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## **An Insurance Primer**

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## **I. Introduction**

Now more than ever, companies face a host of risks that can impact their business. To the extent those risks can be prevented from occurring, they should be. But this paper is not about the risks that can be prevented – it is about the ones that cannot. Planning for and dealing with those events is crucial to minimizing their impact on the business.

This paper, along with the accompanying presentation, will attempt to provide a basic overview of some of key issues involving coverage for commercial enterprises.<sup>1</sup> Following this introduction, the paper begins with an examination of the nature of insurance. Next, a review of the components of a typical policy is presented. Once these preliminary points have been addressed, the paper will take a look at some basic (and some not-so-basic) commercial coverages. After that, the “lawyering” of certain insurance issues is discussed. Finally, some “hot topics” and “practical tips” will be given at the end.

## **II. THE NATURE OF INSURANCE**

If things go right, then insurance should be a waste of money.<sup>2</sup> In strictly monetary terms, to make the decision to buy insurance pay off, something sufficiently bad has to happen to allow the insured to collect more in benefits than it paid in premiums. Though a review of the nature of insurance might seem a bit odd, pausing for a brief moment to consider it from a legal perspective is worthwhile. Here are a few principles that can be distilled from the cases:

Insurance is different. Once an insured files a claim, the insurer has a strong incentive to conserve its financial resources balanced against the effect on its reputation of a “hard-ball” approach. Insurance contracts are also unique in another respect. Unlike other contracts, the insured has no ability to “cover” if the insurer refuses without justification to pay a claim. Insurance contracts are like many other contracts in that one party (the insured) renders performance first (by paying premiums) and then awaits the counter-performance in the event of a claim. Insurance is different, however, if the insurer breaches by refusing to render the counter-performance. In a typical contract, the non-breaching party can replace the performance of the breaching party by paying the then-prevailing market price for the counter-performance. With insurance this is simply not

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<sup>1</sup> The modern economy is so broad and diverse it would be nearly impossible for any seminar paper to adequately cover all forms of commercial coverage, along with all of their complexities. Hopefully, though, this paper can serve as a useful starting point.

<sup>2</sup> Of course, having insurance also accomplishes two other purposes – it provides peace of mind and facilitates transactions with third-parties. Knowing that certain hazards are covered allows large investments that otherwise would not take place, such as building offshore drilling platforms that could be damaged by natural catastrophes. It also enables transactions with third-parties to occur that otherwise would be more difficult, if not impossible, to accomplish. For example, having directors and officers coverage allows companies to recruit qualified candidates to serve as outside directors. Without proper coverage, many such individuals would simply refuse to accept in light of the attacks on corporate leadership seen in the past few years. With the reforms of the Sarbanes-Oxley Act of 2002, this may still be a daunting task. Anita Raghavan, *More CEOs say “No Thanks” to Board Seats*, WALL ST. J. Jan. 28, 2005, at B1.

possible. This feature of insurance contracts distinguishes them from other contracts and justifies the availability of punitive damages for breach in limited circumstances.

*E.I. DuPont de Nemours & Co. v. Pressman*, 679 A.2d 436, 447 (Del. 1996). Texas courts have also weighed in on this subject, noting that:

[T]he objective of an insurance policy is to insure; courts should not construe policies otherwise unless the language clearly requires it.

*Warrilow v. Norrell*, 791 S.W.2d 515, 524 (Tex. App.—Corpus Christi 1989, writ denied)(citing *Goswick v. Employers Cas. Co.*, 440 S.W.2d 287, 289 (Tex. 1969)). Further, a New Jersey court also stated the same concept in different words:

The primary object of all insurance is to insure. A construction should be taken which will render the contract operative, rather than inoperative, and which will sustain the claim for indemnity, if reasonably possible, rather than exclude it.

*Erdo v. Torcon Constr. Co., Inc.*, 645 A.2d 806, 808 (N.J. Super. Ct. App. Div. 1994). It follows, then, that the “purpose of an insurance company is to indemnify its insureds.” *American Home Assurance Co. v. Unauthorized Practice of Law Committee*, 121 S.W.3d 831, 845 (Tex. App.—Eastland 2003, pet. filed). With these background concepts in mind, an examination of the basic structure of a typical insurance policy is next.

### III.

#### NAVIGATING THE COMPONENTS OF A TYPICAL POLICY

Though there is some variance, an examination of most insurance policies typically reveals a familiar format with the following components.

##### A. Declarations Page

The declarations page is a roadmap for the policy, and it contains vital information. Usually, it identifies the named insured, the insurance company that issued the policy, the dates of the policy period, the types and amounts of coverage provided, and a schedule of forms. Listing the forms that should be attached to the policy allows the reader to determine if the policy is complete.

##### B. Insuring Agreements

The insuring agreements provide the substantive grant of coverage. It describes what is covered by the policy, and under what circumstances. Without satisfying an insuring agreement, no coverage will attach. In other words, an insured must make an initial showing that the loss is covered by the policy. *Telepak v. United Servs. Auto. Ass’n*, 887 S.W.2d 506, 507 (Tex. App.—San Antonio 1994, writ denied).

### C. Exclusions

Exclusions carve out certain claims from what may be otherwise covered under the insuring agreements. They serve various purposes, including coordination of coverage with other policies (such as workers' compensation exclusions in a commercial general liability policy), contractual adoption of certain common-law rules such as fortuity, and to eliminate certain categories of claimants such as other insureds. Because they restrict coverage, exclusions are strictly construed. *Gulf Chem. & Metallurgical Corp. v. Associated Metals & Minerals Corp.*, 1 F.3d 365, 369 (5<sup>th</sup> Cir. 1993)(noting that, where an ambiguity exists, the policy should be construed strictly against the insurer and liberally in favor of the insured and that "an even more stringent construction is required" where the question "involves an exception or limitation on [the insurer's] liability. . .").

### D. Definitions

Policies, of course, are created using words. Sometimes these words need to be defined in order to express thoughts with precision. Usually, defined terms are identified through **bold** or underlined print. Occasionally, they are CAPITALIZED. Words used in a policy are given their ordinary and generally accepted meaning "unless they are defined in the policy . . . ." *Prudential Ins. Co. of Am. v. Uribe*, 595 S.W.2d 554, 563 (Tex. Civ. App.—San Antonio 1979, writ ref'd n.r.e.). Counsel should always study defined terms very carefully, for a thorough definition can negate coverage as well as, if not better than, any exclusion.

### E. Conditions

Conditions serve important functions. They outline the respective rights and obligations of the parties, and can be perilous if ignored. They include things such as notice, cooperation, and other items associated with investigation of the claim as well as the handling of certain contingencies such as bankruptcy, the presence of other insurance or claims by other insureds. Like any other contract term, conditions can be waived. Further, as will be discussed in §V(B), *infra*, sometimes they require a showing of prejudice in order to avoid coverage based on the violation of a policy condition.

### F. Endorsements

Finally, many policies contain endorsements that are attached to the main form. These can either broaden or restrict coverage. When reviewing a policy, it is important to consider the impact, if any, of the endorsements on a given fact situation. Endorsements to a policy "generally supersede and control over conflicting printed terms within the main policy." *Mesa Operating Co. v. Cal. Union Ins. Co.*, 986 S.W.2d 749, 754 (Tex. App.—Dallas 1999, pet. denied).

## IV.

### THE BASIC COMMERCIAL COVERAGES (AND A FEW NOT-SO-BASIC ONES)

#### A. The (General) Distinction Between First Party and Third Party Coverage

As a very general rule, policies that protect the company's assets against loss or damage are considered "first party" coverage. Policies that protect the company against liabilities to a third party are considered "third party" coverage. One Texas court put the matter this way:

In first-party insurance coverage, the insured is covered for his own loss. In third-party insurance coverage, the insured is covered for his liability to another for their loss.

*Warrilow v. Norrell*, 791 S.W.2d 515, 527, n.2 (Tex. App.—Corpus Christi 1989, writ denied). Of course, this is only a general rule, and not an absolute one. For instance, there are many "package" policies that contain both first party and third party coverages. Further, even the traditional commercial general liability policy contains some first party coverage, such as the "reasonable expenses incurred by the insured" provision in the "Supplementary Payments" section. Arguably, the duty to defend is also first party coverage. See § VI(B), *infra*. Thus, while the distinction between first and third party coverages is important, it must be considered in terms of the coverage at issue, not simply by the type of policy involved.

#### B. First Party Coverage – Protecting the Company Against Loss

For almost every company, protecting the assets of the business is of paramount importance. This section addresses some of the issues involved in covering the company's property. Before discussing substantive coverages, though, an important distinction among property policies must be noted. Generally, they come in two types – "all risk" or "named perils." The Fifth Circuit described this distinction as follows:

A "named peril" policy is to be differentiated from an "all risks" policy. "A policy of insurance insuring against 'all risks' creates a special type of coverage that extends to risks not usually covered under other insurance; recovery under an all-risk policy will be allowed for all fortuitous losses not resulting from misconduct or fraud, unless the policy contains a specific provision expressly excluding the loss from coverage."

*Ingersoll-Rand Fin. Corp. v. Employers Ins. of Wausau*, 771 F.2d 910, 913 (5<sup>th</sup> Cir. 1985)(quoting *Dow Chem. Co. v. Royal Indem. Co.*, 635 F.2d 379, 386 (5<sup>th</sup> Cir. 1981). Stated differently, under an "all risk" policy, the loss is covered unless caused by an excluded peril. A "named peril" policy is the opposite – the loss is excluded unless caused by a covered peril. Most commercial property policies are "all risk," while the "named perils" variety is usually reserved for specialized hazards, such as flood insurance.

#### 1. Commercial Property Coverage

The foundation for protecting most of the company's property is, naturally, the "commercial property" policy. It is usually a good starting point for protecting the real and

personal property used by the insured in its business activities as well as the income derived from the use of that property. In addition to the basic insuring agreements, such policies often contain “extensions of coverage” that provide coverage for specific items, such as valuable papers, debris removal, expediting expense, and other soft costs.

**a. Protecting the Company’s Property**

First and foremost, the policy generally pays for “direct physical loss or damage” to covered property. Typically, this includes real and personal property of the insured. It also usually includes personal property of others in the “care, custody or control” of the insured, or in an insured building. This provides coverage for personal property not owned by the insured, such as the personal effects of the insured’s employees.

Attorneys handling a claim involving a commercial property loss need to pay particular concern to the doctrine of concurrent causation. In the course of a thorough policy analysis, the lawyer should focus on the cause of the loss to assess whether any particular exclusions may negate coverage. In particular, the lawyer should carefully study the introductory language to the exclusionary provisions. Concurrent causation language commonly found preceding the listed exclusions can sometimes create obstacles to obtaining coverage for losses caused by multiple perils. A recent example of concurrent causation language can be found in *Wong v. Monticello Ins. Co.*, 2003 WL 1522938 (Tex. App.—San Antonio Mar. 26, 2003, pet. denied), where the policy stated:

**B. Exclusions**

1. We will not pay for loss or damage caused directly or indirectly by any of the following. Such loss or damage is excluded, regardless of any other cause or event that contributes concurrently or in any sequence to the loss.

*Id.* at \*1 (emphasis original). The validity of these clauses in Texas has been recently reaffirmed by the First Court of Appeals in *Valley Forge Ins. Co. v. Hicks, Thomas & Lilienstern*, 2004 WL 2903521 \*4-5 (Tex. App.—Houston [1<sup>st</sup> Dist.] 2004, pet. filed). Another court recently offered the following description of the issue:

Anticoncurrent causation provisions, such as the one at issue here, have appeared in recent years in response to the concurrent causation doctrine, under which some courts have found that insurers are “obligated to pay for damages resulting from a combination of covered and excluded perils if the efficient proximate cause is a covered peril.” [A]nticoncurrent causation provisions in insurance contracts avoid application of the doctrine by expressly stating that a loss is excluded from coverage if it results from a combination of covered and excluded perils.

*Preferred Mut. Ins. Co. v. Meggison*, 53 F. Supp. 2d 139, 142 (D. Mass. 1999) (citation omitted).<sup>3</sup> It is clear though that the plain language of these clauses requires that the loss be

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<sup>3</sup> At least a handful of states have refused to recognize these clauses based on public policy reasons. *See, e.g., Howell v. State Farm Fire & Cas. Co.*, 218 Cal. App. 3d 1446, 1456 (Cal. Ct. App. 1990) (“ . . . the State Farm

caused by two or more causes – one covered and one excluded. In any event, understanding the policy and the cause(s) of the loss is a key to dealing with this issue when it arises.

Following a significant loss, a primary objective is to move towards restoring the company's property and operations back to pre-loss conditions as soon as possible. Sometimes, however, perfect replication of pre-loss conditions is not possible. A recent Texas case illustrates this point. In *Republic Underwriters Ins. Co. v. Mex-Tex, Inc.*, 106 S.W.3d 174 (Tex. App.—Amarillo 2003) *rev'd on other grounds*, 150 S.W.3d 423, 427-28 (Tex. 2004), a leaky roof covered a mall with commercial and retail businesses. Although it had been repaired, the roof continued to leak. *Id.* at 176. While considering whether to replace the roof, a hail storm caused further damage to the roof. Despite a question as to how much additional damage the storm caused in light of the pre-existing damage, both the carrier and the insured eventually agreed that the roof would be replaced and that the insurer would pay for it. *Id.* Prior to this agreement, however, the insured, fearing that delay would cause further damage, went ahead and replaced the roof before the parties had agreed on replacement. *Id.* The insured submitted a net claim for \$179,000, but the insurer refused to pay that amount, concluding it could have replaced the roof for \$145,000. *Id.* at 176-77. Since both sides agreed that the roof needed to be replaced, the insured was entitled to coverage for a roof of "like kind and quality" and one "of comparable material and quality." *Id.* at 178-79. The court noted that even the insurer acknowledged that in some cases an exact replacement cannot be found and "something substantially similar" must be used instead. Although the insured's choice of a new roof was slightly different than the previous one, testimony established that it was similar in both cost and quality. *Id.* at 180-81. Concluding that the policy obligated the insurer to pay for a comparable roof, and that such a roof was in fact installed by the insured, the court affirmed the judgment for the insured. *Id.* *Mex-Tex* demonstrates that the policy language can provide the insured with some flexibility as it begins the process of restoring its property to pre-loss conditions.

#### **b. Protecting the Company's Income**

There are numerous types of policies that provide protection to businesses. To begin with, a commercial property policy is usually a good starting point for protecting the real and personal property used by the insured in its business activities, as well as the revenue streams generated by those assets.<sup>4</sup> It is important to note that in many losses, the impact to revenue can greatly exceed the actual property damage. In addition to the basic insuring agreements, such policies often contain "extensions of coverage" that provide coverage for specific items, such as valuable papers, debris removal, expediting expense, and other soft costs. As the scope of coverage can vary from one policy to the next, insureds should carefully examine potential policies for individualized risks. The company's critical risk assessment and property inventory,

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policies would deny coverage whenever an *excluded* peril is a contributing factor to the loss. Since, in most instances, an insurer can point to some arguably excluded contributing factor, this rule would effectively transform an 'all-risk' policy into a 'no-risk' policy."); *Safeco Ins. Co. of Am. v. Hirschmann*, 773 P.2d 413 (Wash. 1989)(en banc); *Western Nat'l Mut. Ins. Co. v. University of N. Dakota*, 643 N.W.2d 4 (N.D. 2002).

<sup>4</sup> But this is often just a starting point, and standing alone, it may not provide complete protection for the insured. Other more specialized forms of coverage may also be necessary in order to obtain more comprehensive coverage of risks to the insured's business. Depending on the individual circumstances, an insured might need other forms of coverage to protect certain assets such as ships, aircraft or other less common forms of property.

combined with advice from the insured's broker, will enable the insured to obtain appropriate coverage for the insured's core business needs.

Once the loss-prevention and insurance placement processes are understood, it is helpful to review some basics of "time element" coverages before moving on to the claim process. "Time element" coverages are so important that, depending on the facts, having adequate protection might mean the difference between a (relatively) smooth resumption of operations and no resumption at all. Before moving on, however, it is worthwhile to consider the words of one court:

Few generalizations about business interruption endorsements can be made, however, because the nature of the coverage varies widely. In any given case, the particular terms and conditions of the policy in question must be examined to determine whether a specific business interruption loss falls within the scope of the coverage.<sup>5</sup>

Not only is this useful advice for the practitioner, it also explains why business interruption cases often turn on nothing more than an analysis of the policy language, with little or no citation to other caselaw in support of a given holding.<sup>6</sup>

### **1. Basic Business Interruption Coverage**

Apart from protecting against losses to the insured's property, protection against impairment of the company's income is also vitally important. Known as "business interruption" coverage, this type of coverage does not protect against physical damage to any property. Rather, it is designed to provide protection to the insured from disruptions in business due to other covered perils that damage the insured's property.<sup>7</sup> In effect, this coverage supplements the insured's lost income while its property is being repaired, rebuilt or replaced. Stated differently:

[T]he purpose of a business interruption policy is to indemnify the insured for loss caused by the interruption of a going business due to the destruction of the building, plant or parts thereof.<sup>8</sup>

Although actual policy language can vary, mere "slowdown" in productivity is typically not enough to trigger business interruption losses. For example, the policy in *Quality Oilfield* provided coverage for:

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<sup>5</sup> *Prot. Mut. Ins. Co. v. Mitsubishi Silicon Am. Corp.*, 992 P.2d 479, 481 (Or. Ct. App. 1999).

<sup>6</sup> *See, e.g. Snelling & Snelling, Inc. v. Fed. Ins. Co.*, 2005 WL 2767610 (N.D. Tex. Oct. 25, 2005)(citing only cases for the summary judgment standard, choice of law, and the rules of contract construction).

<sup>7</sup> Or property central to the insured's business, even if it is not directly owned by the insured. This issue will be discussed in greater detail below.

<sup>8</sup> *Quality Oilfield Prods., Inc. v. Michigan Mut. Ins. Co.*, 971 S.W.2d 635, 638 (Tex. App.—Houston [14<sup>th</sup> Dist.] 1998, no pet.)(citation omitted).

[L]oss resulting directly from the necessary interruption of business caused by damage to or destruction of real or personal property. . . .”<sup>9</sup>

The insured suffered a theft loss of critical data and engineering drawings that reduced its ability to perform its operations. Because the policy did not define “interruption of business,” the court had to determine whether a mere “work slowdown” was enough or if an actual “suspension of operations” was required. After stating that it was an issue of first impression for the Texas courts, the court looked to other jurisdictions and ultimately concluded:

[A]fter considering the policy as a whole and persuasive authority from other jurisdictions, we find that “interruption of business” is an unambiguous term meaning “cessation or suspension of business.” Therefore, Quality was not entitled to business interruption coverage for the work slowdown it experienced and we find the trial court did not err in granting Michigan’s motion for summary judgment.<sup>10</sup>

Valuation of business interruption losses are often the subject of dispute. One recent Texas case illustrates this point. In *Finger Furn. Co., Inc. v. Commonwealth Ins. Co.*,<sup>11</sup> the insured was unable to open several of its furniture stores in the aftermath of Tropical Storm Allison. After the flood, the company re-opened its stores and slashed prices the following weekend, causing a surge in business.<sup>12</sup> The company also filed a business interruption claim for the days while the stores were closed. Using a stipulated value from the prior year’s sales for the same period, the dispute turned on whether the insurer could offset the losses against the post-storm surge in sales.<sup>13</sup> Noting that the policy language required that due consideration be given to the “experience of the business before the date of the damage . . . and to the probable experience thereafter had no loss occurred,” the court held that the post-storm sales could not be used to determine whether the insured actually suffered a loss. Accordingly, the insured was awarded the full value of its stipulated loss, with no offset against the subsequent sales.<sup>14</sup>

There can also be disputes concerning the “period of restoration” of the covered premises. One example of this can be found in *Lava Trading, Inc. v. Hartford Fire Ins. Co.*,<sup>15</sup> where the insured was a tenant of the World Trade Center at the time of the September 11<sup>th</sup> terrorist attacks. Lava Trading sold computer software programs to facilitate electronic trading. Its primary offices, along with a functioning data center, were on the 83<sup>rd</sup> floor of One World Trade Center.

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<sup>9</sup> *Id.* at 637.

<sup>10</sup> *Id.* at 639.

<sup>11</sup> 404 F.3d 312 (5<sup>th</sup> Cir. 2005).

<sup>12</sup> *Id.* at 313.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> 365 F. Supp. 2d 434 (S.D.N.Y. 2005).

Approximately one month later, the insured had operational offices at another location. The policy’s “period of restoration,” was:

[T]he period of time that:

- (a) begins with the date of direct physical loss or damage caused by or resulting from any Covered Cause of Loss at the described premises, and
- (b) ends on the date when the property at the described premises should be repaired, rebuilt or replaced with reasonable speed and similar quality.<sup>16</sup>

The main issue was the point at which the “period of restoration” was complete – the insured’s replacement of suitable operational space, or the rebuilding of the World Trade Center.<sup>17</sup> The court held that the “period of restoration” ended when the insured’s property “should have been repaired, rebuilt or replaced with reasonable speed and similar quality.” Thus, the date when the insured’s offices were functionally replaced marked the end of the restoration period, and not when the World Trade Center’s rebuilding is actually complete.<sup>18</sup>

## 2. Contingent Business Interruption Coverage

For losses that do not directly affect the insured’s property, but do affect key suppliers or customers, “contingent business interruption” coverage is crucial. As the Seventh Circuit noted:

Regular business-interruption insurance replaces profits lost as a result of physical damage to the insured’s plant or other equipment; contingent business-interruption coverage goes further, protecting the insured against the consequences of suppliers’ problems. Regular business-interruption coverage did [Archer Daniels Midland Company] little good in 1993, for the flood largely spared its plants, but contingent business-interruption coverage was just the ticket.<sup>19</sup>

A fairly typical contingent business interruption clause states:

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<sup>16</sup> *Id.* at 439.

<sup>17</sup> Actually, this case is much more complex than the space constraints of this paper allow. It is therefore suggested that interested readers study the case in more detail to gain a complete understanding of this decision.

<sup>18</sup> *Id.* at 440-43.

<sup>19</sup> *Archer Daniels Midland Co. v. Hartford Fire Ins. Co.*, 243 F.3d 369, 371 (7<sup>th</sup> Cir. 2001). Unfortunately for ADM, it later found out that it did not have contingent business interruption coverage for the 1993 flood in the upper Mississippi River basin that inundated approximately eight million acres of farmland and was the single largest flood in the nation’s history. The court noted that the company’s desire to save \$19,000 in premiums by switching carriers cost ADM \$50 million in uncovered losses, because the replacement insurance it purchased did not cover the contingent business interruption losses ADM sustained as a result of the flood. *Archer Daniels Midland Co.*, 243 F.3d at 370-71.

This policy covers against loss of earnings and necessary extra expense resulting from necessary interruption of business of the insured caused by damage to or destruction of real or personal property, by the perils insured against under this policy, of any supplier of goods or services which results in the inability of such supplier to supply an insured locations [sic].<sup>20</sup>

Note that there is a causation element tying the loss to a covered peril, even though the insured need not have an insurable interest in the property that is damaged. This is a common feature in most time-element coverages because it avoids the problem of theoretically limitless coverage by installing a causative requirement in order for coverage to attach.

### 3. Extra Expense Coverage

It is usually the case that insureds incur extra costs following significant losses. This is where “Extra Expense” coverage comes into play. One example of this coverage is as follows:

This “policy” . . . covers the necessary Extra Expense incurred by the Insured during the “period of restoration” in order to continue as nearly as practicable the “normal” operations of the Insured’s business following a “covered property damage loss.”

In the above policy, “Extra Expense” is defined as:

[T]he excess (if any) of the total cost incurred during the “period of restoration” chargeable to the operation of the Insured’s business, over and above the total cost that would normally have been incurred to conduct the business during the same period had no loss or damage occurred.

*Travelers Indem. Co. v. Pollard Friendly Ford Co.*<sup>21</sup> is a good example of how a Texas court has looked at extra expense coverage. There, the insured suffered damages from a tornado, resulting in a thirteen-day interruption of the insured’s normal business activities.<sup>22</sup> The trial court awarded the insured with extra expenses for security, debris removal, employee wages and meals, and temporary storage facilities.<sup>23</sup> The Court of Appeals held:

In this case, normal business being impossible for thirteen days, cleaning up the debris, preserving the remains of the operation, and making preparations for reopening for business would appear to be

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<sup>20</sup> *Archer-Daniels-Midland Co. v. Phoenix Assur. Co. of New York*, 936 F. Supp. 534, 540 (S.D. Ill. 1996).

<sup>21</sup> 512 S.W.2d 375 (Tex. Civ. App.—Amarillo 1974, no writ).

<sup>22</sup> *Id.* at 379.

<sup>23</sup> *Id.* at 377.

acts “in order to continue as nearly as practicable the normal conduct of insured’s business.”<sup>24</sup>

#### 4. Civil Authority Coverage

Occasionally, governmental authorities prohibit access to certain areas even though not all buildings in the area were damaged. Two recent tragedies are prime examples – the shut-down of lower Manhattan following September 11<sup>th</sup>, and the evacuation of New Orleans following Hurricane Katrina. “Civil Authority” coverage is designed to protect against losses arising out of orders like these. A typical provision might read something like the following:

The insurance provided . . . is extended to cover the actual loss sustained by the Insured during the length of time . . . when access to “covered locations” is specifically prohibited by order of civil authority, provided such order is a direct result of actual loss or damage from a [covered] peril to property in the vicinity of the “covered locations” to which access is prohibited.

Importantly, this clause has a geographical limitation to the “vicinity of the ‘covered locations.’” Other clauses, however, are broader. In *730 Bienville Partners, Ltd. v. Assurance Co. of Am.*,<sup>25</sup> the policy provided:

We will pay for the actual loss of “business income” you sustain and necessary “extra expense” caused by action of civil authority that prohibits access to your premises due to direct physical loss of or damage to property, other than at the “covered premises,” caused by or resulting from any Covered Cause of Loss. This coverage will apply for a period of up to 4 consecutive weeks from the date of that action.<sup>26</sup>

The insured operated two hotels in New Orleans and sought coverage for business interruption losses under the “Civil Authority” provisions of its policy due to the FAA’s closure of the nation’s airports after September 11. In other words, the insured argued that the lack of flights kept guests from being able to travel to New Orleans and stay in its hotels. The court rejected this argument, concluding:

While the FAA’s closure of the airports and cancellation of flights may have prevented many guests from getting to New Orleans and ultimately to plaintiff’s hotels, the FAA hardly “prohibited” access to the hotels.<sup>27</sup>

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<sup>24</sup> *Id.* at 379-80.

<sup>25</sup> 2002 WL 31996014 (E.D. La. Sept. 30, 2002).

<sup>26</sup> *Id.* at \*2.

<sup>27</sup> *Id.*

This case stands as an important reminder that courts occasionally impose limits even where the policy may not.

## 5. Service Interruption Coverage

Catastrophic events (both man-made and natural) often result in disruption to utility service providers and their customers, such as downed power lines following storms or broken water mains following earthquakes. “Service Interruption” coverage is available for such losses. The language at issue in one case dealing with this coverage read:

In consideration of additional premium, the Time Element [*i.e.*, business interruption] coverage of this Policy is extended to cover the actual loss sustained caused directly by the interruption of the specified incoming services during a Period of Service Interruption, or if applicable, during the Restoration of Normal Operations . . . .

\* \* \* \* \*

Coverage is provided for loss resulting from interruption of the following specified incoming services: Gas, Water, Electricity, Telephone[,] by reason of any accidental [occurrence] to the facilities of the following suppliers: Any Public Utility[,] that immediately prevents in whole or in part the delivery of useable services specified . . . .<sup>28</sup>

In this case, the city of Salem, Oregon suffered severe flooding, leading its water utility to temporarily shut down operations. During this period, the insured had to purchase water from an outside supplier, and it continued doing so until the purity of the city’s water supply returned to normal.<sup>29</sup> Thus, the court noted:

Here, Siltec’s business operations were impaired because utility service was interrupted, not because its insured property was physically damaged by the flood.<sup>30</sup>

This fact, along with the foregoing policy language, led the court to conclude initially that the insured’s loss was covered. However, the “Service Interruption” endorsement also contained specific exclusions for flood and contamination. Due to these exclusions, the court ruled that there was ultimately no coverage for the loss.<sup>31</sup> This case illustrates how “Service Interruption” coverage works, even though there was no coverage in this instance.

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<sup>28</sup> *Prot. Mut. Ins. Co. v. Mitsubishi Silicon Am. Corp.*, 992 P.2d 479, 483 (Or. Ct. App. 1999).

<sup>29</sup> *Id.* at 482.

<sup>30</sup> *Id.* at 483.

<sup>31</sup> *Id.* at 483-84.

## 6. Ingress/Egress Coverage

Sometimes, access to an insured's property is impaired. The resulting loss of business can be covered under "Ingress/Egress" coverage. Here is one example of this coverage:

Loss of Ingress or Egress: This policy covers loss sustained during the period of time when, as a direct result of a peril not excluded, ingress to or egress from real and personal property not excluded hereunder, is thereby prevented.<sup>32</sup>

In *Fountain Powerboat*, the only road leading to the insured's facility was flooded for days following Hurricane Floyd.<sup>33</sup> Thus, the insured sought coverage under its "Ingress/Egress" coverage for the business interruption losses it sustained as a result of the inaccessibility. The court began by noting:

The court cannot find, and neither party has provided, any case in any jurisdiction that interprets an ingress/egress clause in the business interruption loss section of an insurance policy.<sup>34</sup>

Looking then only to the policy language, the court concluded:

Loss sustained due to the inability to access the Fountain facility and resulting from a hurricane is a covered event with no physical damage to the property required.

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Therefore, the court finds that no requirement for physical loss to the property is required under the contract of insurance in order to trigger business interruption coverage under the ingress/egress clause.<sup>35</sup>

## 7. Border Wars

Occasionally, business interruption losses can fall on the border between direct "business interruption" coverage and "contingent business interruption" coverage. *Zurich Am. Ins. Co. v. ABM Indus., Inc.*,<sup>36</sup> provides just such an example. As it is both interesting and complex, an extended discussion is necessary to fully understand the court's reasoning.

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<sup>32</sup> *Fountain Powerboat Indus., Inc. v. Reliance Ins. Co.*, 119 F. Supp. 2d 552, 556 (E.D.N.C. 2000).

<sup>33</sup> *Id.* at 554.

<sup>34</sup> *Id.* at 556-57.

<sup>35</sup> *Id.* at 556. On an unrelated note, *Fountain Powerboat* is also of independent significance in that it is an example of a court disregarding the rule of *contra proferentem*. The court observed that "when the parties to the insurance agreement are sophisticated and jointly negotiate the policy, there is no need to construe ambiguities against the insurance company." *Id.* at 555.

<sup>36</sup> 397 F.3d 158 (2d Cir. 2005).

ABM Industries (“ABM”) provided an array of janitorial and engineering services at the World Trade Center (“WTC”) complex.<sup>37</sup> It operated the WTC’s heating, ventilating, and air-conditioning (“HVAC”) systems, virtually running the physical plant. In addition, ABM serviced the common areas of the buildings and had contracts to provide janitorial services to some ninety-seven percent of the WTC’s tenants. To perform these duties, ABM maintained a significant presence at the WTC. Employing 800 people at the site, it had office and storage space in the complex, as well as full access to custodial closets and sinks on each floor.<sup>38</sup> Outside of normal business hours, ABM had exclusive use of the freight elevators. It created and staffed a call center that dispatched appropriate personnel to handle problems reported by tenants. Finally, ABM even developed a sophisticated maintenance program for the WTC complex that was designed to fix problems before they happened.<sup>39</sup>

To cover its operations across North America, ABM obtained a policy from Zurich with a blanket limit of \$127,396,375, subject to certain sublimits.<sup>40</sup> Like most property policies, it provided a number of different coverages. To begin with, §7.A(1) of the policy covered loss or damage to “real and personal property, including but not limited to property owned, controlled, used, leased, or intended for use by the Insured.” §7.B(1), the business interruption (“BI”) coverage, insured against “loss resulting directly from the necessary interruption of business caused by direct physical loss or damage . . . to insured property at an insured location.” There was no sublimit for BI coverage, thus making the policy’s full blanket limit of \$127,396,375 available for covered BI losses. The Extra Expense provision covered up to \$50,000,000 of extra expenses “resulting from loss, damage, or destruction covered herein . . . to real or personal property described in [§7.A(1)].” “Extra Expense” was defined as the “total cost chargeable to the operation of the Insured’s business over and above the total cost that would normally have been incurred to conduct the business had no loss or damage occurred.”

Other coverages were also relevant. The contingent business interruption (“CBI”) provision provided coverage for up to \$10,000,000 in actual losses sustained from the necessary interruption of business because of direct physical loss or damage from a covered peril “to properties not operated by the Insured” that wholly or partially prevented the insured’s direct customers from receiving ABM’s services.<sup>41</sup> Finally, the policy contained a “Leader Property” provision that provided coverage for losses arising out of damage to a property that attracted business to the insured, and a “Civil Authority” provision that provided coverage for losses sustained by a lack of access resulting from the order or action of a civil or military authority.

The insured brought claims under the policy for the loss of income it derived from its operations at the WTC, resulting from the destruction of its equipment, offices and storage spaces, the call center, the freight elevators and janitorial closets, the common areas of the WTC, and the tenant spaces where ABM provided services. ABM also brought claims for more than

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<sup>37</sup> *Id.* at 161.

<sup>38</sup> *Id.*

<sup>39</sup> *Id.* at 161-62.

<sup>40</sup> *Id.* at 162.

<sup>41</sup> *Id.*

\$20,000,000 in extra expenses resulting from union negotiations, increased employee termination costs and unemployment expenses, other wage expenses, and claim preparation fees.<sup>42</sup> Finally, ABM asserted claims for losses stemming from police orders that prevented it from servicing some 34 other locations in lower Manhattan during the aftermath of September 11.

Zurich filed a declaratory judgment action in the Southern District of New York to determine the extent of its liability under the policy.<sup>43</sup> After the district court found that the policy was “ambiguous in several pertinent respects,” the parties engaged in discovery concerning the ambiguities. Both sides then filed cross-motions for partial summary judgment. ABM contended that its lost income fell under the BI or Leader Property provisions, and Zurich maintained that (a) most of ABM’s losses fell under the policy’s CBI coverage, which had a \$10,000,000 sublimit; and (b) that there was no coverage under the BI, Extra Expense, Leader Property and Civil Authority provisions. The trial court sided with Zurich, and ABM appealed.<sup>44</sup>

A two-judge panel of the Second Circuit reversed the district court’s rulings on the key coverage issue, remanded on the other coverage issues, and affirmed on an evidentiary point. It began by addressing ABM’s BI claims, noting again that the policy language defined the scope of coverage as “[t]he interest of the Insured in all real and personal property, including but not limited to property owned, controlled, used, leased, or intended for use by the Insured.”<sup>45</sup> The dispute between the carrier and the insured centered on the nature of involvement an insured must have with a piece of property in order to recover on a business interruption claim. Zurich argued that a legally recognized property interest, such as ownership or tenancy, was necessary for coverage to attach. Relying on the rules of construction, the court disagreed and noted that Zurich’s approach would require it “to ignore the phrase ‘but not limited to’ as well as the disjunctive ‘or’ in the provision.” Further, if a property interest were required by the policy, then the words “controlled,” “used,” and “intended for use” would be rendered meaningless. Thus, it held that the policy required only an “insurable interest,” and not the higher standard of a “property interest” that was urged by Zurich.<sup>46</sup>

To further explain its holding, the court analyzed each component of ABM’s BI claim. First, as to the common areas, tenants’ premises and the HVAC systems of the WTC complex, it noted that since ABM did not “own” or “lease” these areas, the relevant inquiry under the policy was whether it “controlled,” “used,” or “intended to use” them. Applying the district court’s definition of “use,” the Second Circuit held that the plain meaning of the word unambiguously included coverage for this case. Observing the reality of ABM’s business purpose, the court ruled that these areas “were the means by which ABM derived its income and were as essential to that function as ABM’s cleaning tools.” Additionally, the court recognized that a contrary rule would discriminate against service providers that focus on physical tasks rather than

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<sup>42</sup> *Id.* at 162-63.

<sup>43</sup> *Id.* at 163.

<sup>44</sup> A more thorough analysis of the district court’s opinion can be found in Michael Sean Quinn & Pamella A. Hopper, *Extra Expenses & Business Interruption Coverages*, 26:3 INS. LITIG. REP. 97 (February 2004).

<sup>45</sup> *Id.* at 165.

<sup>46</sup> *Id.*

intellectual ones, because companies such as ABM generate income largely by working in spaces other than the ones they occupy for their own business needs. Stated differently, the WTC tenants were paying ABM to clean and maintain their offices, not ABM's. As to the spaces ABM did occupy, the court held that it "used" and "controlled" those areas as well. On causation, the court also disagreed with the district judge and held that the "ruination of the WTC, *including* the property at issue, was the cause of ABM's business interruption." (emphasis original). Finally, the court concluded this part of the opinion by revisiting the "insurable interest" versus "property interest" distinction, holding that the district court's imposition of the "legally cognizable 'interest' in the property" requirement was an "impermissible hurdle to insurance coverage, contemplated by neither the parties nor the New York legislature."<sup>47</sup> In light of the insured's business model, it ruled that ABM satisfied New York's "insurable interest" requirement. Since it also satisfied the requirements of the policy, the insured was entitled to recover for its business interruption losses.

Based largely on its conclusions regarding the BI claims, the court rejected Zurich's arguments that the insured's claim was limited to the \$10,000,000 available for contingent business interruption losses. As noted above, the express terms of the policy limited CBI coverage to losses sustained from the necessary interruption of business because of direct physical loss or damage "to properties not operated by the Insured." Given the extensive level of ABM's activities at the WTC, the court concluded that it "operated" the physical spaces it occupied as well as those of other tenants and the common areas. Accordingly, it held that the policy's CBI coverage was inapplicable on these facts.

Because the Extra Expense coverage was also linked to the "insurable interest" provision in §7.A(1), the court held that summary judgment in Zurich's favor was improper on this claim for the same reasons as the BI claim.<sup>48</sup> But, this issue was remanded to the trial court to determine whether causation was satisfied. As for ABM's Civil Authority claim regarding non-WTC properties in lower Manhattan, the Second Circuit rejected the district court's holding and instead ruled that the insured might have coverage under this provision because the WTC's destruction would not have resulted in lack of access to the other properties absent orders by the governing authorities. It also held, however, that a fact question existed as to whether it was these orders, or ABM's own policies, that impaired access to the surrounding properties. Lastly, the court rejected coverage under the "Leader Property" provision because the language of the insuring agreement made it applicable only to "properties not owned or operated by the insured." This conclusion was consistent with the court's previous holdings on the other coverages.<sup>49</sup>

The Second Circuit reached the result on the key issue in this case by focusing on the nature of ABM's business generally and its extensive role at the WTC complex in particular, as well as the policy's language and New York law.

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<sup>47</sup> *Id.* at 167-68.

<sup>48</sup> *Id.* at 170.

<sup>49</sup> Procedurally, the court affirmed the trial judge's exclusion of ABM's evidence in support of a two-occurrence claim, but it contained no discussion of the trial court's decision to deny ABM's motion to amend its pleadings to assert a bad faith counterclaim based on Zurich's conduct both prior to *and* after the commencement of litigation.

### c. Extensions of Coverage

Virtually all property policies contain certain “extensions of coverage” in addition to the main coverages. A leading authority on insurance terminology defines “extended coverage” as:

[a] CLAUSE found in an insurance policy that will provide additional coverage for RISKS to be insured other than those covered under the basic policy’s PROVISIONS.

Harvey W. Rubin, *Dictionary of Insurance Terms* 167 (4th ed. 2000). There are many different coverage extensions. Here are some of the more common ones:

- ❖ Valuable Papers and Records;
- ❖ Accounts Receivable;
- ❖ Pollutant Clean-up;
- ❖ Debris Removal;
- ❖ Fine Arts;
- ❖ Expediting Expense;
- ❖ Property in Transit; and
- ❖ Claim Preparation Expense.

There are three keys to dealing with extensions of coverage. First, the insured must carefully assess whether they apply with respect to a given loss. Second, the insured must determine if there are internal sublimits applicable to these coverages that reduce the amount of money available for a particular extension. Finally, careful attention must be paid to whether the extensions are part of, or in addition to, the main limits of the policy.<sup>50</sup>

### d. Protecting the Company’s Computer Data

In what is perhaps one of the most significant recent developments in Texas caselaw on coverage for business losses, the Tyler Court of Appeals held that losses to a company’s computer systems caused by a virus installed by a “computer hacker” are compensable under a business insurance policy. *Lambrecht & Assocs., Inc. v. State Farm Lloyds*, 119 S.W.3d 16 (Tex. App.—Tyler 2003, no pet.). There, the insured was an employment agency that used computers to maintain databases and communicate with prospective employers and employees. *Id.* at 18-19. The insured’s computers began performing erratically, and ultimately “froze up” entirely. The

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<sup>50</sup> On this last point, the Minnesota Court of Appeals noted that:

When an extension of coverage provision states that extensions of coverage apply “as an additional amount of insurance,” the amounts listed under that section are in addition to the base policy amount.

*Metalmasters of Minneapolis, Inc. v. Liberty Mut. Ins. Co.*, 461 N.W.2d 496, 498 (Minn. Ct. App. 1990).

insured had to replace its server, install new software, and manually re-enter much of its data. *Id.* This led to a decrease in revenue due to the down-time of the company's computer systems. *Id.* The policy covered "accidental direct physical loss to business personal property at the premises described. . . ." It also provided business income coverage for loss of income caused by suspension of operations due to "accidental direct physical loss to business personal property at the premises described. . . ." *Id.* The insured filed a claim for "lost business income and for the expense of replacing the server and software packages and hiring someone to input the data on the new system. *Id.* at 19. The carrier denied coverage on the basis that the loss was neither accidental nor physical, and the insured brought suit in response. *Id.* at 21. With respect to the "accidental" component, the court seized on the Texas Supreme Court's recent decision in *King v. Dallas Fire Ins. Co.*, 85 S.W.2d 185 (Tex. 2002). Noting that the hacker, rather than the insured, caused the loss, the court concluded that it was accidental from the standpoint of the insured. *Id.* at 21-23. The court next rejected the insurer's contention that the loss was not "physical" or "tangible." Rather than address this issue in the abstract, the court instead focused on the policy language and addressed the insured's claim for coverage of the computers and the software by stating:

We hold that the plain language of the policy dictates that the personal property losses alleged by Lambrecht were "physical" as a matter of law. Based on [the office manager's] affidavit, the server falls within the definition of "electronic media and records" because it contains a hard drive or "disc" which could no longer be used for "electronic data processing, recording, or storage." The data that Lambrecht lost as a result of data is also covered because it was the "data stored on such media."

According to the policy, there can be a "loss to papers or records, including those which exist on electronic or magnetic media" that is not "caused by an error in programming." If such a loss occurs, State Farm will pay "the cost of replacing the papers or records with duplicates of like kind and quality, such as prepackaged software programs, if duplicate material is available on the current retail market. . . ." [B]ased on the evidence in the record, the losses were caused by a virus, not an "error in programming." Therefore, the pre-packaged software Lambrecht lost as a result of the virus is also covered under the policy.

*Id.* at 25 (footnote omitted). With respect to coverage for the expenses incurred in restoring the data and the lost income, the court held:

Lambrecht also purchased additional coverage for the "expense to research, replace or restore the lost information on valuable papers and records, including those which exist on electronic or magnetic media, for which duplicates do not exist." In [the office manager's] affidavit, she alleged that "the company incurred additional expenses in employee time to acquire and install a new server and properly reload all of the software in it." According to the plain language of the policy, these expenses Lambrecht incurred in replacing the lost data are covered.

By its direct language, the policy covers loss of business income caused by "accidental direct physical loss to 'electronic media and records'" but only that

income lost for either sixty consecutive days from the date of the loss or the amount of time necessary to repair, rebuild or replace other property at the premises caused by the same occurrence. Accordingly, the business income Lambrecht lost as a result of the virus is covered under the policy because Lambrecht suffered a loss of its “electronic media and records” during the months of February and March.

*Id.* at 25-26. Ultimately, the court summarized its conclusion as follows:

State Farm’s contention that Lambrecht did not suffer an “accidental direct physical loss” runs contrary to the language of the policy, which expressly states that it will pay for loss of business income caused by “accidental direct physical loss” to “electronic media and records.” According to State Farm’s argument, the policy would never cover such a loss because the “electronic media and records” and the “data stored on such media” is not “physical.” The plain language of the policy’s provisions and definitions dictates that such property is capable of sustaining a “physical” loss.

*Id.* at 26. Accordingly, the court reversed the summary judgment in favor of the insurer and remanded the case back to the trial court. This decision is very favorable to policyholders, and one that provides significant protection in light of the constant threats from computer viruses.

## **2. Some Specialized Property Coverages**

The commercial property policy is a good starting point for most businesses. But it is just that—a starting point. Standing alone, it may not provide complete protection for the insured. Other more specialized forms of coverage may also be necessary in order to obtain more comprehensive coverage of risks to the insured’s business. Depending on the individual circumstances, an insured might need other forms of coverage to protect certain assets such as ships, aircraft or other less common forms of property. Additionally, some insureds need specialized coverages such as builder’s risk, employee dishonesty, and intellectual property protection.

As the scope of coverage can vary from one policy to the next, insureds should carefully examine potential policies for these individualized risks. The company’s critical risk assessment and property inventory, combined with advice from the insured’s broker, will enable the insured to obtain appropriate coverage for the property central to the insured’s core business needs.

Although the standard commercial property policy is a good foundation for covering the company’s tangible assets and income stream, many insureds need more specialized coverage to ensure full and adequate protection for the whole range of assets. While there are many, this section presents two examples.

### **a. Protecting the Company’s Intellectual Property**

It is no secret that intellectual property rights have become progressively more important in recent years. This increasing significance has led to a corresponding rise in litigation over

allegations of infringement.<sup>51</sup> Further, as the complexity of these disputes has grown, so too have the costs of litigating them.<sup>52</sup> In short, protecting intellectual property assets against infringement is not only a vital task, it can also be an expensive one. Though the typical costs of pursuing infringement claims have continued to rise, the potential rewards of a successful lawsuit have arguably decreased. In an *en banc* decision last year, the Federal Circuit overturned the long-standing “adverse inference” rule for obtaining enhanced damages as a consequence of willful infringement. *Knorr-Bremse Systeme Fuer Nutzfahrzeuge GmbH v. Dana Corp.*, 383 F.3d 1337, 1343-44 (Fed. Cir. 2004). While such damages are still recoverable, proving them may be more difficult as a consequence of *Knorr-Bremse*.

For large commercial enterprises, protecting intellectual property by pursuing infringers is standard procedure, and often funded directly by the company. For smaller companies without large litigation budgets, however, this can be more problematic. Such companies may well have inadequate resources to fund expensive litigation when their intellectual property assets are at risk. It is therefore not uncommon for these entities to face a difficult choice among four undesirable alternatives: (1) trying to fund the litigation on a shoestring budget; (2) forgoing other uses of the money to direct more funds to the litigation; (3) giving up a share of the potential recovery to attorneys working on a contingency basis; or (4) abandoning pursuit of the infringing party. Historically, contingent fee arrangements may have been the preferred solution to this funding problem. But, the combination of increased expense and decreased reward also suggests that some lawyers may be less likely to take such cases, or if they do, they may require a higher percentage of the recovery.

For these reasons, obtaining insurance coverage for the prosecution of infringement claims may now be more important than ever. In the last few years, the insurance marketplace has begun offering a new line of coverage to protect the owners of intellectual property against acts of infringement by others.<sup>53</sup> Referred to by various names such as “pursuit,” “abatement,” or “enforcement” coverage, this section will provide a brief description of some of the common features associated with these insurance products.

To begin with, the placement process for this coverage is usually more involved than is normally the case with traditional property insurance. In addition to the usual inquiries concerning the putative insured, there is often a detailed investigation of the intangible assets to be covered, including the circumstances surrounding their creation and subsequent measures to protect the holder’s rights. For example, some applications inquire about certain practices of the prospective insured, including whether the patented products routinely contain “patent markings” and whether the patent holder would consider a licensing agreement in order to resolve an infringement claim. Applications often ask whether the prospective insured is aware of any current infringement at the time insurance is sought. It is not unusual for an insurer to require

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<sup>51</sup> From March 31, 2003 through March 31, 2004, the number of new patent suits increased 7.9% over the prior year. William M. Bulkeley, *Patent Ruling Irks Inventors, Aids Companies*, WALL ST. J., Mar. 2, 2005, at B1, B2.

<sup>52</sup> *Id.* Like most other types of litigation, about 95% of all patent cases are either settled or dismissed. For those that do go to trial though, the American Intellectual Property Law Association reports that the average costs for each side are approximately \$2 million.

<sup>53</sup> The last few years have also seen a corresponding development in defending against infringement claims. Traditionally, attempts have been made to seek coverage under the “advertising injury” provisions of the CGL policy, though the required nexus to “advertising activities” has frequently been an obstacle to coverage.

the opinion of independent counsel concerning the validity of the patent(s) before the application is approved. Based on the level of disclosure required by the underwriting process, and the analysis that may be performed prior to the issuance of the policy, it is important to consider steps that will help to maintain the confidentiality of this information. For instance, efforts should be made to structure the pre-issuance analysis in a way that is protected by the attorney-client privilege if at all possible.

Once the policy is issued, the key benefit provided is “litigation expense” incurred in connection with “authorized litigation.” A condition precedent to coverage is the authorization of litigation. Essentially, this requires that the insured provide detailed notice to the carrier of the facts and circumstances surrounding the alleged infringement. These include such things as the identity of the infringing party, the nature of the infringement, the details surrounding discovery of the infringement, the proposed action(s) to be taken against the infringing party, the expected result, and an analysis of the impact the infringement will have on the insured asset. Further, the authorization of litigation usually requires an opinion written by independent counsel that supports the claim. This opinion must be written by qualified counsel that has no connection to the prosecution of the patent. Neutrality is also achieved by the requirement that the independent counsel cannot later be selected as the litigation counsel if an infringement action is ultimately brought. The opinion must be “written to the standards of the profession” and must provide three assurances: (1) the insured intellectual property is valid; (2) the existence of infringement of the insured intellectual property; and (3) that “no legal impediment exists which would result in an unsuccessful prosecution of the suit.” As a further check against pursuing non-meritorious claims, these policies are often written with a co-insurance requirement that forces the insured to shoulder some portion of the costs, usually somewhere in the range of twenty percent. Thus, this decreases the chance that an insured will seek to bring undesirable claims.

Written on a claims-made basis, the alleged infringement “must first begin during the policy period.” Under certain circumstances, however, coverage can be obtained for prior policy years provided that continuous infringement occurred from when the insurance was first in force. With respect to claims ripening after the expiration of the policy period, there are usually “notice of claims” and “notice of circumstances” provisions similar to other claims-made policies. Other matters can also be covered by endorsement, such as the costs of seeking a re-issuance of an insured patent or the costs incurred in connection with a re-examination proceeding. Coverage for the costs of defending against counterclaims of invalidity is also typically included.

Assuming that successful prosecution of an infringement action results in a monetary recovery, the insurer usually receives a share of the proceeds according to a formula set forth in the policy. This recovery is typically capped after the insurer has received a return of its initial investment in the prosecution of the infringement action along with a fractional multiple of that amount. However, if the outcome includes non-monetary relief and the amount of money recovered is insufficient to repay the carrier’s investment, there is a risk that the insured will then have to make up the difference. An endorsement waiving the carrier’s rights on this point is worth careful consideration if the insured intellectual property is likely to yield relatively low recoveries. Lastly, any money returned to the carrier usually goes to reinstate policy limits that have been depleted by the prosecution of the infringement action.

As with virtually every insurance policy, there are typically a number of exclusions. These can include exclusions for pre-authorization expenses, suits against other insureds, willful acts that give rise to the infringement, breach of contract by licensees, and knowledge of pre-existing acts of infringement. Though not a true exclusion, these policies often have territorial limitations that may preclude coverage for pursuing infringers in countries with lax enforcement laws.<sup>54</sup> If possible, this is an area where the insured should attempt to obtain more favorable terms through negotiation or competing bids.

Being relatively new, it is important to note that this coverage is not yet standardized like some other forms of insurance, such as the commercial general liability policy. Thus, while there are common elements in these policies, relative uniformity likely will not be achieved for many years to come.<sup>55</sup> Consequently, the insured should obtain the assistance of an experienced broker and review the proposed coverage carefully. Once the policy is formally bound, the insured should also make certain that what was issued is consistent with what was quoted.

Because protecting intellectual property has become more important over the years, it has become more costly as well. Adding to this problem is the *Knorr-Bremse* decision, which lessens the chances for recovering enhanced damages. For those insureds who depend upon their intellectual property rights but lack the resources to fully protect them, this insurance may now be more valuable than ever as a way to safeguard these critical business assets.

#### **b. Protecting the Company's Interests in the Property of Others**

Often, a company will have an interest in the property of others. One common method for dealing with this situation is to have the company added as an additional insured on another's policy. This approach has particular importance for lenders, including financial services companies or manufacturers who sell equipment on credit. It must be noted, however, that there is a critical distinction between a "loss payable" clause and a "standard mortgage"<sup>56</sup> clause. An explanation of the differences between these clauses can be found in *Kimberley & Carpenter, Inc. v. Nat'l Liberty Ins. Co. of Am.*, 157 A. 730 (Del. Super. Ct. 1931), where the court stated:

We do not propose to go into an extended discussion concerning the origin, the purpose or the development of the standard mortgagee clause. It seems certain, however, that it originated by reason of the inadequate security vested in the mortgagee under the old "loss payable" clause. Under the latter clause the

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<sup>54</sup> For an example of the struggles of enforcing intellectual property rights in some markets, see Peter Wonacott & Sarah McBride, *To Catch Film Pirate, U.S., China Follow Spy Flick to Shanghai*, WALL ST. J. Mar. 7, 2005, at A1; Kate Kelly, *et al.*, *Movie, Music Giants Try New Weapon Against Pirates: Price*, WALL ST. J. Mar. 7, 2005, at B1 (noting that an estimated 90% of all CDs sold in China are pirated, more than 70% in Russia and 60% in Mexico). For an example of an enforcement effort gone awry, see *Levi's Ordered to Pay Contractor \$45 Million*, WALL ST. J. Mar. 7, 2005, at B9 (manufacturer ordered to pay damages after raiding its own supplier for alleged counterfeiting).

<sup>55</sup> At present, the caselaw on this subject is not very well developed. One early case, however, provides some insight. See *Connecticut Indem. Co. v. Markman*, 1993 WL 304056 (E.D. Pa. Aug. 6, 1993). Once more cases have been decided, this judicial guidance is likely to foster uniformity over time.

<sup>56</sup> Originally, this type of provision was called a "standard mortgagee" clause. With time, the accepted convention has changed to a "standard mortgage" clause. Though both names are still seen from time to time, the concept is the same.

mortgagee was a mere appointee of the mortgagor and person insured and any default or breach on the part of the mortgagor operated against the mortgagee and destroyed his rights under the policy. By the “standard mortgagee” clause, however, new rights were set up in the mortgagee. Under it no default or breach on the part of the insured-mortgagor affects the right of the mortgagee . . . and in case of loss, he recovers in his own name by reason of his own status as an assured of the company . . . . [T]he effect of the joint consideration of the policy and the mortgagee clause is that two severable contracts are set up—one in favor of the insured-mortgagor and the other in favor of the insured-mortgagee. The latter is distinct from the former and the rights of the mortgagee are subject to be defeated only by a violation of the terms set out in the mortgagee clause.

*Id.* at 732. More than fifty years later, the Fifth Circuit opined that:

Where the issue has been squarely presented, the modern decisions are unanimous, and the earlier decisions virtually so, in holding that a mortgagee under a standard mortgage clause may (where not guilty himself of any breaches of policy conditions) recover from the insurer for a loss sustained by the mortgaged property, even though the risk be excluded from the policy coverage, where any act of the mortgagor has caused or contributed to the loss as resulting from an excluded risk; and even though as between the mortgagor–insured and the insurer there is no coverage because of some default by the mortgagor.

*Ingersoll-Rand Fin. Corp. v. Employers Ins. of Wausau*, 771 F.2d 910, 913 (5<sup>th</sup> Cir. 1985). Thus, “standard mortgage” clauses were “developed for the purpose of providing mortgagees with protection against mortgagors’ acts or neglect.” John W. Steinmetz, *et al.*, *The Standard Mortgage Clause in Property Insurance Policies*, 33 TORT & INS. L. J. 81, 82 (1997).

Texas courts are also in accord. *See, e.g. Travelers Indem. Co. v. Storecraft, Inc.*, 491 S.W.2d 745, 748 (Tex. Civ. App.—Corpus Christi 1973, no writ);<sup>57</sup> *Horn v. Hedgecoke Ins. Agency*, 836 S.W.2d 296, 298 (Tex. App.—Amarillo 1992, writ denied); *Don Chapman Motor Sales, Inc. v. Nat’l Sav. Ins. Co.*, 626 S.W.2d 592, 596-97 (Tex. App.—Austin 1981, writ ref’d n.r.e.) (“[T]his contract between the insurer and the mortgagee can be invalidated solely by acts of the mortgagee, and is not affected by any act or neglect of the mortgagor in violation of the policy of which the mortgagee is uninformed.”); TEX. INS. CODE ANN. §862.055 (Vernon 2003). Although the language varies, a typical “standard mortgage” clause might read:

The insurance afforded by the Policy shall not be invalidated as regards the interest of the Lienholder by any act or neglect of the Insured . . .

*Underwriters at Lloyd’s, London v. United Bank Alaska*, 636 P.2d 615, 617 (Alaska 1981). Another version states:

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<sup>57</sup> Notably, in the course of its opinion, the *Storecraft* court also observed that “the purpose of an insurance contract is to indemnify against loss; it should be construed in such a way to carry out that purpose, rather than in a way that will defeat it.” *Storecraft*, 491 S.W.2d at 747.

[T]his insurance, as to the interest of the mortgagee . . . shall not be invalidated by any act or neglect of the mortgagor or owner of the within described property. . . .

*First Nat'l Bank & Trust Co. v. Mut. Fire Ins. Co.*, 162 A. 703 (Del. Super. Ct. 1932). Common to most, if not all, of these clauses is some variant of the phrase “act or neglect of [the named insured, mortgagor, owner, etc.] . . .” In case there is any ambiguity, such clauses should be construed in favor of the lienholder, and in favor of coverage. *See Americas Aviation & Marine Ins. Co. v. Beverly Bank*, 229 So. 2d 314, 316 (Fla. Dist. Ct. App. 1969). The Tennessee Supreme Court has provided a simple but useful test for distinguishing between a traditional “loss payable” clause and a “standard mortgage” clause. If a loss payable clause confers greater rights on the loss payee than it confers on the named insured, then it is a standard mortgage clause, and it is therefore a separate contract between the insurer and the loss payee. *Reeves v. Granite State Ins. Co.*, 36 S.W.3d 58, 61 (Tenn. 2001).

Considering the potential legal effect of such provisions before the consummation of a transaction may avoid significant problems down the road. The old adage “an ounce of prevention is worth a pound of cure” seems appropriate in this instance.

Similarly, where sufficient bargaining power exists, the lawyer can draft contractual agreements that shift the risk of loss to counter-parties. For example, a proposed contract may limit the company’s recovery solely to the proceeds of an insurance policy obtained for the contemplated transaction. However, such agreements may leave the company vulnerable if the insurer becomes insolvent or if the facts of the claim negate coverage. This risk can be reduced by altering the transaction to limit the company’s recovery only to the extent of the policy proceeds actually recovered, and then allowing any remaining losses to be recouped from the counter-party.

### **C. Third Party Coverage – Protecting the Company Against Liability**

Now that a review of some basic property coverage issues has been completed, a presentation of core liability coverages is next. Before moving on to the substantive issues, however, a dichotomy similar to the “all risk” versus “named peril” distinction in property policies also exists in liability policies. In liability policies, the coverage is generally written on either an “occurrence” or a “claims-made” basis.<sup>58</sup> A classic Texas case on the subject states:

A “claims-made” policy covers occurrences which may give rise to a claim that comes to the attention of the insured and is made known to the insurer during the policy period. An “occurrence” policy covers all claims based on an event occurring during the policy period, regardless of whether the claim or occurrence itself is brought to the attention of the insured or made known to the insurer during the policy period.

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<sup>58</sup> There are also “claims made and reported,” forms, which are even more restrictive in that they require the claim not only be made during the policy period, but also that it be reported to the carrier. *See, e.g. Pension Trust Fund for Operating Engineers v. Federal Ins. Co.*, 307 F.3d 944, 955-56 (9<sup>th</sup> Cir. 2002). Some courts, however, ignore the distinction and speak of all claims-made policies as being the same. *Textron, Inc. v. Liberty Mut. Ins. Co.*, 639 A.2d 1358, 1361, n.2 (R.I. 1994).

*Yancey v. Floyd West & Co.*, 755 S.W.2d 914, 918(Tex. App.—Fort Worth 1988, writ denied). Another definition, without using both terms to define the other, can be found in *Singleentry.com, Inc. v. St. Paul Fire & Marine Ins. Co.*, 117 Fed. Appx. 933, 936 (5<sup>th</sup> Cir. 2004):

A claims-made policy is distinguishable from an occurrence policy, where an occurrence during the policy triggers coverage. Alternatively, under a claims-made policy, providing notice triggers the insured’s coverage.

*Id.* (citation omitted). As will be shown below, recognizing which type is involved is crucial for determining what notice obligations exist.

## **1. Commercial General Liability Coverage**

The Commercial General Liability (“CGL”) form is the main liability policy for most companies. It has four basic coverages, and two key benefits. They are described briefly here.

### **a. Four Primary Coverages**

The CGL form offers four primary coverages, in two parts. Coverage “A” includes coverage for “bodily injury” and “property damage.” Bodily injury and property damage coverage protect the insured against claims made for injuries to persons (including death) and physical damage to, or loss of use of, tangible property. Coverage “B” protects against claims for “personal injury” and “advertising injury.” Personal injury coverage applies to torts such as invasion of privacy, libel, slander and the like. Advertising injury coverage provides protection for certain acts, such as copyright infringement, done in the course of advertising the insured’s goods, products or services.

The CGL policy also offers two other minor coverages – medical payments and supplementary payments. These provisions cover things such as emergency medical costs and the costs of bonds and interests on judgments, respectively.

### **b. Two Primary Benefits**

In connection with these coverages, the CGL form provides two primary benefits: (1) the duty to defend; and (2) the duty to indemnify.

#### **(i) The Duty to Defend**

A typical duty to defend clause states that the insurer “will have the right and duty to defend the insured against any ‘suit’ seeking [covered] damages.” Normally, the duty to defend is determined by the allegations of the petition, considered in light of the policy provisions, without reference to the truth or falsity of such allegations. *Argonaut Southwest Ins. Co. v. Maupin*, 500 S.W.2d 633, 635 (Tex. 1973). A court can look only to the allegations in the complaint and the terms and conditions of the policy to determine if the duty arises. As one Texas court has explained:

Texas courts follow the “Eight Corners” or “Complaint Allegation” rule when determining the duty to defend action. This rule *requires* the trier of fact to

examine *only* the allegations in the [underlying] complaint and the insurance policy in determining whether a duty to defend exists. *The duty to defend is not affected by facts ascertained before suit, developed in the process of litigation, or by the ultimate outcome of the suit.*

*American Alliance Ins. Co. v. Frito-Lay, Inc.*, 788 S.W.2d 152, 153-54 (Tex. App.—Dallas 1990, writ dism'd)(emphasis added). All doubts as to whether the facts alleged in the underlying petition potentially fall within coverage are resolved in the insured's favor. *National Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc.*, 939 S.W.2d 139, 141 (Tex. 1997). Thus, where the complaint does not state facts sufficient to clearly bring the case within or without the coverage, the general rule is that the insurer is obligated to defend if there is potential coverage based on the facts alleged. *Id.* The Eastland Court of Appeals recently provided an interesting commentary on inarticulate pleading:

The “vague, broadly worded” pleadings containing a “mishmash of legal theories and factual allegations” might very well be the result of very careful, as opposed to very careless, pleading practice.

*Burlington Ins. Co. v. Texas Krishnas, Inc.*, 143 S.W.3d 226, 229 (Tex. App.—Eastland 2004, no pet.). Importantly, once coverage has been found for any portion of a suit, an insurer must defend the entire suit. *St. Paul Ins. Co. v. Tex. Dep't of Transp.*, 999 S.W.2d 881, 884 (Tex. App.—Austin 1999, pet. denied). However, there is no duty to defend where the allegations in the petition fail to state any potential grounds for recovery under the policy. If a petition “does not allege facts within the scope of coverage, an insurer is not legally required to defend a suit against its insured.” *Trinity Universal Ins. Co. v. Cowan, infra* (quoting *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 847-48 (Tex. 1994)). Therefore, when a strict application of the “complaint-allegation” rule is utilized, there can be no consideration of any facts extrinsic to the petition's allegations and the policy's language.

Despite the traditional “eight-corners” rule and the relatively strict adherence to it in Texas, there are some cases where resort to extrinsic evidence has been permitted. As a general proposition, there has been some leniency by a few Texas courts in allowing the introduction of extrinsic evidence where the evidence relates only to issues of coverage and it does not impact the merits of the underlying suit. *See, e.g. Gonzales v. American States Ins. Co.*, 628 S.W.2d 184, 186-87 (Tex. App.—Corpus Christi 1982, no writ); *but see City of Dallas v. Csaszar*, 1999 WL 1268076 (Tex. App.—Dallas Dec. 30 1999, pet. denied). At least one federal district court has held that where the facts alleged are false, the true extrinsic facts can be used in order to negate the duty to defend. *Ohio Cas. Co. v. Cooper Machinery Corp.*, 817 F. Supp. 45, 48 (N.D. Tex. 1993). Unfortunately, however, there is some uncertainty as to the present state of Texas law concerning this issue. There does appear to be stronger footing when the extrinsic evidence goes to “fundamental coverage issues” – that is, where the issue is one that goes to the very existence of coverage, rather than the nature or extent of coverage in a given case. *See, e.g. State Farm Fire & Cas. Co. v. Wade*, 827 S.W.2d 448 (Tex. App.—Corpus Christi 1992, writ denied).

Last year, the Fifth Circuit took the opportunity to consider the various possible exceptions to the eight corners rule, and made an *Erie*-guess as to what the Texas Supreme Court would hold, stating:

In light of the Texas appellate courts' unwavering unwillingness to apply and recent repudiations of the *Wade* type of exception, this Court makes its *Erie* guess that the current Texas Supreme Court would not recognize any exception to the strict eight corners rule. [H]owever, in the unlikely situation that the Texas Supreme Court were to recognize an exception to the strict eight corners rule, we conclude any exception would only apply in very limited circumstances: when it is initially impossible to discern whether coverage is potentially implicated and when the extrinsic evidence goes solely to a fundamental issue of coverage which does not overlap with the merits of or engage the truth or falsity of any facts alleged in the underlying case.

*Northfield Ins. Co. v. Loving Home Care, Inc.*, 363 F.3d 523, 531 (5<sup>th</sup> Cir. 2004).

Finally, all of this may come to a head should the Texas Supreme Court agree to accept the petition for review filed in *Fielder Road Baptist Church v. Guideone Elite Ins. Co.*, 139 S.W.2d 384 (Tex. App.—Fort Worth 2004, pet. filed). The case involved allegations of sexual misconduct, and a “stipulation” filed by the insured stated that the alleged tortfeasor ceased working for the insured *before* the Guideone policy went into effect. *Id.* at 387. Nevertheless, the court held that the evidence went to liability as well as coverage, and also that the insurer was trying to use extrinsic evidence to show the falsity of the petition’s allegations rather than simply trying to fill in a gap in the pleadings. *Id.* at 389. Thus, the court determined that the stipulation was not admissible to determine the duty to defend. *Id.* A petition for review was filed on August 2, 2004, and briefing on the merits was requested by the Court on November 3, 2004.

## (ii) The Duty to Indemnify

The duty to indemnify is separate and distinct from the duty to defend. *Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819, 821-22 (Tex. 1997). Unlike the duty to defend, the duty to indemnify is determined by the actual facts establishing liability in the underlying lawsuit. *Id.* While it has often been said that the duty to defend is broader than the duty to indemnify, there may be some circumstances where the duty to indemnify exists even in the absence of a duty to defend. In *Cowan*, the court held there was no duty to defend but then went on to say in a footnote that it did not need to decide whether the actual facts proved at trial might be sufficient to trigger the duty to indemnify. *Id.* at 826, n.5. This suggests that there might be circumstances where the duty to indemnify exists in certain instances even where the duty to defend does not. For a more definitive holding, see *Hartford Cas. Ins. Co. v. Litchfield Mut. Fire Ins. Co.*, 835 A.2d 91, 95, 102 (Conn. App. Ct. 2003)(holding the duty to indemnify existed even where it held there was no duty to defend).

As noted above, the duties to defend and indemnify are separate and distinct. This is true not only with respect to the trigger for these duties, but also with respect to their scope. While the duty to defend exists for all claims once it is triggered by a single covered claim, the duty to pay applies only to claims that are in fact covered by the policy. Under the doctrine of concurrent causes, when covered and non-covered perils combine to create a loss, the insured is entitled to recover only that portion of the damage caused solely by the covered peril. *Comsys Info. Tech. Servs., Inc. v. Twin City Fire Ins. Co.*, 130 S.W.3d 181, 198 (Tex. App.—Houston [14<sup>th</sup> Dist.] Dec. 4 2003, pet. granted). Thus, the insured must present some evidence upon

which the jury can allocate the damages attributable to the covered peril. Importantly, the insured has the burden of proof on this issue, and therefore, a failure to segregate covered and non-covered perils is an obstacle to recovery. *Id.* See also *Enserch Corp. v. Shand Morahan & Co., Inc.*, 952 F.2d 1485, 1494 (5<sup>th</sup> Cir. 1992); *Swicegood v. Med. Protective Co.*, 2003 WL 22234928 \*5 (N.D. Tex. Sept. 19, 2003). Accordingly, if the facts establishing liability that are proved at trial include both covered and non-covered damages, then an allocation must be performed in order to obtain a partial recovery of the covered damages.

In most cases, it would be entirely improper to fully adjudicate the duty to pay prior to the resolution of the underlying lawsuit. “Duty to defend issues and duty to indemnify issues involve different inquiries.” *Burlington Ins. Co. v. Texas Krishnas, Inc.*, 143 S.W.3d 226, 229 (Tex. App.—Eastland 2004, no pet.). Texas courts have repeatedly observed that the duty to indemnify must be determined by the actual facts establishing liability of the insured in the underlying lawsuit. *Cowan*, 945 S.W.2d at 821. Until those facts are determined, however, it is not possible to assess precisely what “liability” is pertinent to coverage.

Although there may be rare cases in which the duty to defend and duty to indemnify can be determined before the underlying action is resolved, these cases involve simple facts and allegations that obviously are not covered. See *Farmers Tex. County Mut. Ins. v. Griffin*, 955 S.W.2d 81 (Tex. 1997). Stated differently, the insurer “can resolve the indemnity issue before the establishment of liability in the underlying case by proving coverage is *impossible* in the underlying case.” *Roman Catholic Diocese of Dallas v. Interstate Fire & Cas. Co.*, 133 S.W.3d 887, 890 (Tex. App.—Dallas 2004, pet. denied)(emphasis added).

Federal district courts in Texas have been in conflict as to whether the duty to pay can be adjudicated prior to a settlement or judgment in the underlying lawsuit. See and compare *Monticello Ins. Co. v. Patriot Security, Inc.*, 926 F. Supp. 97, 98 (E.D. Tex. 1996)(duty to indemnify can be determined prior to resolution of the underlying lawsuit); with *Aetna Cas. & Sur. Co. v. Metropolitan Baptist Church*, 967 F. Supp. 217, 224 (S.D. Tex. 1996)(determination of the duty to indemnify “should await the outcome of the underlying state lawsuit.”). Last year, the Fifth Circuit held that when a district court determines that the duty to defend exists, the duty to indemnify becomes nonjusticiable. *Northfield Ins. Co. v. Loving Home Care, Inc.*, 363 F.3d 523, 536 (5<sup>th</sup> Cir. 2004). Importantly, the court also noted that, aside from cases where it is nonjusticiable, federal district courts also have discretion under the federal Declaratory Judgment Act to decline to grant relief as to the duty to pay. *Id.* at 536-37.

Delaying the decision on the duty to pay is particularly appropriate in view of both Texas and federal procedure on the issues of amended pleadings and trial by consent. First, the underlying lawsuit may be delayed for some reason, such as an interlocutory appeal, while the coverage lawsuit proceeds expeditiously towards resolution. Thus, it is easy for a situation to develop where the coverage gets decided on the current allegations of the underlying lawsuit, but a subsequent amendment to the pleadings before trial changes the issues in dispute. See, e.g. *Green v. Aetna*, 349 F.2d 919, 926 (5<sup>th</sup> Cir. 1965)(“[t]here is always the possibility of the damage suit plaintiff filing amended pleadings . . .”). Therefore, pre-trial developments can alter the outcome of the facts proved at trial. This is one justification for delaying the decision on the duty to pay.

A second justification for delaying the determination of the duty to indemnify is that both Texas and federal procedure recognize the doctrine of “trial by consent.” See FED. R. CIV. P. 15(b); see also *Deere & Co. v. Johnson*, 271 F.3d 613, 621-23 (5<sup>th</sup> Cir. 2001); *Roark v. Stallworth Oil & Gas, Inc.*, 813 S.W.2d 492, 495 (Tex. 1991); *Jones v. Ray Ins. Agency*, 59 S.W.3d 739, 752 (Tex. App.—Corpus Christi 2001, pet. denied).

Consequently, because pre-trial amendments and “trial by consent” can materially alter the factual findings against the insured, then the determination of the duty to pay should only be made after the facts are finally determined either by trial or settlement.

## **2. Some Specialized Liability Coverages**

Though the CGL form serves as the foundation for most commercial enterprises, it does not cover all pertinent risks. In fact, its greatest strength – the ability to cover many risks for most insureds – is also its greatest shortcoming. By being general enough to serve the major needs of most purchasers, it is not specific enough to cover all needs of every purchaser. Thus, specialized liability coverages fill in these gaps by applying in key areas where the CGL policy does not.

### **a. Excess and Umbrella Coverage**

Though these two coverages can be issued separately, they are frequently issued together in one policy. See, e.g. *Zaiontz v. Trinity Universal Ins. Co.*, 87 S.W. 3d 565, 570 (Tex. App.—San Antonio 2002, pet. denied). Where the underlying polic(ies) provide coverage, then the excess provisions simply add extra limits, usually on a “follow form” basis. Where there is no underlying coverage, then the umbrella provisions are designed to drop down to fill in the gaps. *Id.* In a recent case involving excess coverage, the Fourteenth Court of Appeals declined to apply the duty of good faith and fair dealing to an excess insurer. *Gen. Star Indem. Co. v. Spring Creek Village Apartments Phase V, Inc.*, 152 S.W.3d 733, 737 (Tex. App.—Houston [14<sup>th</sup> Dist.] 2004, no pet. h.).

### **b. Directors and Officers (“D&O”) Coverage**

Claims against senior management continue to be a critical concern for large organizations. The mean settlement amounts in securities class actions rose 33% last year.<sup>59</sup> One study reports that the “average public corporation now has a 10% chance of experiencing at least one shareholder class action suit every five years.” *Id.* Others suggest that the situation is not quite as bleak, at least with respect to outside directors.<sup>60</sup> Regardless of the true extent of potential liability, the risk and uncertainty associated with these issues over the past few years have made D&O coverage more important than ever before.

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<sup>59</sup> Rupal Parekh, *Securities Class Action Settlement Amounts Rise*, BUS. INS. DAILY NEWS, Feb. 14, 2005, available at <http://www.businessinsurance.com/cgi-bin/news.pl?newsID=5036&print=Y> (last visited Feb. 14, 2005).

<sup>60</sup> See, e.g. Bernard Black, et al., *Outside Directors and Lawsuits: What are the Real Risks*, UT LAW 28, 60 (Winter 2005)(arguing that outside directors “have little reason to fear that they will have to pay personally as a result of litigation.”).

D&O coverage is the primary insurance product for protecting corporate management. Almost always written on a claims-made basis, it provides coverage for “wrongful acts” which are broadly defined to include such things as errors, misstatements, misleading statements, omissions, or neglect. The policy requires that the alleged wrongful act be done by an insured in their capacity as a director or officer.

While recent turmoil caused by corporate scandals may drive changes to the structure of the policies, three basic coverages are available – coverage for the directors and officers themselves (“Side A” coverage), coverage for the company based on its indemnity obligations to the directors and officers (“Side B” coverage), and true entity coverage for direct liability of the company (“Side C” coverage). Entity coverage, which was originally designed to benefit insureds by eliminating the allocation problem, led to other problems when certain companies declared bankruptcy and/or their insurers attempted to rescind coverage based on fraud. Possible solutions to these problems include rewriting the policies to account for such contingencies by adding in a “priority of payments” provision, dropping entity coverage out of the policy altogether, or simply offering “Side A” coverage as a stand-alone policy.

Normally, there is no duty to defend under a D&O policy, though there is often a duty to reimburse defense costs on a current basis. Unlike a CGL policy, costs expended in defense of lawsuits typically deplete the limits of coverage.<sup>61</sup> Providing prompt notice of claims is crucial to preserving coverage under a D&O policy. *See* §V(C), *infra*. Where the insured is aware of circumstances that could give rise to a claim that has not yet been made, the insured has the ability to provide a “notice of circumstances” that will effectively attach coverage for the claim if and when it is actually made.

Like every policy, D&O coverage has certain exclusions. These commonly include exclusions for deliberately fraudulent acts, improper personal profits, and claims brought by one insured against other insureds. Given the claims-made nature of the coverage, there are also temporal limitations based on the retroactive date provided in the policy.

In short, this coverage is vital to protecting corporate management, and must be very carefully handled, from the application (and renewal) process through the claim stage. As there can be significant variance from one form to another, counsel needs pay particular attention to the actual policy at issue. Also, the law on D&O coverage is evolving in light of the recent accounting scandals and corporate governance reforms. A brief discussion of some recent issues is set forth in § VI(D), *infra*.

### **c. Corporate Counsel Coverage**

D&O coverage provides protection for the company’s senior management, which often includes high-ranking in-house counsel. Nevertheless, some D&O policies have “professional services” exclusions that negate coverage even for lawyers serving in executive positions. Lawyers in outside firms typically have professional liability coverage, but almost no companies have such legal malpractice policies. Consequently, between gaps in D&O coverage and the

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<sup>61</sup> Ironically, this very characteristic fosters settlement, as protracted litigation simply reduces the amount of money left under the policy for plaintiffs to recover. Thus, this feature helps insulate individual defendants from receiving adverse judgments that might be financially ruinous. *See* note 16, *supra*.

absence of a malpractice policy, in-house lawyers may not have any coverage for claims made against them as a result of performing their duties to the company.

Fortunately, a product designed to serve this need is available. Alternatively called “corporate counsel coverage” or “employed lawyers insurance,” it offers protection to in-house counsel for the unique risks they face as lawyers. Structured very much like a traditional D&O policy, it usually has “Side A” and “Side B” coverage to provide direct coverage to the lawyers, as well as reimbursement of indemnity payments made by the company. This line of coverage usually protects against claims for professional services rendered to the company, as well as pro bono representation of indigent or non-profit clients.

In light of the broad liabilities in-house counsel face, this coverage is designed to provide broad protection for:

- ❖ Claims by non-client third parties;
- ❖ Employment claims arising out of the attorney’s professional services provided to the company;
- ❖ SEC, bar proceedings and other administrative or regulatory claims;
- ❖ Claims by employees the attorney has been instructed to represent; and
- ❖ Claims from pro bono clients approved by the company.<sup>62</sup>

It typically carries a number of exclusions similar to D&O coverage, including ones barring coverage for things such as deliberately fraudulent acts, improper personal profits, prior acts, and ERISA claims. Like a D&O policy, it is written on a claims-made basis and allows for circumstance notice. Unlike a traditional D&O policy, however, most corporate counsel policies provide a duty to defend.

In short, this coverage is worth careful consideration for those companies seeking to provide an extra layer of protection for the unique exposures faced by today’s corporate counsel.

#### **d. Employment Practices Coverage**

With the rise in labor and employment lawsuits over time, exclusions for “employment-related practices” began to appear in many CGL policies. *See, e.g. Potomac Ins. Co. of Ill. v. Peppers*, 890 F. Supp. 634, 641 (S.D. Tex. 1995). As is often the case, once the insurance industry begins to routinely carve out particular categories of claims from one policy, it then creates a separate policy to insure this risk. That is the case here, as the insurance markets responded to the employment-related practices exclusion in the CGL form by developing “Employment Practices Liability Insurance” policies. Generally written on a “claims made and reported” basis, they cover conduct such as harassment, discrimination, wrongful termination and other employment issues.

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<sup>62</sup> For one carrier’s description of its version of this coverage, *see* <http://www.acca.com/resources/chubbandacca.pdf> (last visited March 8, 2005).

#### **e. Employer's Liability Coverage**

Workers' compensation coverage protects the employer against most claims from injured workers. However, where workers' compensation does not apply, employer's liability coverage is designed to serve as a "gap filler." See, e.g. *Producers Dairy Delivery Co., Inc. v. Sentry Ins. Co.*, 718 P.2d 920, 927-28 (Cal. 1986).

#### **f. Miscellaneous Liability Coverages**

With the breadth of activities our industrialized society fosters, there are scores of other types of coverage available in the insurance markets, including everything from specialized media liability policies for authors to venture capital policies for private equity firms to internet policies for online enterprises. New forms of coverage are constantly becoming available to deal with ever-changing risks in an ever-changing business world. Routine consultation with an experienced broker can keep the insured abreast of these developments so that coverage can constantly be updated to provide the broadest possible protection for a particular insured's exposures.

### **D. Other Commercial Insurance Coverages**

Other forms of commercial insurance exist in addition to those discussed already. Two are mentioned here as there are some recent developments to report.

#### **1. Workers' Compensation**

Given the statutory framework for protecting injured employees, obtaining workers compensation coverage usually makes sense for most companies. Often, once the policy is purchased, the company has little further involvement. However, some larger organizations can choose to self-insure this coverage. A legal challenge to this arrangement was recently rejected by the San Antonio Court of Appeals in *ExxonMobil Corp. v. Kirkendall*, 151 S.W.3d 594, (Tex. App.—San Antonio 2004, pet. filed). The court held that, so long as the workers' compensation insurance is provided by an authorized insurer, a company will not forfeit its subscriber status even if there is collateral agreements negate any real risk transfer. *Id.* at 600-01.

#### **2. Terrorism Insurance**

With the tragic events of September 11, 2001, the world saw the destructive power of terrorism on an unimaginable scale. No longer just a concern in certain parts of the world, terrorism now has a global reach. The Terrorism Risk Insurance Act of 2002 ("TRIA") provided a federal backstop to reinsure up to \$100 billion in terrorism coverage on an annual basis. It also required carriers to "make available" terrorism coverage to policyholders.

Currently, TRIA is set to expire on December 31, 2005. The Treasury department is in the process of preparing a report on the state of the terrorism market.<sup>63</sup> This report is expected to

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<sup>63</sup> Mark A. Hoffman, *Treasury Working to Complete TRIA Report*, BUS. INS. DAILY NEWS, Mar. 3, 2005, available at <http://www.businessinsurance.com/cgi-bin/news.pl?newsID=5120> (last visited Mar. 3, 2005).

have an impact on lawmakers as they consider extending the program into 2006 and beyond.<sup>64</sup> Further developments in this area should be monitored for those insureds with high-risk assets.

## V. THE “LAWYERING” OF INSURANCE ISSUES

Loss prevention and avoidance is often the least expensive form of protecting against the risk of loss. Because losses happen despite these efforts, obtaining the best insurance coverage available in the marketplace is critical to managing risks that cannot be prevented or avoided. From an insurance standpoint, the company should have an accurate inventory of all property subject to possible loss for which insurance can and should be obtained. Next, an assessment of potential risks must also be conducted to obtain a view of general hazards as well as any particularly specialized liabilities faced by the company. Once coverage is in place, claims should be handled carefully to minimize any chance of dispute. Though most claims are paid without controversy, if a dispute over a claim cannot be satisfactorily resolved, then litigation or arbitration may be necessary. This section of the paper deals with each of these issues.

### A. Placing the Coverage

Lawyers are occasionally asked to review and analyze various potential policies that the company is contemplating for purchase. A typical inquiry may involve providing copies of the various forms offered by the broker to the lawyer with a request for a recommendation as to whether one or more of the proposed policies is “adequate” for the insured’s needs. Normally, this simply seeks the lawyer’s assistance in determining which polic(ies) should be purchased.

Attorneys presented with such inquiries should be careful to understand the limitations of the analysis they are able to provide. This begins with recognition of the fact that perfect coverage does not exist. Every insurance policy has limitations on coverage that may be outcome-determinative with respect to a given loss that has yet to take place. Further, while prior loss history may provide insight as to the probability, scope and extent of potential losses, such retrospective information can never be a perfect predictor of future events. Thus, it can be exceedingly difficult to provide recommendations with any degree of certainty as to losses that have not yet occurred and about which the facts are unknown.

Understanding that perfect coverage does not exist, the next question is whether the lawyer can recommend a given policy as “adequate.” This can present a problem of incomplete information. As lawyers usually deal with insurance policies only after a loss has occurred, there is a corresponding gap in time between placement of the coverage and the happening of the loss. Sometimes this is only a short period, but other times it can be longer, especially in the case of multi-year package policies. The result of this temporal gap is that the lawyer often deals with coverage as it was being written some time ago. Consequently, lawyers do not normally have access to the most current information concerning the latest coverages available in the marketplace. New insurance products come into the marketplace all the time, and even widely-used industry language evolves over time. Further, even for those lawyers who routinely provide

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<sup>64</sup> Mark A. Hoffman, *TRIA Renewal Hinges on Treasury Analysis: Lawmaker*, BUS. INS. DAILY NEWS, Feb. 10, 2005, available at <http://www.businessinsurance.com/cgi-bin/news.pl?newsId=5020&bt=renewal> (last visited Mar. 7, 2005).

advice to insureds in the placement process by evaluating competing policy forms, information concerning premiums and deductibles is often left out of the information presented to the lawyer. These information gaps can present problems that make it difficult for many lawyers to opine on which, if any, polic(ies) should be purchased by the client.

Fortunately, brokers have such information and can bridge these gaps where lawyers often cannot. They can provide the insured with information as to the best available coverage the marketplace has to offer for the amount of premiums the insured is willing to pay. Nevertheless, if there are specific questions as to a hypothetical loss scenario or a question as to the effect of the proposed policy language in light of existing caselaw, the lawyer may be able to provide meaningful guidance on these more limited inquires.

## **B. The Claim Process**

Most claims are resolved long before reaching litigation. Thus, in order to be in a position to provide full assistance, a lawyer must be familiar with the claims process and be able to provide assistance in this arena. Also, while litigation is usually not necessary, it is always possible. Accordingly, an eye towards litigation issues is helpful as well. Normally, this can be accomplished simply by being cognizant of the policy's terms and conditions, along with an awareness that both conduct and communications may well become evidence in a subsequent lawsuit.

### **1. Property Claims**

#### **a. Assessing and Quantifying the Loss**

One of the first steps following a loss is to begin the process of assessing the damage. Determining the nature and extent of the loss is crucial not only to preparing the claim that will ultimately be submitted to the carrier but also to the process of rebuilding, repairing and returning operations to normal as soon as practicable.

If the company maintains an accurate and up-to-date inventory of its property, then the loss assessment stage can be a relatively simple matter. If, on the other hand, the loss is large and complex, then it may be advisable to engage the services of disaster recovery specialists and other similarly skilled professionals to assemble an inter-disciplinary team with the needed expertise for a comprehensive assessment of the loss.

While the insured focuses on assessing the loss, counsel can assist the process by engaging in a thorough and comprehensive analysis of the policy. This includes reviewing the insuring agreements, coverage extensions, applicable sub-limits, relevant exclusions and exceptions thereto, policy conditions, definitions, endorsements, and any other pertinent language bearing on the loss at issue.

A complete understanding of the policy enables the lawyer to ascertain the corresponding rights and obligations of the parties in conjunction with the loss, along with any potential ambiguities created by the policy's language. This allows the attorney to advise the insured on certain issues, such as the notice and proof of loss provisions in the policy.

Some claims are simple, and can be quantified with the company's own personnel and perhaps a handful of estimates from repair contractors and equipment providers. Others can be much more complex, especially those involving losses to scientific or other unique property. For these types of claims, it is often advantageous to obtain the assistance of professionals, such as accounting and technical advisors.

Just as it is important to quantify the damage to the insured's property, it is also critical to keep accurate records of all monies expended in the efforts to bring operations back up to speed. Various extensions of coverage such as "soft costs" or "claim preparation costs" may provide some coverage for these expenditures.

As noted before, because most claims are resolved during this process, the lawyer must be prepared to assist with this stage of the claim. However, it is also important to remember that litigation is always a possibility, even if a remote one at best. Therefore, in addition to providing advice on the claim process and the parties' rights and obligations under the policy, the lawyer must also bear in mind that all conduct and communications may later become evidence in a subsequent coverage dispute. While the facts of the loss may be fixed, the actions of the insured and the insurer are not. Therefore, by keeping this point in mind, the lawyer may assist the company by helping it to avoid the creation of additional problems after the loss.

## **b. Common Loss Conditions**

### **(i) Proof of Loss**

Once the loss has been assessed and quantified, and notice in accordance with the policy's provisions has been given, the insured should be prepared to begin the claim presentation process. Often, this includes the filing of a formal proof of loss. The Fourteenth Court of Appeals recently explained:

The purpose of a proof of loss is to advise the insurer of facts surrounding the loss for which a claim is being made, and to afford the insurer an adequate opportunity to investigate, to prevent fraud, and to form an intelligent estimate of its rights and liabilities.

*In Re Republic Lloyds*, 104 S.W.3d 354, 359 (Tex. App.—Houston [14<sup>th</sup> Dist.] 2003, no pet. h.)(citations omitted). Further, the court went on to note that:

[S]tatements made in proofs of loss are not conclusive as to the claimant, provided they were made in good faith and without an intent or attempt to defraud the insurer. [I]t follows, therefore, that mere mistakes or bona fide errors in a proof of loss may be corrected unless the insurer has acted upon the proofs in such a way that to permit correction would be inequitable. [T]hus, because statements in the proof of loss are merely prima facie evidence and not conclusive, the statements may be shown to have been an honest mistake or may be otherwise contradicted or explained.

*Id.* Although a proof of loss can be amended under appropriate circumstances, it is crucial that the insured have as complete an understanding as possible of the claim it intends to present so

that it can ensure a full recovery of all covered losses. The importance of this point can be seen by reviewing *Cantu Servs., Inc. v. General Star Indem. Co.*, 2003 WL 22211544 (Tex. App.—Fort Worth Sept. 25, 2003, pet. denied). There, the insured shopping center suffered damages from a hail storm. After initial negotiations concerning the damage, the insurer accepted the repair estimate from the insured’s roofing consultant. In the letter accepting the estimate, the insurer’s adjuster, James Greenhaw, stated:

No other amounts such as interior or walkway ceilings would be added as not caused by hail damage to the roof.

*Id.* at \*1-2. Two months later, the insured signed a sworn proof of loss verifying these damages and submitting a claim in accordance with the agreement. The claim was then paid by the carrier and accepted by the insured. *Id.* at \*2. A year later, the insured gave notice of a claim to its new insurer for leaks in its roof. The subsequent carrier denied coverage on the basis that the damage happened in the prior policy period. The insured then made claims against both carriers, which were denied. After suit was filed, the insured dismissed the second carrier and proceeded solely against the first. The trial court granted summary judgment on the affirmative defenses of accord and satisfaction, acceptance of benefits and waiver. After reviewing the evidence, the Court of Appeals stated:

Greenhaw made it clear that no payment was being made to Cantu Services for any damage to the “interior or ceiling walkway” because that damage was “not caused by hail damage to the roof.” Cantu Services accepted payment based on Greenhaw’s assessment without disputing his assessment that damage to the interior or ceiling walkway was not covered because it was not caused by hail damage. Therefore, Cantu Services cannot now contend that General Star is also liable for this, or other damage purportedly existing during Greenhaw’s second inspection. Cantu Services had the opportunity to dispute Greenhaw’s second assessment and Arrington’s calculations before accepting payment, but it did not do so.

*Id.* at \*3. The insured then claimed that it was unaware of the other damage until later, but the court rejected this claim based on the fact that the prior inspection revealed no such damage, and the fact that the insured “implicitly conceded” that no other hail damage existed when it accepted payment for the initial claim. *Id.* at \*3-4.

Thus, while a proof of loss is not necessarily final, acceptance of the insurer’s offer can operate to foreclose further claims under certain circumstances. Consequently, the insured must be in a position to know the extent of its damage, or at least make sure that it is not foreclosing the possibility of obtaining full coverage where the extent of the loss remains uncertain.

## (ii) Appraisal

In addition to requirements such as notice and proof of loss, another key provision is the appraisal clause. It is often invoked where there is a disagreement as to the value of the loss. One Texas court stated:

The purpose of an appraisal provision is apparently to afford a simple, speedy, inexpensive and fair method of determining the loss or damage resulting from the happening of a contingency insured against.

*Fire Ass'n of Philadelphia v. Ballard*, 112 S.W.2d 532, 534 (Tex. Civ. App.—Waco 1938, no writ). Just recently, the Texas Supreme Court reaffirmed the use of appraisal clauses, stating:

This Court distinguished between appraisal and arbitration clauses over a hundred years ago. In *Scottish Union & National Insurance Co. v. Clancy*, we concluded that while arbitration determines the rights and liabilities of the parties, appraisal merely “binds the parties to have the extent or amount of the loss determined in a particular way.” We held that appraisal clauses are enforceable. Texas courts have continued to recognize this distinction, as has the United States Court of Appeals for the Fifth Circuit. And Texas courts have enforced appraisal clauses since that decision.

*In re Allstate County Mut. Ins. Co.*, 85 S.W.3d 193 (Tex. 2002)(footnotes omitted).

Most appraisal clauses allow each party to select one appraiser, and those two then jointly select an impartial umpire. Though selection of the party-appointed appraiser can be crucial to a successful outcome, a party should not use an appraiser paid on a contingency basis. See *Gen. Star Indem. Co. v. Spring Creek Village Apartments Phase V, Inc.*, 152 S.W.3d 733, 737 (Tex. App.—Houston [14<sup>th</sup> Dist.] 2004, no pet. h.).

Appraisal clauses are useful where the parties disagree on the value of the loss. Nevertheless, like any other contract provision, they can be waived. It has been said that:

Provisions of an insurance policy requiring proofs of loss and appraisal are inserted for the insurer’s benefit and may be waived by it.

*International Serv. Ins. Co. v. Brodie*, 337 S.W.2d 414, 415 (Tex. Civ. App.—Fort Worth 1960, writ ref’d n.r.e.). *Brodie* involved a residential fire claim, and the insured argued that the proof of loss and appraisal provisions had been waived by the carrier’s conduct. The court first found that the insurer waived the proof of loss provision because it demanded an appraisal. *Id.* at 415-16. Further, the court then found the carrier failed to timely demand an appraisal, and that it did not demand an appraisal “in accordance with the terms and conditions of the policy.” *Id.* Thus, the court concluded:

It is our opinion that the procedure invoked by the Company was unwarranted and Mrs. Brodie was not required under the terms of the policy to submit to the delay, inconvenience, expense, and probable futility of such an appraisal. This suit was filed on March 12, 1959. The Company did nothing else toward having an appraisal in accordance with the terms of the policy.

“This clause of the policy (appraisal) was inserted wholly for the protection of the insurer. \* \* \* But the insurer will not be permitted to use this clause oppressively, or in bad faith.” [T]he insurer “must proceed promptly to take the necessary steps to have the amount of the loss adjusted as provided in the policy, \* \* \*.” [M]rs.

Brodie should not be maneuvered out of her right to recover the full loss by a demand that she submit to an appraisal which does not conform to the conditions set out in the policy.

*Id.* at 417 (citations omitted). Thus, the carrier waived both the proof of loss provisions as well as the appraisal provisions. It is also important to note that some appraisal provisions are optional while others are mandatory. Nevertheless, even mandatory appraisal provisions can be waived. *See, e.g. Boston Ins. Co. v. Kirby*, 281 S.W. 275, 276 (Tex. Civ. App.—Eastland 1926, no writ).

### (iii) Contractual Limitations Clause

Many property policies attempt to contractually limit the time in which suit can be brought, sometimes using periods as short as 12 months from the date of loss. Of course, any attempt to use a limitations period shorter than two years is void in this state. TEX. CIV. PRAC. & REM. CODE ANN. §16.070 (Vernon 1997). Nevertheless, counsel should be aware of these limitations and comply with them if they are enforceable. In other words, do not assume that the standard four-year limitations period applicable to contracts generally is applicable to a first-party property policy.

## 2. Liability Claims

### a. Notice

In an occurrence form, the occurrence triggers coverage. Notice, however, provides the insurer with knowledge of the suit and that it is expected to provide a defense. There is no duty to undertake the defense until notice is given. *Harwell v. State Farm Mut. Auto. Ins. Co.*, 896 S.W.2d 170, 173 (Tex. 1993).

In a claims-made form, notice is even more fundamental. It is the very act that triggers coverage. *Singleentry.com, Inc. v. St. Paul Fire & Marine Ins. Co.*, 117 Fed. Appx. 933, 936 (5<sup>th</sup> Cir. 2004). Thus, absent notice, coverage does not attach.

### b. Notice of Circumstances in Claims-Made Policies

There are, of course, some situations where the insured can reasonably expect a claim to be made, but where it has not yet been formally brought. In such a case, the claims-made forms allow for “notice of circumstances” that may later give rise to a claim. To determine how much detail is needed, the provisions of the policy are key, and the focus is whether the insured *objectively* complied with the policy’s notice provisions. *Fed. Deposit Ins. Corp. v. Mijalis*, 15 F.3d 1314, 1335 (5<sup>th</sup> Cir. 1994).

### c. Cooperation

Most policies contractually obligate the insured to cooperate with the carrier in investigating claims and in the defense of suits. It is intended to “guarantee to insurers the right to prepare adequately their defense on questions of substantive liability.” *Quorum Health Resources, L.L.C. v. Maverick County Hosp. Dist.*, 308 F.3d 451, 468 (5<sup>th</sup> Cir. 2002). If an

insured's conduct prejudices the insurer's ability to defend the lawsuit on the insured's behalf, it is a breach of the cooperation clause. Nevertheless, where the insurance company does not perform, an insured cannot "co-operate unless the [insurance] company [first] operate[s]." *Am. Fidelity & Cas. Co., Inc. v. Williams*, 34 S.W.2d 396, 405 (Tex. Civ. App.—Amarillo 1930, writ ref'd). Thus, an insurer who "wrongfully refuses to defend" cannot insist upon compliance with the policy's conditions, including the cooperation clause. *Quorum*, 308 F.3d at 468.

#### **d. Other Insurance**

Many liability policies have "other insurance" clauses designed to deal with scenarios where two or more insurers are potentially liable for the loss. Last year, the Fifth Circuit reaffirmed the "knockout" rule of conflicting other insurance clauses. Thus, where there are two or more policies that would, in the absence of the other(s), provide coverage for the loss, then the competing "other insurance" clauses will be disregarded and the insurers will be proportionally liable. *Royal Ins. Co. of Am. v. Hartford Underwriters Ins. Co.*, 391 F.3d 639, 642-43 (5<sup>th</sup> Cir. 2004)(citing *Hardware Dealers Mut. Fire Ins. Co. v. Farmers Ins. Exch.*, 444 S.W.2d 583 (Tex. 1969)).

### **C. Litigating a Coverage Dispute**

More than two centuries ago, Lord Mansfield observed that "[m]ost of the disputes in the world arise from words." *Morgan v. Jones*, 98 Eng. Rep. 587, 596 (K.B. 1773). This observation is particularly true in the context of disputes involving insurance coverage. This section of the paper presents a brief summary of some common issues in coverage litigation.

#### **1. Declaratory Judgment Actions and Breach of Contract Claims**

The declaratory judgment action is a useful tool for determining the respective rights and obligations under a given insurance contract where uncertainty exists. Essentially, it allows the parties to obtain a judicial declaration as to the coverage, if any, afforded under a policy for a particular claim. The "purpose of a declaratory judgment is to obtain a clarification of one's rights." *J.E.M. & S.J.B. v. Fidelity & Cas. Co. of N.Y.*, 928 S.W.2d 668, 671 (Tex. App.—Houston [1<sup>st</sup> Dist.] 1996, no writ). Texas adopted the Uniform Declaratory Judgment Act in 1943, and it did not take long for its utility in insurance cases to become apparent. *See Barrett v. Safety Cas. Co.*, 179 S.W.2d 537 (Tex. Civ. App.—Dallas 1944, no writ). Declaratory judgment actions are said to be "*sui generis*; they are unique in that the declarations of 'rights, status and other legal relations' are not truly legal or equitable." *Tex. Dep't of Pub. Safety v. Moore*, 985 S.W.2d 149, 156 (Tex. App.—Austin 1998, no pet.)(citations omitted).

In addition to settling rights with respect to a given claim, declaratory judgment actions can also be used for other purposes, such as obtaining a ruling as to whether a person or entity enjoys the status of an additional insured under the policy. While the use of declaratory judgment actions most often involves third-party liability claims, it should be noted that they can involve other forms of insurance, such as property coverages, as well. *See United States Aircraft Ins. Group v. Dwiggins, L.L.C.*, 2003 WL 22432915 \*3 (D. Del. Oct. 15, 2003).

An important procedural consideration involves forum selection issues. Though the substantive rules of decision should be the same in either federal or state court, important

differences exist in procedural issues, such as whether the underlying plaintiff is a proper party to a suit involving liability coverage. One important difference is the recovery of attorneys' fees. In Texas state court actions, the trial court has discretion to award attorney's fees in a declaratory judgment case. The Texas Declaratory Judgment Act provides four limitations on the trial court's discretion for such an award: (1) the fees must be reasonable; (2) they must be necessary; (3) they must be equitable; and (4) they must be just. *Id.* See also *Bocquet v. Herring*, 972 S.W.2d 19, 21 (Tex. 1998).

Once the act is properly invoked, the court can award fees as it sees fit in accordance with the statutory guidelines above. *Templeton v. Driess*, 961 S.W.2d 645 (Tex. App.—San Antonio 1998, pet. denied). This applies to any party, regardless of whether that particular party sought declaratory relief or not. *GeoChem Tech Corp. v. Verseckes*, 929 S.W.2d 85, 92 (Tex. App.—Eastland 1996), *rev'd on other grounds*, 962 S.W.2d 541 (Tex. 1998). Thus, an award of attorney's fees under the act is not limited to the plaintiff or the party seeking affirmative relief. *Id.* However, it is well-settled that the federal Declaratory Judgment Act does not allow the award of attorney's fees in diversity cases that "would not otherwise be available under state law." *Utica Lloyd's of Tex. v. Mitchell*, 138 F.3d 208, 210 (5<sup>th</sup> Cir. 1998); see also *Titan Holdings Syndicate, Inc. v. City of Keene, N.H.*, 898 F.2d 265, 273 (1<sup>st</sup> Cir. 1990). Further, the "otherwise available" state law must be substantive. *Utica Lloyd's of Tex. v. Mitchell, supra* (citing *Mercantile Nat'l Bank v. Bradford Trust Co.*, 850 F.2d 215, 216 (5<sup>th</sup> Cir. 1988)(holding that fees in a federal declaratory judgment action are available only where the restrictive American rule permits such awards or where *controlling substantive law* permits recovery)(emphasis original)).

In *Utica Lloyd's of Tex. v. Mitchell*, the court went on to hold that Chapter 37 of the Texas Civil Practice and Remedies Code allowed the recovery of attorney's fees in a declaratory judgment action, but also held that the statute was procedural rather than substantive. Consequently, the court stated:

[W]e now hold, that a party may not rely on the Texas [Declaratory Judgment Act] to authorize attorney's fees in a diversity case because the statute is not substantive law.

*Id.* at 210. Therefore, the Fifth Circuit established that an insurer cannot rely upon the provisions of the Texas Declaratory Judgment Act to recover its attorney's fees in a coverage dispute. The attorneys' fees issue is just one example of how the forum in which the battle is waged may make a difference as to the ultimate outcome.

Declaratory judgment actions work particularly well in disputes over the duty to defend. There, the carrier can provide a defense subject to a reservation of rights and then seek a judicial declaration concerning coverage. If the dispute ripens into an outright denial of coverage, then a breach of contract claim is warranted.

## **2. Extra-Contractual Claims**

There are extra-contractual claims that can be considered in addition to a suit for declaratory judgment and/or breach of contract. Here are the basic forms of extra-contractual claims under Texas law.

### **a. The Texas Insurance Code**

The Texas Supreme Court has noted that the Insurance Code is “somewhat different from Texas’s other statutory codifications in that it is not a formal, unified Code containing uniform definitions.” *Dallas Fire Ins. Co. v. Tex. Contractors Surety & Cas. Agency*, 2004 WL 2913657 (Tex. Dec. 17, 2004). Thus, it is very important to focus on the actual statute involved rather than looking at in the context of the entire code.

#### **(i) TEX. INS. CODE ANN. Chapter 541**

Chapter 541 of the Texas Insurance Code is the primary vehicle for asserting statutory bad faith claims in Texas. The main prohibitions are set forth in §541.060. Some of the more commonly used provisions include:

- (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to engage in the following unfair settlement practices with respect to a claim by an insured or beneficiary:
  - (1) misrepresenting to a claimant a material fact or policy provision relating to coverage at issue;
  - (2) failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of:
    - (A) a claim with respect to which the insurer's liability has become reasonably clear; or
    - (B) a claim under one portion of a policy with respect to which the insurer's liability has become reasonably clear to influence the claimant to settle another claim under another portion of the coverage unless payment under one portion of the coverage constitutes evidence of liability under another portion;
  - (3) failing to promptly provide to a policyholder a reasonable explanation of the basis in the policy, in relation to the facts or applicable law, for the insurer's denial of a claim or offer of a compromise settlement of a claim;
  - (4) failing within a reasonable time to:

- (A) affirm or deny coverage of a claim to a policyholder; or
  - (B) submit a reservation of rights to a policyholder;
- (5) refusing, failing, or unreasonably delaying a settlement offer under applicable first-party coverage on the basis that other coverage may be available or that third parties are responsible for the damages suffered, except as may be specifically provided in the policy;
- (6) undertaking to enforce a full and final release of a claim from a policyholder when only a partial payment has been made, unless the payment is a compromise settlement of a doubtful or disputed claim;
- (7) refusing to pay a claim without conducting a reasonable investigation with respect to the claim;
- (8) with respect to a Texas personal automobile insurance policy, delaying or refusing settlement of a claim solely because there is other insurance of a different kind available to satisfy all or part of the loss forming the basis of that claim; or
- (9) requiring a claimant as a condition of settling a claim to produce the claimant's federal income tax returns for examination or investigation by the person unless:
- (A) a court orders the claimant to produce those tax returns;
  - (B) the claim involves a fire loss; or
  - (C) the claim involves lost profits or income.
- (b) Subsection (a) does not provide a cause of action to a third party asserting one or more claims against an insured covered under a liability insurance policy.

§541.061 prohibits:

- (a) making an untrue statement of material fact;
- (b) failing to state a material fact that is necessary to make other statements made not misleading, considering the circumstances under which the statements were made;
- (c) making a statement in such manner as to mislead a reasonably prudent person to a false conclusion of a material fact;

- (d) making a material misstatement of law; or
- (e) failing to disclose any matter required by law to be disclosed, including a failure to make disclosure in accordance with another provision of this code.

TEX. INS. CODE ANN. §541.061 (Vernon Supp. 2004-05). Under §541.152 of the statute, a plaintiff may recover its actual damages plus court costs and reasonable and necessary attorney's fees. *Id.* If the jury finds that the statutorily proscribed conduct was committed "knowingly," then it may also award up to three times the amount of actual damages as additional exemplary damages. *Id.*

There is some uncertainty as to the nature of the damages required in order to obtain a recovery under the statute. Recent Texas cases suggest the statute requires an injury that is independent from the denial of policy benefits. *See Provident Am. Ins. Co. v. Castaneda*, 988 S.W.2d 189, 198-99 (Tex. 1998); *see also Parkans Int'l, Inc. v. Zurich Ins. Co.*, 299 F.3d 514, 519 (5<sup>th</sup> Cir. 2002); *United Servs. Auto. Ass'n v. Gordon*, 103 S.W.3d 436, 442 (Tex. App.—San Antonio 2002, no pet.); *but see Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129 (Tex. 1988), and *Waite Hill Servs., Inc. v. World Class Metal Works, Inc.*, 959 S.W.2d 182 (Tex. 1998). Consequently, it is vital for an insured to carefully examine the full measure of its damages to see if an "independent injury" can be shown.

**(ii) TEX. INS. CODE ANN. CHAPTER 542**

Entitled "Prompt Payment of Claims," Subchapter B of Chapter 542 serves to encourage just that – prompt payment of claims. If an insurer delays payment of a valid claim more than sixty days after it has received all information reasonably necessary to determine coverage, then it violates Chapter 542 and must pay the damages required under the statute. TEX. INS. CODE ANN. art. 542.058. The Texas Supreme Court has construed Article 21.55 as a strict liability statute – if an insurer fails to timely acknowledge and/or pay valid claims, then Chapter 542 damages are automatic. *Allstate Ins. Co. v. Bonner*, 51 S.W.3d 289, 291 (Tex. 2001). There is no "good faith" exception to the statute. *See, e.g. Higginbotham v. State Farm Mut. Auto. Ins. Co.*, 103 F.3d 456, 461 (5<sup>th</sup> Cir. 1997). Damages for violation of Chapter 542 are set forth as follows:

- (a) If an insurer that is liable for a claim under an insurance policy is not in compliance with this subchapter, the insurer is liable to pay the holder of the policy . . . in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

TEX. INS. CODE ANN. §542.060. This serves as an incentive to carriers to promptly investigate and dispose of claims. Whether it applies to claims involving the duty to defend is an ongoing debate discussed in §VI(B), *infra*.

## **b. Common-Law**

Certain common-law claims exist as well. Essentially, there are two: the duty of good faith and fair dealing; and the *Stowers* duty.

### **(i) Duty of Good Faith and Fair Dealing**

Often shortened simply to “bad faith,” the duty of good faith and fair dealing requires insurers to “attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim with respect to which the insurer’s liability has become reasonably clear.” *Universe Life Ins. Co. v. Giles*, 950 S.W.2d 48, 56 (Tex. 1997). This is the same standard set forth in TEX. INS. CODE ANN. art. 21.21 §4(10)(ii). Notably, the duty of good faith and fair dealing does not apply in the third party context. *Maryland Ins. Co. v. Head Indus. Coatings & Servs., Inc.*, 938 S.W.2d 27, 28-29 (Tex. 1996)(per curiam).

### **(ii) *Stowers***

Last year, the *Stowers* case celebrated its seventy-fifth anniversary as a landmark of Texas law. Also called the “duty to settle,” the *Stowers* doctrine requires that liability insurers accept reasonable settlement demands at or within the policy’s limits. *G.A. Stowers Furniture Co. v. Am. Indem. Co.*, 15 S.W.2d 544 (Tex. Comm’n App. 1929, holding approved). Further, a violation of the *Stowers* duty is also a violation of TEX. INS. CODE ANN. art. 21.21. *Rocor Int’l, Inc. v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA*, 77 S.W.3d 253, 255 (Tex. 2002).

## **3. Choice of Law**

Ordinary declaratory judgment actions do not contain extensive choice-of-law problems. However, where such problems do exist, the outcome of the choice-of-law analysis can be determinative of the controversy. Such situations can arise where the insured is based in State A, the carrier is based in State B, and the underlying litigation is pending in State C. This segment of the paper will highlight certain issues relevant to the determination of what law is to be applied to the dispute.

Of course, the first step in any conflicts analysis is to determine whether there is in fact a true conflict. If both states have the same law as to a given issue, then a false conflict exists and further analysis is pointless. In other words, the Texas Supreme Court observed:

In order to resolve the [conflict issue] we must first determine whether there is a difference between the rules of Texas [and the other state(s) involved].

*Duncan v. Cessna Aircraft Co.*, 665 S.W.2d 414, 419 (Tex. 1984).

### **a. Statutory Provisions**

Where applicable, TEX. INS. CODE ANN. art. 21.42 provides:

Art. 21.42. Texas Laws Govern Policies

Any contract of insurance payable to any citizen or inhabitant of this state by any insurance company or corporation doing business within this State shall be held to be a contract made and entered into under and by virtue of the laws of this State relating to insurance and governed thereby, notwithstanding such policy or contract of insurance may provide that the contract was executed and the premiums and policy (in case it becomes a demand) should be payable without this State, or at the home office of the company or corporation issuing the same.

TEX. INS. CODE ANN. art. 21.42 (Vernon 1981).

**b. Case Law**

The Texas Supreme Court adopted the modern approach of the Second Restatement of Conflict of Laws in *Duncan*. After criticizing the inherent defects and “numerous inadequacies” found in the traditional *lex loci* rules, the court endorsed the “most significant relationship” approach of the Second Restatement, stating that it “produces reasoned choice of law decisions grounded in those specific governmental policies relevant to the particular substantive issue.” *Id.* at 421. Adopting the modern Restatement’s approach, the court said:

[C]onsequently, the *lex loci* rules will no longer be used in this state to resolve conflicts problem. Instead, in all choice of law cases, except those contract cases in which the parties have agreed to a valid choice of law clause, the law of the state with the most significant relationship to the particular substantive issue will be applied to resolve that issue.

*Id.* *Duncan* has been continually reaffirmed as the law in Texas. See *Minnesota Mining & Mfg. v. Nishika Ltd.*, 953 S.W.2d 733, 735 (Tex. 1997); *Maxus Exploration Co. v. Moran Bros., Inc.*, 817 S.W.2d 50, 53 (Tex. 1991); *DeSantis v. Wackenhut*, 793 S.W.2d 670, 679 (Tex. 1990).

For larger insureds, the “uniform contract interpretation” approach is used by many courts where the insurance policy is intended to cover insureds that have nationwide risks. In other words, where the insured regularly does business in several different states, its insurance coverage should be determined by the law of a single state – the one with the most significant contacts to the policy at issue. See, e.g., *Sandefur Oil & Gas, Inc. v. AIG Oil Rig of Tex. Inc.*, 846 F.2d 319, 324-25 (5<sup>th</sup> Cir. 1988). Nevertheless, as will be shown in *Scottsdale Ins. Co. v. Nat’l Emergency Servs., Inc.*, *infra*, it is important to remember *Duncan*’s concluding remark – “the law of the state with the most significant relationship to the particular substantive issue will be applied to resolve that issue.”

In *Reddy Ice Corp. v. Travelers Lloyds Ins. Co.*, 145 S.W.3d 337 (Tex. App.—Houston [14<sup>th</sup> Dist.] 2004, pet. denied), the court began by noting that it was faced with a true conflict. It then observed that the determination of which state’s law applied was a question of law for the court to decide. *Id.* at 340 (citing *Torrington Co. v. Stutzman*, 46 S.W.3d 829, 848 (Tex. 2000)). The court then began its analysis under art. 21.42, which called on it to decide an issue of first impression – whether a corporation’s principal place of business is the place it “inhabits” within the meaning of the statute. Importantly, the court also added that the key inquiry focused on the actual insured claiming coverage, not just the named insured. *Id.* at n.4. After analyzing

historical conceptions of corporate domicile, the court concluded that “inhabitant” meant the state of incorporation, and did not also extend to its principal place of business. *Id.* at 342-44. Finding art. 21.42 inapplicable on that basis, the court then went on to analyze the case under the “most significant relationship” test. To begin with, the relevant question is what contacts the state has with the coverage dispute, not the underlying action. *Id.* Because the policies provided nationwide coverage, the “primary factors” to be examined were the place of contracting, the place of negotiation, and the domicile, residence, nationality, place of incorporation and place of business of the parties. Applying these factors, the court found that most of the contacts centered in Texas. Thus, Texas law controlled. *Id.* at 346.

*Scottsdale Ins. Co. v. Nat’l Emergency Servs., Inc.*, 2004 WL 1688540 (Tex. App.—Houston [1<sup>st</sup> Dist.] 2004, pet. denied), is another recent choice-of-law case. This case was a dispute about premiums, rather than coverage. *Id.* at \*2. Like *Reddy Ice*, the court first determined that art. 21.42 did not apply. It then undertook a comprehensive analysis of the Restatement factors using the relevant sections for general conflicts analysis, contract actions, general tort actions, and fraud and misrepresentation claims. It concluded that Texas law applied, given that the action was filed in Texas and the relationship was also centered in Texas. *Id.* at \*9. Of significance, however, is one point made at the conclusion of its analysis – the fact that Texas had a private cause of action for unfair or deceptive insurance practices while Virginia did not. Thus, the court held that it would not allow an insurer to evade the protections afforded by the Texas Insurance Code by merely selecting as the first named insured one from a state with no such protections. *Id.*

#### **4. Burden of Proof**

##### **a. Proving Coverage**

Under Texas law, the insured has the initial burden of proving that the loss is covered by the policy. *See, e.g. Employers Cas. Co. v. Block*, 744 S.W.2d 940, 945 (Tex. 1988). Typically, this involves satisfying the insuring agreement, any conditions precedent to coverage, and other policy requirements that must be met for coverage to attach.

##### **b. Proving an Exclusion**

Where the insured has met the initial burden of proof, TEX. INS. CODE ANN. art. 21.58(b) comes into play. It provides:

(b) In any suit to recover under a contract of insurance, the insurer has the burden of proof as to any avoidance or affirmative defense that must be affirmatively pleaded under the Texas Rules of Civil Procedure. Any language of exclusion in the policy and any exception to coverage claimed by the insurer constitutes an avoidance or an affirmative defense.

TEX. INS. CODE ANN. art. 21.58(b)(Vernon Supp. 2002). Therefore, the insurer must plead and prove the applicability of any exclusion or other coverage-negating language.

**c. Proving an Exception to an Exclusion**

Once the insurer has satisfied its statutory burden, the insured must demonstrate the existence of facts sufficient to show that the loss falls within an exception to the exclusion at issue. *Telepak v. United Servs. Auto. Ass'n*, 887 S.W.2d 506, 507-08 (Tex. App.—San Antonio 1994, writ denied).

**5. Using Loss Conditions as a Defense to Coverage – Prejudice is (Probably) Required**

Where the coverage defense at issue is the alleged violation of a policy condition, Texas law imposes a higher burden on insurers than it does for policy exclusions. This section of the paper will analyze this issue, beginning with the most important decision on this point, a 1994 opinion from the Texas Supreme Court, and then turning to some other relevant cases.

**a. *Hernandez v. Gulf Group Lloyds***

In *Hernandez*, the Texas Supreme Court began by framing the issue as follows:

In this cause, we consider whether an insurer may deny an uninsured/underinsured motorist claim on the basis of a “settlement without consent” exclusion clause absent any showing that the settlement prejudiced the insurer.

*Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691, 692 (Tex. 1994). In addition, the court also set forth its conclusion at the beginning of the opinion, stating:

We hold that an insurer may escape liability on the basis of a settlement-without-consent exclusion only when the insurer is actually prejudiced by the insured’s settlement with the tortfeasor.

*Id.* The case arose out of a car accident resulting in the death of a passenger. Pursuant to a stipulation, the sole proximate cause of the accident was the negligence of the driver of the vehicle. The driver was nineteen years old, and his sole asset was a \$25,000 automobile liability policy. The decedent was covered by her parents’ automobile policy, with uninsured/underinsured (“UM/UIM”) limits of \$100,000. *Id.* Thus, the damages exceeded available coverage limits.

Six weeks following the accident, the decedent’s parents entered into a settlement with the driver for his policy limits, without the consent of the insurer. When the parents then sought recovery of the policy limits from their UM/UIM coverage, the carrier denied based upon the “settlement without consent” clause. *Id.* at 692. The court noted that the insureds did not question the validity of the clause, but instead:

They argue, however, that such an exclusion is unenforceable absent a showing by the insurer that it has been prejudiced by an insured’s failure to obtain consent before settling with an uninsured or underinsured motorist. We agree.

*Id.* The court then went on to note:

A fundamental principle of contract law is that when one party to a contract commits a material breach of that contract, the other party is discharged or excused from any obligation to perform.

In determining the materiality of a breach, courts will consider, among other things, the extent to which the nonbreaching party will be deprived of the benefit that it could have reasonably anticipated from full performance. The less the nonbreaching party is deprived of the expected benefit, the less material the breach.

*Id.* at 692-93 (internal citations omitted). The court also observed that other factors are relevant to the determination of materiality, including:

(i) the extent to which the injured party can be adequately compensated for the part of that benefit of which he will be deprived; (ii) the extent to which the party failing to perform or to offer to perform will suffer forfeiture; (iii) the likelihood that the party failing to perform or to offer to perform will cure his failure, taking account of all the circumstances including any reasonable assurances; (iv) the extent to which the behavior of the party failing to perform or to offer to perform comports with standards of good faith and fair dealing.

*Id.* at 693, n.2 (citing Restatement (Second) of Contracts § 241 (1981)). Consequently, the court has adopted a functional approach to this issue. Where prejudice exists, coverage does not. Where prejudice is absent, coverage cannot be avoided by an immaterial breach.

In *Hernandez*, the court held that no prejudice existed because no valid subrogation claim was extinguished by the insured's unilateral settlement with the driver. Given the relatively low liability limits, the fact that consent to settlement is given almost as a matter of course in such cases, and that the driver was judgment proof, the insurer was in essentially the same position it would have been in had consent been obtained. In either case, it would not have had a viable subrogation claim on these facts. *Id.* at 693-94. *Hernandez* was an 8-1 opinion, with Justice Enoch dissenting. The dissent pointed out that historically the Texas courts did not require prejudice because the policies themselves did not require prejudice, and that the real point of this clause is to protect insurers' subrogation rights even where no prejudice might result. *Id.* at 694-95. Despite Justice Enoch's dissent, however, subsequent treatment of *Hernandez* has sided squarely the majority's view.

**b. *Hanson Prod. Co. v. Americas Ins. Co.***

*Hanson Prod. Co. v. Americas Ins. Co.* involved a "notice of claim" provision instead of a "settlement without consent" provision. *Hanson Prod. Co. v. Americas Ins. Co.*, 108 F.3d 627, 628 (5<sup>th</sup> Cir. 1997). Suit was first brought against the insured in October 1991, and an amended petition was filed in August, 1993. Notice was not given until January, 1994. *Id.* at 628.

After trial of the underlying suit, a settlement was reached but the insurer refused to fund it, relying upon the defense of late notice. The court was "strongly influenced by the Texas

Supreme Court’s decision” in *Hernandez*, and noted that “the court’s reasoning was straightforward.” *Id.* at 630. Continuing, the Fifth Circuit held:

We believe that the reasoning of *Hernandez* applies with equal if not greater force to a notice-of-occurrence, notice-of-claim, or notice-of-suit clause. The fundamental principle of contract law recognized in *Hernandez*—that a material breach by one contracting party excuses performance by the other party, and an immaterial breach does not—is equally applicable to notice cases. [I]f anything, we believe that the failure to give notice of a claim poses a smaller risk of prejudice than failure to obtain consent to a settlement. In many instances of untimely notice of a claim, the insurer is not prejudiced at all, and ultimately may not face any coverage obligation. Conversely, in any if not most cases where an insured settles a case without the insurer’s consent, the insurer faces at least some liability. If the Texas Supreme Court does not presume prejudice in a settlement-without-consent case, we are persuaded that it would not presume prejudice in a failure-of-notice case.

*Id.* at 630-31 (emphasis original). Lastly, the court noted that this approach was the modern trend in other jurisdictions, and that this additional reason supported its *Erie*-guess.

### **c. Exceptions to the Prejudice Requirement**

#### **(i) Claims-Made Policies**

Though the prejudice requirement has been adopted in other contexts, Texas courts have repeatedly held that it does not apply to claims-made policies. For instance, in *Hirsch v. Tex. Lawyers Ins. Exch.*, 808 S.W.2d 561, 565 (Tex. App.—El Paso 1991, writ denied), the court stated:

Hirsch contends that notice-prejudice is applicable to claims-made policies. However, the clear intent and purpose of claims-made policies is to cover periods listed. *Yancey v. Floyd West & Company*, 755 S.W.2d 914. To require a showing of prejudice for late notice would defeat the purpose of “claims-made” policies, and in effect, change such a policy into an “occurrence” policy.

*Id.* See also *Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co.*, 174 F.3d 653, 660 (5<sup>th</sup> Cir. 1999)(“Whether St. Paul suffered prejudice as a result of Matador’s late notice is irrelevant.”); *Singleentry.com, Inc. v. St. Paul Fire & Marine Ins. Co.*, 117 Fed. Appx. 933, 936 (5<sup>th</sup> Cir. 2004).

#### **(ii) Coverage “B” of the CGL Policy**

The Fifth Circuit affirmed a district court’s holding that the “notice prejudice” rule did not apply in the context of “Coverage B.” *Gemmy Indus. Corp. v. Alliance Gen. Ins. Co.*, 1999 WL 33644433 (5<sup>th</sup> Cir. Nov. 5, 1999). See also *New Era of Networks, Inc. v. Great Northern Ins. Co.*, 2003 WL 23573645 (S.D. Tex. Aug. 5, 2003); but see *St. Paul Guardian Ins. Co. v. Centrum G.S., Ltd.*, 2003 WL 22038321 (N.D. Tex. Aug. 29, 2003).

**d. *Ridglea Estate Condominium Ass'n v. Lexington Ins. Co.***

Finally, earlier this year the Fifth Circuit again spoke to the issue of whether prejudice is required. In *Ridglea Estate Condominium Ass'n v. Lexington Ins. Co.*, 2005 WL 121877 (5<sup>th</sup> Cir. Jan. 21, 2005), the Fifth Circuit again followed *Hernandez* and *Hanson*, stating:

We conclude that the prejudice requirement applies equally to all insurance policies issued in Texas, including the property insurance policy at issue here. As such, we hold that the district court erred in holding that Lexington was not required to show prejudice in order to raise breach of the policy's prompt notice provision as a defense.

*Id.* at \*6 (footnote omitted). Interestingly, just six weeks before issuing its opinion in *Ridglea*, the court decided *Singleentry.com, Inc. v. St. Paul Fire & Marine Ins. Co.*, 117 Fed. Appx. 933, 936 (5<sup>th</sup> Cir. 2004), declaring that “[a] showing of prejudice is required only in narrowly defined cases involving bodily injury and property damage.” *Singleentry.com* was a claims-made policy, so the court's ruling was consistent with other claims-made cases.

As a result of these conflicting precedents, the precise state of Texas law on this point is uncertain at the moment. Thus prudence dictates that, in the event of a possible claim, notice should be given as soon as possible under every potentially applicable policy. Aside from the claims-made context, though, it appears that an insurer will most likely have to establish prejudice in order to rely upon violation of a policy condition to avoid coverage.

**e. *Examples of Prejudice***

Prejudice can sometimes be a flexible concept. Recently, the Northern District of Texas gave some concrete examples. In a case where notice was given more than four years after the accident and three months after entry of judgment, the court held:

The case was in a decidedly different posture than it would have been if Clarendon had received the notice that was required under the Policy. Clarendon was deprived of the opportunity to investigate the accident, to contribute to the development of a defense strategy, to participate in the lawsuit, to evaluate the settlement demands, to accept or reject any of the settlement demands, or to otherwise represent its interests during the pendency of the underlying litigation. These rights were guaranteed to Clarendon under the Policy, and they were foreclosed by the lack of notice of the claim. The late notice's foreclosing those rights prejudiced Clarendon.

*Clarendon Nat'l Ins. Co. v. FFE Transport. Servs., Inc.*, 2004 WL 3210604 \*6 (N.D. Tex. Nov. 26, 2004). Importantly, the court went on to declare that it was “irrelevant” that the insured had a competent lawyer who vigorously defended the suit. *Id.* The fact that the carrier was deprived of the right to settle the case was sufficient to establish prejudice. *Id.*

#### **D. Additional Insured Issues**

Contractual obligations to procure insurance are not unusual. *O.R. Mitchell Motors, Inc. v. Joe Marotta & Sons, Inc.*, 358 S.W.2d 741, 743 (Tex. Civ. App.—San Antonio 1962, no writ). Texas law has long recognized that “a suit will lie for a breach of the obligation to procure insurance.” *Id.* For example, in *Texas Van Lines v. Godfrey*, 313 S.W.2d 922 (Tex. Civ. App.—Dallas 1958, writ ref’d n.r.e.), the court stated:

Appellant’s liability is not predicated on the theory that appellant itself was the insurer. It is predicated on the theory that appellant breached its contract to obtain insurance coverage for appellee.

*Id.* at 925. Finding ample evidence to support the contract claim, the court affirmed the trial court’s judgment in favor of the plaintiff in the amount of \$1,000 – the same amount of insurance requested by the plaintiff. *Id.* at 923-26. Just a few weeks ago, the Corpus Christi Court of Appeals held:

Coastal’s motion established its entitlement to summary judgment on its breach of contract claim. Coastal proved the existence of a valid contract, which it performed and SWBT breached by failing to indemnify Coastal and to maintain insurance. Coastal also proved that it suffered damages: it did not receive indemnity and insurance benefits. We therefore hold that Coastal was entitled to judgment as a matter of law on its claim for breach of contract.

*Coastal Mart, Inc. v. Southwestern Bell Tel. Co.*, 2005 WL 110442 \*6 (Tex. App.—Corpus Christi Jan. 20, 2005, no pet. h.). Similar results can be found in *Horizon Petroleum Co. v. Barges Dixie 162, 234 & 236*, 753 F.2d 382, 384-85 (5<sup>th</sup> Cir. 1985)(“The plaintiffs, by procuring cargo insurance policies that prohibited assignment of policy benefits, breached their . . . contracts with Dixie.”); *Doherty v. Davy Songer, Inc.*, 195 F.3d 919, 921-26 (7<sup>th</sup> Cir. 1999)(“Part of their contract required Morrison to procure insurance . . . [M]orrison’s insurer rejected the claim because it did not fall under the insurance policy Morrison had obtained. [B]y failing to procure the required insurance, Morrison is responsible for resulting damages . . .”). Notably, courts have not made a distinction between a failure to procure any policy versus a failure to procure an adequate policy. Regardless of the way in which the proper coverage was not obtained, it is a breach nonetheless. *See and compare Godfrey* (no policy), *with Doherty* (inadequate policy).

## **VI.**

### **PRACTICAL TIPS FOR HANDLING INSURANCE ISSUES**

Insurance is one of the most valuable assets the company has. Too often, it is also one of the most neglected and least understood. Here are ten tips for maximizing its value.

**1. Read the Policy.**

This is important, because the policy is the contract that governs the rights and obligations of the parties. In fact, the insured has a legal duty to read the policy. *Ruiz v. Gov't Emp. Ins. Co.*, 4 S.W.3d 838, 842 (Tex. App.—El Paso 1999, no pet.). Besides, even if the insured fails to do so, it will still be charged with knowledge of the policy's terms and conditions. *Id.*

**2. Read the Policy. Again.**

**3. Loss Prevention is Best, But Loss Mitigation is the Next Best Thing.**

Though it is almost always cheaper to prevent losses altogether, they occur despite these efforts. When they do, a comprehensive suite of key coverages will help mitigate the loss to the company. Most risks can be managed through insurance, leaving the company free to move its business forward. But this can only occur if the insurance portfolio is routinely reviewed and kept up to date in order to fully protect the company.

**4. It (usually) Never Hurts to Ask.**

When reviewing a proposed policy, consider whether certain changes could make it more favorable. If so, then balance the benefit to be obtained by making them against the possible loss of *contra proferentem* should a dispute arise. In jurisdictions with a “sophisticated insured” exception that negates *contra proferentem*, it is almost always beneficial to try to negotiate the policy's terms, as the insured has nothing to lose and much to gain. Though insurance companies often say “take it or leave it,” this is not always true.

**5. Review New Policies When They Arrive.**

When a new policy arrives, review it to make sure that the coverage quoted is the same as what was actually provided. Do not assume that the policy was correctly prepared, especially where manuscripted provisions are present.

**6. Additional Insured Status – Treat the Coverage Like it Was Your Own.**

When added to another's policy as an additional insured, the company should treat that coverage as if it were its own for one simple reason – it is. Thus, it should be routine practice to always ask for the actual policies from counter-parties. It is easier to fix problems before the loss happens than it is afterwards.

**7. Always Keep the Policies.**

Since the insured has the burden of proving coverage, this is usually easier to accomplish with a copy of the policy. Further, occurrence-based forms exist in perpetuity, and can often provide coverage years after the acts giving rise to the claim occurred. Thus, as with any valuable papers, all policies should be safeguarded.

## **8. Comply with the Policy – Coverage May Depend on It.**

Compliance is critical, and coverage may depend on it.

A cautionary tale concerning compliance with the policy’s description of covered property can be found in *Evergreen Nat’l Indem. Co. v. Tan It All, Inc.*, 111 S.W.3d 669 (Tex. App.—Austin 2003, no pet.). In *Tan It All*, the policy provided coverage for the insured’s “business personal property” located in or within 100 feet of the described premises. Approximately \$45,000 of tanning equipment was stolen from one of the insured’s trucks, which was parked some 280 feet from the actual suite occupied by the insured. Because the policy identified the actual suite used by the insured, the court concluded that, in order for coverage to attach, the property must have been located in or within 100 feet of the insured’s suite. As the truck (and hence, the stolen property) was not within this limitation, then there was no coverage for the loss. *Id.* at 677-78. The difference between a covered claim and a non-covered claim in this case was 180 feet – a little more than half the length of a football field. Once coverage is in place, the insured should make every effort to ensure compliance with any limitations on coverage, or it should seek a suitable modification of the policy for instances where compliance is not possible given the particular circumstances surrounding the insured premises.

Compliance with notice provisions and other loss conditions is also critical. When deciding whether to give notice, err on the side of disclosure. Though “better late than never” may apply, sooner is always better than later. When deciding how much detail to provide in a circumstance notice, err on the side of more facts rather than less.

## **9. Never Assume There is No Coverage.**

Better to check and make sure. An initial determination of whether a potential claim exists can usually be made within a couple of hours. This almost always is time well spent.

## **10. When You Think There is No Coverage, Look for Another Route.**

Sometimes it is easy to conclude that a given loss is not covered by a given policy. Occasionally, these determinations are wrong. When you think that a loss is not covered, look again. Then look for another route. Is there another claim that can be made under the policy? Is there another policy that might respond?

## **VII. CONCLUSION**

Unfortunately, commercial enterprises large and small face a tremendous variety of risks in today’s world. Fortunately, however, many of these risks can be dealt with through insurance. Critically assessing a company’s risks and obtaining the proper types and amounts of necessary coverage is the first step. From there, understanding the core coverage concepts and the procedural issues will help resolve any claims that occur. Should a claim ultimately result in litigation, an informed and knowledgeable policyholder is more likely to obtain a fair result than an unformed one. By engaging in each of these activities, the company should have an understanding of the risks it faces and be well prepared to deal with them.