometimes be disputed. Such controversies may pertain to the approval itself, to proofing the approved activity, or both. Obviously, the ASP must be an outside firm under the policy, and the historical, structural, contractual and behavioral connections might be issues.

3. It leaves it unclear what the range of professions ASPs must be. The term of designation is not really defined, even though the text says it is.

4. It makes the insurer's written consent a necessary condition for its obligation to compensate the insured. But to what does the requirement of written consent apply? The hiring of an ASP? The performance of that which the ASP has approved? At each specified phase of performance, how is an involved entity's reasonableness to be measured? How are ASP-dissatisfactions to be handled?

5. It makes it impossible for the insured to have the right to recover if it pays expenses which a rational ASP would approve and at levels of expense that the ASP would also approve.

6. It provides no timetables in accordance with which approvals must be conducted and paid.

7. provides coverage only for the "mitigations" of the insured's damages resulting from publicity. The trouble here is that the term "mitigation" often refers to performing activities which prevent an injury from a covered peril from getting worse, and does not refer to compensation for the covered injury itself.

And, of course, there are more.

There is something odd about this CyberRisk Policy using the subtitle it does for its reputation coverage. As these things go, there is relatively extensive literature on crisis management outside the insurance area. The matter is so extensively planned, practiced, and used that even relatively superficial sources, like Wikipedia, have lots of information, including bibliographies. The "Wiki-point" illustrates how widely the matter is discussed. However, I have not found it helpful.

III. Preliminary Conclusion

This essay should give the reader a good general idea of what liability sections of cyber policies look like, although not the details of all of them—actually, only a medium-sized fraction. It also provides commentary on provisions of the First-Party (1PP) section of the policy. A detailed discussion of 1PPs will come in Part Three, to be published in a future issue of the *Journal of Texas Insurance Law*.

1 The idolized shape will be used as it is designated as a brand name.

2 It is also a good idea to remember that more and more real-world policies are explicitly excluding perils, injuries, risks, and causations occurring in the cyber-world.

3 The terms "data" and "information" are often not distinguished carefully, if at all. Sometimes they are said to have quite different meanings. When this is true, "information" means facts or true propositions about facts, sometimes stored in computers."Data" may be taken to mean quantities, characters, or symbols stored in computers.

4 For the convenience of the reader, some of these names have been simplified or abbreviated.

5 Oddly, the phrase "Run-Off Extended Reporting Period" is not defined, although it is far less well-known. For example, in this policy, the phrase **Extended Period** is defined but "Run-Off Extended Period" is not. Usually the latter is simply used as another name for **Extended Period**. Alternatively, in D&O policies, there is usually a clause which specifies that the policy ends at the point in time, if there is one, that the insured company (or, the company for which the insured works) loses control of itself. This may happen as the result of a sale or merger.

6 Generally speaking, courts do not recognize exclusionary language in insuring agreements and definitions as exclusions. This is important because insureds bear the burden of proof in demonstrating the satisfaction of an insuring agreement, while it falls upon insurers to prove that an exclusion applies.

7 In general, insurers often waive this requirement if the project was itself reasonable and necessary, the amounts spent were reasonable, and the insurer would have consented to it had it been asked.

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By Micah E. Skidmore

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NEGOTIATING COVERAGE & PURSUING CLAIMS UNDER CYBER-SECURITY & PRIVACY INSURANCE

I. Introduction

During an investor conference call on Wednesday, February 26, Target CFO John Mulligan reported that the highest profile data breach of 2013 cost the retailer $61 million in out-of-pocket expenses during the fourth quarter, of which $44 million was covered by insurance.[1] Future direct costs, including privacy notification, credit monitoring, card reissuance, card merchant penalties, forensic consultants, consumer losses, legal fees, regulatory penalties and public relations, may ultimately total hundreds of millions of dollars.[2]

The Target breach is only the latest in a series of significant cyber-attacks affecting hundreds of private and public entities and millions of individuals worldwide. In addition to third-party and regulatory claims arising out of compromised personal information, corporate victims of electronic loss may experience damaged information systems, interruption of business operations, disclosure of valuable trade secrets or other sensitive commercial information and follow-on fiduciary and shareholder derivative litigation. Like Target, the costs associated with these risks may be extraordinary.[3]

As the incidence of corporate cyber-attacks escalates, recourse to traditional insurance coverage may not provide a complete solution. Within the past two months, at least two opinions have been issued denying coverage for cyber-related claims under commercial general liability insurance policies. In April 2011, hackers gained access to Sony Corporation's Qirocity network and the customer accounts of more than 100 million users.[4] In a subsequent suit by Sony's general liability carriers, Zurich America and Zurich Insurance Co., Ltd., New York Supreme Court Justice Jeffrey Oing issued a verbal ruling on Friday, February 21, 2014, finding that Zurich had no duty to defend Sony in connection with class action lawsuits, miscellaneous claims and regulatory actions arising out of the 2011 breach because "coverage for oral or written publication of materials that violate a person's right to privacy only applies to material published by Sony as the policyholder, not to the hackers who stole users' confidential information."[5]

In *Recall Total Information Management, Inc. v. Federal Insurance Company*, No. AC 34716 (Jan. 14, 2014), the Appellate Court of Connecticut found that data logistics provider Recall was not entitled to coverage for $6 million in damages paid to IBM following the loss of 130 computer tapes, containing personal information of more than 500,000 IBM current and former employees. According to the Court, the subject liability policy required "electronic, oral, written or other publication of material that... violates a person's right of privacy," and notwithstanding Recall's assertion that "the mere loss of the tapes constitutes a publication," "[t]here is nothing in the record suggesting that the information on the tapes was ever accessed by anyone."[6]

The confluence of increasing cyber-attacks and potentially limited traditional liability coverage may draw more corporate policyholders to dedicated network security/cyber/privacy coverage. Within the past few years, most major insurance carriers have unveiled new or revised policy forms specifically designed to protect against the burgeoning threat of cyber-attacks and related liability and other risks.[7] Such policies typically include what are traditionally thought of as both liability coverage for third-party claims and in some cases regulatory claims as well as first-party coverages from privacy notification coverage, crisis management, extortion, and vandalism coverage to data loss, business interruption, and extra expense. Still other policies may contain quasi-fidelity coverages protecting against loss resulting from computer fraud and funds transfer fraud. Alternatively, corporate insureds may address so-called "cyber" risks with customized "riders" and "endorsements" to traditional liability, property and fidelity policies.

Every "cyber" policy form is unique and deserving of a careful review. Nonetheless, among the variety of "cyber" insurance offerings available in the market, common issues arise. Part II provides a summary of significant issues to review when negotiating "cyber" coverage terms, including familiar policy provisions, pertinent considerations and related issues to avoid in anticipation of a claim.

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Once a dedicated cyber insurance contract is placed, corporate policyholders should also be familiar with the various issues that may arise in pursuing a claim for coverage. According to one source, three out of four companies have either experienced or expect to experience a "material data breach that results in the loss of customers and business partners."[8] Part III highlights a variety of issues that every cyber policyholder should know in making and pursuing a claim under a dedicated network security or privacy liability policy.

II. What to Watch for When Purchasing & Negotiating Dedicated "Cyber" or Network/ Privacy Coverage

Insuring Agreements

"Cyber" policy forms offered by many major carriers may include a litany of separate grants of coverage, including data loss, business interruption, privacy notification, credit monitoring, reputational response, cyber extortion, forensics and regulatory investigation response. When considering what policy form is appropriate, policyholders should carefully determine the risks to which their particular business operations are most susceptible and then attempt to match those risks with available insurance offerings. Whereas cyber extortion, for example, may be a significant concern for some businesses operating with a substantial public profile, the "reputational risk" associated with a cyber-event for other online companies may be relatively small. Those insureds with a narrower "cyber" risk profile might be better off selecting the form that is most specifically tailored to the risk at hand—if only to avoid the unnecessary premium associated with superfluous coverage. But as a general proposition, even for those policyholders with wide ranging exposure to a variety of different types of e-risks, a policy form with only a few, broad grants of coverage may be preferable to one with a dozen or more very narrow insuring clauses. All other things being equal, the form with the broadest single insuring clause may offer more protection and may be less susceptible to the argument (in opposition to coverage for a future claim) that, if the parties intended coverage, they would have expressly allowed for the risk at issue.

Who is Insured

When investigating a particular policy form, determine all elements of coverage that are tied to the definition of who is an "insured." For example, most policies will require, at a minimum, that a claim be made against an "insured." Other policies will also limit covered "damages" to those that an "insured" incurs or is legally obligated to pay. Still other contracts limit covered "wrongful acts" to those committed by an "insured." Particularly when the triggering conduct is tied to who qualifies as an "insured," those individuals described in the definition of "insured" should include anyone within the insured organization responsible for network security, whether classified as employees or independent contractors. Alternatively, the "wrongful acts" that trigger coverage should be broadly stated to include conduct, not only by an "insured," but also anyone for whom the insured may be liable or a service provider or contractor responsible for the insured's computer systems, networks or website. When a third-party service provider is insured under your policy, or when you are an additional insured under a third-party's policy, be sure to obtain and document the appropriate waivers of subrogation from the counterparty's insurer.

Trigger of Coverage

Network security or privacy liability coverage typically is written on a "claims made" basis. But many policy forms will include retroactive dates requiring that the underlying "wrongful act" occur after a specific date. While the retroactive date may initially coincide with the insured's first placement of coverage with a particular carrier, prio -acts coverage usually can be obtained for additional premium.[9]

While generally captioned as "claims made" policies, network and privacy liability policies may include specific coverages that are textually not tied to the making of a "claim" within the policy period. Some policy forms, for example, offer coverage for privacy notification expenses arising out of an incident or event, as opposed to a "claim." Other policies require the "injury" giving rise to the privacy notification expenses or other loss to occur during the policy period. When such coverage is subject to sublimits, retentions or deductibles, insureds should look very carefully at how the "injury," "event" or "incident" that will determine the number of retentions/deductibles or the amount of policy limits applicable to an insured's loss are defined.

While many jurisdictions have developed a body of case law intended to address how many "occurrences" exist for purposes of coverage under a general liability or other "occurrence"-based policy, much less guidance is available to determine the number of "incidents," "events," or "breaches" for purposes of coverage under a network or privacy liability policy. Due to the delays that often occur in discovering a network security or privacy breach, any number of breaches and/or temporally discrete data exfiltrations may have occurred prior to the reporting of an insurance claim.[10] Complete, accurate or reliable logs may not even be available to document or determine when or how many breaches occurred. To avoid complicated disputes over the attachment point or limits on coverage, policyholders and carriers should be very deliberate in addressing such issues with appropriate policy terms.

Even when policy limits and self-insured obligations are defined in terms of a "claim," policyholders should carefully review the terms of "interrelated wrongful acts" provisions,

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which generally aggregate "claims" arising out of the same or in some cases similar conduct. While a natural inclination for policyholders faced with a "per claim" retention or deductible may be to aggregate as many "claims" as possible through an expansive "interrelated wrongful acts" provision, an overly broad provision may have the unintended consequence of placing a given "claim" in a prior period either beyond an applicable retroactive date or at point for which notice or adequate underwriting disclosure was not given.[11]

Policies also vary in defining the event that triggers liability coverage either by limiting the "wrongful acts" insured or by limiting the "injuries" claimed against the insureds. While the scope of either the covered "wrongful acts" or covered "injuries" will vary by policy, query whether conceptually it is most advantageous for the insured when making and pursuing a claim to be put to the burden of establishing a specific "injury" to a claimant or that specific "wrongful conduct" occurred.

Cyber security policies may also include so-called "first-party" coverage for the insured's own loss of data or lost profits from the interruption of virtual operations. For such coverages, it is the discovery of the loss, usually by one or more of a defined group of corporate leaders, that triggers not only coverage, but the insured's notification obligations. As with crime/fidelity coverage, policyholders should opt where possible for general notice obligations, *i.e.*, notice as soon as practicable, in favor of discrete time periods within which notice must be given to be timely.[12] Policyholders should also consider whether the corporate leadership, whose knowledge triggers coverage, notice or other obligations, is consistent with t he i nsured's i nternal r eporting hierarchy.

Definition of "Claim"

Most network and privacy liability policies address "claims" as would a D&O or professional liability policy. When reviewing and negotiatong policy terms, parties should consider adding language to the "claim" definition that would include requests to enter into a tolling agreement and demands for mediation, arbitration or other alternative dispute resolution processes. Appeals of proceedings otherwise included in the definition of "claim" should also be included. As appropriate to the insured's risk profile, policyholders should also request terms that would include regulatory investigations of an insured person or organization, including subpoenas or informal demands for documents, testimony or other information. In particular, whereas limiting coverage for regulatory investigations to insured persons may (or may not) make sense in the context of a D&O policy, the same limitation arguably is not appropriate and should be avoided in a network security or privacy liability policy.

Definition of "Loss" or "Damages"

Covered "loss" or "damages" should include amounts paid as defense costs, settlements, judgments, pre- and post-judgment interest."Damages" should also include fee awards. Most policies exclude fines and penalties from covered "loss" or "damages"; although, penalties ordered to be paid under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health ("HITECH") Act, the Gramm-Leach-Bliley Act ("GLBA"), state privacy laws or similar laws, rules and regulations should be included, to the extent insurable under applicable law that most favors coverage for such damages. To the extent not strictly qualifying as "defense costs," "loss" or "damages" should also include (1) the cost of retaining experts, including forensic consultants to investigate and remediate an alleged breach of privacy or network security; and (2) related costs to notify individuals as required by applicable state and federal privacy laws, including credit monitoring expense. In some cases, forms may allow or policyholders may seek out coverage for the cost of retaining public relations professionals to manage a public response to a network security breach, including the related cost of any necessary communications or advertising.

Conduct Exclusions

In the pattern of D&O and professional liability policies, many network or privacy liability forms will exclude coverage for "loss" resulting from "claims" arising out of (1) dishonest, fraudulent, criminal or malicious conduct or an intentional violation of law; or (2) the gaining of any profit or advantage to which the insured is not legally entitled. Many of these same exclusions do not apply unless or until there has been a "final adjudication" establishing such excluded conduct against the insured. While "final adjudication" is a necessary first step, such exclusions should also be phrased to require that the "final adjudication" triggering the exclusion take place in the underlying "claim," as opposed to a subsequent proceeding to determine coverage. Insureds should avoid policy terms that would eliminate the need for a "final adjudication" in the event of an adverse admission, finding, or plea by an insured. Parties should consider an exception to the typical "conduct exclusions" for claims alleging an intentional distributed denial of service attack ("DDoS") perpetrated against a claimant using the insured's computer systems, when under the control of a third-party cyber operator.

Insured v. Insured Exclusions

Network and privacy liability policies will often exclude loss arising from claims brought or maintained by or on behalf of an "insured" akin to similar exclusions in traditional D&O and professional liability policies. Although, "insured v. insured" exclusions in network and privacy liability policies seldom include the various exceptions to which similar

exclusions are usually subject in D&O and professional liability contracts. As a result, policyholders should be vigilant to ensure that "insured v. insured" exclusions in network and privacy liability policies do not apply, *e.g.*, to (1) derivative claims brought without the active assistance of individual insureds; (2) claims brought by employees alleging the disclosure of employees' personal information; (3) claims brought by a bankruptcy trustee, examiner, debtor in possession, receiver or creditors' committee, without limiting the exception to claims brought in a "bankruptcy proceeding"; and (4) claims brought by an insured person in the form of a cross-claim or third-party claim for contribution or indemnity which is part of, and results directly from, an otherwise covered claim.

"Prior Knowledge & Foresight" Exclusions

Whether in the insuring agreement or in an exclusion, many network security and privacy liability policies do not insure "damages" arising from "claims" based upon "wrongful acts" committed prior to the inception of the policy, if prior to the inception of the policy, the insured knew or *reasonably could have foreseen* that the subject wrongful act could lead to a claim. Textually, these types of exclusions can apply in the absence of a subjective expectation of a future claim if, knowing what the insured subjectively knows, a future claim might reasonably be anticipated.[13] According to Verizon's 2013 Data Breach Report, months or in some cases years elapse between the initial compromise and discovery for a substantial majority (66%) of cyber events.[14] While, on one hand, these data suggest something about the reasonableness of an insured's ignorance of a past cyber breach, policyholders should be wary of exclusions purporting to limit or exclude coverage based on what an insured "should have" known or anticipated. At a minimum, policyholders should be sensitive to whether these restrictions are placed in the insuring terms or in the form of an exclusion and carefully weigh benefits and drawbacks of each. In any event, policies should always include an appropriate severability provision such that the facts and knowledge pertaining to one insured shall not be imputed to any other insured with respect to "prior knowledge and foresight" exclusions, as well as other exclusions and representations made in connection with the application for and underwriting of the subject policy.

War Exclusions

Among the network and privacy liability forms offered by major insurers, some purport to exclude coverage for "loss" arising from "claims" attributable to war, invasion, acts of foreign enemies, hostilities, and warlike operations, whether war is declared or not. Recent media and third-party reports suggest that a significant number of network security breaches are perpetrated by foreign actors, including those allegedly acting under the auspices of foreign governments.[15] Given the difficulty inherent in conclusively determining the identity of cyber attackers, these types of exclusions may never be implicated, but insurers and insureds alike should carefully consider the implications of including what would normally be considered a "standard" "war" exclusion in a network and privacy liability policy.

Intellectual Property Coverage & Exclusions

A significant and increasing percentage of cyber events are motivated by the theft of intellectual property.[16] Unfortunately, different network and privacy liability policies address intellectual property matters in different ways. Many exclude coverage for "claims" arising out of the misappropriation or infringement of trade secrets, copyrights, trademarks, patents, or other intellectual property "by or on behalf of the insured." Others contain similar exclusions, but apply to the infringement or misappropriation of a third party's intellectual property without regard to whether such conduct was undertaken by an insured or not. For policyholders vulnerable to the loss of sensitive intellectual property, whether owned by the policyholder itself or for which the policyholder may be liable to a third party, the variations in policy forms may have dramatic consequences. For first-party intellectual property loss exposure, policyholders may be hard-pressed to find adequate coverage in any form. For third-party intellectual property liability coverage, insureds should vigilantly scrutinize policy forms to ensure that any intellectual property exclusion(s) are appropriately qualified and/or the definitions of "claim" and "loss" are broad enough to meet the insured's anticipated risk.

TCPA & Anti-Spam Claims

Some policy forms exclude coverage for claims alleging, arising out of or based upon unsolicited electronic dissemination of faxes, e-mails or other communications, including those violating the Telephone Consumer Protection Act or similar federal and state anti-spam statutes. Such exclusions should be appropriately circumscribed or include exceptions to avoid eliminating coverage for claims based on a DDoS attack perpetrated against a third party using the insured's computers.

Breach of Contract Exclusions

Borrowing from provisions in D&O and professional liability coverage, network and privacy liability policies frequently exclude coverage for loss arising from claims for or arising out of any contractual liability or obligation or from a breach of contract, except to the extent that the insured would have been liable in the absence of such contract or agreement. To the extent that claims from customers (or employees) arising from either a network or privacy breach may ultimately be rooted in a contract or agreement, policies with "breach of contract" exclusions should include appropriate exceptions to preserve this coverage.

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Policy Limits, Retentions, and Deductibles

As alluded to above, both insurers and insureds should carefully review what event, *i.e.*, a claim or network breach, determines (1) the number of retentions or deductibles that must be satisfied to access coverage; and (2) whether the insured is entitled to a single limit or aggregate limit of liability under a given policy. Policyholders should be aware of and avoid provisions that increase or multiply the deductible or retention applicable to claims that arise out of the same malicious code that was the subject of a prior claim. To the extent that a policy's terms require the insured to pay or bear a retention or deductible uninsured, policyholders should opt instead for terms that permit exhaustion of a retention or deductible either by or on behalf of the insured, including a third party or other insurer.[17]

Defense and Settlement

To the extent that a network or privacy liability policy does not provide a "duty to defend," policyholders should ensure that defense costs are required to be advanced on a current basis and not simply prior to the final disposition of the "claim." Applicable law in many states permits the insured to select independent counsel in the event that the insurers' coverage position creates a conflict of interest for defense counsel.[18] Policyholders should not contractually waive the right to select independent counsel. In the event that a policy form requires the insured to select from an approved list of panel counsel firms to defend a particular type of claim, the insured should request the inclusion of its preferred defense counsel on the list of approved firms.

Arbitration & Appraisal Provisions

When considering a policy form that compels binding arbitration of disputes arising out the policy, insureds should carefully weigh the benefits of arbitration, in expediency and avoided discovery expenses, against the cost of forfeiting a jury trial and/or some remedies or relief that may not readily be available in arbitration. In the event that an arbitration provision is preferred or cannot be avoided, policyholders should consider including various procedural requirements intended to permit additional control over the process and allow all parties to realize the advantages for which arbitration proceedings are favored. For example, insureds may request the appointment of non-neutral arbitrators by each side, with a neutral selected by each party-appointed arbitrator. Insureds may also request a favorable venue and/or expedited proceedings, such as by requiring the hearing to take place within 30 days of the selection of the neutral arbitrator. Policyholders may seek the elimination of provisions limiting or precluding the recovery of fee awards, interest, punitive or other damages in arbitration. To the extent that a policy contains an appraisal provision to address disputes over the valuation of first-party losses, policyholders should ensure that the appraisal clause appropriately circumscribes the scope of the appraisal to valuation as opposed to substantive coverage disputes. Insureds should also carefully review provisions addressing the rights of both parties to pursue coverage litigation, if any, after the appraisal process is completed.

Like every policy, every policyholder is unique. Not all of the above-referenced recommendations are possible or even advisable for every insured organization. Market conditions change over time. Policy forms evolve. But by being attuned to these and similar issues during the underwriting and negotiation process, policyholders ideally will maximize their recovery and minimize disputes in the event of a claim.

III. What to Know When Making a Claim Under a Dedicated "Cyber" or Network/Privacy Policy

Notice to the Insurer

In the event of a cyber-attack, and particularly one involving the disclosure of "personal information," notice to regulators, law enforcement and affected individuals may be mandated by statute. Companies responding to a network/privacy breach should also consider compliance with contractual notice obligations, including those in applicable insurance policies. Each network security or privacy liability policy contains a section describing the insured's duties in the event of a claim or loss. Because, as indicated above, network and privacy liability policies contain attributes of both first-party and third-party insurance, the insured's duty to give notice may depend on the type of exposure at issue.

With respect to liability coverage, inevitably, the insured must give written notice to the insurer "as soon as practicable" after a defined individual or set of individuals becomes aware of a claim or suit. In any event, notice under "claims made" policies must be given during the policy period or an extended reporting period (usually 30-90 days after policy expiration), if applicable. So long as the notice is given within the applicable policy/reporting period, the insurer may have to show prejudice to deny coverage on the basis of notice that is otherwise not given "as soon as practicable."

Most policies will also allow the insured to give notice of a potential claim or circumstances likely to give rise to a claim, with the understanding that a future claim will be deemed to have occurred at the time the original notice was given, even if the potential claim is made after the expiration of the noticed "claims made" policy. Because future policies may not insure claims about which the insured was or should have been aware at the time a future policy is placed, companies should also carefully determine whether circumstances exist that are likely to give rise to a claim, and report appropriately, before existing coverage and notification periods expire. This decision should be made in consultation with counsel to the extent that notification of

a potential claim could have implications for the insured's liability in a future claim.

While the broad definition of "claim," referenced above, generally favors the insured, the obligation to provide "notice" is correspondingly broadened as well. With this broad duty, policyholders must be careful to provide notice of "claims" that may not intuitively merit reporting to the insurer, including regulatory actions and any demand for monetary or other relief.[19] Policyholders should also consider which individuals' knowledge will trigger reporting obligations under an applicable network security or privacy liability policy and plan accordingly to ensure that information flows appropriately from those with critical knowledge to those with responsibility for giving notice to the insurer.

With respect to first-party coverage, a policyholder's notice obligations may be triggered by one or more individuals' awareness (or reasonable belief) that an event, injury or wrongful act, as opposed to a claim or suit, has occurred. Notice requirements for first-party coverage may also include the obligation to alert law enforcement and to document the insured's loss in a "sworn proof of loss." As with third-party coverage, policyholders seeking coverage for first party exposure should know which persons' awareness and which events require notice to the insurer.

Timely compliance with a network and privacy liability policy's notice provisions is important and should be part of the company's breach response plan. If a company is reliant on third-party contractors to facilitate network security, policyholders should demand or otherwise ensure that appropriate notice is given under policies that cover the company as additional insured or may provide a source of redress for damages sustained in a cyber-attack.

Selection of Counsel & Forensic Investigators

When a data breach occurs, the benefits afforded under a network security or privacy liability policy may include the retention of legal counsel as well as forensic investigators to identify and respond to the cause of first-party and third-party loss. In connection with these benefits, disputes may arise regarding the choice of the counsel or consultant to be retained. With respect to counsel, in most cases, the insurer assumes no duty to defend under a network and privacy liability policy. The insured typically retains the right to select counsel. Although, textually, the insurer may also retain the right to consent to defense costs incurred by the insured. In other cases, depending on the policy terms, the insurer may in fact have a "duty to defend," and a concomitant right to select counsel, or have designated pre-approved panel counsel from among whom the insured is contractually required to choose for its defense.

After receiving notice from an insured of a third-party claim, the insurer generally has three options: (1) accept coverage without qualification; (2) deny coverage outright; or (3) issue a reservation of rights identifying potential issues that may affect coverage for indemnity while agreeing to pay for the insured's defense. Many jurisdictions have long recognized that when an insurer has asserted coverage defenses that overlap with the facts that are to be adjudicated in an underlying claim or suit, defense counsel selected by the insurer has a conflict of interest that justifies the insured in retaining independent counsel to be paid for by the insurer.[20] If and when disputes arise regarding the right to select counsel, policyholders should review the insurer's "reservation of rights" carefully to determine whether a disqualifying conflict of interest exists, entitling the insured to select the lawyer of its choosing to defend the claim or suit.

On a related note, insurers responding to a third-party claim arising out of a data breach (as well as third-party claims generally) may insist that the insured's counsel adhere to billing "requirements" or "guidelines" that are intended by the insurer to address the type and manner of costs that will be paid toward the insured's defense. In many cases, billing "requirements" or "guidelines" are not part of the insured's policy or otherwise contractually binding on the insured or its counsel. In responding to fee audits or invoice deductions made by insurers, policyholders should be aware that billing "requirements" and "guidelines" have been criticized by courts, and defense counsel may not ethically be permitted to agree to such "requirements" to the extent that doing so could compromise the insured's defense.[21] Instead, the insurer is typically required to pay all reasonable costs and expenses incurred to defend the insured, including the fees of experts and consultants.

With respect to experts and consultants, policyholders may be obligated by contract to undergo a forensic investigation upon discovery of a data breach. Particularly, if the breach involves unauthorized access to payment card information, card providers may contractually require an investigation by forensic investigator pre-approved by the card provider. The insured may elect to perform its own investigation, and may seek coverage for the cost of that investigation from a network security or privacy liability carrier. The insurer responding to notice of a breach under a cyber/network security or privacy policy may insist upon the retention of a select group of forensic consultants with whom the insurer has negotiated reduced rates. If there are unresolved coverage issues, the policyholder should again consider whether a disqualifying conflict exists that would enable the insured to select its own independent consultant to be paid for by the insurer. Alternatively, if the insurer does not identify any coverage issues before pursuing an investigation using its own "panel" consultant, the question becomes whether the insurer waived coverage defenses if the results of the investigation would otherwise prejudice the insured.[22]

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Subrogation & Voluntary Payments

Under the terms of many network and privacy liability policies (as well as the common law of some jurisdictions), once an insurer has paid the insured's defense costs or even a portion of a first-party claim, the insurer becomes "subrogated" to the rights of the insured against any third-parties. In being "subrogated," the insurer is entitled to pursue whatever claims the policyholder might have against perpetrators or responsible third parties. Most network or privacy liability policies expressly create rights of subrogation and require the insured to (1) facilitate the insurer's exercise of those rights; and (2) do nothing to prejudice or impair an insurer's claim against a third party. In topically related provisions, many network and privacy liability policies prohibit the insured from settling claims, admitting liability or making voluntary payments for defense costs or other amounts without the insurer's prior written consent. These provisions apply to the insured's dealings with potential plaintiffs, injured parties, regulators, potentially responsible network security contractors, among others.

Compliance with these provisions is an important part of the insured's pursuit of coverage under a network security or privacy liability policy. With respect to defense costs, subject to the foregoing discussion regarding selection of counsel, the insured should be careful to keep the insurer appraised of actions being taken to defend a third-party claim and obtain acknowledgment of the insured's receipt of such communications. With respect to settlements, the insured should give the insurer the opportunity to participate and engage in settlement discussions and decisions as early as possible. Those participating on behalf of the insured in the defense of claims and those responsible for risk management and communication with the insurance carrier should coordinate efforts to ensure that no settlement, admission or other action is made inconsistent with the subrogation and voluntary payments provisions of the applicable network security or privacy liability policy. Unless, as discussed below, there are potential privilege issues that would dictate otherwise, open correspondence between the insurer and insured (as well as among the risk and legal teams within an insured) is key.

Claim Documentation/Proof of Loss

After the insured provides notice of a network or privacy breach, the insured is often required to provide a sworn proof of loss within some interval after the breach is discovered, *i.e.*, 120–180 days. The proof of loss documents the amounts the insured is claiming for first-party damages, including network remediation expenses, notification costs, public relations fees, business interruption and extra expense. As part of the insured's data plan, procedures should be implemented to ensure that all costs incurred in responding to a breach are properly accounted for and documented to be included in the requisite proof of loss. In many instances, the full cost of the breach will not be realized within the policy's deadline to provide the "proof of loss." Policyholders must be vigilant to request an extension of this deadline as appropriate under the circumstances.

Protecting Privileged Communications

Communications made in responding to a network or privacy breach are important. Characterizations, whether well-founded or speculative, of events and circumstances relating to the breach, including whether personal information has been compromised, when the breach occurred, and when it was discovered, may have significant implications for the policyholder's liability to third-parties and its insurance coverage. Ideally, the insured's data breach plan will include some procedure to control the flow of external communications regarding the breach. When appropriate, counsel should be engaged early to ensure that specific communications, including those made in anticipation of litigation or otherwise entitled to privilege, are controlled.

As a general proposition, materials prepared and communications made in anticipation of litigation, including communications with an "insurer," may be protected from disclosure as "work product." In some jurisdictions, communications between an insured and its liability insurer regarding a matter of common interest between them are deemed privileged. In other jurisdictions, the "common interest privilege" does not extend to communications with an insurer that is not a party in pending litigation.[23] Moreover, given the dual nature of network security and privacy liability policies in insuring both third-party and first-party claims, some communications between the insured and its cyber insurer may not qualify as being made in anticipation of litigation. Policyholders and their counsel should be aware that communications with a network and privacy insurer may not be protected from disclosure to third-party claimants or regulators and should act accordingly (particularly when unresolved coverage issues remain between the insurer and its insured).[24]

Do Not Overlook Traditional Insurance Coverage

Even for those policyholders benefitting from a dedicated network or privacy liability policy, pursuit of coverage for a data breach should include consideration of the recovery potentially available under more traditional policies, including general/E&O/D&O liability insurance, commercial property insurance, and crime/fidelity insurance.

Commercial general liability ("CGL") insurance typically contains two principal coverage parts, A & B. Coverage A insures sums that the insureds become legally obligated to pay as damages because of "bodily injury" or "property damage" caused by an "occurrence" during the policy period.

Coverage B typically insures sums that the insureds become legally obligated to pay as damages because of "personal and advertising injury" caused by various enumerated "offenses" committed during the policy period, including false arrest or imprisonment, malicious prosecution, wrongful eviction, slander, libel, business disparagement, publication that violates a person's right of privacy, use of another's advertising idea in an advertisement, or infringing on another's copyright, trade dress or slogan.

Although in some circumstances, "property damage" may arise out of a cyber breach,[25] Part B's specific coverage for "[o]ral or written publication, in any manner, of material that violates a person's right of privacy" may apply to a data breach that results in the "publication" or disclosure of customers', employees', or other parties' private, personally identifiable information.[26]

Commercial property insurance generally provides coverage for all risks of direct physical loss or damage to real and personal property, subject to exclusions. The loss of use of computer hardware and even data caused by a cyber attack may qualify as direct physical loss,[27] and the resulting damage, including business interruption, may be covered by a traditional commercial property policy, subject to the particular terms and exclusions that may be found in any given policy form. Likewise, the loss of an insured's product, the theft of trade secrets or other personal property in a cyber attack may also constitute physical loss or damage triggering coverage under a commercial property policy. To the extent that there is no accompanying loss or damage to "data," the loss of valuable intellectual property or products may avoid exclusions relating to "software" or "data" related losses in some commercial property policy forms. Physical damage to property, such as the damage reported to a water pump from a cyber penetration at an Illinois utility in 2011,[28] would also fit within the coverage traditionally afforded by a commercial property policy.

While crime and fidelity insurance usually excludes coverage for the loss of intellectual property and there may not be coverage for the theft of personal information or other intangible data from a cyber attack,[29] policyholders faced with a data breach should not overlook the potential for recovery under such policies. Even some quasi third-party liabilities directly resulting from the theft of customer information may be insured under a crime policy.[30] [31]

1 Dhanya Skariachan & Jim Finkle, *Target shares recover after reassurance of data breach impact*, Reuters.com (Feb. 26, 2014), *available at* http://www.reuters.com/article/2014/02/26/us-target-results-idUSBREA1P0WC20140226.

2 *Id.* ("Mark Rasch, a former cyber crimes prosecutor who worked on some of the biggest U.S. payment card breach cases, said that it was too early to estimate how big the bill would be, but it would certainly be in the hundreds of millions of dollars and could top $1 billion.").

3 Ponemon Institute, 2013 Cost of Data Breach Study: Global Analysis (May 2013) (estimating the average cost of a breach at $5.4 million or $199 per record for U.S. companies).

4 Stephanie Bodoni, *Sony Fined $394,500 Over Hacker Attack on PlayStation Data*, Bloomberg.com (Jan. 24, 2013), *available at* http://www.bloomberg.com/news/2013-01-24/sony-fined-394-000-over-2011-hacker-attack-on-playstation-data.html.

5 Judy Greenwalt, *Zurich owes no defense in Sony PlayStation hacking: Court*, Businessinsurance.com (Feb. 25, 2014), *available at* http://www.businessinsurance.com/article/20140225/NEWS07/140229914.

6 *But see, e.g.*, *Netscape Commc'ns Corp. v. Fed. Ins. Co.*, 2009 WL 2634945, at *1 (9th Cir. 2009) ("As an initial matter, the district court correctly determined that the claims against AOL were 'personal injury offenses' and within the policy's coverage. The policy covered claims alleging that AOL had made known to any person or organization material that violated a person's right of privacy. Although the underlying claims against AOL were not traditional breach of privacy claims, given that coverage provisions are broadly construed, the underlying complaints sufficiently alleged that AOL had intercepted and internally disseminated private online communications. While some cases have stated that coverage is triggered by a disclosure to a third party, they do so in dicta while deciding whether the personal injury clause covers invasion of 'seclusion privacy' claims. They do not address the policy's language covering disclosure to 'any' person or organization, which we find dispositive." (citations omitted)).

7 *See, e.g.*, ACE Privacy Protection Privacy & Network Liability Insurance Policy, Form No. PF-27000 (05/09); Beazley Information Security & Privacy Insurance with Electronic Media Liability Coverage, Form No. F00106 (052011 ed.); Cybersecurity by Chubb, Form No. 14-02-14874 (02/2009); Philadelphia Insurance Cyber Security Liability Coverage, Form No. PI-CYB-001 (05/10); Travelers CyberRisk Form No. CYB-3001 (Ed. 07-10); Zurich Security and Privacy Protection Policy, Form No. U-SPR-1000-B CW (7/09).

8 Ponemon Institute, Is Your Company Ready for a Big Data Breach? (Mar. 23, 2013) ("76 percent of respondents say their organization already had or expect to have a material data breach that results in the loss of customers and business partners. Similarly, 75 percent say they have had or expect to have such an incident that results in negative public opinion.").

9 Some policies add the additional requirement that the "wrongful act" giving rise to the subject "claim" take place prior to the end of the policy period. If so, policyholders should consider how this requirement may or may not be consistent with the option to give "notice of circumstances," whereby a future claim (potentially involving future or continued conduct by the insured) may be deemed to have been made during the period in which "notice of circumstances" was provided to the insurer.

10 *See, e.g.*, Mandiant, APT1: Exposing One of China's Cyber Espionage Units (Feb. 19, 2013) (describing the activities of

an organization of Chinese-based operators engaged in cyber espionage and referred to as "APT1": "[W]e found that APT1 maintained access to the victim's network for an average of 356 days. The longest time period APT1 maintained access to a victim's network was at least 1,764 days, or four years and ten months. APT1 was not continuously active on a daily basis during this time period; however, in the vast majority of cases we observed, APT1 continued to commit data theft as long as they had access to the network.").

11 *United Westlabs, Inc. v. Greenwich Ins. Co.*, 2011 WL 2623932, at *15 (Del. Sup. Ct. Jun. 13, 2011) (denying coverage for defense and indemnity under two errors and omissions liability policies in connection with an ongoing vendor dispute on the basis that (1) by virtue of an interrelated wrongful acts provision, the vendor's claims against the insured were deemed to have been made prior to the inception of the applicable policies; and (2) the insured's failure to reference a prior settlement and dismissal without prejudice of claims between the insured and vendor in policy applications forfeited coverage under both policies).

12 *Cf. FDIC v. St. Paul Cos.*, 634 F. Supp. 2d 1213, 1223 (D. Colo. 2008) ("Although Century's fraud was discovered in January 1998, notice was not provided to Defendants until August 1998. This late notice, well beyond the 30-day maximum allowed under the Bond, precludes FDIC's ability to recover under the Computer Systems Fraud coverage for losses caused by Century's conduct, unless the Court adopts the notice/prejudice rule posited by Plaintiff. As discussed below, the Court will not do so.").

13 *Cf. Westport Ins. Corp. v. Atchley, Russell, Waldrop & Hlavinka, L.L.P.*, 267 F. Supp. 2d 601, 611 (E.D. Tex. 2003) (construing a similar exclusion in a professional liability policy to contain both subjective and objective elements: "[i]n sum, Exclusion B denies coverage in three situations, as follows: (1) when the insured has subjective knowledge of an impending claim; (2) when facts subjectively known to the insured would lead a reasonable attorney to conclude that a grossly flagrant or glaring breach of duty occurred; or (3) where facts subjectively known to the insured would lead a reasonable attorney to conclude that at least some breach of duty occurred *and* where those same facts also indicate that the client is dissatisfied to a point that would lead a reasonable attorney to conclude that the client likely would file a claim.").

14 Verizon, Data Breach Investigations Report 51–52 (2013).

15 *See, e.g.*, Mandiant, APT1: Exposing One of China's Cyber Espionage Units (Feb. 19, 2013); Administration Strategy on Mitigating the Theft of U.S. Trade Secrets 1 (Feb. 2013) ("Emerging trends indicate that the pace of economic espionage and trade secret theft against U.S. corporations is accelerating. There appears to be multiple vectors of attack for persons and governments seeking to steal trade secrets. Foreign competitors of U.S. corporations... have increased their efforts to steal trade secret information through the recruitment of current or former employees." (citing The Office of the National Counterintelligence Executive (ONCIX), "*Foreign Spies Stealing US Economic Secrets In Cyberspace*", November 2011, at 1, *available at* http://www.ncix.gov/publications/reports/fecie_all/Foreign_Economic_Collection_2011.pdf)).

16 Christopher Versace, *Sourcefire CEO – Cyber Attacks And The New Cyber Security Model*, Forbes, Jun. 13, 2013 ("Symantec's Internet Security Threat Report, Volume 18, published this past April, revealed a 42% surge during 2012 in targeted attacks compared to the prior year. Designed to steal intellectual property, these targeted "cyber-espionage" attacks are increasingly hitting the manufacturing sector, as well as small businesses. While it may raise some eyebrows to those not in the know, you may be surprised to learn that 31% of all targeted attacks are aimed at businesses with fewer than 250 employees."); The Econimist Intelligence Unit, Cyber Theft of Corporate Intellectual Property: The Nature of the Threat (2012).

17 *See generally Cont'l Cas. Co. v. N.A. Capacity Ins. Co.*, 683 F.3d 79, 90 (5th Cir. 2012) ("Although it is undisputed that [the insured] never paid its self-insured retention limit, the policy does not explicitly require the insured to pay the amount itself. Both Continental and National Union spent millions of dollars on [the insured's] defense, thereby satisfying the self-insured retention limit. Such a limit 'represents the amount of the loss that the insured is responsible for before coverage is triggered.' Conversely, it is the part for which the insurer is not responsible. Here, this responsibility was met on the insured's behalf."); *Pak-Mor Mfg. Co. v. Royal Surplus Lines Ins. Co.*, 2005 U.S. Dist. LEXIS 34683, at *29–30 (W.D. Tex. Nov. 3, 2005) (stating that an insured "may satisfy the self-insured retention by making its payment in whatever form it wants"); *Gen. Star Nat'l Ins. Co. v. World Oil Co.*, 973 F. Supp. 943, 947-48 (C.D. Cal. 1997) (analyzing a policy requiring the insured to "pay a $100,000 deductible" and concluding that "it does not unambiguously require World Oil to pay the deductible itself"; rather, "[t]he General Star policy nowhere states that the insured cannot purchase coverage for the amount of the deductible"); *Vons Cos. v. United States Fire Ins. Co.*, 92 Cal. Rptr. 2d 597, 605 (Cal. Ct. App. 2000) ("Nowhere does the SIR expressly state that Vons itself, not other insurers, must pay the SIR amount."); *Fla. Ins. Guar. Ass'n v. Jacques*, 643 So.2d 101, 102 (Fla. Ct. App. 1994) (finding that the insured's deductible for its general liability policy could be satisfied by payments made under the insured's business automobile insurance policy).

18 *See, e.g.*, *N. County Mut. Ins. Co. v. Davalos*, 140 S.W.3d 685, 688 (Tex. 2004); Todd R. Smyth, *Annotation, Duty of Insurer to Pay for Independent Counsel When Conflict of Interest Exists Between Insured and Insurer*, 50 A.L.R.4th 932, 938 (1986) ("Most courts appear to allow the insured to select independent counsel when a conflict of interests arises.").

19 *Cf. Munsch Hardt Kopf & Harr P.C. v. Executive Risk Specialty Ins. Co.*, 2007 WL 708851 (N.D. Tex. Mar. 8, 2007) (holding that an insured's failure to report an EEOC charge precluded coverage for a subsequent suit under a policy defining claims subject to notice as including "any judicial, administrative or other proceeding against any Insured for any Employment Practices Wrongful Act").

20 *See, e.g.*, *N. County Mut. Ins. Co. v. Davalos*, 140 S.W.3d 685, 689 (Tex. 2004) ("In the typical coverage dispute, an insurer will issue a reservation of rights letter, which creates a potential conflict of interest. And when the facts to be adjudicated in the liability lawsuit are the same facts upon which coverage depends, the conflict of interest will prevent the insurer from conducting the defense." (citation omitted)); Cal. Civ. Code § 2860(b)

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("[W]hen an insurer reserves its right on a given issue and the outcome of that coverage issue can be controlled by counsel first retained by the insurer for the defense of the claim, a conflict of interest may exist."); *Gafcon, Inc. v. Ponsor & Assocs.*, 120 Cal. Rptr. 2d 392, 417 (Cal. Ct. App. 2002) ("[W]hen the basis for the reservation of rights is such as to cause assertion of factual or legal theories which undermine or are contrary to the positions to be asserted in the liability case... a conflict of interest sufficient to require independent counsel, to be chosen by the insured, will arise." (citations omitted)).

21 *See, e.g.*, *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W2d 625, 634 (Tex. 1998) (Gonzalez, J., concurring) ("[s]ome insurance companies impose billing restrictions and subject lawyers to billing audits.... There is a real risk that *these efforts at cost containment compromise a lawyer's autonomy and independent judgment* on the best means for defending an insured." (emphasis added)); State Bar of Texas Ethics' Opinion No. 533 ("[I]t is impermissible under the Texas Disciplinary Rules of Professional Conduct for a lawyer to agree with an insurance company to restrictions which interfere with the lawyer's exercise of his or her independent professional judgment in rendering such legal services to the insured/client.").

22 *Cf. Ulico Cas. Co. v. Allied Pilots Ass'n*, 262 S.W.3d 773, 778 (Tex. 2008).

23 *See, e.g.*, *In re XL Specialty Ins. Co.*, 373 S.W.3d 46, 52 (Tex. 2012) (orig. proceeding) ("[I]n jurisdictions like Texas, which have a pending action requirement, no commonality of interest exists absent actual litigation. Accordingly, our privilege is not a 'common interest' privilege that extends beyond litigation. Nor is it a 'joint defense' privilege, as it applies not just to defendants but to any parties to a pending action. Rule 503(b)(1)(C)'s privilege is more appropriately termed an 'allied litigant' privilege.").

24 *See, e.g.*, *In re Ford Motor Co.*, 988 S.W.2d 714, 719 (Tex. 1998) (attorney-client privilege not applicable to statement given by insured to insurer following auto accident); *In re W&G Trucking, Inc.*, 990 S.W.2d 473, 475 (Tex. App.—Beaumont 1999, orig. proceeding) (statement given by an employee of the insured to the insurer following an accident was not protected by the attorney-client privilege); *see also Bovis Lend Lease, LMB, Inc. v. Seasons Contracting Group*, 2002 WL 31729693, at *8 (S.D.N.Y. Dec. 5, 2002) (compelling production of correspondence between insurer and insured because (1) "[m]erely because a communication is between an insurer and insured does not render it privileged;" and (2) at the time this letter was written, the insurer was not defending the insured); *Calabro v. Stone*, 225 F.R.D. 96, 98 (E.D.N.Y. 2004) (same); *First Pac. Networks, Inc. v. Atl. Mut. Ins. Co.*, 163 F.R.D. 574, 578–80 (N.D. Cal. 1995) (communications between insured, independent counsel and insurer not privileged where "there is sufficient tension between the carrier's interests and the interests of the insured to trigger" the insured's right to independent counsel).

25 *See, e.g.*, *Eyeblaster, Inc. v. Fed. Ins. Co.*, 613 F.3d 797, 802 (8th Cir. 2010) (finding that a general liability insurer had an obligation to defend an internet marketing firm against allegations that the firm's "rich media advertising" had infected a user's computer causing it to "freeze up" and lose data: "Federal did not include a definition of 'tangible property' in its General Liability policy, except to exclude 'software, data or other information that is in electronic form.' The plain meaning of tangible property includes computers, and the Sefton complaint alleges repeatedly 'loss of use' of his computer. We conclude the allegations are within the scope of the General Liability policy."); *Computer Corner, Inc. v. Fireman's Fund Ins. Co.*, 46 P.3d 1264, 1266 (N.M. Ct. App. 2002) (reciting the following procedural history in a coverage dispute over a general liability insurer's obligations to indemnify a computer service firm for third-party claims alleging damages resulting from the cost incurred to restore lost data: "[T]he district court found that the computer data in question 'was physical, had an actual physical location, occupied space and was capable of being physically damaged and destroyed.' The district court concluded 'computer data is tangible property.' These rulings are not challenged on appeal."); *Retail Sys., Inc. v. CNA Ins. Cos.*, 469 N.W.2d 735, 737 (Minn. Ct. App. 1991) (affirming the trial court's finding that a general liability insurer had a duty to defend underlying allegations that the insured data processing consultant lost computer tape containing the results of a political survey in 1984 because "the data on the tape was of permanent value and was integrated completely with the physical property of the tape."); *State Auto Prop. & Cas. Ins. Co. v. Midwest Computers & More*, 147 F. Supp. 2d 1113, 1116 (W.D. Okla. 2001) (finding for purposes of a computer repair firm's claim under a liability policy for defense and indemnity against a third-party claim for lost appraisal data and loss of use of computers that (1) computer data cannot be touched, held or sensed by the human mind and is not tangible property; (2) "[b]ecause a computer clearly is tangible property, an alleged loss of use of computers constitutes 'property damage' within the meaning of plaintiff's policy"; but (3) because the loss occurred during the insured's operations, the damages were excluded from the policy's coverage).

26 *See generally Am. States Ins. Co. v. Capital Assocs. of Jackson County*, 392 F.3d 939, 941 (7th Cir. 2004) (responding to arguments over the scope of "advertising injury" coverage by stating, in dicta, that "[t]he language reads like coverage of the tort of 'invasion of privacy,'" and "[p]erhaps the language reasonably could be understood to cover improper disclosures of Social Security numbers, credit records, email addresses, and other details that could facilitate identity theft or spamming"); *see also Tamm v. Hartford Fire Ins. Co.*, 2003 WL 21960374, at *4 (Mass. Super. Ct. July 10, 2003) (The Eagle complaint alleges that Tamm accessed the private email accounts of Eagle and its executives and sent these private communications and materials to several outside counsel for Eagle. The allegations of sending these private communications via e-mail to outside attorneys seemingly satisfies both prongs under the invasion of privacy clause of the policy.).

27 *See, e.g.*, *Lambrecht & Assocs., Inc. v. State Farm Lloyds*, 119 S.W.3d 16 (Tex. App.—Tyler 2003, no pet.); *Am. Guarantee & Liab. Ins. Co. v. Ingram Micro, Inc.*, 2000 WL 726789 (D. Ariz. 2000).

28 *See, e.g.*, Ellen Nakashima, *Foreign Hackers Targeted U.S. Water Plant In Apparent Malicious Cyber Attack, Expert Says*, The Washington Post, Nov. 18, 2011 (describing damage done to a water pump at an Illinois water utility through controls exerted from an ip address in Russia).

29 *Peoples Telephone Co., Inc. v. Hartford Fire Ins. Co.*, 36 F. Supp. 2d 1335, 1340-41 (S.D. Fla. 1997) (finding that lists containing

electronic serial numbers and mobile telephone identification numbers stolen by an employee and sold to third parties to clone cellular phones did not constitute "tangible property" for purposes of the employer's claim under a crime insurance policy); *but see Vonage Holdings Corp. v. Hartford Fire Ins. Co.*, 2012 WL 1067694, at *3 (D.N.J. Mar. 29, 2012) (denying the insurer's motion to dismiss the insured telecommunications company's claims that the misappropriation of the insured's communications lines by computer hackers resulted in loss covered by a policy insuring loss of and from damage to money, securities, and other property following and directly related to the use of any computer to fraudulently cause a transfer of property from inside the premises to a person outside the premises or a place outside the premises).

30 *See, e.g.*, *Retail Ventures, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 691 F.3d 821 (6th Cir. 2012) (affirming coverage for expenses incurred for customer communications, public relations, customer claims, including chargebacks, card reissuance, credit monitoring and VISA/Mastercard fines, following the third-party theft and use of account information relating to 1.4 million DSW customers under a computer fraud rider to a "Blanket Crime Policy" insuring "Loss which the Insured shall sustain resulting directly from... the theft of any Insured property by Computer Fraud" notwithstanding the insurer's objections that (1) the loss was not "solely" or "immediately" caused by the theft of insured property; and (2) the loss was excluded by a provision denying coverage for "loss of proprietary information... other confidential information of any kind").

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ANNUAL SURVEY OF TEXAS INSURANCE LAW – 2014

I. INTRODUCTION

This year's survey of Texas insurance cases harvested a smaller crop—142, down from 150 last year and 300 two years ago.

In *Greene v. Farmers Ins. Exch.*, No. 12–0867, 2014 WL 4252271 (Tex. Aug. 29, 2014), the court allowed an insurer to rely on a policy's vacancy clause to deny coverage, even though the vacancy did not cause the loss.

The Texas Supreme Court also held that the "contractual liability" exclusion does not apply to poor workmanship, in *Ewing Constr. Co. v. Amerisure Ins. Co.*, 420 S.W.3d 30 (Tex. 2014).

The supreme court also addressed the consequences when an insurer pays a plaintiff but a hospital lien is not satisfied. *McAllen Hosps., L.P. v. State Farm Co. Mut. Ins. Co. of Tex*, 433 S.W.3d 535 (Tex. 2014). A court of appeals decided whether an insurer can challenge the amount of a hospital lien, in *Allstate Indem. Co. v. Memorial Hermann Health System*, 437 S.W.3d 570 (Tex. App.—Houston [14th Dist.] 2014, no pet.).

The court of appeals in *Prudential Ins. Co. v. Durante*, No. 08–12–00077–CV, 2014 WL 4259434 (Tex. App.—El Paso Aug. 29, 2014, pet. granted), construed the new provision in the prompt payment of claims statute, which gives more time to a life insurer that files an interpleader. The court held the insurer did not qualify for the extension.

The Fifth Circuit returned to one of its favorite *Erie*-guesses, despite the fact that the Texas Supreme Court has demurred on the issue several times. In *Star-Tex Resources, L.L.C. v. Granite State Ins. Co.*, 553 F. App'x 366 (5th Cir. 2014) (per curiam), the court looked outside the eight corners to consider extrinsic evidence to decide a liability insurer had no duty to defend, where the extrinsic evidence related solely to a fundamental issue of coverage that did not overlap with the merits.

The Fifth Circuit also addressed whether an insurer had a disqualifying conflict that would let the insured choose its own lawyer, at the insurer's expense, in *Graper v. Mid-Continent Cas. Co.*, 756 F.3d 388, 393 (5th Cir. 2014).

Another case solved the *Gandy* problem of assigning an insured's claim to the plaintiff, in *Great American Ins. Co. v. Hamel*, No. 08–11–00302–CV, 2014 WL 4656618 (Tex. App.—El Paso, Sept. 19, 2014, no pet.).

Several cases dealt with plaintiff's inability to adequately segregate fees between recoverable claims and nonrecoverable ones.

Finally, one thoughtful district court broke the trap of having an adequate "fair notice" state court pleading be judged by the stricter federal *Twombly-Iqbal* standard. *Esteban v. State Farm Lloyds*, No. 3:13–CV–3501–B, 2014 WL 2134598 (N.D. Tex. May 22, 2014).

II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile

Where a named insured rejected UIM and PIP coverages in writing and then renewed her policy seven more times, the insurer was not required to offer UIM and PIP coverage again. Further, the character of the policies as renewal policies was not altered by the fact that, in later years, her son was added as another named insured. *Cain v. Progressive County Mut. Ins. Co.*, No. 14–12–00954–CV, 2014 WL 4638923 (Tex. App.—Houston [14th Dist.] Sept. 18, 2014, no pet.).

Loss of use damages were not available for a total loss. An insured was hit by another driver, totaling the insured's tow truck. The driver's insurance company paid its policy limits, which replaced the truck. Then the insured sued his under-insured insurer, after it refused to pay him for his loss-of-use damages for not being able to operate his business for four months while he found a replacement truck. The court held that in a total-loss case, a chattel owner can recover only the

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market value of the property, not loss-of-use damages. *Am. Alternative Ins. Corp. v. Davis*, No. 10-13-00275-CV, 2014 WL 2917081 (Tex. App.—Waco June 26, 2014, pet. filed).

An automobile insurer was entitled to summary judgment where the policy unambiguously excluded coverage for an uninsured motor vehicle that was "owned by or furnished or available for the regular use of [the insured] or any family member." *Mata v. State Farm Mutual Insurance Co.*, No. 04-14-00239-CV, 2014 WL 6474223 (Tex. App.—San Antonio Nov. 19, 2014).

B. Homeowners

The supreme court held that a vacancy clause negated coverage, even though the vacancy did not harm the insurer. *Greene v. Farmers Ins. Exch.*, No. 12–0867, 2014 WL 4252271 (Tex. Aug. 29, 2014). The homeowner's insurance policy provided that coverage was suspended effective sixty days after the dwelling became vacant. It was undisputed that Greene's house was vacant, but it was also undisputed that the vacancy did not cause the fire. The court first considered the anti-technicality statute, Tex. Ins. Code § 862.054, which provides that a breach or violation of a policy warranty, condition, or provision does not render the policy or contract void and is not a defense to a suit for loss, unless it contributed to cause the destruction of the property. The court held the statute did not apply because the vacancy was not a "breach" of the policy.

The court also distinguished its prior decisions requiring that an insurer show prejudice before a failure to comply with the policy excuses coverage. For instance, in *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691 (Tex. 1994), the court held that breach of a consent to settlement clause did not excuse liability, where the insurer was not prejudiced. S*ee also Lennar Corp. v. Markel Am. Ins. Co.*, 413 S.W.3d 750 (Tex. 2013). Similarly, the court held that late notice that did not prejudice the insurer would not void coverage in *PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 630 (Tex. 2008), and *Prodigy Communications Corp. v. Agric. Excess & Surplus Ins. Co.*, 288 S.W.3d 374 (Tex. 2009). The court distinguished these cases, holding that the vacancy clause in the present case was material, but the breaches in the other cases were immaterial.

Finally, the court distinguished its holding in *Puckett v. U.S. Fire Ins. Co.*, 678 S.W.2d 936 (Tex. 1984), where the court refused on public policy grounds to allow an insurance company to avoid coverage based on the insured's immaterial breach of a condition requiring an airworthiness certificate for the airplane that was insured. The court distinguished *Puckett* because in this case the court found there was no breach. Further, the court held that it is for the legislature and Texas Department of Insurance to decide what coverage should be and to establish public policy. The court reasoned that TDI had made a policy choice by approving the insurance form in this case, which allowed the limitation on coverage.

Justice Boyd, joined by Justice Willett, concurred, but he found the court's decision in conflict with the prior decisions in *PAJ, Prodigy*, *Lennar,* and *Hernandez*. Balancing consistency with disruption, the concurring justices would limit the prejudice requirement to those four cases applying to late notice and settlement without consent, but would not extend it further.

The standard mortgage clause in a residential insurance policy provides coverage to a mortgagee for a loss by fire of a vacant property, despite the policy's vacancy clause. *SWE Homes, LP v. Wellington Ins. Co.*, 436 S.W.3d 86 (Tex. App.—Houston [14th Dist.] 2014, no pet.). An insured's mortgagee sought coverage for a fire loss to a vacant dwelling. The insurer denied coverage on grounds that the vacancy clause excluded coverage. The court of appeals disagreed. The mortgage clause stated that the mortgagee could recover under the policy despite "any act or neglect of the mortgagor." The court concluded that although there was no coverage for the insured because the property had remained vacant for the period specified by the vacancy clause, the mortgagee could still recover because it had complied with all of the provisions in the mortgage clause. Interpreting the policy otherwise would render the mortgage clause meaningless and would violate section 862.055 of the Insurance Code, which prohibits the interest of a mortgagee under a fire insurance contract from being invalidated by an act of the mortgagor or an occurrence beyond the mortgagor's control.

In another homeowner's case, water damage was excluded as flood damage. An insured homeowner sought coverage for property damage caused by water diverted onto his property when a third party placed large cylinders across a drainage ditch. The insurer denied coverage, arguing that the overflow of water onto the insured's property was excluded from coverage as flooding, regardless of the cause of the overflow. The court of appeals agreed. Since the policy did not define "flood," the court used the common meaning "a rising and overflowing of a body of water." It did not matter that the overflow of water was caused by the presence of obstructions on top of a ditch in light of language in the policy that said it excluded the loss "regardless of … the cause of the excluded event[.]" *George v. State Farm Lloyds*, No. 07-12-00465-CV, 2014 WL 2481894 (Tex. App.—Amarillo May 19, 2014, no pet.).

C. Commercial Property

An insured that suffered property damage only to find that the property coverage it had was not what it requested was entitled to recover damages without obtaining a coverage determination from the court. *Insurance Alliance v. Lake Texoma Highport, LLC*, No. 05-12-01313-CV, 2014 WL 6466851 (Tex. App.—Dallas Nov. 19, 2014). The jury found that the insurance agency breached its contract with the insured to obtain property coverage of $15,000,000 without sublimits or co-insurance penalties. The agency

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argued that because the broker had given seventeen different policy versions, that required the insured to get the court to determine what coverage was actually provided. The court of appeals rejected this argument and presumed that the jury resolved any questions about the insured's coverage when it made its damage findings. The jury was asked to determine the amount of coverage that would have been available, less the amount of coverage that was actually obtained.

Theft of copper sheeting owned by a customer was not covered by a warehouse company's commercial property policy, where it was covered by the customer's own policy. *United Nat. Ins. Co. v. Mundell Terminal Servs., Inc.*, 740 F.3d 1022 (5th Cir. 2014). The warehouse company had a policy that covered its business personal property and property held by others. However, the policy had an exclusion for property that was covered under another policy. The court held this exclusion applied. The court found that the customer's interests were insured under both the warehouse policy and the customer's own policy. The court concluded that the "other insurance" clause applied because the customer's insurance covered the same property interest in favor of the same party – i.e. the customer's interest in the copper.

The court rejected the warehouse company's argument that the court should not reach this conclusion, because that would subject the warehouse company to a subrogation claim by the customer's insurer. The court noted that the warehouse company could have purchased liability insurance for such a risk but did not.

A commercial property insurer's failure to give the mortgagee notice of cancellation did not affect the cancellation as to the insured. *Molly Props., Inc. v. Cincinnati Ins. Co.*, 557 F. App'x 258 (5th Cir. 2014) (per curiam). It was undisputed that the insurer gave cancellation notice to the insured and that the insured failed to pay its premiums. The court rejected the insured's argument that it was a third-party beneficiary of the contract between the insurer and the mortgagee. The court found no evidence that that agreement was made for the benefit of the insured.

An insured trucking company's video game consoles were stolen while in its terminal. *W.W. Rowland Trucking Co., Inc. v. Max Am. Ins. Co.*, 559 F. App'x. 253 (5th Cir. 2014). The parties agreed that theft was a covered peril. However, the insurer argued that an exclusion applied that required the insured's terminals to be "100% fenced, gated, locked, and lighted 24 hours per day, 7 days per week," or else the "[c]overage is null and void." An investigation showed that thieves had entered and left the terminal by cutting a hole in the fencing. The Fifth Circuit held that Texas's Anti-Technicality Statute applied, which requires a causal link between the breach in the policy provision and the loss in order for an insurer to deny a claim under a property insurance policy. Therefore, the court ordered the insurer to pay the claim.

A commercial building was "vacant" within the meaning of a commercial property policy where it had been unoccupied for several years. *Bedford Internet Office Space, LLC v. Travelers Cas. Ins. Co.*, No. 3:12–CV–4322–N, 2014 WL 4230315 (N.D. Tex. Aug. 25, 2014). The fact that it had been leased to a new tenant did not change the outcome, where the tenant had not yet moved in and neither the tenant nor the landlord were engaged in any "customary operations" as required by the policy.

A property owner's claims for water damage caused by a defective roof were barred by the exclusion for negligent work. *Mag-Dolphus, Inc. v. Ohio Cas. Ins. Co.*, No. H–13–08S2, 2014 WL 4167497 (S.D. Tex. Aug. 13, 2014). The court found that the exclusion was unambiguous. The court also held it was not against public policy for the insurer to rely on the exclusion, rejecting the insured's argument that the insurer should have inspected and noticed the defective work because the roof was replaced as a result of a prior leak claim.

D. Life insurance

Where a life insurance policy lapsed for non-payment of premium a year before the insured died, the life insurer did not breach its contract by refusing to pay. *Lombana v. AIG Am. Gen. Life Ins. Co.*, No. 01–12–00168–CV, 2014 WL 810858 (Tex. App.—Houston [1st Dist.] Feb. 27, 2014, pet. denied).

An ex-wife was not entitled to proceeds under a life insurance policy where she was named as beneficiary prior to the divorce. The court relied on the statute that provides that a divorce makes an earlier designation of a spouse as policy beneficiary ineffective. No exceptions provided by the statute applied in this case. *Branch v. Monumental Life Ins. Co.*, 422 S.W.3d 919 (Tex. App.—Houston [14th Dist.] 2014, no pet.). The ex-wife also could not claim ownership of the policy based on her payment of premiums, where the prior court in the divorce action had awarded ownership to the husband.

The *Branch* court also held that the fact that the insurer attached a sample policy to its interpleader petition did not affect the ex-wife's claim. The insurer was not required to attach the policy in issue, but could summarize its provisions. Further, in the interpleader action, it was the ex-wife's burden to prove her entitlement to the proceeds, not the insurer's burden to negate it.

A widow was entitled to fifty percent of life insurance proceeds where her husband filed a change of beneficiary form designating her as primary beneficiary for that portion, even though the form was rejected because it was ambiguous as to the contingent or additional beneficiary designations. Although the policy required a change of beneficiary form "in a form that meets our needs," the court found that the insured substantially complied with the

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change of beneficiary designation. Although the contingent beneficiary designation was unclear, it was undisputed that the designation of the widow as primary beneficiary for fifty percent was clear. *Prudential Ins. Co. v. Durante*, No. 08–12–00077–CV, 2014 WL 4259434 (Tex. App.—El Paso Aug. 29, 2014, pet. granted).

The death of an insured during the two-year contestability period bars a life insurance policy from becoming incontestable. *Mut. of Omaha Life Ins. Co. v. Costello*, 420 S.W.3d 873 (Tex. App.—Houston [14th Dist.] 2014, no pet.). The insured under a life insurance policy died within the two-year contestability period set forth in the policy. After investigating the claim, the insurer concluded that the insured had misrepresented her health history in the insurance application. It then denied the claim and rescinded the policy. The beneficiary sued to recover the policy proceeds and, after litigating for several years, argued that the insurer failed to contest the validity of the policy within two years by failing to institute its own court proceeding. The court of appeals rejected this argument. Section 1101.006 of the Insurance Code requires that a policy "must provide that a policy in force for two years from its date of issue during the lifetime of the insured is incontestable, except for nonpayment of premiums." The court found that the language "during the lifetime of the insured" means that an insured must survive the two-year contestability period for the policy to become incontestable. As a result, the insurer could challenge the policy's validity.

E. Title insurance

The Fifth Circuit held that a title insurance policy providing survey coverage covered a flowage easement that was larger than depicted by the survey. *Lawyers Title Ins. Corp. v. Doubletree Partners, L.P.*, 739 F.3d 848 (5th Cir. 2014). Doubletree bought land that it planned to develop. Lawyer's Title provided the title insurance and offered Doubletree expanded survey coverage. Doubletree later discovered a serious error in the survey: it substantially underrepresented the area of the property that was subject to a flowage easement that allowed the federal government to flood that portion of the property.

The policy originally excluded "any discrepancies, conflicts, or shortages in area or boundary lines, or any encroachments or protrusions, or any overlapping of improvements." Because Doubletree paid for survey coverage, this exception was amended to exclude only "shortages in area." The parties disputed the effect of this language. Lawyers Title argued that the policy still did not cover the flowage easement, because it was not a boundary line or encroachment. Lawyers Title argued that these terms referred to defects at the boundary of the property. On the other hand, Doubletree argued that the words could be read to also include the flowage easement.

The court found both interpretations were reasonable and, therefore, held that it had to construe the language of this exclusion in favor of coverage. The court went on to say that, because the policy was subject to two interpretations and was ambiguous, it could consider "extraneous evidence to determine the true meaning of the instrument." After considering correspondence related to the policy, the court again concluded that Doubletree's interpretation of the policy was reasonable.

The *Doubletree* court erred on this second point. The court cited *Italian Cowboy Partners, Ltd. v. Prudential Ins. Co. of Am.*, 341 S.W.3d 323, 333-34 (Tex. 2011). But that case —while it included an insurance company as a party— involved a lease, not an insurance policy. As the Fifth Circuit correctly recognized in other parts of its opinion, once a policy is subject to more than one reasonable interpretation, it is construed in favor of coverage, as a matter of law. While the courts may consider extraneous evidence to determine the true meaning of an instrument with regard to other types of contracts, that is not true with insurance policies.

The *Doubletree* court also held that the flowage easement exception in the policy did not apply, because it was ambiguous. The exception provided that the insurer did not insure against loss arising out of the "flowage easement"… "and shown on survey." The court found Doubletree's interpretation was reasonable and that this language could be taken to mean that only the easement as shown on the survey was accepted. Because the survey failed to show the full extent of the easement, it was not "shown on the survey."

Finally, the court held that an exclusion did not apply. The exclusion precluded coverage for any defect "created, suffered, assumed or agreed to by the insured claimant." The court agreed with Doubletree's argument that because Doubletree did not know the extent of the easement, it did not create, suffer, assume, or agree to it.

A dedication agreement that affected real property's historic status and use was not a defect in title. Although it affected the value of the property, it did not affect ownership. *McGonagle v. Stewart Title Guar. Co.*, 432 S.W.3d 535 (Tex. App.—Dallas 2014, pet. filed). The court further held that the dedication agreement also fit within an exclusion for defects and encumbrances "assumed or agreed to by the insured claimant." The evidence showed that the dedication agreement was attached to the purchase contract and was known to the buyers, even though they believed that the agreement was deleted.

An insured purchased several properties in Tulum, Mexico for hotel development. *Citigroup Global Markets Realty Corp. v. Stewart Title Guar. Co.*, 417 S.W.3d 592 (Tex. App.—Houston [14th Dist.] 2013, no pet.). It obtained title insurance for the properties. The title insurer researched the properties and learned of a 1981 decree by the Mexican federal government that appropriated land to create the Tulum National Park. However, the insurer's report noted

the tracts purchased by the insured were not affected by the condemnation. The insurer did not list the decree as an exception from coverage in its title policies. In its efforts to develop the properties, the insured learned that several of the properties were not developable because they were subject to the decree and within the Park. The insured and its lender both filed suit against the title insurer.

The jury found the insured knew of an encumbrance on ten of the sixteen properties on the date of purchase. On appeal, the court held that sufficient evidence supported that finding. The evidence at trial showed that several of the insured's agents had discussed a decree in the zone where the property was located, that the property was in the park, and that they were aware of the risk that they might not be able to build anything because of zoning and archeological restrictions. Therefore, the insured knew of and assumed or agreed to the effects of the decree on those ten properties.

The jury also found the insured did not know about the decree and did not assume or agree to its effect as to six properties, but awarded zero damages. The court also found that the evidence was sufficient to support this result. The jury was asked to determine damages by selecting the lesser of the amount for which the properties were insured or the difference between the value of the insured estate as insured and the value of the insured estate as subject to the decree. Under the language "as insured," the properties were already taken or acquired by the decree in 1981. The jury could thus conclude that the value of the properties as insured was identical to their value subject to the decree.

F. Other policies

A policy styled as "Automated Teller Machine and Contingent Cash In Transit" that provided coverage for theft from an armored motor vehicle company did not require the insured to first exhaust all remedies against potentially responsible third-parties before the insurer would become obligated to pay for the loss. *Certain Underwriters at Lloyd's of London Subscribing to Policy Number: FINFR0901509 v. Cardtronics, Inc.*, 438 S.W.3d 770 (Tex. App.—Houston [1st Dist.] 2014, no pet.). The president of an armored car company who worked for Cardtronics, owner of several automated teller machines, stole $16,000,000. The insurer refused to pay, asserting that the policy required that Cardtronics first exhaust any remedies it had against the armored car company and any insurer for the armored car company.

The court rejected the insurer's argument as unreasonable. There was nothing in the policy that expressly required exhaustion of remedies. The coverage language said, "we will only pay for the amount of loss you cannot recover: (1) under your contract with the armored motor vehicle company; and (2) from any Insurance or indemnity carried by, or for the benefit of customers of, the armored motor vehicle company." The court rejected the argument that the "cannot recover" language required Cardtronics to first seek recovery from others before the insurer was obligated to pay. The insurer's construction conflicted with other provisions in the policy that required Cardtronics to submit a proof of loss by a certain deadline and the insurer to respond to the claim by a certain deadline, and Cardtronics to file suit by a certain deadline. None of these deadline provisions could apply if Cardtronics were first required to pursue recovery from others. The court harmonized the provisions of the policy by accepting Cardtronics' proposed construction that would require the insurer to pay whatever amount Cardtronics was unable to recover from others by the time its proof of loss was due. The court found this interpretation was reasonable and gave meaning to all of the provisions of the policy.

III. FIRST PARTY THEORIES OF LIABILITY

A. Breach of Contract

An insured debtor still had the right to sue a property insurer for underpayment of a water damage claim, even after foreclosure, where the amount of the claim was more than the amount of the debt. *Peacock Hospitality, Inc. v. Ass'n Cas. Ins. Co.*, 419 S.W.3d 649 (Tex. App.—San Antonio 2013, no pet.).

A court rejected a life insurance beneficiary's argument that the insurer breached an implied oral contract to reinstate a life insurance policy that had lapsed for non-payment of premium. *Lombana v. AIG Am. Gen. Life Ins. Co.*, No. 01–12–00168–CV, 2014 WL 810858 (Tex. App.—Houston [1st Dist.] Feb. 27, 2014, pet. denied) (mem. op.). The court found no evidence that the insurer's representative had authority to enter into such an oral contract and no evidence of the parties' "mutual assent" or meeting of the minds. Further, the beneficiary admitted she knew that a premium payment would be required for the policy to be reinstated, and it was undisputed that no premium payment was made.

The insureds in *Salazar v. State Farm Lloyds*, No. H-13-1904, 2014 WL 2862760 (S.D. Tex. June 24, 2014), sued their insurer for breach of the policy and extracontractual duties for denying their claim for damage loss to the home interior caused by water leaking from plumbing pipes under the home. The court held that the insurance policy's dwelling foundation endorsement explicitly and unambiguously limited liability for foundation damage to fifteen percent of the dwelling limit of liability. Therefore, the insurer's motion for summary judgment on that issue was granted.

An insured's building incurred damage from a hailstorm. The insured did not give notice to the insurer about the damage for at least nineteen months. The insurer demonstrated that other, non-covered perils could have contributed to the insured's loss. Therefore, the court held that summary judgment in favor of the insurer should be granted on the

breach of contract claim. Additionally, because the insured failed to provide summary judgment evidence to raise a genuine fact issue that they suffered an injury independent of their policy claim, summary judgment was also granted in favor of the insurer on the insured's statutory and common law bad faith claims. *Hamilton Prop. v. Am. Ins. Co.*, No. 3:12-CV-5046-B, 2014 WL 3055801 (N.D. Tex. July 7, 2014).

B. Unfair Insurance Practices, Deceptive Trade Practices & Unconscionable Conduct

Where a life insurer properly denied coverage under a policy that had lapsed for non-payment of premium, the court also properly dismissed the plaintiff's claims for unfair insurance practices, deceptive trade practices, and breach of duty of good faith and fair dealing. *Lombana v. AIG Am. Gen. Life Ins. Co.*, No. 01–12–00168–CV, 2014 WL 810858 (Tex. App.—Houston [1st Dist.] Feb. 27, 2014, pet. denied).

In *USAA Texas Lloyd's Co. v. Menchaca*, No. 13-13-00046-CV, 2014 WL 3804602 (Tex. App.—Corpus Christi July 31, 2014, pet. filed), an insured's house was damaged in a hurricane. After submitting the claim to her insurer, the insurer said the damage was under the deductible amount so no payment would be made. The insured sued her insurer. At trial, the insurer stipulated to the reasonableness of the insured's electrician's estimate, which was over the deductible amount. The jury returned a verdict stating that the insurer did not fail to comply with the terms of the insurance contract, but found that the insurer did refuse to pay a claim without conducting a reasonable investigation. On appeal, the insurer argued that because the jury found no breach of contract, the insured's extra-contractual claims must fail. The appeals court disagreed, holding that the insurer complied with the policy, but violated the insurance code, and the insurer would have been contractually obligated to pay policy benefits had the insurer complied with the insurance code. Therefore, the court affirmed.

A jury's failure to find an insurance broker liable for misrepresentations and unfair insurance practices was supported by evidence that the broker never made any direct misrepresentations to the insured or the insured's agent, and the broker provided the insurance policy that its intermediate broker requested. *Insurance Alliance v. Lake Texoma Highport, LLC*, No. 05-12-01313-CV, 2014 WL 6466851 (Tex. App.—Dallas Nov. 19, 2014).

Although the court in *Lawyers Title Ins. Corp. v. Doubletree Partners, L.P.*, 739 F.3d 848 (5th Cir. 2014), found in favor of the insured on coverage under a title insurance policy, the court nevertheless agreed that the insured failed to state a claim for statutory claims for unfair insurance and deceptive trade practices. The court found that the insurer had a reasonable basis for denying the claim, even though the court ultimately rejected that basis.

An insured sued his insurer for failing to conduct a reasonable investigation of his home foundation claim. The insurer hired both an engineer and plumber to investigate the claim, and both concluded that the foundation movement was not the result of a plumbing leak. The insured's expert was asked during his deposition if there was a problem with the investigation process, to which he answered "no." Therefore, the court found that the insurer was entitled to summary judgment on the issue of conducting a reasonable investigation. *Walker v. Nationwide Prop. & Cas. Ins. Co.*, 992 F. Supp. 2d 703 (W.D. Tex. 2014).

An insurance agent was entitled to summary judgment on the plaintiffs' misrepresentation claims, where there was no evidence that the agent made any false representations about specific terms of their policy. The plaintiffs alleged that the agent misrepresented coverage because they requested coverage for "all perils possible," but the policy contained an exclusion for negligent workmanship. *Mag-Dolphus, Inc. v. Ohio Cas. Ins. Co.*, No. H–13–08S2, 2014 WL 4167497 (S.D. Tex. Aug. 13, 2014).

An investigator was held not to be engaged in the business of insurance and thus not a proper party to a suit under the Insurance Code. *Michels v. Safeco Ins. Co. of Indiana*, 544 F. App'x 535 (5th Cir. 2013). Insureds sued both their homeowners insurer and its investigator for violations of the Insurance Code, seeking coverage for smoke damage to their home that occurred during the Bastrop wildfires. The trial court dismissed the investigator, who was a nondiverse party, as improperly joined. The Fifth Circuit affirmed. It held that the insureds did not have a reasonable basis for recovery against the investigator because the investigator was not engaged in the business of insurance, as defined in the Insurance Code. The investigator was an engineer hired only to determine the cause and extent of damages to the home, knew nothing about the coverage of the policy, and made no decisions with respect to insurance coverage.

C. Prompt Payment of Claims

A court held that an insurer was liable for prompt payment penalties where the insurer filed an interpleader action but did not do so within ninety days as required by the statute. The court held that the insurer was not entitled to the additional thirty days and instead had to pay the claim within sixty days, because the insurer did not receive "notice of an adverse, bona-fide claim." The court held that there was no bona-fide adverse claim, where the widow was clearly entitled to fifty percent of the proceeds and the children were entitled to the other half. *Prudential Ins. Co. v. Durante*, No. 08–12–00077–CV, 2014 WL 4259434 (Tex. App.—El Paso Aug. 29, 2014, pet. granted).

An insured sued his uninsured-motorist insurer for failing to pay a claim in accordance with the five-day payment provision under Tex. Ins. Code § 542.057. That section

requires an insurer to pay the insured within five business days after notice that the insurer will pay all or part of the claim. In this case, the insured and insurer were exchanging settlement offers, and the insured argued that the insurer was required to pay the amount it had offered in settlement within five days of making the offer, even though the insured rejected the offer. The court held that the fact the insurer "approved" part of the claim for settlement purposes is not a notice of acceptance for the purpose of the prompt-payment statute. *Terry v. Safeco Ins. Co. of Am.*, 972 F. Supp. 2d 965 (S.D. Tex. 2013).

A prompt pay violation does not turn on whether the insured suffered an independent injury or the reasonableness of the insurer's position. Because the insurer had a duty to defend and breached that duty, the insurer violated the statute by erroneously rejecting the insured's requests for a defense and delaying payment of fees and expenses incurred in the underlying litigation. *Admiral Ins. Co. v. Petron Energy, Inc.,* 1 F. Supp. 3d 501 (N.D. Tex. 2014).

D. Breach of the Duty of Good Faith and Fair Dealing

Although the court in *Lawyers Title Ins. Corp. v. Doubletree Partners, L.P.*, 739 F.3d 848 (5th Cir. 2014), found in favor of the insured on coverage under a title insurance policy, the court nevertheless agreed that the insured failed to state a claim for breach of the duty of good faith and fair dealing. The court found that the insurer had a reasonable basis for denying the claim, even though the court ultimately rejected that basis.

Fees incurred in a coverage action are not an injury independent of the denial of policy benefits within the meaning of Chapter 541 of the Insurance Code. *Admiral Ins. Co. v. Petron Energy, Inc.,* 1 F. Supp. 3d 501 (N.D. Tex. 2014). A district court granted an insurer's motion for summary judgment as to all of the insured's claims for unfair insurance practices. In particular, the court found that there was insufficient evidence that the insured suffered any injury independent of the insurer's denial of policy benefits. The fees and litigation expenses incurred by the insured in this coverage action were not an independent injury.

The court erred by requiring proof of an independent injury other than the amounts owed under the policy. This goes directly against the supreme court's holding that policy benefits are damages recoverable under the statutory cause of action and may even be damages as a matter of law."We hold that an insurer's unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld." *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 136 (Tex. 1988).

E. Fraud

A life insurer was not liable for fraud by nondisclosure related to information it gave a beneficiary about reinstating a lapsed policy, because there was no confidential or fiduciary relationship giving rise to a duty to disclose. Further, there was no evidence of any material misrepresentation to support a claim for fraud. *Lombana v. AIG Am. Gen. Life Ins. Co.*, No. 01–12–00168–CV, 2014 WL 810858 (Tex. App.—Houston [1st Dist.] Feb. 27, 2014, pet. denied).

F. ERISA

An ERISA plan administrator did not abuse its discretion by denying disability benefits to a plan participant. *Spenrath v. Guardian Life Ins. Co. of Am.*, 564 F. App'x 93 (5th Cir. 2014) (per curiam). An ERISA plan participant sued a plan administrator under ERISA for wrongfully denying her long-term disability benefits. In particular, the participant argued that the administrator failed to credit the medical evidence contained in the record that showed her disability. The administrator argued that it based its decision on the entire administrative record. The Fifth Circuit held that the administrator did not abuse its discretion. The evidence showed that the administrator examined the participant's medical evidence. Its denial letter specifically discussed much of the participant's evidence. A panel of independent medical specialists, upon which the administrator relied, also thoroughly considered the evidence. Further, the administrator did not abuse its discretion by failing to consider the participant's subjective evidence. Instead, it relied on the panel of medical specialists to determine whether there was a disparity between her subjective complaints and the objective findings, and the panel concluded there were discrepancies. Finally, the administrator did not abuse its discretion by relying on expert opinions that allegedly mischaracterized the evidence. None of the alleged errors in the expert testimony undermined the administrator's ultimate conclusion or affected the substantial nature of the evidence in its support. The administrator did not act arbitrarily by giving more weight to the conclusions of the independent experts than to the participant's providers.

Substantial evidence supported an ERISA plan administrator's decision to deny accidental death benefits. *McCorkle v. Metropolitan Life Ins. Co.*, 757 F.3d 452 (5th Cir. 2014). An ERISA plan beneficiary sought benefits under her deceased husband's accidental death coverage. Her husband, the plan participant, had visited his family doctor complaining of stress and trouble sleeping. The doctor ruled out depression and treated the participant for insomnia and anxiety with a prescription of Lunesta. One evening, he took Lunesta as prescribed and a few hours later shot himself. The coroner reported the death cause as "suicide," but noted that he was under the influence of Lunesta and thus did not "consciously and intentionally t[ake] his own life." The plan administrator denied benefits. The district court found the denial improper and reversed. In its review of the case, the Fifth Circuit emphatically noted that district courts are serving in an appellate role when they review administrative denials of benefits and that the administrator's determination

must be affirmed unless it is arbitrary or not supported by at least substantial evidence, even if that determination is not supported by a preponderance. The Fifth Circuit held that substantial evidence supported the plan administrator's determination that the participant committed suicide. The participant died of a self-inflicted gunshot wound, not an accidental discharge of a gun. The possibility that the participant was hallucinating was insignificant in the court's analysis.

IV. THIRD PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile liability insurance

An exception to an exclusion did not create coverage for an injured employee. An employee was injured at work when his concrete truck rolled over. His employer did not subscribe to workers' compensation insurance. However, his employer filed a claim for his injuries under its business auto policy, and then assigned its insurance claim to the employee. The insurance policy provided that it did not insure bodily injury to an employee of the insured arising out of or in the course of employment by the insured. The employee argued that an exception to the exclusion applied: "But this exclusion does not apply to bodily injury to domestic employees not entitled to workers' compensation benefits or to liability assumed by the insured under an insurance contract." The employee argued that "domestic employee" is ambiguous because it could either refer to employees who work in a household or to employees who are citizens of the United States, and he would fall under the latter. The court held that "domestic employee" unambiguously referred to employees who work in a home. Consequently, the exception did not apply. *West v. S. Co. Mut. Ins. Co.*, 427 S.W.3d 576 (Tex. App.—Dallas 2014, no pet.).

B. Comprehensive general liability insurance

The fact that a general contractor entered into a contract in which it had agreed to perform construction in a good workmanlike manner did not trigger the contractual liability exclusion. *Ewing Constr. Co. v. Amerisure Ins. Co.*, 420 S.W.3d 30 (Tex. 2014). The contractor agreed to build tennis courts for a school district, but the tennis courts immediately started to flake, crumble, and crack. The liability insurer denied the contractor's claim. The liability insurer relied on the contractual liability exclusion, which excludes coverage for "'property damage' for which the insured is obligated to pay damages by reason of the assumption of liability in the contract or agreement."

The insurer argued that by agreeing to perform in a good and workmanlike manner, the contractor assumed liability in the contract and, therefore, the loss was excluded. The supreme court disagreed and instead agreed with the contractor that the agreement to build the tennis courts in a good and workmanlike manner did not enlarge the contractor's obligations beyond any general common law duty it had. Because the contract did not expand the contractor's obligations, there was not an "assumption of liability" within the meaning of the exclusion.

The supreme court also rejected the insurer's argument that if it held the exclusion inapplicable that would convert a liability policy into a performance bond. The court noted that, while this exclusion did not apply, other exclusions could.

The point the *Ewing* court made was applied, *Blanton v. Continental Ins. Co.*, 565 F. App'x 330 (5th Cir. 2014). At issue was whether a liability policy covered the insured's substandard conduct in installing and later repairing two diesel engines in a boat. After the decision in *Ewing*, the insurer conceded that the contractual liability exclusion did not preclude coverage. However, the court found that other exclusions applied. First, the defective installation and subsequent repairs were excluded by a provision that excluded liability arising out of a defect, deficiency, or inadequacy in "your product" or "your work." Moreover, the exception for loss that is sudden and accidental did not apply, because the underlying petition alleged that the defects appeared over time.

The policy also excluded damage to "your product," which the court held clearly included the engines that the insured installed and later attempted to repair.

The loss of use claim by the boat owner was also excluded under a ship repairs liability policy, which excluded loss due to "demurrage, loss of time, loss of freight, loss of charter and/or similar and/or substituted expenses." The court held that the meaning of "demurrage" was well settled to include loss of use of a vessel.

Further, the ship repairs liability policy also excluded "the expense of redoing the work improperly performed by [the insured] or on [the insured's] behalf or the cost of replacement of materials, parts or equipment furnished in connection therewith."

In *Crownover v. Mid-Continent Cas. Co.*, 757 F.3d 200 (5th Cir. 2014), homeowners initiated arbitration against their contractor, with the arbitrator determining that the homeowners had a meritorious claim for breach of the express warranty to repair contained in the contract. The contractor went bankrupt, so the homeowner sued the contractor's insurer. The insurer argued that an exclusion applied. The exclusion stated, "[t]his insurance does not apply to [ ] 'property damage' for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement." The Fifth Circuit held that, because the only ground on which the arbitrator awarded damages to the homeowners was breach of the express warranty to repair in the contract, the exception to the exclusion for "liability the insured would have in

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the absence of the contract or agreement" did not apply. Therefore, summary judgment in favor of the insurer was affirmed.

Under Texas law, "and" can be used disjunctively, rather than conjunctively. *Trammell Crow Residential Co. v. Am. Protection Ins. Co.*, 574 F. App'x 513 (5th Cir. 2014) (per curiam). Trammell Crow operated a number of apartment complexes in Colorado and was sued by residents due to a mold problem. APIC was paid funds from Trammell Crow's expense account to reimburse its defense costs. Trammell Crow then sued APIC, alleging that it was not required to reimburse APIC's defense costs. The question on appeal was whether APIC's costs and expenses in the litigation with the other insurer qualified as a "claim expense" under the APIC policy. A claim expense under the policy included expenses "incurred by the insured and by us[.]" Trammell Crow argued that APIC's defense costs were not claim expenses because they were incurred exclusively by APIC, rather than by both APIC and Trammell Crow. However, the Fifth Circuit determined that "and" in the definition was disjunctive, and that costs incurred by either or both Trammell Crow or APIC qualified as a "claim expense." Thus, the court held that Trammell Crow was required to reimburse APIC's defense costs up to the amount of the deductible under the policy.

Punitive damages were covered by a CGL policy. A judgment including punitive damages was rendered against the insured in Colorado. The insurer denied coverage for the punitive damages award, arguing that it was against Colorado law to do so. Having determined that Texas law applied, the court concluded that the policy's plain language provided coverage for the judgment. The policy covered "those sums that [the insured] becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage'…." The policy did not expressly exclude coverage for punitive damages. Therefore, the policy covered the punitive damages awarded against the insured in the underlying suit. *Tesco Corp. (US) v. Steadfast Ins. Co.*, No. 01-13-00091-CV, 2014 WL 4257737 (Tex. App.—Houston [1st Dist.] Aug. 28, 2014, no pet.).

An "own, rent, or occupy" exclusion precluded coverage for a tenant that leased a portion of the property and conducted its operations there. The tenant "occupied" the premises, including the roof, which it damaged. *Liberty Mut. Fire Ins. Co. v. Lexington Ins. Co.*, No. 04–13–00586–CV, 2014 WL 4823614 (Tex. App.—San Antonio Sept. 30, 2014, no pet.).

C. Umbrella/excess insurance

Umbrella insurers were obliged to pay losses in excess of the underlying policies even though the underlying policies were exhausted by claims that would not have been covered by the umbrella policies. *Indem. Ins. Co. of N. Am. v. W&T Offshore, Inc.*, 756 F.3d 347 (5th Cir. 2014). W&T Offshore sustained significant damage to its energy exploration and development operations as a result of Hurricane Ike. W&T had several layers of coverage. The primary and umbrella policies allowed recovery for removal of debris expenses. The primary policies also allowed coverage for property damage and operators' extra expenses, but the umbrella policies did not. W&T's property damage and operators' extra expense claims exhausted the underlying policies. The umbrella insurers sought a declaratory judgment that they were not obliged to pay their policy limits for removal of debris, because the underlying policies were exhausted by claims that would not have been covered by the umbrella policies.

The district court accepted this argument, but the Fifth Circuit reversed. The Fifth Circuit relied on the plain language of a provision in the umbrella policies stating that they would pay amounts in excess of the "retained limit." That phrase was defined to include all sums above the underlying policy limits, without specifying that the underlying claims had to be covered. In contrast, another provision of the policy provided that the umbrella insurers had additional duties, including the duty to defend, when the underlying limits were exhausted by claims that would have been covered by the umbrella policy.

D. Homeowners liability insurance

A homeowner's liability policy did not cover the negligence of a son that led to the father's injuries, where the policy excluded coverage for bodily injury "to you or an insured." The father was defined as both "you" and "an insured." The court rejected the argument that the severability clause made a difference. That clause provided that "this insurance applies separately to each insured." No matter which insured's perspective was considered, the exclusion still excluded the father as "you" and "an insured." *Hodges v. Safeco Lloyds Ins. Co.*, 438 S.W.3d 698 (Tex. App.—Houston [1st Dist.] 2014, no pet.).

V. DUTIES OF LIABILITY INSURERS

A. Duty to defend

A liability insurer's duty to defend its homebuilder insured for claims for "property damage" caused by water leaks was triggered where the suit alleged that the injury manifested itself during the policy term. The duty was triggered where the suit alleged water damage that occurred during the policy period, even though it may have manifested or been discovered later. *Great Am. Ins. Co. v. Hamel*, No. 08–11–00302–CV, 2014 WL 4656618 (Tex. App.—El Paso, Sept. 19, 2014, no pet.).

A liability insurer had a duty to defend a city sued on several theories that could impose liability apart from any excluded liability for "inverse condemnation." *City of College Station, Tex. v. Star Ins. Co.*, 735 F.3d 332 (5th Cir. 2013). The city was sued by a real estate investment company that wanted to

develop commercial property. Because of zoning issues with the city, the company sued the city alleging: (1) that the city's actions were discriminatory and lacked a rational basis violating its 14th Amendment right to equal protection; (2) that the city's repeated denials of requests for rezoning were arbitrary and capricious, violating its 14th Amendment right to substantive due process; (3) that the city's intentional actions in denying the zoning requests constitute a taking in violation of the Texas constitution; and (4) that the city's individual council members had intentionally interfered with the company's existing and perspective contracts and business relationships for its development. The city's insurer refused to defend or indemnify the city, asserting that all of the claims fell within the "inverse condemnation" exclusion in the policy.

The court found that inverse condemnation is a legal term of art used to refer to an action brought by a property owner seeking just compensation for a regulatory "taking." The inverse condemnation exclusion excepted coverage for "any liability … actually or allegedly arising out of or caused or contributed to by or in any way connected with any principal of imminent domain, condemnation proceeding, [or] inverse condemnation … by whatever name called." The court found that the third cause of action fit within the exclusion, but the others did not. The court found that the city could be liable under the other theories independent of any liability arising out of the inverse condemnation. Therefore, the insurer had a duty to defend.

The Fifth Circuit held that an insurer did not have a disqualifying conflict that allowed the insured to choose its own defense counsel, in *Graper v. Mid-Continent Cas. Co.*, 756 F.3d 388, 393 (5th Cir. 2014). The court relied on *N. Cnty. Mut. Ins. Co. v. Davalos,* 140 S.W.3d 685 (Tex.2004), to reject the argument that an insured is entitled to select its own counsel when the *potential* for a conflict of interest exists."Instead, the test to apply is whether 'the facts to be adjudicated in the [underlying] lawsuit are the same facts upon which coverage depends.'"

The court rejected the insured's argument that the rule should be flexible and permit a disqualifying conflict to arise when the insurer has hired attorneys who may be tempted to develop facts or legal strategy that ultimately could support the insurer's coverage position. The court rejected this argument and held that the "same facts" test in *Davalos* is the proper analysis.

Under this analysis, the court found that the fact issues raised by the reservation of rights letter were different from the facts at issue in the underlying infringement case. First, the underlying case raised the issue of limitations, and the insurer reserved its right to deny the claim because it occurred before the beginning of the policy. The court held these were different issues. On the limitations issue, the question was when the claim accrued, not when the accident infringement occurred. The court conceded that of course the claim could not accrue until after the infringing acts occurred. Nevertheless, the court concluded that the limitations determination would lack the specificity necessary to decide whether the claim was covered under the policy. An adjudication of when the plaintiff's claim accrued would not be a judicial ruling necessarily deciding when the infringing conduct occurred.

Second, the court held that the plaintiff's allegation that the insureds acted willfully in infringing the copyright did not raise the same issue as whether the insureds acted "with the knowledge that the act would violate the rights of another," within a policy exclusion. The court reasoned that "willful" under the Copyright Act includes both knowing and reckless conduct, so that a finding that the defendants acted willfully would not necessarily establish whether they acted knowingly within the meaning of the exclusion.

The court's reasoning on the first issue seem a bit facile. The court conceded that accrual would encompass the date the act occurred, because a plaintiff cannot discover his claim until after the act has occurred. Therefore, deciding that the plaintiff's claims accrued before a certain date would necessarily establish that the conduct occurred before a certain date. If the date for limitations was prior to the date for coverage under the policy, then litigating the accrual date would necessarily also litigate the occurrence date for purposes of denying coverage.

The Fifth Circuit reiterated that, in certain situations, a court may look to evidence outside the eight-corners in determining an insurer's duty to defend. *Star-Tex Resources, L.L.C. v. Granite State Ins. Co.*, 553 F. App'x 366 (5th Cir. 2014) (per curiam). An insured sought defense for a suit against it concerning an auto collision caused by the insured's employee. The insurer denied coverage, relying on the policy's exclusion for damages arising out of use of an auto. The insured argued that this exclusion did not apply because the petition in the underlying suit did not state that the employee was driving or operating an automobile at the time of the collision, only that the auto collision was caused by the employee's negligence. The Fifth Circuit held that, based on the pleadings, it could not determine whether there was a potentially covered claim, as other reasonable inferences were possible that would not place the employee in an automobile at the time of the accident. However, the court concluded that it could consider extrinsic evidence to determine whether the insurer owed a duty to defend because it was "initially impossible to discern whether coverage is potentially implicated and … the extrinsic evidence goes solely to a fundamental issue of coverage which does not overlap with the merits[.]" In particular, the court looked at a notice of claim sent to the insurer by the plaintiff, which stated that the employee was driving the car. In looking at the eight corners as well as this extrinsic evidence, the court held that the insurer had no duty to defend the insured.

A liability insurer owed a defense to a correctional facility sued for civil rights violations for withholding prescription medications from a prisoner. The civil rights endorsement in the policy covered "'bodily injury' caused by alleged civil rights violations, so long as such violations and any resulting injuries are not expected or intended from the standpoint of the insured." The claim arose when the insured withheld prescription medications from a prisoner, allegedly resulting in his death. In the underlying suit, the defendant invoked the medical malpractice limits provided for "health care" providers. The insurer argued that this position was inconsistent with the insured's position that withholding medications was not "medical services" within the meaning of the policy exclusion. The court noted that estoppel applies when a party takes one position and then later assumes a contrary position or when a party asserts to another's disadvantage or right inconsistent with the position the party previously took. The court held neither form of estoppel applied. The position taken in the underlying case did not involve the same language as the coverage case. Further, the position taken in the underlying case benefited the insurer by limiting the amount of the defendant's exposure. *LCS Corr. Svcs., Inc. v. Lexington Ins. Co.*, No. 2-13-CV-287, 2014 WL 1787771 (S.D. Tex. May 5, 2014).

An insurer did not owe a duty to defend the employee of an insured because the employee was not an "insured." The pleading in the underlying suit alleged that the employee's actions were not in connection with his employment. Under the eight-corners rule, that allegation removed the employee from the definition of an "insured." The additional statement in the pleading that the employee alleged he was acting in the course and scope of his employment was insufficient to establish a duty to defend. The eight-corners rule focuses on the plaintiff's factual allegations, not the defendant's allegations. *Carter v. Westport Ins. Corp.*, 997 F. Supp. 2d 590 (S.D. Tex. 2013).

Doubts as to whether a complaint's allegations trigger coverage should be resolved in the insured's favor. *Canal Ins. Co. v. XMex Transport, LLC*, No. EP-13-CV-156-KC, 2014 WL 4385941 (W.D. Tex. Sept. 4, 2014). An insured trucking company sought a defense from its insurer relating to litigation concerning a fatal truck accident. One plaintiff in the underlying suit alleged that the individual defendants were acting in the course and scope of their employment with the insured; another plaintiff alleged that they were not. None of the pleadings specifically identified the truck at issue. Yet the court concluded that the allegations in the pleadings were sufficient to trigger coverage under the policy. Following the general rule that "the insurer is obligated to defend if there is, potentially, a case under the complaint within the coverage of the policy," the court resolved doubts in the pleadings in favor of the insured.

Summary judgment favored an insured, but not an additional insured in *Burlington Ins. Co. v. JC Instride, Inc.*, No. H-13-2844, 2014 WL 3057063 (S.D. Tex. July 7, 2014). An insured general contractor was hired by a company to clean mud tanks owned by another company. An employee of the hiring company was injured when he got into a mud tank that contained caustic materials, contrary to the insured's representation to him. The employee sued the owner of the tank and the insured. The tank owner sought a defense as an additional insured from the insured's liability insurer. The insurer denied coverage on the grounds that the policy's employee exclusion applied. The insured also sought coverage, which was granted subject to a reservation of rights, but eventually denied on grounds that the policy's pollution exclusion applied. The district court considered both of these arguments in deciding the parties' cross-motions for summary judgment. The court concluded that the employee exclusion excluded coverage for the tank owner as an additional insured. The employee was "hired to do work for or on behalf of" the insured, by virtue of the contract between the employer cleaning company and the insured. Thus, the insurer had no duty to defend the tank owner. However, the court found that the insurer did have a duty to defend the insured. Although the caustic materials in the mud qualified as pollutants under the policy, the pollution exclusion did not apply because the employee was injured by entering the mud tank, not by a "dispersal" or emission of the caustic materials.

In reconsidering a prior decision, a district court found that it was correct in not considering extrinsic evidence to decide an insurer's duty to defend. The extrinsic evidence in question overlapped with the merits and contradicted the allegations in the underlying litigation. *Admiral Ins. Co. v. Petron Energy, Inc.,* 1 F. Supp. 3d 501 (N.D. Tex. 2014). Additionally, the policy's auto exclusion did not apply to preclude a duty to defend. Whether the tortfeasor in the underlying suit was alleged to be an employee of all employers or a single employer made no difference because a jury could conclude that the tortfeasor was an employee of only one of the employers. The court further concluded that the earlier ruling on the insurer's duty to indemnify was premature.

The court also determined that an insurer breached its contract by failing to tender a defense to the insured in an underlying suit. The court's earlier decision wrongly applied the independent injury test for "extra-contractual" damages, applicable under some sections of the Texas Insurance Code, to the insured's breach of contract claim. The insured did not need to show it suffered increased fees in the underlying suit, only that they had incurred legal expenses due to the insurer's failure to provide a defense. *Admiral Ins. Co. v. Petron Energy, Inc.,* 1 F. Supp. 3d 501 (N.D. Tex. 2014).

A garage liability insurer had neither a duty to defend nor a duty to indemnify an employee involved in an automobile

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accident that occurred while he was driving his employer's vehicle during a personal trip. The employee was not an "insured" under the policy because he was on vacation and his use of his employer's vehicle was in the capacity of a customer and unrelated to his employment. *Sentry Select Ins. Co. v. Home State Co. Mut. Ins. Co.*, 994 F. Supp. 2d 789 (E.D. Tex. 2013).

A regulatory complaint may be considered a "claim" under a "claims made and reported" policy. An insurance agency sued its liability insurer after the insurer denied coverage for the agency in an underlying suit. The insurer argued that it owed no duty to defend or indemnify because the "claim" occurred before the policy commenced. The court agreed. The policy provided coverage for "claims made and reported" during the policy period. Here, the plaintiff in the underlying suit had filed a complaint about the agency with the Texas Department of Insurance a year before the policy commenced. The court concluded that the complaint with TDI constituted a claim under two definitions in the policy: it was a "demand against any insured" and "a … regulatory investigation against any insured." *Regency Title Co., LLC v. Westchester Fire Ins. Co.*, 5 F. Supp. 3d 836 (E.D. Tex. 2013).

B. Duty to indemnify

Two insurers insured an ambulance company that was named in a personal injury lawsuit after a patient was injured while being loaded into an ambulance. *Nat'l Cas. Co. v. W. World Ins. Co.*, 553 F. App'x 373 (5th Cir. 2014). The insurers disputed which of them had a duty to indemnify the insured. One policy, issued by National Casualty, covered damages resulting from use of an auto; the other policy, issued by Western World, excluded damages resulting from use of an auto. The Fifth Circuit found that the damages resulted from use of an auto and that National Casualty had a duty to indemnify. Although the gurney was not touching the ambulance when the incident occurred, one of the EMTs was touching both the gurney and the ambulance and had begun the process of placing the patient into the ambulance.

An earlier appeal in the case regarding the duty to defend had determined that "the 'sole purpose' of the alleged attempt to place [the patient] in the ambulance was to use the ambulance"; "[t]he alleged attempt to load her into the ambulance 'directly caused' her injury"; and "[a]ttempting to load a patient onto an ambulance is 'not an unexpected or unnatural use of the vehicle.'" The court concluded that it was bound to this earlier opinion because it was now determined that the patient was injured while being placed into the ambulance.

Justice Owen dissented, reasoning that there was no "use" of an auto when the patient was dropped from a gurney just before EMTs were about to place her into an ambulance and, further, that the conclusions of the prior case were not binding because they were based on the pleadings, and not on the evidence at trial.

A liability policy did not cover an arbitration award against a law firm for improper billing practices. *John M. O'Quinn, P.C. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, No. 4:00-CV-2616, 2014 WL 3543709 (S.D. Tex. July 17, 2014). A class of plaintiffs sued their prior law firm seeking reimbursement of expenses associated with an earlier class action lawsuit because the expense reimbursement was not contemplated by the representation agreement. The plaintiffs prevailed and recovered the expenses and disgorgement of some fees the law firm had earned. The law firm sought indemnity from its umbrella insurance carrier, which denied the claim. The trial court granted summary judgment for the carrier, finding no coverage. The court found that the law firm did not suffer a "Loss" within the meaning of the policy because the damages awarded against the firm were restitutionary in nature. The court also found that the "Professional Legal Services" provision did not provide coverage because the firm's billing and fee-setting practices, from which the underlying suit arose, were not an integral part of the legal representation that it provided to the plaintiffs. Additionally, any coverage would have been excluded because the loss arose from the firm's "gaining profit or advantage to which it was not legally entitled."

C. Settlements, assignments, and covenants not to execute

In the first successful case since *Gandy*, a court of appeals affirmed a judgment against an insurer in favor of a plaintiff who took an assignment of the insured's claims. In *Great American Insurance Co. v. Hamel*, No. 08–11–00302–CV, 2014 WL 4656618 (Tex. App.—El Paso, Sept. 19, 2014, no pet.), the court rejected the insurer's argument that it was not bound by the judgment against its insured, based on the Supreme Court's decision in *State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996). In *Hamel*, a home builder was sued after the homeowners discovered water damage caused by defective construction. The insurer refused to defend, contending that the loss was excluded. The plaintiffs then proceeded to a bench trial where they presented evidence of the builder's negligence and the extent of their damage. The trial court ruled in their favor. The builder then assigned to the plaintiffs its claims against the insurer. The plaintiffs proceeded to trial against the insurer, resulting in a judgment finding the insurer liable for the underlying judgment.

The insurer argued that under *Gandy*, the underlying judgment was not binding because it did not result from an "actual trial" as required by the policy language. The policy provided that suit could be brought against the insurer only to recover on a judgment that is "obtained after an actual trial." The court rejected this argument, holding that an insurance company cannot insist on compliance with an actual trial requirement where the insurer has breached its duty to defend.

The court also found sufficient evidence to support the trial court's findings that the builder defended himself in good faith, his testimony was truthful, and was not unduly influenced or affected by any stipulations or agreements or understandings between the parties. The court found there was no evidence that the underlying judgment was collusive or fraudulent. The court therefore concluded that the *Gandy* requirement of a "fully adversarial trial" was satisfied and the underlying judgment was therefore binding on the insurer.

The court also found *Gandy* distinguishable. The settlement and assignment of claims in *Gandy* was held invalid when: (1) it was made prior to an adjudication of plaintiff's claims against the insured in a fully adversarial trial; (2) the insurer had tendered a defense; and (3) either (a) the insurer has accepted coverage, or (b) the insurer has made a good faith effort to adjudicate coverage prior to the adjudication of the plaintiff's claim. The court found none of these factors present in this case.

An umbrella liability insurer sued its insured and the insured's commercial general liability insurer, seeking a declaration that it had no duty to indemnify the insured against a jury verdict. *Empire Indem. Ins. Co. v. N/S Corp.*, 571 F. App'x 344 (5th Cir. 2014) (per curiam). The Fifth Circuit held that a settlement between the plaintiff and the insured in the underlying suit extinguished any obligation of the umbrella insurer to indemnify the insured. In particular, the settlement reached in the underlying suit contained an unconditional release. The agreed judgment, entered after the settlement was executed, could not revive the insured's liability. Because the insured was not, and could never be, legally liable for the judgment based on the full release in the settlement agreement, the umbrella insurer had no duty to indemnify.

D. Excess & primary coverage

An employee of an insured was involved in a car accident while driving a truck owned by another insured. The employer's insurer asked the truck insurer to tender a defense when the injured party sued the employer. The truck insurer declined, stating it would share the defense costs. The Fifth Circuit held that the "other insurance" clauses in the two insurers' policies did not limit liability or coverage based on the existence of other available insurance, so the clauses did not conflict, which would have resulted in the defense costs being shared pro rata. Because the clauses did not conflict, the court held that under the terms of the "other insurance" clauses, the truck insurer was obligated to provide primary coverage to the employer and was liable for the entirety of the defense. *Am. States Ins. Co. v. Ace Am. Ins. Co.*, 547 F. App'x. 550 (5th Cir. 2013).

An excess insurer's coverage was triggered even though the underlying insurers settled for an amount less than their policy limits. *Plantation Pipe Line Co. v. Highlands Ins. Co.*, No. 11-12-00029-CV, 2014 WL 4346160 (Tex. App.—Eastland Aug. 29, 2014, pet. filed). An insured pipeline company sought coverage relating to a leak in one of its underground pipelines. The pipeline company had many layers of insurance. It reached a settlement with its lower-level insurers for less than the full limits of those policies, but agreed to pay the difference between the underlying settlement amounts and the underlying policy limits. The pipeline company then sued its top tier excess liability insurer, which denied coverage, arguing that the lower-level insurers had not actually paid the full limits of their policies. The court disagreed. The policy did not require the lower-level insurers to pay "full policy limits" before coverage attached; it required them to pay "ultimate net loss." Although that phrase was not defined in the excess policy, it was defined in a lower-level policy, the terms of which were adopted by the excess policy. Under the lower-level policy, "ultimate net loss" meant "all sums which the insured or … his insurer, or both, become legally obligated to pay as damages, … by … settlement [.]" Using this definition, the court concluded that the excess insurer was liable because the pipeline company and the other carriers altogether paid a sum in excess of the attachment point of the excess policy.

VI. THIRD PARTY THEORIES OF LIABILITY

A. Fraud

A certificate submitted to a state agency was not misrepresentation of coverage. An insured pest control company sued its insurer and insurance agent for fraud and misrepresentation after the insurer denied liability coverage for a suit brought against the insured by a homeowner for an allegedly improper wood destroying insect inspection (WDI). The policy excluded WDIs from coverage, but the insurer issued a certificate of insurance sent to the Texas Department of Agriculture that did not list any categories of pest control work as excluded. Because the certificate filed with the state did not identify any exclusion, the insured argued that it reasonably relied on the fact that full coverage was provided. The court of appeals disagreed. The insured had previously acknowledged in the application for insurance and the renewal application that the insurance did not include coverage for liability arising from WDI. Also, the plain language of the endorsements in the original and renewal policies excluded coverage for inspection services. The certificate specifically stated that it neither amended, extended, or altered the coverage afforded by the policies and was furnished for information only. The court concluded that the policies and application would not have caused a reasonable person to believe that the insured had coverage for liability arising from inspections, including WDI. Consequently, the insured could not prove its causes of action for DTPA, insurance code violations, fraud, and negligent misrepresentation. *Simon v. Tudor Ins. Co.*, No. 05-12-00443-CV, 2014 WL 473239 (Tex. App.—Dallas Feb. 5, 2014, no pet.).

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VII. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Attorney's fees

An award of attorney's fees was reversed and remanded where the plaintiff's attorney did not segregate time, or estimate the allocation of time, between breach of contract and statutory claims that allow fee recovery and negligence claims that do not allow fees. *Prudential Ins. Co. v. Durante*, No. 08–12–00077–CV, 2014 WL 4259434 (Tex. App.—El Paso Aug. 29, 2014, pet. granted).

In *United Nat'l Ins. Co. v. AMJ Investments, L.L.C.*, No. 14-12-00941-CV, 2014 WL 2895003 (Tex. App.—Houston [14th Dist.] June 26, 2014, no pet.), a building's owner and its property insurer disputed the amount the insurer should pay under the policy after the building sustained damage from a hurricane. The court of appeals upheld the bad faith claims that the lower court found against the insurer, but reversed the attorney's fee award. The insured's attorney used the lodestar method of proving attorney's fees, but had not kept billing records. Instead, he estimated the amount of time it took him for general tasks, such as discovery. The court held that the insured failed to introduce evidence that was sufficiently specific to permit the determination of a reasonable fee for its attorney's services, and reversed and remanded.

An insured did not have to segregate attorney's fees awarded against an insurance agency found liable for breach of contract and an insurance broker found liable for negligence where the insured's claims against both arose out of the same transaction and resulted in a single injury where the agency and broker failed to provide the coverage the insured requested. *Insurance Alliance v. Lake Texoma Highport, LLC*, No. 05-12-01313-CV, 2014 WL 6466851 (Tex. App.—Dallas Nov. 19, 2014). The court reasoned that although there was some testimony about actions specific to the broker, the jury could have determined that any fees the insured spent dealing with the broker would have been incurred anyway to bring its claims against the agency.

B. Mental Anguish

In *Great American Insurance Co. v. Hamel*, No., 08–11–00302–CV, 2014 WL 4656618 (Tex. App.—El Paso, Sept. 19, 2014, no pet.), the plaintiffs recovered mental anguish damages along with their property damage in a suit against the builder for negligent construction that allowed water damage. On appeal, the insurer argued that mental anguish damages were not recoverable, because the plaintiffs presented no evidence of any physical manifestations so that their mental anguish damages did not constitute damages because of "bodily injury." *See Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819 (Tex. 1997). The plaintiffs responded that their mental anguish was because of "property damage," and was therefore covered. The court did not accept either argument, but instead held that mental anguish is not recoverable based solely on negligent property damage, citing *City of Tyler v. Likes*, 962 S.W.2d 489 (Tex. 1997). The evidence in this case only showed that the builder was negligent, not that he acted with a heightened degree of misconduct that would allow a recovery of mental anguish damages.

VIII. DEFENSES & COUNTERCLAIMS

A. Accord & satisfaction

A property insurer's prior payment for a claim related to Hurricane Ike in 2008 did not support the defense of accord and satisfaction in a subsequent suit based on another claim arising from another storm. The court found evidence that the insurer issued a $2,500 settlement check, but there was no evidence that the insureds ever accepted it or released their claims. *Mag-Dolphus, Inc. v. Ohio Cas. Ins. Co.*, No. H–13–08S2, 2014 WL 4167497 (S.D. Tex. Aug. 13, 2014).

B. Allocation

Plaintiffs who suffered water damage to their home that covered several policy years were not required to allocate those damages between or among insurers or policies. *Great American Insurance Co. v. Hamel*, No. 08–11–00302–CV, 2014 WL 4656618 (Tex. App.—El Paso, Sept. 19, 2014, no pet.)

C. Attorney's fees for vexatious litigation

A federal magistrate abused his discretion by awarding attorney's fees against the insured's lawyers for unreasonably and vexatiously multiplying proceedings in violation of 28 U.S.C. § 1927. *Lawyers Title Ins. Corp. v. Doubletree Partners, L.P.*, 739 F.3d 848 (5th Cir. 2014). The Fifth Circuit held that there was no evidence that the attorneys had asserted the extracontractual claims against the title insurer in bad faith, for any improper motive, or in reckless disregard of any duty owed to the court. Instead, the evidence showed that the attorneys felt obliged to assert the claims as compulsory counterclaims and had offered to put those claims on hold pending resolution of the breach of contract issues, but the insurer's attorneys had rejected this offer.

D. Insurer's waiver of, or estoppel to assert, defenses

A beneficiary could not assert that an insurer was estopped from denying coverage on a life insurance policy that had lapsed for non-payment of premium. The court held that when a valid contract exists covering the alleged promise, a plaintiff cannot recover under promissory estoppel. In this case, the policy governed the terms under which the insurer would pay. Therefore, promissory estoppel would not apply. *Lombana v. AIG Am. Gen. Life Ins. Co.*, No. 01–12–00168–CV, 2014 WL 810858 (Tex. App.—Houston [1st Dist.] Feb. 27, 2014, pet. denied).

The court also found no evidence of continued negotiations or representations by any authorized person on behalf of the insurance company, so waiver did not apply.

E. Payment

Payment of an insurance settlement check to an insured without the endorsement of a mortgagee as copayee does not constitute payment to a "holder" and thus does not discharge the insurer of its liability. *Viewpoint Bank v. Allied Prop. & Cas. Ins. Co.*, No. 05-12-01370-CV, 2014 WL 3867810 (Tex. App.—Dallas Aug. 7, 2014, pet. filed). In settlement of an insurance claim, an insurer issued checks payable jointly to its insured and the insured's mortgagee. After the insured negotiated and deposited checks without the mortgagee's endorsement and retained all of the proceeds, the mortgagee sued the insurer to recover payment. Relying on *McAllen Hospitals, LP v. State Farm Mut. Ins. Co. of Tex.*, 433 S.W.3d 535 (Tex. 2014), the court held that the insurer was not discharged from its liability on the underlying obligation or the checks under article 3 of the UCC. Additionally, the mortgagee had a conversion cause of action against the insurer under the UCC, and that remedy was not exclusive. Consequently, the insurer was obligated to pay the checks to the mortgagee.

F. Reformation

In *Lawyers Title Ins. Corp. v. Doubletree Partners, L.P.*, 739 F.3d 848 (5th Cir. 2014), the court held that an insurer was entitled to reform an insurance policy that was issued without the exception and coverage agreed to by the parties. The insurer and insured both agreed that a title insurance policy would include an exception for a flowage easement and additional survey coverage purchased by the insured. Due to a software error, the policy was issued without those forms. The court held that reformation is proper when (1) an original agreement exists between the parties, and (2) a mutual mistake occurred in reducing the agreement to writing. The evidence showed that the parties agreed to the easement and additional coverage, so the first prong was satisfied. The court also held the mistake was mutual because, even though the insurer unilaterally made the mistake, the insured knew a mistake had been made because it had agreed to the easement in the title commitment and had paid for the additional coverage that was mistakenly omitted.

G. Restitution

An insurer could not recoup payments under equitable theories of restitution, unjust enrichment, and subrogation, where the insurance contract addressed the issues in dispute. *Gotham Ins. Co. v. Warren E&P, Inc.*, No. 12–0452, 2014 WL 1190049 (Tex. Mar. 21, 2014). The insurer provided coverage for an oil well operator in case of an oil well blow out. After an oil well blew out and the insurer paid, the insurer then sought to recoup its payments based on its argument that the operator breached the insurance contract by not using due diligence and made misrepresentations about the amount of its interest.

The supreme court held that the insurer could not proceed on its equitable claims because it was limited to contractual claims where the policy addressed the matter at issue. As shown by the insurer's contract claims, there were provisions in the policy that addressed the issues. There was some evidence that the operator breached the due diligence requirement in the policy by failing to use a proper blowout preventer. There was some evidence that the operator misrepresented its interest in the well, which affected the amount owed by the insurer. Therefore, the Court remanded for determination of the insurer's contract claims.

IX. PRACTICE & PROCEDURE

A. Appraisal

An appraisal award could not be disregarded for being non-itemized. *Michels v. Safeco Ins. Co. of Indiana*, 544 F. App'x 535 (5th Cir. 2013). Insureds sued both their homeowners insurer and its investigator seeking coverage for smoke damage to their home that occurred during the Bastrop wildfires. The trial court granted the insurer's motion to compel appraisal. The insureds argued on appeal that the appraisal award should have been disregarded because it was not fully itemized and thus not in compliance with the policy. The Fifth Circuit disagreed and held that the insureds were estopped from making this argument, because the insureds' appraiser had requested that the umpire use a non-itemized, lump sum form. Further, the award substantially complied with the policy. The appraisers prepared itemized estimates, met to discuss them, and then submitted disputes to the umpire.

In *United Neurology, P.A. v. Hartford Lloyd's Ins. Co.*, 995 F. Supp. 2d 647 (S.D. Tex. 2014), the insured attempted to have an appraisal award regarding property damage caused by a hurricane set aside. The insured argued that the award was improper because the appraisers looked at causation in determining the award. The court held that appraisal panels act within their authority when they determine whether damage was caused by a covered event or was the result of non-covered pre-existing conditions like wear and tear, or in this case, neglect under the terms of the policy. Therefore, the insured's motion to set aside the award was denied.

The "law of the case" doctrine prevented an insured from relitigating an insurer's liability under a homeowner's policy. *Farmers Group Ins., Inc. v. Poteet*, 434 S.W.3d 316 (Tex. App.—Fort Worth 2014, pet. denied). An insured's house was damaged by soot. She sought coverage from her home insurer. The insurer invoked the appraisal process, but failed to ever designate its appraiser and instead initiated a lawsuit asking the court to appoint an umpire. That suit was ultimately dismissed for want of prosecution. The insured

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then sued the insurer for breaching the contract. In an initial appeal of summary judgment, the court of appeals determined that the insured failed to present evidence of her damages by failing to segregate between covered and uncovered losses. However, the court remanded the case on the issue of the insurer's breach of the appraisal provision. In the remand, the parties disputed the scope of the trial. In particular, the insurer argued that the law of the case precluded retrial of any damages except for those associated with the appraisal process itself. The insured argued, however, that her recoverable damages should include the full amount of her claimed loss. She based her argument on the appraisal provision in the policy, which said that an award under that provision would be "binding" on both parties. Her point was that, had appraisal taken place, it would have determined the extent of her damages. The court agreed with the insurer, holding that the scope of the trial on remand was limited to the appraisal and the damages resulting from breach of the appraisal clause. The law of the case applied to preclude the insured from attempting to recover any damages relating to the property. Further, the court noted that an appraisal does not necessarily determine the amount of a covered loss. An appraisal amount may include both covered and uncovered losses, and causation is a liability question for the courts. Consequently, the insured was incorrect in arguing that the insurer would have compensated her for her loss, covered or not, if the insurer had complied with the appraisal provision.

B. Arbitration

The court in *Why Nada Cruz, L.L.C. v. Ace American Ins. Co.*, 569 F. App'x. 339 (5th Cir. 2014), held that an arbitrator did not exceed his powers in dismissing an arbitration where the insured did not file for arbitration until over two years after the date of the loss. The arbitrator held that the policy required that the request for arbitration be filed one year from the date of loss. A letter to the insurer stating that the insured would request arbitration did not meet the requirement for actually filing for arbitration.

C. Choice of law

A New York resident purchased an insurance policy, which, through a series of assignments, allowed a settlement trust to acquire the rights to the "pay on death benefits." After the insured's death, the settlement trust submitted a request to the insurer for payment. The insurer refused, arguing the rights were fraudulently acquired as part of a stranger owned life insurance scheme. The settlement trust sued the insurer. The insurer argued that New Jersey law should apply because the policy application had choice of law contacts with New Jersey. The other two interested jurisdictions were Texas, where the insurer was domiciled and suit was filed, and New York, where the insured was a resident. New Jersey law conflicted with Texas and New York law on the issue of the insurer's ability to challenge the validity of the insurance policy based on the insurable interest requirement once the contestability period had expired. The court held that New York law applied, relying on *Restatement (Second) of Conflicts of Laws* section 192, which creates a choice of law presumption in favor of the jurisdiction where the insured was domiciled at the time she applied for life insurance. *American Nat'l Ins. Co. v. Conestoga Settlement Trust*, No. 04-13-00719-CV, 2014 WL 3734215 (Tex. App.—San Antonio July 30, 2014, pet. filed).

Texas law, and not Colorado law, applied in a liability coverage dispute regarding coverage for a Colorado judgment against an insured that included an award of punitive damages. *Tesco Corp. (US) v. Steadfast Ins. Co.*, No. 01-13-00091-CV, 2014 WL 4257737 (Tex. App.—Houston [1st Dist.] Aug. 28, 2014, no pet.). The court concluded that Texas law governed the scope of coverage under the policies by looking at various factors. In particular, the insurer had its principal place of business in Texas, the insured did business in Texas, the policies were negotiated and executed in Texas, and the policies were issued from underwriters in Texas through a Texas broker. The only connection to Colorado was that the underlying judgment was entered there. Moreover, applying Colorado law would invalidate a portion of the policy, whereas applying Texas law would uphold it. The court noted that the law favors applying the law of the state that would uphold the validity of the contract.

D. Discovery

The supreme court held that a request for other claim files was overly broad and that the trial court, therefore, abused its discretion by allowing such discovery. *In re Nat'l Lloyds Ins. Co.*, No. 13–0761, 2014 WL 5785871 (Tex. Oct. 31, 2014) (per curiam). Irving's home was damaged by storms in Cedar Hill in 2011 and 2012. She contended that the insurer undervalued her claims and sued for unfair insurance practices. She sought discovery of other claims handled by the same adjusters and adjusting company. The trial court allowed discovery limited to those adjusters and to other Cedar Hill policyholders. To support her contention that her claims were undervalued, Irving proposed to compare the insurer's evaluation of the damage to her home with its evaluation of damage to other homes. The supreme court held this discovery was overly broad because it was not probative of how the insurer handled Irving's claim. The court held there were too many variables regarding the other claims for them to be relevant to Irving's claim. The court noted that it was not holding that evidence of other claims can never be relevant in coverage litigation, but that it was irrelevant in this case.

E. Experts

In a suit against a builder for water intrusion damage to a home, the trial court properly allowed expert testimony from a repair contractor and an engineer regarding the extent and timing of the damage. *Great Am. Ins. Co. v. Hamel*, No., 08–11–00302–CV, 2014 WL 4656618 (Tex. App.—El Paso Sept. 19, 2014, no pet.). The court found both experts

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were sufficiently qualified by their experience and education to give opinions about the wetness of wood in the house and the progression of wood rot caused by the water leaks.

A building's owner and its property insurer disputed the amount the insurer should pay under the policy after the building sustained damage from a hurricane. *United Nat'l Ins. Co. v. AMJ Inv., L.L.C.*, No. 14-12-00941-CV, 2014 WL 2895003 (Tex. App.—Houston [14th Dist.] June 26, 2014, no pet.). The trial court found that the insurer had knowingly violated the Texas Insurance Code. The insurer argued on appeal that it could not have knowingly failed to settle the claim when its liability was reasonably clear because there was no evidence that its liability was "reasonably clear," and also argued that its reliance on expert advice is not evidence of bad faith. The court held that in some circumstances, reliance on expert advice can be evidence of bad faith. In this case, although the insurer argued it properly relied on its experts, there was evidence that the insurer agreed to pay for repairs as set forth in its consultant's estimate. Therefore, the jury could have concluded that once the insurer reached that agreement, it was no longer reasonable for the insurer to rely on the contrary opinion of other experts.

Where the insurer cross-examined the insured's witness about whether he was an expert and elicited testimony that he was an expert on determining damages under a policy, that provided sufficient expert testimony to calculate the money owed under a policy that fell short of the policy that was requested. *Insurance Alliance v. Lake Texoma Highport, LLC*, No. 05-12-01313-CV, 2014 WL 6466851 (Tex. App.—Dallas Nov. 19, 2014).

F. Hospital liens

A hospitals lien was not discharged by the insurer's settlement check made jointly payable to the hospital and plaintiff, where the plaintiff deposited the check without the hospital's knowledge or endorsement. *McAllen Hosps., L.P. v. State Farm Co. Mut. Ins. Co. of Tex*, 433 S.W.3d 535 (Tex. 2014). The court held that the check that was jointly payable to the injured party and the hospital did not constitute "payment" under the hospital lien statute, Tex. Prop. Code § 55.007. Therefore, the release was not valid, the cause of action was revived, and the hospital retained its lien.

The court did not address whether the hospital had a direct action against the insurer because that issue was not properly raised. However, the court did strongly suggest that there would be no private cause of action, because no such remedy appears in the statute.

The court also noted that the hospital had the ability to sue the bank that accepted the deposit without both required endorsements, but that remedy did not preclude the hospital seeking other remedies.

Another court held that an insurer subject to a hospital lien had standing to seek declaratory judgment that the charges were unreasonable. *Allstate Indem. Co. v. Memorial Hermann Health System*, 437 S.W.3d 570 (Tex. App.—Houston [14th Dist.] 2014, no pet.). The hospital rendered services and treatment totaling $4,956.50 to Allstate's insured and perfected a hospital lien for that amount. Allstate then paid on behalf of its insured $2,118.12 to the injured plaintiff, without getting a release of the hospital lien. When the hospital sent a demand letter for the full amount, Allstate obtained a review, which found that the reasonable charges were only $1,081.88, which Allstate tendered to the hospital. Allstate then sued for declaratory judgment that it either had the right to challenge the reasonableness and necessity of the services or that the lien statute denied Allstate due process.

The court held that Allstate had standing to seek declaratory relief. Allstate was affected by the lien because Allstate paid the settlement funds that were subject to the lien. Allstate had a real and substantial controversy involving a genuine conflict of tangible interest and not merely a hypothetical dispute. The court also found that Allstate had alleged an injury to the extent the hospital was claiming it was entitled to pay more than Allstate asserted was reasonable.

G. Motion for new trial

An order granting a new trial was reversed on mandamus review. *In re United Servs. Automobile Ass'n*, No. 01-13-00508-CV, 2014 WL 4109756 (Tex. App.—Houston [1st Dist.] Aug. 21, 2014) (orig. proceeding). Insured homeowners sued their homeowner's insurance company for violations of the Insurance Code after their home was damaged by Hurricane Ike and a subsequent flood. Following trial, the jury awarded the insureds $400,000 in damages. The insureds moved for a new trial, which the trial court granted, and the insurer sought a writ of mandamus to overturn that order. The court of appeals granted the mandamus and ordered that judgment be entered on the verdict, finding that all five of the trial court's reasons for granting the motion were incorrect. In particular, the court of appeals found that it was an abuse of discretion to grant a new trial because: (1) the evidence supported the jury's finding that the insurer did not breach the policy by failing to make a payment within days of a notification of payment; (2) the insurer's closing argument did not violate the order in limine; (3) the jury's award for diminished value of the insured's home was not against the weight and preponderance of the evidence; (4) the jury's failure to award attorney's fees in the event of an appeal was consistent with the evidence because the insured's attorney never testified to the amount of fees reasonable or necessary for an appeal, only what the cost of an appeal would be; and (5) the jury's verdict as to mental anguish damages was supported by a finding that the insurer "knowingly" made misleading statements, since "knowingly" was included in one of the jury questions.

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H. Removal and remand

Where a plaintiff sued State Farm Lloyds and its adjuster for unfair insurance practices, a separate State Farm entity could not remove the case to federal court claiming improper joinder of the adjuster and asserting diversity of citizenship. *Jongh v. State Farm Lloyds*, 555 F. App'x 435 (5th Cir. 2014) (per curiam). After Dr. Jongh filed suit against State Farm Lloyds and its adjuster, contending that they improperly investigated and underpaid her claims, State Farm filed an answer asserting that it had been incorrectly named as State Farm Lloyds. However, State Farm did not intervene or otherwise request that the state court substitute it as the proper party. State Farm then removed the case to federal court contending that the adjuster was improperly joined, that it was diverse, and that therefore the federal court had diversity jurisdiction. The case proceeded to a bench trial resulting in a take-nothing judgment in favor of the adjuster and State Farm.

The Fifth Circuit held that State Farm and State Farm Lloyds are separate entities. State Farm was never a party to the suit, as it had not been substituted in, and therefore lacked the authority to remove the case to federal court.

The court also rejected the argument that the adjuster was improperly joined to defeat diversity. State Farm Lloyds and the adjuster were both Texas citizens. There was no improper joinder to defeat diversity jurisdiction, because there was no diversity with any of the actual parties to the suit. While State Farm was diverse, it was not a party to the suit.

In a fairly routine case, a federal court held that the plaintiff could properly state claims for unfair insurance practices against an insurance adjuster. *Esteban v. State Farm Lloyds*, No. 3:13–CV–3501–B, 2014 WL 2134598 (N.D. Tex. May 22, 2014). The court rejected the insurer's argument that the adjuster was not subject to liability, because he was not an employee of the insurance company. The court rejected this argument because of the statutory language and holdings of the Texas Supreme Court and Fifth Circuit that establish that it is the adjuster's conduct that creates liability under Texas Insurance Code Chapter 541, not his status as an employee.

In a very significant part of the court's decision, the court then considered whether the plaintiff's pleadings stated a claim against the adjuster. The court addressed what has been a very thorny issue for plaintiffs – In judging the sufficiency of the pleadings, does the federal standard or the Texas "fair notice" standard apply? The court noted that the federal pleadings standard under *Twombly* and *Iqbal* is arguably more stringent than the Texas "fair notice" requirement. This has proven to be a trap for plaintiffs who file state court petitions that are sufficient under the fair notice standard, but then are judged on removal under the more stringent federal standard. Application of the more stringent federal standard leads to dismissal of the plaintiff's claim, where a pleading that was insufficient under the "fair notice" standard would only require repleading.

The court concluded that fundamental fairness compelled applying the Texas "Fair Notice" standard and cited a Fifth Circuit opinion to that affect. *See De La Hoya v. Coldwell Banker Mex. Inc.*, 125 F. App'x 533, 537-38 (5th Cir. 2005).

The court then concluded that the plaintiff had sufficient allegations against the adjuster. She alleged that he improperly adjusted her claim; that his report failed to include many of her damages; that his estimate did not allow adequate funds to recover repairs; that he misrepresented the scope of damage as well as the amount of insurance coverage; that he engaged in the business of insurance and was therefore a person under Chapter 541; and that he had improperly adjusted her claim and misrepresented certain key facts. The court found these allegations while "relatively spare and lacking in specificity," were sufficient under the lenient Texas "Fair Notice" standard.

I. Res Judicata & collateral estoppel

Insureds' claims for damage from a water leak were not barred by res judicata or collateral estoppel based on the insurer's prior payment of a claim related to Hurricane Ike in 2008. The court found summary judgment evidence establishing that the later claim resulted from a subsequent storm. Therefore, the prior litigation and claim settlement did not bar the subsequent suit. *Mag-Dolphus, Inc. v. Ohio Cas. Ins. Co.*, No. H–13–08S2, 2014 WL 4167497 (S.D. Tex. Aug. 13, 2014).

J. Severance & separate trials

A court issued a writ of mandamus compelling a trial court to grant severance of the plaintiff's breach of contract and unfair insurance practice claims under an uninsured/under-insured motorist policy. *In re Progressive Co. Mut. Ins. Co.*, 439 S.W.3d 422 (Tex. App.—Houston [1st Dist.] 2014, orig. proceeding). The court recognized that severance is not always required. However, the court cited several other courts that concluded severance is required with UM/UIM coverage because the insurer is not liable for breach of contract until the insured first proves that the other driver was negligent and under-insured, and the amount of the plaintiff's damages. The court concluded that it would be manifestly unjust to require the parties to engage in discovery on extra-contractual claims that was much broader than discovery on the breach of contract claim.

K. Standing

A ship owner that was harmed by an insured shipyard's negligence had standing to sue the shipyard's liability insurer. *Nat'l Liab. & Fire Ins. Co. v. R&R Marine, Inc.*, 756 F.3d 825 (5th Cir. 2014). A ship sank at a shipyard during Hurricane Humberto. The shipyard's liability insurer sued the shipyard and the vessel's owner to disclaim liability

under the policy. The vessel owner counterclaimed that the policy obligated the insurer to cover all sums for which the shipyard became liable and also asserted negligence claims against the shipyard. The shipyard was found to be negligent and liable to the vessel owner. After determining the shipyard's negligence liability, the court analyzed whether its insurer was liable to the vessel owner under the policy. The Fifth Circuit held that the vessel owner had standing to bring its counterclaim against the insurer under Federal Rule of Civil Procedure 13(a), even though no final judgment had established the shipyard's liability at the time the counterclaim was filed, which would preclude standing under Texas law. The Federal Rules of Civil Procedure were controlling, and under Rule 13(a), which was designed to promote judicial economy, the owner's counterclaim was compulsory. The court further held that the insurer's liability was limited to its policy limits and reduced the damages award accordingly. The court also held that attorney's fees were unavailable to the vessel owner under chapter 542 of the Insurance Code, because that chapter does not apply to marine insurance. However, attorney's fees were recoverable under section 38.001 of the Texas Civil Practice & Remedies Code. Making an *Erie* guess, the court concluded that the vessel owner was a third-party beneficiary and could sue to enforce the policy and thus recover attorney's fees under section 38.001. Finally, the court reduced the judgment interest from 18% to 6%, because the 18%, derived from section 542.060 of the Insurance Code, did not apply to marine insurance.

A plaintiff's assignment of claims to her insurer precluded her from having standing to assert claims. *Pringle v. Atlas Van Lines*, No. 4:13-CV-571-O, 2014 WL 1577870 (N.D. Tex. Apr. 16, 2014). The plaintiff asserted that a moving company lost and damaged several of her items in a move. The insurer for the entity that arranged the move reached a settlement with plaintiff and paid the agreed amount, obtaining an assignment of her claims. However, plaintiff still brought suit against the entity that arranged the move and the mover. The court held the evidence established that plaintiff assigned the claims arising out of the shipment of her household goods to the insurer, and therefore, she lacked standing to pursue her claims against them.

Plaintiffs in a tort suit could not simultaneously sue an insurer and its insured. *In Re First Mercury Ins. Co.*, 437 S.W.3d 34 (Tex. App.—Corpus Christi 2014) (orig. proceeding). The family of a shooting victim sued a security company and its liability insurer, alleging negligence on the part of the company and fraud by the insurer in connection with a settlement agreement with another victim. The insurer filed a plea to the jurisdiction, contending that it was not directly liable to the family. The trial court denied the plea, and the insurer sought mandamus relief, which was granted. The court of appeals held that the family lacked standing because they did not have a direct claim against the insurer until final judgment or agreement established that the security company was liable to the family. The court also determined that the insurer lacked an adequate remedy by appeal because allowing the family to proceed simultaneously against the insurer and the insured would create potential conflicts of interest for the insurer, and evidence pertaining to the allegedly fraudulent settlement would introduce prejudicial evidence concerning the existence of insurance.

A similar decision was reached in *Debes v. General Star Indem. Co.*, No. 09-12-00527-CV, 2014 WL 3384679 (Tex. App.—Beaumont July 10, 2014, no pet.) (mem. op.). There, a landlord sued its tenant's property insurer for breach of contract, alleging that the insurer failed to compensate him under the policy for his losses arising from a fire in the leased property. The court held that the landlord lacked standing to bring the suit because he was neither an insured nor a third-party beneficiary to the policy. The policy named only the tenant as the insured, and there was no evidence that the tenant assigned her breach of contract claim to the landlord. Thus, the landlord lacked privity with the insurer to bring the claim. Further, the policy contained no language that showed an intent of the insurer and tenant to confer any benefit on the landlord. Consequently, the landlord was not a third party beneficiary to the policy.

A federal court denied an insured's motion to dismiss or abate a liability insurer's declaratory action in deference to the pending state court underlying tort suits. *Canal Ins. Co. v. Xmex Transp., LLC*, 1 F. Supp. 3d 516 (W.D. Tex. 2014). The insurer's coverage suit and the underlying tort suits were not parallel actions because the insurer was not a party to the underlying suits and the insurer's duties under the policy were not before the state court. Also, while the question of the insurer's duty to indemnify would require the federal court to address many of the factual questions at issue in the underlying state actions, there was no res judicata concern because the federal court could not rule upon the duty to indemnify until the underlying suits were over. Other factors under the *Trejo* and *Brillhart* standards supported the federal court retaining the insurer's action.

L. Subrogation

As a matter of first impression, the Waco Court of Appeals held that a workers' compensation carrier may use the MCS-90 endorsement to recover its subrogation interest from the automobile liability insurer of an employer. *S. Co. Mut. Ins. Co. v. Great West Cas. Co.*, 436 S.W.3d 348 (Tex. App.—Waco 2014, no pet.). An employee was involved in a vehicle collision while acting in the course and scope of his employment. The collision injured the underlying plaintiff. The employer's liability insurance company denied coverage of the plaintiff's claims because the vehicle was not one covered by the policy. The plaintiff then sought compensation for his injuries through his workers' compensation carrier, which paid him. As the plaintiff's subrogee, the workers' compensation carrier sued the employer's liability insurer for

the amount it paid the plaintiff, pursuant to a federal motor carrier endorsement, the MCS-90, which was attached to the liability insurer's policy with the employer. The liability insurer argued that the workers' compensation carrier could not recover through the MCS-90 endorsement because the endorsement was not applicable to disputes among insurers. The workers' compensation carrier argued that it could by asserting its subrogation rights. The court agreed with the workers' compensation carrier. The MCS-90 endorsement makes an insurer liable for any liability resulting from the negligent use of any vehicle by the insured, even if the vehicle is not covered under the policy. Because of its subrogation rights, the workers' compensation carrier gained the plaintiff's right to sue the liability insurer and recover under the MCS-90 endorsement.

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By David S. White and Rachelle H. Glazer

Thompson & Knight, LLP

RECENT FIFTH CIRCUIT AND TEXAS SUPREME COURT INSURANCE DECISIONS

Texas Supreme Court

Texas Supreme Court Holds that Discovery Request for Other Insureds' Claim-Files Was Overbroad.

In re Nat'l Lloyds Ins. Co., No. 13-0761, 2014 WL 5785871 (Tex. Oct. 31, 2014) (per curiam).

In this narrow holding, the Texas Supreme Court held that the trial court abused its discretion by ordering the defendant insurer to produce evidence related to insurance claims of third parties.

After her Cedar Hill home was damaged by storms, plaintiff Mary Erving filed claims with her homeowner's insurer, National Lloyds Insurance Company. Although National Lloyds paid the claims, Erving became concerned that her claims had been undervalued. As a result, Erving sued National Lloyds for breach of contract, breach of duty of good faith and fair dealing, fraud, conspiracy to commit fraud, and violations of the Texas Deceptive Trade Practices Act and chapters 541 and 542 of the Texas Insurance Code.

During discovery, Erving requested all claim-files from the past year for properties in Dallas and Tarrant Counties involving the two adjusting firms that handled her claims. National Lloyds objected to this request as overbroad and unduly burdensome. Nevertheless, the trial court ordered production of claim files related to properties in Cedar Hill and to the storms that caused damage to Erving's home. The order was also limited to claims that were assessed by the same adjusting firms that had assessed the damage to Erving's home. After the court of appeals denied mandamus relief, National Lloyds sought relief from the Texas Supreme Court.

Erving argued that her discovery request was proper and would support her contention that her claims were undervalued by creating a comparison between National Lloyds' evaluation of the damage to her home with its evaluation of damage to other homes in the area. The supreme court was not persuaded, and held that Erving's discovery request was overbroad. According to the court, "[s]couring claim files in hopes of finding similarly situated claimants whose claims were evaluated differently from Erving's is at best an 'impermissible fishing expedition.'"[1] Even if Erving's request was narrowly tailored, "such limits in and of themselves do not render the underlying information discoverable."[2] Because Erving's request was not reasonably calculated to lead to the discovery of admissible evidence, the supreme court conditionally granted mandamus relief and ordered the trial court to vacate its discovery order. However, in footnote 2, the court clarified that its holding does not mean that evidence of third-party insurance claims can never be relevant in coverage litigation.

Texas Supreme Court Reaffirms "No Direct Action" Rule in Plaintiff's Declaratory Judgment Action.

In re Essex Ins. Co., No. 13-1006, 2014 WL 6612590 (Tex. Nov. 21, 2014) (per curiam).

In this mandamus proceeding, the Texas Supreme Court reaffirms Texas's "no direct action" rule barring a third-party plaintiff from suing a tortfeasor's liability insurer directly until the tortfeasor's liability has been finally determined by agreement or judgment. The plaintiff, Rafael Zuniga sued San Diego Tortilla ("SDT") after a serious injury sustained while operating a tortilla machine. SDT's liability insurer, Essex, agreed to defend SDT, subject however to a reservation of rights to deny coverage based in part on an exclusion for bodily injury to the named insured's employees. Mr. Zuniga and SDT asserted that Zuniga was working as an independent contractor.

After Essex rejected Zuniga's offer to settle for policy limits, Zuniga filed an amended petition adding the insurer as a defendant and seeking a declaration that the policy requires Essex to indemnify SDT for its liability to Zuniga. Essex

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moved to dismiss the claims against it under Texas Rule of Civil Procedure 91a, arguing that the "no direct action" rule, the plaintiff's lack of standing, and lack of ripeness bar Zuniga from suing the insurer until SDT's liability has been determined. The trial court denied the motion to dismiss. Essex filed a petition for writ of mandamus, which the appellate court denied, but which the supreme court conditionally granted.

Zuniga's basic argument is that its claims against Essex do not violate the "no direct action" rule because he was seeking only a declaration of Essex's obligation to cover SDT, not a money judgment.[3] Unfortunately for Zuniga, however, the high court noted that it had already held that the "no direct action" rule applied to declaratory judgment actions in *Angus Chem. Co. v. IMC Fertilizer, Inc*.[4] Moreover, allowing Zuniga to pursue claims against Essex while the SDT suit was proceeding, held the court, would prejudice both Essex and SDT in their defenses against Zuniga's claims because it would: (1) create a conflict of interest for Essex, and (2) necessarily require the admission of evidence of liability insurance in violation of Texas Rule of Evidence 411.[5] This prejudice would exist regardless of the declaratory relief sought.

Zuniga also argued that the supreme court had previously allowed parties to seek declaratory judgment regarding an insurer's duty to indemnify even before the insured defendant's liability had been determined.[6] The court responded:

> But none of these cases implicates the "no direct action" rule because in each of these cases, it was the insurer or the insured defendant, not the plaintiff, who sought declaratory relief, or the insured defendant's liability to the plaintiff had in fact been determined before the declaratory judgment suit was filed.[7]

Zuniga failed to cite to any cases in which the Texas Supreme Court held that the plaintiff who is not a party to the insurance policy may seek a declaratory judgment regarding an insurer's duty to indemnify an insured defendant before that liability had been determined. As a result, the court concluded that the trial court had abused its discretion, conditionally granted mandamus relief, and directed the trial court to vacate its order denying Essex's motion to dismiss and grant the motion.

Fifth Circuit

Broad "Independent Contractor" Exclusion Applied to Workplace Injury, Despite Alleged Status of "Temporary Employee."

Preferred Contractors Ins. Co. Risk Retention Group v. Finnels, 582 Fed. Appx. 310 (5th Cir. 2014) (per curiam).

This case features a broad "independent contractor" exclusion that might be of interest to those practicing in the construction industry. Calvin Finnels is a truck driver who was injured while helping to install a section of wall that he had just delivered to a work site. Finnel was hired by one of four commonly-owned companies performing construction work for a residential subdivision. Finnels sued two of the four companies, including the company that hired him, alleging that he was acting as an "independent contractor" at the job site. Finnels obtained a $75,000 judgment against OMI, the defendant that had not hired him.

Before trial, however, Preferred Contractors ("PCIC"), who insured all four companies, filed a declaratory judgment action against OMI and Finnels. The district court in the coverage suit granted summary judgment in favor of PCIC based exclusively on the following "independent contractor" exclusion:

> This policy does not apply to any claim(s) for "bodily" injury", arising out of claim(s), or suit(s) by general contractors, subcontractors, *independent contractors*, their employees or volunteer workers, or any persons or companies who are affiliated with such persons or entities who provide work or products on job sites where the insured provides work, products or services as a contractor or subcontractor. This exclusion applies whether or not the persons or entities making such claims are hired, or retained by the insured on the job site where the claim(s) or suit(s) arise from.[8]

Because Finnels explicitly alleged that he was an independent contractor, the lower court held that coverage for his injuries was excluded. Finnels appealed.[9]

Finnels asserted four arguments before the Fifth Circuit: (1) the company he was driving for was not a "subcontractor"; (2) Finnels was not an independent contractor of OMI; (3) PCIC failed to produce evidence that OMI was either a contractor or "subcontractor," as required by the exclusion; and (4) Finnels qualified as a "temporary worker" insured under the policy. The reviewing panel shrugged off the first three arguments, observing that all that was needed for the exclusion to apply was for Finnel to be an independent contractor, which he alleged he was, and for an insured to provide services as a contractor or subcontractor to the same site. It really did not matter which was contractor and which subcontractor. The undisputed facts established the nature of the contract work at the site.[10]

Regarding Finnels's claim to qualify as a "temporary employee,"[11] the court found that the argument was irrelevant. Once it was established that Finnel was suing as an independent contractor, the exclusion applied, and the "temporary employee" category was only relevant to avoid the separate "employee exclusion." Judgment for the insurer was affirmed. Limitations such as this independent contractor exclusion are appearing in general liability policies with increasing frequency, probably as the insurance

industry reacts to court decisions such as *Lamar Homes*,[12] that broaden coverage for construction injuries.

ERISA Benefit Plan Claims Administrator Acted Properly When Requesting Additional Coverage Information Before Adjudicating Claims.

Hollingshead v. Aetna Health Inc., No. 14-20158, 2014 WL 5560255 (5th Cir. Nov. 4, 2014) (per curiam).

This case reached the Fifth Circuit Court of Appeals after the district court dismissed the plaintiff's putative class action complaint for failure to state a claim for violations of the Employee Retirement Income Security Act ("ERISA").

Through his employer, plaintiff Joe Hollingshead participated in a self-funded ERISA benefit plan (the "Plan"), with Aetna as the Plan's claims administrator. The Plan included a number of coordination of benefits provisions, indicating how benefits would be paid in the event that Plan participants had medical coverage from more than one source. Under the Plan, certain sources of insurance coverage were considered "primary," while other sources were considered "secondary." In the event that the Plan was secondary, its benefits were to be determined after those of the primary plan. Practically, this meant that benefits under the Plan could be reduced. In fact, the Plan contained a provision explaining that failure to provide Aetna with necessary information and documentation could cause payment of benefits to be delayed or even denied. Under the Plan, no-fault auto insurance was considered primary.

Hollingshead's son was the designated beneficiary under the Plan. After his son was seriously injured in a car accident, Hollingshead submitted numerous medical claims to Aetna. In accordance with the Plan, Aetna requested information from Hollingshead regarding the applicability of any no-fault insurance coverage and postponed processing his claims. Hollingshead never provided this information. Instead, he filed a putative class action against Aetna and asserted claims under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) and ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). Aetna moved to dismiss, and Hollingshead amended his complaint to allege that Aetna violated ERISA by "immediately" denying his medical claims instead of denying them upon Hollingshead's failure to provide the requested information. The district court ultimately dismissed Hollingshead's ERISA claims for failure to state a claim. The Fifth Circuit affirmed.

As the court explains, Hollingshead failed to state a claim under ERISA § 502(a)(1)(B) because the materials attached to his first amended complaint established that Aetna acted in accordance with the express terms of the Plan. Under the Plan, Aetna was required to request no-fault coverage information before adjudicating a claim. Aetna did just that, but Hollingshead never provided the requested information.

The court further held that Hollingshead failed to state a claim for breach of fiduciary duty in violation of ERISA § 502(a)(3) because Hollingshead had "adequate redress... through his right to bring suit pursuant to section 1132(a)(1)." The fact that Hollingshead could not prevail on his section 1132(a)(1) claim did not make his alternate claim viable. Finally, the court upheld the district court's denial of Hollingshead's motion for leave to file a second amended complaint. According to the court, Hollingshead's proposed additions to his complaint were "futile and frivolous," particularly his attempt to add a state-law claim given ERISA's clear preemptive effect.

Homeowners Insurer Failed to Conduct a Reasonable Investigation Before Denying Roof Damage Claim.

Santacruz v. Allstate Tex. Lloyd's, Inc., No. 13-10786, 2014 WL 5870429 (5th Cir. Nov. 13, 2014) (per curiam).

In this somewhat unusual bad-faith action, the Fifth Circuit reverses summary judgment in favor of the insurer because the reviewing panel found that the insurer had failed to make a reasonable investigation before denying the claim. The result is unusual not only because the insurer's bad-faith summary judgment was reversed, but also the reason for reversal was not that the insurer had no reasonable basis for the denial but rather, it failed to conduct a reasonable investigation before denial. Under Texas' bad-faith standard, an insurer must demonstrate both.[13]

A rainstorm blew several shingles off the insured's roof, causing leaks and extensive damage to his personal property. The insured promptly reported the incident to Allstate who informed the insured that it could not send an adjuster for several days. However, because more storms were forecast, the insured, upon the advice of his own local contractor, informed Allstate that he had to repair the roof immediately to prevent further damage. Allstate repeated that it needed to inspect the roof before it could be repaired. The insured proceeded with repairs that day. A few days later, an Allstate adjuster came and took pictures of the roof and interior but did no further investigation. Allstate denied the homeowner's claim, who sued Allstate for breach of the duty of good faith and fair dealing and intentional infliction of emotional distress. The district court granted Allstate's motion for summary judgment and denied Santacruz's motion for leave to amend his complaint to add a breach of contract claim.[14]

On appeal, the panel noted that the lower court had focused only on the first prong of the bad-faith standard, whether Allstate had a reasonable basis for denial, by holding that Allstate reasonably believed that it could deny the claim because the policy provided that the insured must "provide [Allstate] access to the damaged property."[15] Allstate argued that Santacruz had failed to do this. Santacruz countered that he had to repair the roof immediately because the policy required him to "protect the property from further damage" and "make reasonable and necessary repairs to protect the property." The panel stated that:

> We agree that Allstate's reading of the policy places Santacruz in a lose-lose situation: on the one hand, he is required to take action to mitigate the damage, but on the other hand he is required not to repair the damage prior to the adjuster's inspection.[16]

Moreover, it was not clear, noted the panel, that Santacruz had refused access to the property because he did not prohibit the adjuster from visiting his home after repairs, and the policy did not contain an explicit provision allowing the insurer a reasonable time and opportunity to inspect before repairs are undertaken.[17]

On the bad-faith claim itself, the panel understood Allstate's defense to rest not so much on the "access" provision of the policy, but on Allstate's view that repairing the roof before the adjuster's inspection prevented Allstate from determining whether the damage was the result of wind, a covered peril, or some other non-covered peril such as normal deterioration or the weight of the rain on the roof.[18] However, the panel found, even if Allstate was justified on that basis, the insurer failed to address the other prong, that it must reasonably investigate a claim.[19] The panel held that Santacruz had produced enough evidence to allow a jury to determine that Allstate failed to conduct a sufficient investigation. Specifically:

> Allstate did not attempt to talk to the contractor, who submitted an affidavit in this case describing what he observed concerning the roof and attributing the cause to wind damage. Nor is there any evidence showing that Allstate obtained weather reports or inquired with neighbors to see if they suffered similar damage, which would tend to show the damage was caused by wind rather than normal wear and tear.[20]

The panel also found that Santacruz had produced sufficient evidence to support the extent of his damages. Accordingly, the panel reversed and remanded the case for trial.[21]

Factors Cannot Circumvent Structured Settlement Protection Acts Through Arbitration, and Attorneys' Fees are Recoverable for Attempts to Do so.

Symetra Life Ins. Co. v. Rapid Settlements, Ltd., No. 13-20412, 2014 WL 7334917 (5th Cir. Dec. 23, 2014).

This case involved a structured settlement dispute between Symetra Life Insurance and Symetra Assigned Benefits Service (collectively "Symetra"), and Rapid Settlements ("Rapid"), a factor. To protect annuitants from transferring their rights to future periodic payments for an inadequate lump sum payment, states have enacted Structured Settlement Protection Acts ("SSPAs"). Under these Acts, companies seeking to acquire structured settlement payment rights must make certain disclosures regarding the proposed transfer, and a state court must find that the transfer is in the best interest of the payee. A factor failing to comply with these provisions may be liable for any costs and attorneys' fees "arising as a consequence" of its non-compliance.

According to the Fifth Circuit, Rapid structured its transactions to circumvent the SSPAs. Rapid would contract with Symetra annuitants, but these proposed transfers would generally be rejected by state courts. When disputes would arise between Rapid and the annuitants, Rapid would invoke the mandatory arbitration clause included in its contracts. During the ensuing arbitrations, Rapid would essentially re-offer the terms of the contract, whereby Rapid would pay the annuitant the same lump sum if the annuitant agreed to an arbitration award that transferred the same future payments. Rapid would then convert its arbitration awards into judgments.

Symetra eventually sued Rapid for tortious interference and violation of the SSPAs, seeking declaration that Rapid's scheme violated the SSPAs and that all of Rapid's attempted transfers with Symetra annuitants were ineffective. Symetra also sought damages, attorneys' fees, and an injunction preventing Rapid from transferring future payments via arbitration. The district court enjoined Rapid from conducting its arbitrations, awarded Symetra's attorneys' fees incurred in state court litigation as damages for tortious interference, but denied its request for attorneys' fees under the SPPAs. Both parties appealed.

On appeal, Symetra challenged the district court's denial of statutory attorneys' fees. Under the Texas and Washington SSPAs, factors may be liable for attorneys' fees if: (1) the fees follow a transfer of structured settlement payment rights; (2) the factor violated the SSPA; and (3) there is a causal connection the violation(s) and the fees incurred. Here, the district court reasoned that Symetra's challenge to Rapid's business practices did not qualify for attorneys' fees because it did not "follow a transfer" of structured settlement payment rights. But as the Fifth Circuit explains, Symetra challenged up to ten individual transfers, thereby bringing its claims within the language of the statutes.[22] Texas and Washington courts have held that a transfer "includes the transfer agreement between the payee and the transferee." Accordingly, the annuitants' contracts with, or arbitration awards in favor of, Rapid qualified as "transfers." Thus, Symetra was entitled to recover attorneys' fees incurred in challenging specific transfers, but it could not recover fees incurred to enjoin future violations of the Acts.[23]

Rapid appealed the district court's decision to award Symetra attorneys' fees incurred in an Indiana state court proceeding as damages for tortious interference. Rapid argued that Symetra's involvement in the Indiana case was not foreseeable. According to the court, however, years of prior litigation against Rapid had put it on notice that its arbitration scheme violated various SSPAs. Therefore, it was entirely foreseeable that disputes could arise among annuitants, Rapid, and Symetra.[24]

Rapid also appealed the district court's requirement that state court transfer orders list first-refusal rights, arguing that this is not required under the SSPAs. The court disagreed. Under the statutes, all transfers must be "approved in advance in a final court order." A transfer is "any sale, assignment, pledge, hypothecation, or other alienation or encumbrance of structured settlement payment rights." Washington courts have held that first-refusal rights are encumbrances under its act, and Texas courts are likely to do the same. Therefore, the court held that the SSPAs require explicit court approval of first-refusal rights.[25] Accordingly, the court reversed and remanded the district court's denial of statutory attorneys' fees, but affirmed the district court's award of damages and permanent injunctive relief.

1 *In re Nat'l Lloyds Ins. Co.*, 2014 WL 5785871 at *4 (Tex. Oct. 31, 2014) (quoting Texaco, Inc. v. Sanderson, 898 S.W.2d 813, 815 (Tex. 1995) (per curiam)).

2 *Id.*

3 *In re Essex Ins. Co.*, 2014 Tex. LEXIS 1164 at *4 (Tex. Nov. 21, 2014).

4 *Angus Chem. Co. v. IMC Fertilizer, Inc.,* 939 S.W.2d 138, 138 (Tex. 1997). However, the declaratory judgment filed in the *Angus* case was not, as here, an action filed against the insurer, so Zuniga may be excused for thinking that *Angus* might be distinguished on its facts.

5 *In re Essex* at *5. Basically, the conflict is that it is in Essex's interest to establish that Zuniga is an employee of SDT, triggering the employee exclusion, whereas SDT would obtain indemnity from Essex if Zuniga is an independent contractor. *Id.* at *5, n.3.

6 *Id.* at *6 (citing *Burlington N. & Santa Fe Ry. Co. v. Nat'l Union Fire Ins. Co.,* 334 S.W.3d 217, 219-20 (Tex. 2011); *Texas Ass'n of Counties Cnty. Gov't Risk Mgmt. Pool v. Matagorda Cnty.,* 52 S.W.3d 128, 135 (Tex. 2000); and *Farmers Tex. Cnty. Mut. Ins. Co. v. Griffin,* 955 S.W.2d 81, 84 (Tex. 1997).

7 *Id.* at *7 (citing *Burlington N. & Santa Fe Ry.*, 334 S.W.3d at 219-20; *Matagorda*, 52 S.W.3d 128 at 135; *Griffin*, 955 S.W.2d at 84).

8 *Preferred Contractors* 582 Fed. Appx. at 312-13.

9 For some reason, the insured, OMI, did not appeal. Nevertheless, the appellate court held that a third party claiming liability against the insured was a proper party in the declaratory suit. *Id.* at 312, n.2 (quoting *Dairyland Ins. Co. v. Makover*, 654 F.2d 1120, 1123 (5th Cir. Unit B 1981)).

10 *Preferred Contractors* 582 Fed. Appx. at 313.

11 The policy covered a "temporary employee," defined as "a person who is furnished to [the insured] to substitute for a permanent employee on leave to meet seasonal or short term workload conditions," on an additional-insured basis. *Id.* at 313-14.

12 *Lamar Homes, Inc. v. Mid–Continent Cas. Co.,* 242 S.W.3d 1, 8–9 (Tex. 2007).

13 *See Arnold v. Nat'l Cnty. Mut. Fire Ins. Co.,* 725 S.W.2d 165, 167 (Tex. 1987) (To plead breach of [the duty of good faith and fair dealing], a plaintiff must allege "that there is no reasonable basis for denial of a claim or delay in payment *or a failure on the part of the insurer to determine whether there is any reasonable basis for the denial or delay*.").

14 *Santacruz v. Allstate Tex. Lloyd's, Inc.,* 2014 WL 5870429 at *3-4 (5th Cir. Nov. 13, 2014).

15 *Id.* at *5.

16 *Id.*

17 *Id.* at *6.

18 *Id.* at *6-7 (citing *State Farm Lloyds v. Nicolau,* 951 S.W.2d 444, 448 (Tex. 1997); *Lyons v. Millers Cas. Ins. Co. of Tex.,* 866 S.W.2d 597, 600 (Tex. 1993)).

19 *Id.* at *7 (citing *Universe Life Ins. Co. v. Giles,* 950 S.W.2d 48, 56 n.5 (Tex. 1997) and *State Farm Fire & Cas. Co. v. Simmons,* 963 S.W.2d 42, 44 (Tex. 1998) (stating that an insurer cannot insulate itself from a bad faith claim by conducting an investigation "in a manner calculated to construct a pretextual basis for denial")).

20 *Id.* at *8.

21 On Santacruz's appeal of the denial of his motion for leave to amend to add a breach of contract claim, the reviewing panel left the denial intact but noted that upon remand, the lower court had discretion to grant leave in light of "the new procedural posture which will require the setting of a trial date." *Id.* at 13.

22 *Symetra Life Ins. Co. v. Rapid Settlements, Ltd.,* No. 13-20412 2014 WL 7334917 *8 (5th Cir. Dec. 23, 2014).

23 *Id.* at *9.

24 *Id.* at *10-11.

25 *Id.* at *12.

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