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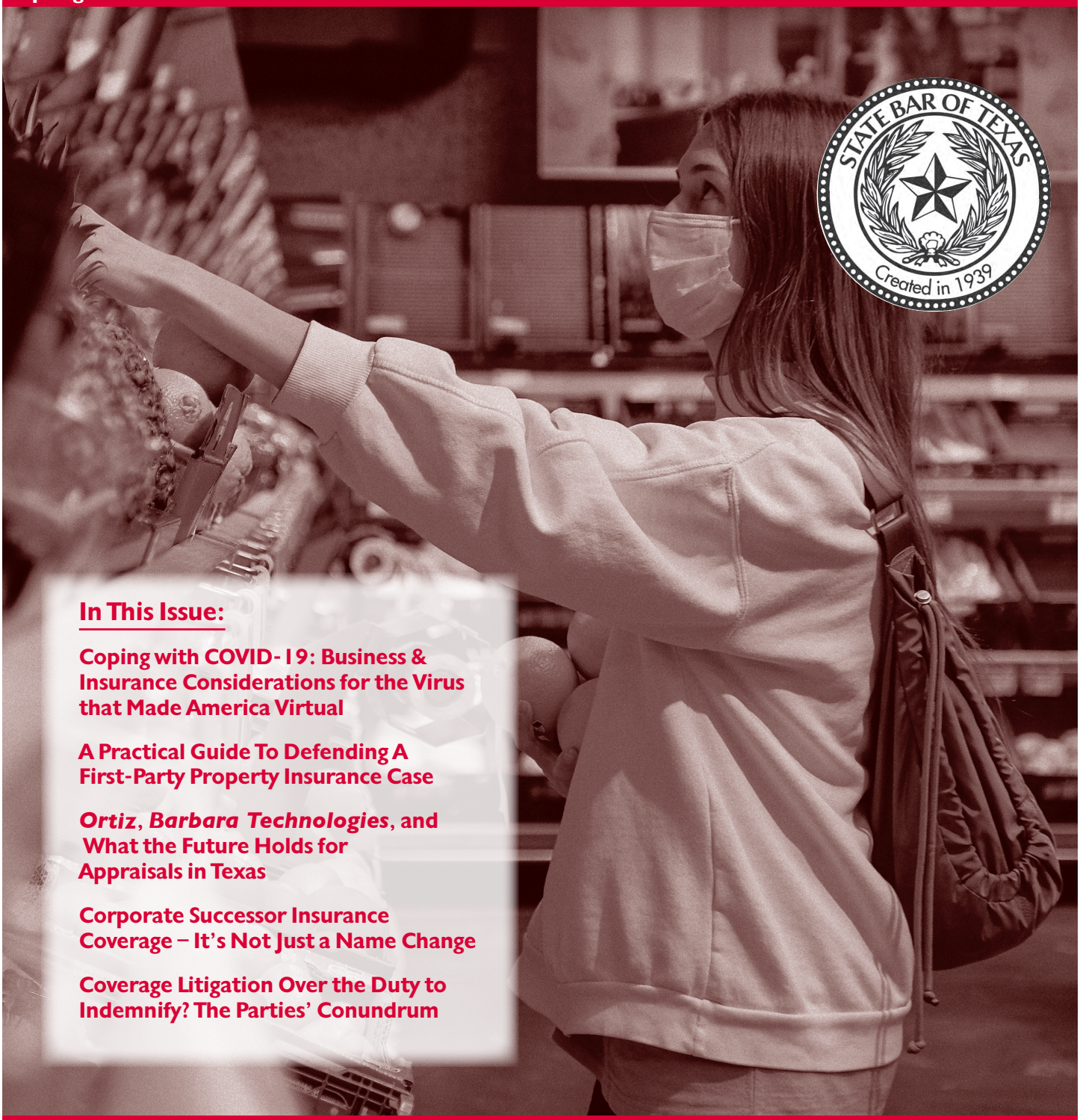

In This Issue:

Official pu lication of the Insurance Law Section of the State Bar of Texas

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THE INSURANCE LAW SECTION OF THE STATE BAR OF TEXAS

Officers for 2019-2020

CHAIR:

William J. Chriss
The Snapka Law Firm (Of Counsel)
606 N. Carancahua St.
Suite 1511
Corpus Christi, TX 78401
Ph: (361) 884-3330
wjchrisspc@gmail.com

CHAIR ELECT:

Pamella A. Hopper
Law Office of Pamella A. Hopper
4508 Duval Rd., #302
Austin, TX 78727
Ph: (512) 497-3647
pahopperlaw@gmail.com

SECRETARY:

Douglas P. Skelley
Shidlofsky Law Firm LLP
7200 N Mopac Expwy., Ste. 430
Austin, TX 78731
Ph: (512) 685-1400
Fax: (866) 232-8710
doug@shidlofskylaw.com

TREASURER:

Stephen A. Melendi
Tollefson Bradley Mitchell & Melendi, LLP
2811 McKinney Avenue, Ste 250
Dallas, TX 75204
Ph: (214) 665-0100
Fax: (214) 665-0199
stephenm@tbmmlaw.com

TECHNOLOGY OFFICER:

Jes Alexander
Esurance, an Allstate Company
1122 Alma Rd., Ste. 100
Richardson, TX 75081
Ph: (972) 755-5851
JAlexander2@esurance.com

PUBLICATIONS OFFICER:

Rebecca DiMasi
Shidlofsky Law Firm PLLC
7200 N. Mopac Expwy., Ste. 430
Austin, TX 78731
Ph: (512) 685-1400
rebecca@shidlofskylaw.com

Council Members 2019-2020

(2 Yr Term Exp 2020)

Tamara D. Bruno
Pillsbury Winthrop Shaw Pittman LLP
Two Houston Center
909 Fannin St., Ste. 2000
Houston, TX 77010-1028
Ph: (713) 276-7608
Fax: (713) 276-7673
tamara.bruno@pillsburylaw.com

(2 Yr Term Exp 2020)

Robert J. Cunningham
Roach & Newton, LLP
1111 Bagby, Suite 2650
Houston, TX 77002
Ph: (713) 652-2033
Fax: (713) 652-2029
rcunningham@roachnewton.com

(2 Yr Term Exp 2020)

Catherine L. Hanna
Hanna & Plaut, L.L.P
211 E. 7th Street, Suite 600
Austin, TX 78701
Ph: (512) 472-7700
Fax: (512) 472-0205
channa@hannaplaut.com

(2 Yr Term Exp 2020)

Jason C. McLaurin
McLaurin Law, PLLC
4544 Post Oak Place, Suite 350
Houston, TX 77027
Ph: (713) 461-6500
Fax: (713) 237-0401
jmclaurin@mdlawtex.com

(2 Yr Term Exp 2020)

Craig L. Reese
Fletcher, Farley, Shipman & Salinas, LLP
9201 N Central Expy., Ste. 600
Dallas, TX 75231-6457
Ph: (214) 987-9600
Fax: (214) 987-9866
craig.reese@fletcherfarley.com

(2 Yr Term Exp 2020)

Jennifer Weber Johnson
Law Office of Mark A. Ticer
10440 N. Central Expressway
Suite 600
Dallas, TX 75231
Ph: (214) 219-4220
Fax: (214) 219-4218
jjohnson@ticerlaw.com

(2 Yr Term Exp 2021)

Christopher H. Avery
Thompson, Coe, Cousins & Irons, L.L.P.
One Riverway, Ste. 1400
Houston, TX 77056
Ph: (713) 403-8210
Fax: (713) 403-8299
cavery@thompsoncoe.com

(2 Yr Term Exp 2021)

Cathlynn H. Cannon
2616 Red Bluff Ct.
Plano, TX 75093
Ph: (214) 789-2613
chc2616@gmail.com

(2 Yr Term Exp 2021)

Blair Dancy
Cain & Skarnulis PLLC
400 West 15th St., Ste. 900
Austin, TX 78701
Ph: (512) 474-5040
Fax: (512) 477-5011
bdancy@cstrial.com

(2 Yr Term Exp 2021)

Linda M. Dedman
Dedman Law, PLLC
Hillcrest Tower
12720 Hillcrest Rd., Ste. 1045
Dallas, TX 75230
Ph: (214) 361-8885
Fax: (214) 363-4902
ldedman@coveragelawdallas.com

(2 Yr Term Exp 2021)

Andrew R. Kunau
The Travelers Companies
9601 McAllister Fwy., Ste. 700
San Antonio, TX 78216
Ph: (210) 525-3727
Fax: (866) 354-1630
akunau@travelers.com

(2 Yr Term Exp 2021)

Matthew S. Paradowski
Martin, Disiere, Jefferson & Wisdom, LLP
9111 Cypress Waters, Suite 250
Dallas, TX 75019
Ph: (214) 420-5517
Fax: (214) 420-5501
paradowski@mdjwlaw.com

(2 Yr Term Exp 2021)

Sarah E. Stogner
Flanagan Partners LLP
307 Carol Lane
Midland, TX 79705
Ph: (504) 214-0140
sstogner@flanaganpartners.com

(2 Yr Term Exp 2021)

R. Wade Vandiver
Argo Group US, Inc.
175 E. Houston St.
San Antonio, TX 78205
Ph: (210) 321-8433
rvandiver@argogroupus.com

Executive Director

Donna J. Passons
Texas Institute of CLE
P.O. Box 4646
Austin, TX 78765
Ph: (512) 451-6960
Fax: (512) 451-2911
donna@clesolutions.com

Council Advisor

Marc E. Gravely
Gravely PC
16018 Via Shavano
San Antonio, TX 78249
Ph: (210) 833-3160
mgravely@gravely.law

Council Advisor Alternate

Matthew J. Kolodoski
Thompson, Coe, Cousins & Irons, LLP
700 N. Pearl St., 25th Fl.
Dallas, TX 75201
Ph: (214) 871-8200
matthew.kolodoski@gmail.com

Judicial Liaison (Term Expires 2021

Justice Brett Busby
Supreme Court of Texas
PO Box 12248
Austin, TX 78711
Ph: (512) 463-1336

Judicial Liaison (Term Expires 2021

Justice Debra H. Lehrmann
Supreme Court of Texas
PO Box 12248
Austin, TX 78711
Ph: (512) 463-1320

Journal of Texas Insurance Law
INSURANCELAWSECTION.ORG

EDITOR IN CHIEF

REBECCA DIMASI
Shidlofsky Law Firm PLLC
7200 N. Mopac Expwy., Ste. 430
Austin, TX 78731
Ph: (512) 685-1400
rebecca@shidlofskylaw.com

PUBLICATION DESIGN

JON-MARC GARCIA
ATX Graphics
www.atx-graphics.com
jon-marc@atx-graphics.com

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

Anyone interested in submitting a manuscript for publication should contact Rebecca DiMasi, Editor In Chief, at (512) 685-1400 or by email at rebecca@shidlofskylaw.com. Manuscripts for publication must be typed double-spaced with endnotes. Replies to articles published in the ***Journal*** are welcome.

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MISSION STATEMENT

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

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Comments

FROM THE EDITOR

By Rebecca DiMasi
Shidlofsky Law Firm PLLC

In keeping with the times, this edition of the *Journal* provides a summary of issues raised by the COVID-19 pandemic from an insurance perspective to guide practitioners in advising clients. While the insurance disputes raised by the losses currently being sustained across the country (and the world) will not be resolved in the near future, the issues raised in the article provide a starting point from which litigation will no doubt follow. The *Journal* also provides practical tips for handling a first-party case from the carrier perspective, an analysis of the current state of appraisal law in Texas, insights into declaratory judgments on the duty to indemnify in the third-party context, and coverage for a successor entity.

Thanks to the authors and to Managing Editor Jason McLaurin for his invaluable assistance. Thanks also to Associate Editors David Kirby and Chris Avery for their excellent editing skills.

The *Journal* is always open to publishing articles relating to Texas insurance law for the benefit of the bench and bar. If you have an article to submit, or a proposed topic, feel free to send me an email at rebecca@shidlofskylaw.com.

Rebecca DiMasi
Editor In Chief

Comments

FROM THE CHAIR

By William J. Chriss, Chair

As this issue of the *Journal of Texas Insurance Law* goes to press, insurance lawyers throughout the nation are dealing with the issues raised by business income loss and disruption caused by the Covid-19 pandemic. As with Hurricane Harvey, our practices are an integral and important part of critical response to natural disasters. The Insurance Law Section continues to lead in providing cutting edge continuing education to insurance practitioners, and we are constantly improving the services provided to its members.

We began the 2019-20 year by conducting a strategic planning retreat to develop goals and projects for the year.

Our Young Lawyers Committee hosted a number of networking events across the state in order to involve new members and promote exchange of ideas.

The section continues to improve its website, insurancelawsection.org, by adding additional content and making it more user-friendly. In addition to the printed and electronic versions of the *Journal of Texas Insurance Law*, the pre-eminent law review dedicated to Texas insurance law, the section issues weekly "Right Off The Press" email updates that provide summaries and links to the most recent Texas state and federal decisions that touch upon related issues, as well as current listings of insurance related employment opportunities.

In the meantime, stay safe.

Sincerely,

William J. Chriss
Chair of the Insurance Law Section of the State Bar of Texas

By Paul K. Stafford

COPING WITH COVID-19: BUSINESS & INSURANCE CONSIDERATIONS FOR THE VIRUS THAT MADE AMERICA VIRTUAL

The Value of Knowledge

The proverbial phrase, "What you don't know can't hurt you," has been discredited as an idiom—especially in times such as these—as has its corollary, "Ignorance is bliss." To the contrary, what you don't know can, and often does, hurt you and others, and a lack of knowledge does not minimize the likelihood of an occurrence—it often increases it. But what is the value of knowledge, and what is the benefit of ignorance?

As for knowledge, according to the Centers for Disease Control, there are at least seven known strains of coronavirus to date,[1] with the possibility of an eighth.[2] Severe Acute Respiratory Syndrome CoV2 (SARS CoV2) is a new strain of coronavirus discovered in 2019 that causes coronavirus disease (COVID-19). The virus infects the upper respiratory tract and can lead to the onset of pneumonia, which is the primary mechanism that leads to death for a small percentage of infected individuals. Additionally the virus can enter the blood system and also potentially relocate to other areas like the heart and digestive tract.[3]

Prior to its spread across China in December 2019, few Americans had ever heard of the coronavirus or COVID-19. Our daily lives progressed relatively unimpeded by societal or governmental intervention—perhaps blissfully. However, that changed dramatically when, on March 11, the World Health Organization declared the COVID-19 outbreak a global pandemic.[4]

Lightning Strikes, as Do Viruses

It has been said that lightning doesn't strike the same place twice. Yet, researchers have determined that charged atmospheric particles often do not completely discharge upon a lightning strike, with the stored charge returning to the atmosphere to initiate further discharges, often in the same locations, and often in rapid succession.[5] Like lightning, viruses attack, retreat, mutate and return, and they have infiltrated our shores for centuries – matched only by our resolve to control and eradicate them.

Prior to the WHO's March 11 declaration, the last pandemic declared by the World Health Organization was the "swine flu" (H1N1) in 2009.[6] These two WHO pandemic declarations are distinct in several ways. SARS CoV2 is a virus, COVID-19 is not the flu, and the H1N1 pandemic did not result in widespread national disruptions, work stoppages, and closures in the United States. Official actions to combat the spread of COVID-19 have included declarations on March 12 by local authorities in The City of Houston and Harris County,[7] as well as for The City of Dallas[8] and Dallas County,[9] followed on March 13 by President Trump's declaration of a National Emergency,[10]and Texas Governor Greg Abbott's declaration of a State of Disaster in all Texas counties.[11] Governments have subsequently issued various "social distancing" guidelines[12] and "stay home, stay safe" shelter-at-home orders,[13] with exceptions for "essential activities, "essential government functions, and "essential businesses."[14] The disruption of daily life, activities, and the economy that has ensued is unprecedented in American society—and will continue for weeks and perhaps months. The inevitable alteration of American business, civil society and culture will be more lasting.

Acts of God, *Force Majeure*, Contracts, and Insurance Coverages

Acts of God v. Force Majeure

People act in response to acts of God, and people will determine which was more impactful—COVID-19 or the world's response to it.

In life, an act of God is an occurrence uncontrollable and inexplicable by man yet accepted as providence - like a lightning strike or a virus pandemic. Similar to an act of God, *force majeure* is an unforeseeable act or occurrence that is outside or beyond the control of the parties and allows relief for nonperformance. The act or occurrence can be one uncontrollable or inexplicable by man but can also be an occurrence based upon the acts of man—like a declaration of a disaster area based upon fires from a lightning strike or an emergency declaration based upon disease from a virus pandemic. In contracts, illegality, impracticality, or impossibility[15] are implied defenses to nonperformance.

Paul K. Stafford has been a business and insurance litigator for approximately 25 years (paul.stafford@tklaw.com), has served as an adjunct professor of Insurance Law at Texas Tech School of Law since 2002 (paul.stafford@ttu.edu), and is the 2020 Chair of the Dallas Bar Association's Tort & Insurance Practice Section.

Contracts

Many businesses enter into contracts with equal bargaining power, and should include Act of God and *force majeure* provisions in those executed agreements. However, if you have ever entered into a lease or a mortgage, purchased a cellphone or subscribed to a cellphone service, leased or purchased a vehicle, uploaded data or downloaded an app, subscribed to cable television or entered into a contract for an event, you have been a party to a contract of adhesion.[16] That is a contract with a lot of boilerplate language, where a consumer does not have the same bargaining power as the drafter of the contract and has little opportunity or leverage to negotiate the contractual terms, but the consumer signs the contract anyway based upon the necessity of the contractual goods or services offered.

Another such contract of adhesion is a contract of insurance, with various types of insurance policies designed to protect the policyholder. Several types of insurances and policies are relevant regarding the COVID-19 pandemic, as well as the ability of consumers and businesses to respond to the COVID-19 pandemic.

Commercial Property Insurance

Most businesses purchase commercial property insurance to protect a business's property, buildings and contents due to a covered loss. Commercial property insurance may also provide coverage for business interruption, which may cover loss of income or increased expenses.

Before most property insurance policies are triggered, the loss must result from a covered occurrence, and there must be a direct physical loss of or damage to the insured property. Absent specific definition in the policy, the "direct physical loss" requirement is, by nature, a fact-specific inquiry, and courts lack uniformity in the application of the law. Although not necessarily direct physical damage, contamination can result in direct physical loss, thereby potentially triggering coverage for the loss.

The virus SARS CoV2 and the disease COVID-19 may be considered a "pollutant" or "contaminant," which according to standard policy forms promulgated by the Insurance Services Office (ISO) may subject them to a pollution exclusion or insurance limitation for contaminants,[17] but the specific policy language would determine this—specifically regarding "biological" or "communicable diseases." If the policy language is silent or ambiguous, a determination could be made by the courts as to the categorization of SARS CoV2 and COVID-19 as well as the applicability of any insurance coverage or exclusion for damages caused by SARS CoV2 or COVID-19, or the response to it.

For insurance purposes, property damage caused by an Act of God – like lightning—are usually covered occurrences. COVID-19 may also be characterized as an Act of God; however, a COVID-19 epidemic evolves gradually, as does the response to it—which is both an epidemiological event and an act of man. Voluntary quarantines or isolation may not trigger coverage as a "direct physical loss," but damages and losses resulting from "civil authority"—such as a federal, state, county or local government forcing closures or restricting the ability to perform a contract or prohibiting access to insured property—may invoke contractual protection or trigger insurance coverage as a *force majeure*. Policyholders must promptly notify insurers of a *force majeure* claim or assertion, and comply with all notification requirements consistent with an "as soon as practicable" standard.[18]

Business Interruption

Due to COVID-19 and the response, business interruption, loss of workers, increased cost of production, delivery delays and decline in demand for goods and services are now inevitable. For business interruption or business income claims to be compensable, the interruption and resultant damages must be based upon a covered occurrence. In addition, businesses invoking the business interruption coverage in their property insurance should review the specific language of the policy and consult with legal counsel, as well as preserve and provide proper documentation of loss of income or increased expenses. Many business interruption or business income policies have a 72-hour "deductible" (waiting period before covered business income losses become compensable by an insurer).[19] This "deductible" may adversely impact the value of an insured's claim, particularly considering COVID-19 is believed to only survive up to four hours in the air and up to three days on a surface. Businesses must also determine reporting requirements for business interruption claims, as well as procedures for timely filing and pursuing a business insurance claim.

Contingent Business Interruption

Thus far, China and Italy have suffered the greatest impact of COVID-19—major trading partners of the U.S. and countries whose suppliers provide components critical to U.S. goods and services. With other countries now being hit by COVID-19, additional supply chain disruptions are inevitable—and increased costs of production and decline in demand for goods and services are likely. Accordingly, contingent business interruption coverage may also be available through existing commercial property insurance for supply-chain disruptions causing business interruption. As with business interruption coverage, businesses must provide proof of causation between the covered occurrence and the asserted damages or loss, as well as adhere to the policy provisions and procedures regarding prompt notification of the loss to the insurer.

"Inhabitability"

With social distancing recommendations and numerous stay-at-home orders issued in March, quarantines and isolation

of people and properties have now become commonplace. Consequently, if a property becomes uninhabitable due to COVID-19 or the threat of COVID-19, a determination must be made as to the "inhabitability" of the property and whether the "inhabitability" was impacted by the contamination. A total loss of habitability of a premises may not be required to assert a claim of loss of habitable use of a portion of the premises. Lessees should review any real estate or lease agreements for potential remedies (including rent abatements) as well as mitigation requirements. In addition, insurers have endorsements for particular communicable diseases and are developing an endorsement for COVID-19. For example, in February 2020, the insurance industry responded to COVID-19 with limited optional coverage for certain COVID-19-related losses, including COVID-19 "civil authority" coverage, which may not require proof that the virus is physically present in the temporarily uninhabitable property.

Workers' Compensation

If a property becomes uninhabitable due to employees becoming exposed to or infected with COVID-19, a determination must be made (for property insurance and business interruption purposes, as well as for workers' compensation purposes) as to whether the employees were operating within the course and scope of their employment at the time of the COVID-19 exposure or infection. Consistent with the "work relatedness" test,[20] proving course and scope may be easier in the healthcare industry, public safety sector (EMT's, police and firefighters) and "high-risk" sectors (entertainment, manufacturing, transportation and retail). For example, in specialty policies for the health care and hospitality industries (hotels, cruise ships and amusement parks) often contain specific endorsements for losses resulting from "communicable or infectious diseases" and often do not require a "direct physical loss" for property or business interruption coverage. For workers' compensation, a determination should also be made as to whether noninfected employees are eligible to receive compensation benefits due to the "inhabitability" of their workplace.

Employees may have a cause of action for negligent practices of an employer in maintaining a safe work environment or failing to take proper precautions to safeguard against COVID-19. Accordingly, employers should review their workers' compensation and liability policies to familiarize themselves with their coverage.

Directors and Officers Insurance

The Dow and S&P have fluctuated greatly in the past few days and weeks, and investors have lost significant portions of their portfolio values. Shareholders could allege that the acts or omissions of directors or officers contributed to financial loss (for example, a drop in share price) or exposed the company to liability. Accordingly, although companies may believe such claims to be without merit, businesses should review current and renewable D&O insurance language and coverages.

Commercial General Liability Insurance

Businesses also purchase commercial general liability insurance to protect against damage by or to third parties and liability arising therefrom. Customers may have a cause of action against businesses for acts or omissions regarding COVID-19, which could implicate a business's CGL policy protection against bodily injury claims by customers. A CGL's "Coverage A" typically covers claims of negligence resulting in bodily injury;[21] however, the coverage typically requires an "accidental" occurrence, which is a requirement not consistent with an intentional act.[22] A CGL's "Coverage B" typically covers claims of detention and false imprisonment,[23] which may be applicable in certain COVID-19 quarantine or isolation claims. As with commercial property insurance, the CGL policy may exclude "pollutants" or "contaminants," which may subject COVID-19 to a pollution exclusion or insurance limitation for contaminants, but the specific policy language would determine this, and should be reviewed by the business.

Cancellation Insurance

Along with social distancing, cancellations have become the norm—including travel, sporting events, concerts, festivals, parties, luncheons, banquets and play dates. Cancellation insurance is thought to provide coverage for such disruptions and cancellations, and the lack of such coverage can quickly become headlines (such as with the March 6th cancellation of South by Southwest;)[24] however, cancellation insurance coverage traditionally excludes losses resulting from communicable diseases leading to quarantine or restrictions. Furthermore, many insurers began specifically excluding coverage for COVID-19 in mid-January. However, it is arguable that many cancellations were not due to a communicable disease but due the "civil authority" response to COVID-19, which made performance impossible or impracticable and precluded mitigation through rescheduling or otherwise. Accordingly, coverage may be afforded, but policyholders should review their policies for any applicable language or coverages.

As we endure the COVID-19 epidemic and become an increasingly virtual society, we must realize that cancellations, workplace disruptions, business interruptions and civil authority will be more prevalent. In all the instances and scenarios articulated above that may implicate contractual rights or obligations or insurance liabilities or coverages, policy language must be carefully reviewed to determine whether certain policies may provide coverage.

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14 *Id.*
15 Section 261, Restatement (Second) of Contracts, and Tex. Bus. & Com. Code § 2.615(1).
16 Section 211, Restatement (Second) of Contracts.
17 *See* ISO Standard Form CP 01 40 07 06 "Exclusion for Loss Due to Virus or Bacteria", promulgated in 2006.
18 For occurrence policies, *see PAJ v. Hanover*, 243 S.W.3d 630 (Tex. 2008); For claims-made policies, see *Fin. Indus. Corp. v. XL Specialty Ins. Co.,* 285 S.W.3d 877 (Tex. 2009) and *Prodigy Commc'ns Corp. v. Agric. Excess & Surplus Ins. Co.,* 288 S.W.3d 374 (Tex. 2009).
19 *See* ISO Standard Form CP 00 30 40 02 (Business Income and Extra Expense Form Coverage Form).
20 U.S. Department of Labor, Occupational Health and Safety Administration, Standard Number 1904.5 (Determination of work relatedness)
21 *See* ISO Standard Form CG 00 01 04 13.
22 *Id.*
23 *Id.*
24 https://www.sxsw.com/attend/participation-credentials-terms-conditions/.

By Catherine L. Hanna and Sarah E. Scott

A PRACTICAL GUIDE TO DEFENDING A FIRST-PARTY PROPERTY INSURANCE CASE

So, you have a new file. Those who regularly represent insurance carrier clients do not typically have the opportunity to "triage" a new case. Absent conflicts, counsel for carriers take the cases their clients send. Insurance cases are not like any other, even in typically defense-friendly jurisdictions, and insurance defendants often face an uphill battle with juries. This guide is intended to assist a defense lawyer faced with defending these challenging cases.

I. THE NEW CASE ARRIVES

A. Initial Review

Your first job is to make sure you have all of the relevant documents. You should carefully review the policy to confirm you have the complete copy, including all endorsements, in effect on the date of loss. You should also have a complete copy of the insurance carrier's claims file, which generally consists of some sort of claims diary or journal documenting the actions taken during the claim as well as claims correspondence, estimates, evaluations, and the like. It should be a comprehensive guide to the "who, what, when, where, and how" over the life of the claim. You will want to determine whether the files of any independent adjusters who evaluated the claim have been incorporated into your client's file or if you will need to get them separately. You should also ask your client how they retain communications like emails and text messages between adjusters and insureds or vendors; you don't want to see that rude or inappropriate text message for the first time at the deposition of your adjuster.

B. Evaluation and Analysis

Insurance litigation often turns on what happened when, so a timeline can be extremely helpful in answering some important questions. How much time transpired between the date of the claimed loss and the report to your client? When were acknowledgements and requests for information sent to the insured? What payments were made and when? Since the adjuster usually has little or no independent memory of the claim, you are starting behind, while the claimant likely remembers much of the claim in great detail. Having a clear timeline of events early on will help you figure out potential weaknesses in your case. For instance, were there large gaps in time when the insured was waiting on a response to start repairs? Did the insured get a timely denial letter? Did the denial go out *before* the claim was even investigated? Are there inconsistencies in dates of inspections or documents that are apparent from the claim file that would undermine the adjuster's credibility? Remember, it is easy for jurors to become angry at adjusters they perceive as overly bureaucratic or rude, even if they complied with the legal requirements for claims handling. You need to be on the lookout for any behavior that will make it easier for jurors to side with the claimant if there is a question about credibility or damages.

Next, you need to make sure that you don't inadvertently produce privileged documents in the claim file. Flag and remove those documents up front, so you are prepared when discovery starts and you can avoid drafting a privilege log at the last minute. The same reasoning applies to documents that you might have received that are not related to the claim file. Underwriting documents, including documents regarding reserves, may or may not be relevant in your case, but odds are they won't be responsive to the same kind of discovery requests as claim file documents.

After you are sure you have all the needed documents from the claim file, it is time to have a discussion with your client about the case. You need to diplomatically point out any legal and factual weaknesses or potential issues *before* they arise during litigation. You may also be requested or required to prepare a litigation budget at this point. Many carriers have templates you are required to use, but it is often difficult to foresee the various litigation tasks and expenses that may arrive in even the most garden-variety case. Our best advice on this task—and throughout the handling of the case—is to maintain good client communication throughout the process. Insurance carriers, like any other client, don't like surprises.

II. ANSWERING THE LAWSUIT

If the plaintiff hasn't sent a proper notice, you may want to file a verified answer seeking an abatement until you receive a demand. Although proper notices do not have to be detailed, they do need to comply with all the elements set forth in Chapter 542. Once you are armed with a specific number that the claimant will be seeking, you can better evaluate the potential range of damages your client is facing.

Catherine L. Hanna is a partner at Hanna & Plaut, LLC in Austin, Texas. Her practice focuses on representation of clients in appellate matters as well as direct representation of insurance carriers in connection with coverage and first-party bad faith litigation. Sarah E. Scott is also with Hanna & Plaut and her practice focuses on insurance law, including coverage issues and bad-faith litigation.

Because insurance carriers are among the least popular defendants, it is important to take advantage of any rules to ensure a favorable forum. Cases that are originally filed in state court may be removed to federal court where there is diversity of citizenship and an amount in controversy of more than $75,000. In Texas, where state trial court judges are selected through partisan elections, federal forums will often be more favorable. Federal judges with lifetime appointments often have more time and staff available to consider dispositive motions. In addition, jurors are drawn from a broader area, which generally results in more rural, conservative jurors. For these reasons, attorneys for plaintiffs may include a Texas-resident adjuster as a defendant to defeat diversity. It is important to consider whether the case can still be removed by arguing that the adjuster was improperly joined and her citizenship should be disregarded. For cases governed by Section 542A of the Texas Insurance Code (which applies to weather-related claims), the carrier has the option to elect to assume the liability for acts of its individual adjusters. Such an election may or may not mean that the individual adjuster is not properly named as a defendant. This election must occur *prior to suit being filed* to render the lawsuit removable, so the window to elect liability is short.

III. DISCOVERY

When assessing how to proceed with discovery in the case, one should ask what facts and motivations are driving the lawsuit. Making this determination can, in itself, be difficult, and answering discovery in an insurance lawsuit presents its own unique challenges.

A. Discovery of Plaintiff

1. Written Discovery

In addition to standard written discovery requests, you may want to issue subpoenas to prior insurance carriers. If there are issues related to repairs, the plaintiff's mortgage company (generally also an insured on most policies) may also be involved. You will want to subpoena those mortgage company files early in the process, as they can take time to be produced.

2. Depositions

When we depose the plaintiff we are, of course, gathering facts related to their perspective on the claimed loss and damages. For instance, we will want to find out their opinions about the actions and attitudes of the adjusters and representatives they may have dealt with over the course of the claim. But perhaps most importantly, we want to get a sense of how they will be seen by a jury.

One should do their best to have a good understanding of facts and details of the case. It helps to have a broad outline with questions that come up in most insurance first-party claims, but it is also important to ask open-ended questions to open up new areas of inquiry. Too often, litigators who are married to an overly detailed outline end up missing key follow-up questions that unearth critical facts.

In addition to deposing the plaintiff, you should consider deposing any public adjuster, contractors or people in charge of conducting repairs, and causation experts that have been designated.

B. Answering Discovery

1.Written Discovery

The focus of the plaintiff's case will often derive from your client's claims file. It is discoverable. You should carefully review the file and discuss with your client—prior to production—to determine when your client reasonably anticipated litigation. Many claims notes or claims journal entries may be protected from discovery pursuant to the work-product privilege if they were created prior to that date.

While the claims file generally contains all the information relevant to plaintiff's claims, most plaintiff's lawyers will seek discovery well beyond those documents. The Texas Supreme Court and most Texas appellate courts have been supportive of attempts to limit overly broad discovery requests, stating that discovery is a tool to make the trial process more focused, not a weapon to make it more expensive. The court must also consider the proportionality of the discovery with respect to the needs of the case, the amount in controversy, the parties' access to relevant information, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. (This becomes especially relevant when requests for electronic discovery seek to review files in specific formats or ask for metadata.)

It may be appropriate to bring the concept of proportionality into discovery disputes. For example, all of the carrier's manuals and training materials may not be relevant to a garden-variety hail claim, but a more limited production of manuals in effect at the time of the claim and relevant to the claim may be appropriate. Insurance carrier clients also often have concerns about dissemination of proprietary materials, given that plaintiff's attorneys may attempt to use the same materials in multiple cases against the carriers. However, most courts are unsympathetic to those concerns, given that a confidentiality or protective order can arguably prevent dissemination.

2. Depositions

a. Corporate Representative

Corporate representative depositions are make-or-break propositions. Sometimes, that choice is out of your hands,

and many insurance carriers have identified particular employees for whom giving testimony on behalf of the company is part of their job description. An ideal corporate representative will be someone with general knowledge of the case and the willingness to become a case expert. He or she should also have an unflappable demeanor.

In addition to selecting the right witness, it is important to ensure that the deposition topics are narrowly tailored and stated with "reasonable particularity." It is useful to have a conversation with opposing counsel to clarify vague topics and to limit overly broad ones, as both parties have an interest in a shared understanding of the topics at issue and bringing a knowledgeable and well-prepared representative to the deposition. When deciding whether to involve the court, it is important to familiarize yourself with the case law on both federal and state requirements to protect your client from improper corporate representative deposition notices. For instance, depending on the jurisdiction, it may be prudent to move for a protective order instead of simply objecting to proposed topics.

Once the deponent is selected, preparation is paramount. It is prudent to first have fact-gathering meetings. Since a corporate representative is obligated to present the information that is available to the company, it is useful to outline what information needs to be gathered and by whom. After those meetings are accomplished, it is then prudent to schedule at least two face-to-face meetings with the deponent. These sessions should allow for time to practice with mock cross-examination. This is important for experienced deponents as well as rookies.

b. The Adjuster

The deposition of the handling adjuster has been referred to as "A Stake in the Heart of the Vampire." While a weak adjuster witness may not cause your case to crumble into dust, it certainly will affect its defensibility. Unlike the corporate representative, you will have no choice in selecting this witness. Again, preparation and practice is the key to survival, but the preparation process may be even more challenging, as you take a busy adjuster away from her regular duties. The challenge increases when the handling adjuster is no longer employed by your client. In that case, you will need to have a conversation with your client about representing the former employee, as they likely have agreements in place governing those situations. In preparation for the deposition, the adjuster should conduct a detailed review of the claims notes, correspondence, and any prepared estimates. It is also important to prepare these witnesses to practice answering questions without becoming defensive.

IV. EXPERTS

You will want to identify causation experts early in the case. Your insurance carrier client may have already used an engineer to provide a report. You may want to have your own engineer and cost-of-repair expert reinspect the premises and give you a gut check on the carriers' initial analysis. While it is not pleasant to have to tell your client that the initial claims analysis, coverage determination, or cost-of-repair estimate was wrong, that news is much better relayed at the beginning of the case rather than after months of litigation.

You will also want to consider whether to hire a claims handling expert, as it can be useful to have an expert explain the insurance claims process to the jury. You should make that determination well in advance of any expert designation deadlines. There is nobody more qualified than an insurance claims handling expert to find the quicksand in your case, and you do not want to hear that news the day before you are set to designate.

V. MOTION PRACTICE

Because insurance carriers are unpopular defendants, your best bet for an outright win is with the judge. As discussed above, jurisdiction and venue are critical. Regardless of jurisdiction, the defense lawyer should analyze the case for potential dispositive motions—both full and partial—and develop the case accordingly. Keep in mind that while the insured has the initial burden to establish coverage, the insurance carrier has the burden to establish the applicability of an exclusion from coverage (which needs to be affirmatively pled). Where causation of property damage is at issue, there may be fact questions that present an insurmountable hurdle to summary judgment. Nonetheless, you should still consider using dispositive motions to limit causes of action and streamline the case.

VI. TRYING THE CASE

Most insurance cases settle. Some are resolved on summary judgment. Rarely, a case gets all the way to the courthouse. One tested approach to trying a case where an insurance carrier is a defendant is "less is more." In other words, the goal is to be the voice of reason and redirect the jury away from the emotional appeals that the plaintiff can be expected to make. Your client may represent itself on TV with a duck, a lizard, an emu, or a Flo, but the cuteness of those mascots is not generally translated to a feeling of warmth toward insurance carrier defendants.

A. Motions in Limine

It is advised that you keep a running list of potential motions in limine during the discovery phase of the case. Discovery requests, motions to compel, and lines of deposition questions will reveal the types of evidence that a plaintiff may seek to introduce in order to color the jury's view of your client. Although being thorough is always a positive attribute for an attorney, be careful when relying on form motions in limine. Courts may have standing orders governing the points you are raising, and judges do not

appreciate rehashing issues that have already been addressed. Similarly, it is important to narrow areas of contention in your motions to avoid wasting the court's time during pretrial hearings. Coming to pretrial hearings prepared to argue only those points that are truly in contention will start you off on the right foot with the court.

B. Voir Dire

Entire volumes can be written about the importance of voir dire. In a case involving an insurance company defendant, it is important to learn how many of your potential jurors have had experiences with insurance claims or your client in particular. It may be difficult to hear jurors express negative opinions of your client and/or the insurance industry, but it is critical to know who has the most negative attitudes and can be challenged for cause. It is also important, when dealing with storm claims, to have a sense of what areas of the community were hardest hit by the storm so that you can minimize the impact of jurors with personal experience of the event. Voir dire is also your chance to humanize your corporate client, and it is when you make that critical first impression to the jury.

Given the importance of voir dire, it is best to bring in help so that you can make the most of the limited time you have to question and analyze jurors. Bring an associate with an easy-to-fill-out diagram of jurors. Work on a system of shorthand to identify relevant items about jurors to determine the use of peremptory strikes. Know how long you will have to analyze any juror cards or information. And try to keep in mind the number of jurors who will be seated so you do not waste time questioning people who are outside of the "strike zone" of potential jurors. Finally, know the case law with the relevant criteria for striking jurors for cause so you can articulate why certain jurors need to be struck and why plaintiff's strikes do not qualify.

C. Witnesses

The bulk of your case will likely be presented through cross-examination of the plaintiff's witnesses. As with motions in limine, less is more—typically, there are only a few truly key points that need to be made on a cross exam. Make the points you need to be able to bring up in closing, then move on. Jurors will be more sympathetic if they think you are trying not to waste their time.

In many cases, the plaintiff adversely calls your corporate representative as their first witness. As in the deposition stage, the choice of corporate representative is critical, especially if they are the first witness. A common theme of the first-party cases that end with shocking verdicts is the jury's perception that the adjuster or corporate representative was dismissive or uncaring toward the plaintiffs.

D. Closing Arguments and the Charge

Like voir dire, the charge conference in a first-party insurance case merits an article of its own. That being said, the main goal for an insurance defendant is to minimize the questions on the charge. Both the Insurance Code and the DTPA have extensive laundry lists of potential bad acts by insurance carriers and adjusters. Thus, the practitioner should use pre-trial motions, motions for directed verdict, and charge conference objections to limit the number of blanks in the jury charge so the jury has fewer opportunities to agree that your client did something wrong.

In closing, while the plaintiff may make emotional appeals, defense counsel should focus on carefully walking the jury through the questions of the charge. It is important to remind the jury of the evidence that refutes the allegations and of the plaintiff's failure to carry their burden to introduce the evidence needed to support a verdict. Be sure to explain, for each cause of action, what the plaintiffs needed to prove and how they failed to do so. This is particularly helpful when it comes to boilerplate requests for damages that are, at best, thinly supported.

Plaintiff's counsel then has his last turn, the jury exits the courtroom, and we wait. What is the best advice for this part of the trial? Make sure your box of trial supplies is well-stocked with chocolate.

1 Two often-overlooked requirements are that (1) the claimant specifically state the attorneys' fees accrued to date and (2) copy the client.

2 *In re Allstate Cty. Mut. Ins. Co.,* 227 S.W.3d 667, 668 (Tex. 2007).

3 *In re State Farm Lloyds*, 520 S.W.3d 595, 613-614 (Tex. 2017).

4 https://www.ticerlawfirm.com/Articles/A-Stake-Into-the-Heart-of-the-Vampire.shtml.

By Christopher H. Avery

ORTIZ, BARBARA TECHNOLOGIES, AND WHAT THE FUTURE HOLDS FOR APPRAISALS IN TEXAS

Appraisal is not a new concept in insurance law, nor is it intended to be a complicated concept. When an insurer and a policyholder disagree on the value of the loss, they will each appoint appraisers. If the appraisers are unable to agree, an umpire will then decide the amount of loss. Perhaps that is why the Supreme Court of Texas had only addressed the concept five times in its entire history prior to *State Farm Lloyds v. Johnson*.[1] Since then, hurricanes, hailstorms, and an incredible increase in insurance litigation, have led to disputes about almost every aspect of appraisal. Those developments have led to two new decisions in *Ortiz v. State Farm Lloyds* and *Barbara Technologies v. State Farm Lloyds* that signal even more litigation can be expected.

I. The Lead-Up to *Ortiz* and *Barbara Technologies*

Understanding the *Ortiz* and *Barbara Technologies* opinions requires an examination of the cases and issues that have exploded in the last decade. Consider that a simple Westlaw search shows approximately 511 cases dealing with appraisal from 1888 until the Texas Supreme Court's 2009 decision in *State Farm Lloyds v. Johnson*. In the ten years since *Johnson*, there have been approximately 483 cases. The drastic increase in litigation about appraisal is due to a variety of factors, many of which appear to have motivated the Supreme Court's new decisions.

A. State Farm Lloyds v. Johnson

In 2009, the Supreme Court addressed the types of disputes that were appropriate for appraisal, but particularly what constituted a dispute over the "amount of loss" as required by most policy terms. In that case, Ms. Johnson and her insurer, State Farm, disputed the costs of repairing hail damage sustained in a 2003 storm.[2] Ms. Johnson's contractor argued for full replacement at $13,000, while State Farm's inspector argued that only the ridgeline had been damaged at a cost of $499.50.[3] Although Johnson invoked the appraisal provision of her policy,[4] State Farm disagreed and argued that the dispute was over causation, not the "amount of loss."

The Supreme Court disagreed with State Farm that the dispute before it related to causation, and therefore, was beyond the bounds of appraisal. It began its analysis by observing that "[a] dispute about how many shingles were damaged and needed replacing is surely a question for the appraisers."[5] After all, if the parties must agree on every shingle that must be replaced, appraisal would be superfluous. Thus, "[t]o the extent the parties disagree which shingles needed replacing, that dispute would fall within the scope of appraisal."[6]

On the other hand, "when different causes are alleged for a single injury to property, causation is a liability question for the courts."[7] For example, when the parties disagree over whether foundation damage was due to plumbing leaks (a covered loss) or simply settling (an excluded loss), the issue is one of causation for the courts.[8] But the Supreme Court also recognized that there must be some type of agreement as to what was damaged before a court could decide liability, including the issue of wear and tear. Otherwise, no loss could ever be appraised unless the property had been in pristine condition before the alleged loss.[9]

Nevertheless, the Supreme Court was clear that while appraisal should go forward before a challenge to litigation, that process still cannot change a policy's terms. It stated:

> No matter what the appraisers say, State Farm does not have to pay for repairs due to wear and tear or any other excluded peril because those perils are excluded. But whether the appraisers have gone beyond the damage questions entrusted to them will depend on the nature of the damage, the possible causes, the parties' dispute, and the structure of the appraisal award (as discussed more fully below). State Farm cannot avoid appraisal at this point merely because there might be a causation question that exceeds the scope of appraisal.[10]

The Supreme Court concluded its opinion with three observations that have led to much of the dispute over appraisal, and which it later revisited in *Ortiz* and *Barbara Technologies*:

Christopher H. Avery is a Partner with Thompson Coe in Houston. He focuses his practice on commercial property and coverage matters involving allegations of bad faith. His experience includes successful litigation of complex coverage issues, as well as large property and business interruption claims.

1. Appraisal is intended to take place before suit is filed as it is a condition precedent to suit.[11] According to the Supreme Court "[a]ppraisal requires no attorneys, no lawsuits, no pleadings, no subpoenas and no hearings."[12] As discussed in more detail below, this observation has largely been proven incorrect and led to the concerns that prompted *Ortiz* and *Barbara Technologies*.

2. Appraisal can be structured to decide the amount of loss without deciding liability.[13] Once again, while such an observation appears clear enough in writing, the opposite can be equally true in practice.

3. The "scant precedent" involving disputes about the scope of appraisal suggests that appraisals "generally resolve such disputes."[14] As time would tell, this would prove to be the most incorrect observation of all.

Ultimately, the Supreme Court refused to say whether the appraisal it ordered on remand would be binding, but it provided some guidance for the thousands of cases that would soon be filed in Texas courts.

B. Hurricane Ike

What the Supreme Court probably could not see when it issued the *Johnson* decision was that tens of thousands of first-party property lawsuits were about to be filed as a result of a major hurricane. Nine months after the Supreme Court heard oral arguments, Hurricane Ike struck Southeast Texas slightly east of Houston. Winds associated with the hurricane damaged properties across most of southeast Texas, causing thousands of policyholders to file claims. The Texas Department of Insurance estimated that Hurricane Ike had generated approximately 815,000 claims within 9-months of the storm.[15] Still more would be filed over the next several years.

Along with the serious amount of claims came an onslaught of lawsuits. Attorneys and public adjusters advertised heavily, leading to tens of thousands of lawsuits in Harris, Galveston, Montgomery, Fort Bend, Chambers, and Jefferson Counties. Both policyholders and insurers sought to gain an advantage through appraisals. Courts then struggled to decide a multitude of issues relating to the process, including whether appraisal could be waived if it had not been demanded during the claims handling process.[16] Policyholders, in particular, argued that if an insurer had already denied a claim and then waited months, or even after suit, to invoke appraisal, that the process had been waived. Insurers, on the other hand, argued that appraisal was a condition precedent that was mandatory even after a delay or suit.

C. In re Universal Underwriters

In 2011, the Supreme Court decided the issue in a way that would impact thousands of pending and future cases. In *In re Universal Underwriters*, the Supreme Court held that waiving appraisal was difficult, if not impossible.[17] In that case, an auto dealer reported a large claim for hail damage that resulted in a payment of $4,081.95.[18] The policyholder disagreed and asked for a re-evaluation that resulted in an additional payment of $3,000.[19] The policyholder then filed suit, but the insurer then invoked appraisal.[20]

At the trial court, the insurer filed a Motion to Compel Appraisal.[21] The policyholder argued that the insurer had waived appraisal by waiting to invoke it until after suit was filed. The trial court agreed with the policyholder and denied the insurer's Motion. The Fort Worth Court of Appeals then affirmed the trial court's decision when the insurer sought mandamus review.[22] The Texas Supreme Court, however, disagreed and reversed the order denying appraisal.

The Supreme Court began its analysis by once again indicating a preference for appraisal over litigation as "[a]ppraisals can provide a less expensive, more efficient alternative to litigation . . . and they 'should generally go forward without presumptive intervention by the courts.'"[23] "Indeed, appraisals . . . proceeded for well over a century with little judicial involvement."[24] Based on that preference, the Supreme Court then reiterated its prior holdings that waiver "'requires intent, either the intentional relinquishment of a known right or intentional conduct inconsistent with that right.'"[25] In the context of appraisals that requires more than a simple delay of time.

To determine if appraisal has been waived, two points must be taken into account: (1) delay from the point of impasse; and (2) prejudice to the opposing party.[26] The Supreme Court first explained that the length of delay is not enough because all circumstances must be taken into account. For appraisals, this means from the point of impasse, which is "not the same as a disagreement about the amount of loss;" rather, it is "apparent breakdown of good-faith negotiations."[27]

Based on the facts before it, the Supreme Court could not conclude that the delay alone was sufficient to constitute waiver.[28] The insurer had never denied liability for the loss, nor had it refused to discover the issue further.[29] And it had invoked within one-month after receiving the suit.[30] Thus, the invocation of appraisal was timely.[31]

The Supreme Court continued by ruling that even if the insurer had delayed in requested appraisal, "mere delay is not enough to find waiver; a party must show that it has

been prejudiced."[32] After all, "it makes little sense to prohibit appraisal when it can provide a more efficient and cost-effective alternative to litigation."[33] The Supreme Court had enforced similar prejudice requirements in other contexts, such as arbitration, and other courts were in agreement. But in the context of appraisal the Supreme Court believed that it would be difficult "to see how prejudice could ever be shown, when the policy, like the one here, gives both sides the same opportunity to demand appraisal."[34] Therefore, according to the Supreme Court, requiring appraisal in the absence of prejudice could help "short-circuit" litigation.

D. More Storms, More Lawsuits

After *Universal Underwriters*, the Supreme Court's goal of "short circuiting" litigation was put through a series of tests. From 2012 to 2016, Texas experienced several severe weather events that led to several thousand more claims and cases. In 2012, severe hailstorms struck the Rio Grande Valley, once again resulting in the submission of thousands of claims. These storms were different because they also involved an unprecedented number of claims (40% according to the Texas Department of Insurance) that involved either an attorney or public adjuster.[35] In 2014, another severe hailstorm struck the Panhandle, while others caused significant damage in San Antonio and the Dallas-Fort Worth Metroplex in 2015.[36] As if on cue, in 2016, even more storms struck across North Texas, once again resulting in a huge number of claims and lawsuits.[37]

During the same period, Texas courts increasingly relied on a 2004 case from the Corpus Christi Court of Appeals to meet the Supreme Court's encouragement to keep litigation out of the courts. In *Breshears v. State Farm Lloyds*, the Corpus Christi Court of Appeals held that an insurer's timely payment of an appraisal award precluded any finding of breach of contract or of a violation of Chapter 542 of the Texas Insurance Code.[38] Only six courts cited to *Breshears* in the immediate years following the decision, but after *Johnson* and *Universal Underwriters*, the number of citing courts ballooned to 79. At the same time, almost every Court of Appeals followed its lead, as did the Fifth Circuit, and held that timely payment of an appraisal award precluded future litigation, absent some other type of challenge to the award.[39]

The atmosphere caused by an increasing number of storms and claims, as well as an increase in appraisal demands resulted in significant disagreements between policyholders and insurers. Insurers argued that appraisal was frequently being used to create coverage for questionable claims. Indeed, some policyholder attorneys even demanded mediation or appraisal upon filing suit without any prior notice to the insurer.

On the other hand, policyholders argued that the *Breshears* line of cases was being used by insurers essentially as a "cover up" to bad faith. According to those arguments, an insurer could determine it had acted in bad faith, then invoke appraisal, pay the award, and avoid any potential liability for its actions, including for prompt payment penalties.

E. 2017, Menchaca, and Statutory Revisions

As cases continued to test the bounds of appraisal, major new developments were on the horizon. In 2017, three key events occurred: (1) the Supreme Court revisited the Texas standard for bad faith; (2) the Texas Legislature amended the Insurance Code in an attempt to address many instances of lawsuit abuse; and (3) Hurricane Harvey, one of the most expensive hurricanes in Texas history, struck the Texas coast.

Of the three developments, the first two had the largest impact on the issue of appraisal. First, in *USAA Texas Lloyds Co. v. Menchaca*, the Supreme Court re-visited its previous holdings regarding the standard to show bad faith to "eliminate confusion regarding the Court's previous decisions addressing insureds' claims against their insurance companies."[40] In *Menchaca,* USAA challenged whether an "independent injury" was necessary to assert extra-contractual claims, including those under the Texas Insurance Code.[41]

The Supreme Court held that such a finding was generally not necessary, and articulated five rules:

1. **The General Rule**. The "general rule" is that a policyholder cannot recover policy benefits as actual damages if there is no right to the benefits.[42]

2.**The Entitled-to-Benefits Rule**. The natural corollary to the "general rule" is that if a policyholder can establish its right to policy benefits, they may be recovered as damages under the Insurance Code.[43]

3. **The Benefits Lost Rule**. If an insurer's improper action (such as misrepresentation or violation of the Insurance Code) causes a policyholder to lose their policy benefits, they may still be recovered under the Insurance Code.[44]

4. **The Independent Injury Rule**. If an insurer's improper actions cause an injury separate and apart from the policy benefits, they may be recovered under the Insurance Code.[45] But the Supreme Court repeated its previous statements that it had yet see such and injury and questioned whether it could occur.

5. **The No-Recovery Rule**. Finally, the "no-recovery rule" serves as the catch-all to the previous rules and holds that if

a policyholder cannot establish a right to policy benefits or an "independent injury" it cannot recover.[46]

After *Menchaca*, both policyholders and insurers argued as to whether the decision impacted appraisal awards. Most courts that considered the issue agreed that it did not and continued ruling that timely payment of an appraisal award precluded any further litigation.[47] This line of cases reasoned that "[w]hen an insurer has fully paid an appraisal award, no additional benefits are being wrongfully withheld under the policy, and in that situation, the only way an insured can recover any damages beyond policy benefits is where a statutory violation or act of bad faith caused an injury independent of the loss of benefits."[48] Thus, according to these courts, without evidence of some other harm, timely paying an appraisal award fits in the fifth *Menchaca* rule. Although these cases appeared to be unanimous in their holdings, the Supreme Court would soon rule otherwise.

The second development, amendments to the Texas Insurance Code, had been several years in the making. Following the overwhelming number of lawsuits filed as a result of Hurricane Ike and the subsequent hailstorms, many insurers and tort reform organizations petitioned the Texas Legislature to address many perceived lawsuit abuses, including appraisal. Policyholder representatives were quick to respond with their own assertions about protecting Texas consumers. In 2017, the Texas Legislature responded by enacting new revisions to the Texas Insurance Code in the form of new Chapter 542A. The new Chapter modified several previous provisions, including the requirements for a pre-suit demand letter and as to the applicable interest for claims under the Texas Prompt Payment of Claims Act ("TPPCA"). As expected, both sides then began arguing as to what exactly the bill meant and how it should apply.

Ironically enough, the third major event of 2017 occurred mere days before Chapter 542A was to take effect when Hurricane Harvey stalled off the Texas coast and inundated the state with Biblical amounts of rain. Once again, many claims were filed and many arguments were made by both sides. In this context, the Supreme Court once again took up the issue of appraisal.[49]

II. The Supreme Court's Decisions in *Ortiz* and *Barbara Technologies*

All of the factors above came into play in the briefing and oral arguments for both *Ortiz* and *Barbara Technologies*. While policyholders pointed out the potential for abuses by insurers, the insurers responded by pointing out the consistency in application of the previous rulings by almost every state and federal court to encounter them. Ultimately, all of the arguments resulted in two split-decisions that are likely to have major impacts on litigation about appraisal in the future.

A. Ortiz v. State Farm Lloyds

The *Ortiz* decision arose out of a homeowner's claim for hail damage. State Farm inspected the loss and determined the amount of damage caused by wind or hail to be $732.53, which was below the policy's $1,000 deductible.[50] Ortiz disputed that amount and requested a re-inspection that resulted in a revised estimate of $973.94. Ortiz then filed suit against State Farm asserting causes of action for: (1) breach of contract; (2) violations of Chapter 542; and (3) statutory and common law bad faith.[51]

Two months after appearing in the case, State Farm invoked the policy's appraisal provision. Although Ortiz argued that State Farm had waived its right to invoke appraisal, the trial court disagreed and compelled appraisal.[52] That process resulted in an award of $9,447.52 as replacement cost value and $5,243.93.[53] State Farm paid the award within seven days and then moved for summary judgment on all of Ortiz's claims.[54] The trial court granted the motion and the San Antonio Court of Appeals affirmed, but did not specifically address Ortiz's claims for violations of Chapter 542.[55]

At the Supreme Court, Ortiz argued that State Farm necessarily breached the policy because the appraisal award was higher than its original evaluation of damages.[56] The Supreme Court disagreed with Ortiz and sided with the courts that had unanimously rejected such an argument. The Supreme Court explained:

> It simply does not follow that an appraisal award demonstrates that an insurer breached by failing to pay the covered loss. If it did, insureds would be incentivized to sue for breach every time an appraisal yields a higher amount than the insurer's estimate (regardless of whether the insurer pays the award), thereby encouraging litigation rather than "short-circuit[ing]" it as intended.[57]

Additionally, appraisal is specifically provided for by the policy contract, which is "significant."[58] By invoking the provision and then paying the award, State Farm had complied with the policy terms.[59] Thus, the breach of contract claim could not survive payment of the appraisal award.

The Supreme Court also disagreed that State Farm's actions created a viable claim for bad faith. It began its analysis by reciting *Menchaca*'s "general" rule that a policyholder cannot recover damages for a statutory bad faith violation if the policyholder does not have a right to those benefits under the policy.[60] The corollary to that rule is that if coverage is available, then the policyholder can maintain the claim.[61] And, in any event, if an insurer's violation of the statute results in damages separate and apart from those provided for by the policy, they may be recovered.[62]

On the facts before it, the question was not whether Ortiz had a right to policy benefits.[63] State Farm argued that even if Ortiz was entitled to those benefits, he had received all to which he was entitled because of the appraisal payment.[64] Ortiz, however, maintained that he would be entitled to recover additional attorneys' fees and expenses essentially as independent damages.[65] The Supreme Court disagreed because while such amounts were compensatory in that they helped make a claimant whole, they are not "damages." As such, Ortiz could not recover on his bad faith claim against State Farm.[66]

B. Barbara Technologies v. State Farm Lloyds

Barbara Technologies involved almost identical facts to *Ortiz*. In 2013, Barbara Technologies made a claim with State Farm for wind and hail damage.[67] State Farm determined that the damages were below the policy's deductible.[68] Barbara Technologies then requested a second inspection that resulted in a finding of no additional damage.[69] Barbara Technologies then filed suit and State Farm invoked appraisal.[70] State Farm quickly paid the appraisal award.[71]

Unlike in *Ortiz*, Barbara Technologies then amended its petition to only assert claims seeking payment for Chapter 542 violations.[72] It argued that State Farm had violated that statute by not paying within the sixty-day time limit and moved for summary judgment.[73] State Farm filed a cross-motion for summary judgment and asserted that it could not have violated the statute when it was not yet liable for a claim.[74] The trial court agreed with State Farm as did the San Antonio Court of Appeals.[75]

The Supreme Court described the issue created by the rulings as "whether an insured's claim for prompt pay damages under the TPPCA survives the insurer's payment in full after the amount of loss" was determined in appraisal.[76] The Supreme Court began its analysis by noting that the TPPCA has three main components. First, there are non-payment requirements and deadlines, such as the deadlines to acknowledge a claim and commence an investigation.[77] Second, there are deadlines for paying claims. Third, there is the enforcement mechanism of penalty interest and attorneys' fees.[78]

To prove a claim under the TPPCA, the policyholder must establish that the insurer was liable for the claim and that the insurer failed to comply with one or more of the statutory deadlines.[79] If the policyholder cannot establish either point, the insurer will prevail. Ultimately, the real basis for liability is that the insurer is liable for the claim and failed to pay in the appropriate amount of time.[80]

Although the Supreme Court recognized that these points, and the corresponding timeline, are clearly set out in the TPPCA, the TPPCA says absolutely nothing about the appraisal process.[81] Arguments could be made that this silence meant the deadlines were not to apply to appraisals; however, the Supreme Court pointed out that the Legislature was clearly aware of appraisal, as it had existed for over 150 years and was referenced in other statutes.[82] Under such circumstances, the Supreme Court concluded that the Legislature must have intended "neither to impose specific deadlines for the contractual appraisal process with the TPPCA scheme nor to exempt the contractual appraisal process from the deadlines provided by the TPPCA."[83]

Before analyzing the TPPCA deadlines, the Supreme Court curiously limited its inquiry by stating that it must determine whether an insurer can be liable when it denies a claim, but then pays an appraisal award.[84] State Farm had not denied Barbara Technologies' claim, but determined that it did not reach the deductible. Nevertheless, the Supreme Court deemed that conclusion to have been a "rejection" of the claim in an "inherently adversarial" process.[85] The Supreme Court's determination that the under-deductible conclusion was a "rejection" is key to understanding its analysis and final ruling.

State Farm argued that its invocation of the appraisal process served as an additional information request under Section 542.055(b),[86] which allows insurers to make "additional requests" for information following the initial 15-day deadline to request "all items, statements, and forms that the insurer reasonably believes . .. will be required from the claimant."[87] The Supreme Court disagreed and explained that it read the term "additional requests" to mean two key points in time: (1) the initial request that must be made within fifteen business days after receiving the claim; and (2) additional requests revealed to be necessary during the claim.[88] According to the Supreme Court, an appraisal demand is neither because it is based on a contractual right to engage in a specific dispute resolution process, not a request for additional information.[89]

Nevertheless, to be liable under Section 542.060(a) an insurer must actually be *liable* for a claim. It explained:

> To be clear, nothing in the TPPCA suggests that the invocation of a contractual appraisal provision alters or suspends any TPPCA requirements or deadlines. Rather, under the TPPCA, until an insurer is determined to owe the claimant benefits and thus is liable under the policy—either by accepting the claim and notifying the insured that it will pay, or through an adjudication of liability—the insurer is required to pay nothing, is subject to no payment deadline, and is not subject to TPPCA damages for delayed payment. *See* TEX. INS. CODE § 542.060(a) (imposing prompt pay damages when an insurer is liable under the policy and violated a provision of the TPPCA). This is not to say that a rejected claim can never trigger damages under the TPPCA; to the contrary, if an insurer later accepts a claim after initially rejecting it, or if an insurer is adjudicated liable for a claim it rejected, TPPCA deadlines and prompt pay requirements will apply. *See id.* §§ 542.057–.060. But use of a policy's appraisal process to resolve a dispute as to the value of loss—that is, the amount of benefits the insured would be entitled to under the policy if the insurer were determined liable for the claim—and payment based on the appraisal has no bearing on the TPPCA's payment deadlines or enforcement of those deadlines.[90]

Therefore, "unless and until the insurer later accepts the claim, thereby admitting liability, or there is a judgment that the insurer wrongfully rejected the claim, the insurer is not 'liable for a claim under an insurance policy' under section 542.060."[91]

Having made that determination, the Supreme Court then turned to the question of whether the appraisal process or a subsequent award payment was an acknowledgement of finding of liability. The Supreme Court first observed that in many circumstances, an insurer's payment of an appraisal award may result from a "calculated risk assessment that paying the appraisal value will ultimately be less risky" than litigation.[92] As such, simply paying an appraisal award is not by itself enough to trigger liability under section 542.060. Nevertheless, the Supreme Court was clear that if a determination of liability was ever made with respect to a claim that the insurer had "rejected," prompt payment penalties would apply.[93]

As applied to the facts before it, the Supreme Court concluded that neither party had met its summary judgment of proof to show it was entitled to judgment as a matter of law.[94] Barbara Technologies had not demonstrated that State Farm was liable for the claim as a matter of law; neither had State Farm demonstrated that prompt payment penalties were foreclosed as a matter of law.[95] As such, the Supreme Court remanded the case for further consideration.

III. What Does the Future Look Like After *Ortiz* and *Barbara Technologies?*

Ortiz and *Barbara Technologies* may have been an effort by the Texas Supreme Court to strike a balance between policyholders and insurers, while at the same time maintaining its previous encouragements to keep appraisal disputes out of litigation. The goal, however, may not be met until policyholders and insurers test the bounds of what is clear or not from the decisions.

A. The Size of An Award Will Drive Future Litigation

The most obvious point that can be gleaned from *Barbara Technologies* is that the size of appraisal awards will likely drive which cases are tested in litigation. If the award favors the insurer, the policyholder must weigh whether the amount of Chapter 542 penalties is high enough to justify further litigation. This is particularly true for residential claims where some awards may only result in penalties of few thousand dollars. On the other hand, insurers faced with a large award favoring the policyholder, will likely have to decide whether they wish to challenge coverage in the face of potentially significant Chapter 542 penalties. Between the two, it appears likely that the future cases challenging this point will arise with commercial claims, where costs of repairs are frequently higher than the costs of litigation for both sides.

Such a result appears consistent with the Supreme Court's goals of trying to minimize litigation about appraisal. *Johnson* and *Universal Underwriters* both emphasized that appraisal is a process that does not require judges or lawyers and should best be kept from litigation. *Barbara Technologies* may make that goal a reality for those cases that are not significant enough to warrant further litigation or that may pose questionable arguments for either the policyholder or insurers. Thus, for many claims, the question of future litigation will come down to costs.

B. Partial Payments Will Likely Be An Issue

The corollary to this observation is that further guidance will be needed for appraisal awards involving multiple types of repairs. As larger damage amounts are more likely to result in litigation, it appears that future cases will primarily involve commercial policies, rather than the thousands of residential cases that led to the new decisions. In that regard, there are sharp differences between the two types of cases. Commercial claims frequently include many different types of damages, beyond simply roofing. For example, soft metals and HVAC frequently show signs of hail damage, while roofing surfaces like TPO may show no or few signs of damage. If the insurer elects to pay part of the award, but not all, the question then becomes whether that decision can be challenged as being in bad faith under *Ortiz*. The answer would seem to be "no," if there is a *bona fide* basis for the dispute, but that will not stop future challenges to that decision. As such, not only will future litigation be likely to involve more commercial claims, they may also involve claims where multiple types of damage are at issue.

C. The Potential for Abuses May Have Shifted

One of the primary arguments advanced by the policyholders in both cases was the real or imagined possibility of abuses by insurers. According to those arguments, an insurer could receive a lawsuit, review its file and determine that it had acted in bad faith, but then hide all of those facts simply by paying the appraisal award. Indeed, one justice commented on just such a point during oral argument. Whether real or imagined, the current state of the rulings may have shifted the main argument about appraisal abuses from the insurer to the policyholder.

Based on the current rulings, a policyholder with potentially weak arguments for coverage could wait to challenge an insurer's decision as to coverage for several months or even a year before invoking appraisal. Based on *Universal Underwriters*, the insurer would then probably have to engage in appraisal and address whatever award resulted. Even if the award is in its favor, the insurer would then face arguments that it still potentially owed prompt payment penalties. If the award was favorable, the penalties may be negligible, but if the policyholder dragged out the timeline, the danger for potentially high fees increases. As a result, it would appear that the arguments about abuse of the appraisal process have now shifted from the policyholder to the insurer.

One related question to the potential for abuse is whether it makes a difference if the policyholder, rather than the insurer invokes appraisal. State Farm invoked appraisal in both *Ortiz* and *Barbara Technologies* and improper invocation by insurers was one of the concerns the Supreme Court appeared to address in its opinions. But the invocation of appraisal in a questionable coverage situation is a different matter entirely. Perhaps the insurer had a wholly reasonable basis for denying a claim; it will now have to engage in appraisal and potentially fight an award or deal with settlement demands that essentially hold it hostage. Such a situation has the potential to rewrite coverage terms, or at the very least, set them aside in favor a doctrine taken far out of its context. With such considerations in play, it is not difficult to see that litigation about appraisal is far from over, despite the Supreme Court's goals.

IV. Conclusion

None of these points should be taken as all inclusive. They are offered as initial observations about two new decisions dealing with an issue that has simply exploded over the last decade. More partisan articles will describe the various arguments, but for now, policyholders and insurers should not be deluded into thinking that *Ortiz* or *Barbara Technologies* have offered the guidance to finally eliminate appraisal from the courts. Quite the opposite is true. Thus, like *Johnson* did ten years ago, *Ortiz* and *Barbara Technologies* will likely have further reaching effects than intended.

1 290 S.W.3d 886, 888 (Tex. 2009) ("Although the history of such clauses is both deep and wide, they have required this Court's attention only five times since *Scottish Union*: in 1892, 1897, 1919, 1965, and 2002.").

2 *Id.* at 887.

3 *Id.*

4 The policy used what is arguably the most popular form of the appraisal clause:

> If you and we fail to agree on the amount of loss, either one can demand that the amount of the loss be set by appraisal. If either makes a written demand for appraisal, each shall select a competent, disinterested appraiser. Each shall notify the other of the appraiser's identity within 20 days of receipt of the written demand. The two appraisers shall then select a competent, impartial umpire . . . . The appraisers shall then set the amount of the loss. If the appraisers submit a written report of an agreement to us, the amount agreed upon shall be the amount of the loss. If the appraisers fail to agree within a reasonable time, they shall submit their differences to the umpire. Written agreement signed by any two of these three shall set the amount of the loss.

See id. at 887–88.

5 *Id.* at 891.

6 *Id.* Although State Farm argued that the dispute was one of

causation, it had not put forward any evidence or suggestion of a different cause to Ms. Johnson's roof damage other than hail.

7 *Id.* at 892 (citing *Wells v. Am. States Preferred Ins. Co.*, 919 S.W.2d 679, 685–86 (Tex. App.—Dallas 1996, writ denied)).

8 *Id.*

9 *See id.* at 892–93.

10 *Id.* at 893.

11 *Id.* at 894.

12 *Id.*

13 *Id.*

14 *Id.*

15 *See* Texas Department of Insurance, Hurricane Harvey Data Call at 4 (Sept. 30, 2018), *available at* https://www.tdi.texas.gov/reports/documents/harvey-dc-04252019.pdf.

16 *See, e.g.*, *In re Cont'l Cas. Co.*, No. 14-10-00709-CV, 2010 WL 3703664 (Tex. App.—Houston [14th Dist.] Sept. 23, 2010, no pet.) (finding appraisal was a condition precedent to filing suit); *Boone v. Safeco Ins. Co. of Ind.*, No. H-09-1613, 2010 WL 2303311, at *4 (S.D. Tex. June 7, 2010) (concerning pre-suit notice); *Sanchez v. Prop. & Cas. Ins. Co. of Hartford*, No. H-09-1736, 2010 WL 413687 (S.D. Tex. Jan. 27, 2010) (addressing whether insurer's delay before invoking appraisal constituted waiver); *Woodward v. Liberty Mut. Ins. Co.*, No. 3:09-CV-0228-G, 2010 WL 1186323 (N.D. Tex. Mar. 26, 2010) (addressing whether award was substantially in compliance with policy terms); *JM Walker LLC v. Acadia Ins. Co.*, 356 Fed. App'x 744 (5th Cir. 2009) (addressing whether award was enforceable to due to alleged mistake).

17 *See* 345 S.W.3d 404, 405 (Tex. 2011).

18 *Id.* at 405–06.

19 *Id.* at 406.

20 *Id.*

21 *Id.*

22 *Id.*

23 *Id.* at 407 (quoting *Johnson*, 290 S.W.3d at 895).

24 *Id.*

25 *Id.* (quoting *In re Gen. Elec. Capital Corp.*, 203 S.W.3d 314, 316 (Tex. 2006)).

26 *Id.* at 408, 411.

27 *Id.* at 408–10.

28 *Id.* at 410.

29 *Id.*

30 *Id.*

31 *Id.*

32 *Id.* at 411 (citing 15 Lee R. Russ & Thomas F. Segalla, Couch on Insurance § 210:77 (3d ed. 1999)).

33 *Id.*

34 *Id.* at 412.

35 *See* Texas Department of Insurance, Final Presentation to the Legislature, Interim Charges: The Cost of Weather-Related Property Claims and Related Litigation at 13 (Feb. 1, 2017) available at https://www.tdi.texas.gov/reports/documents/weatherrelated-propertyclaims.pdf.

36 *Id.* at 39.

37 *Id.* at 54.

38 155 S.W.3d 340, 345 (Tex. App.—Corpus Christi 2004, pet. denied).

39 *See, e.g.*, *Hinojos v. State Farm Lloyds*, 569 S.W.3d 304, 313 (Tex. App.—El Paso 2019, pet. filed); *Zhu v. First Cmty. Ins. Co.*, 543 S.W.3d 428, 436 (Tex. App.—Houston [14th Dist.] 2018, pet. dismissed); *Anderson v. Am. Risk Ins. Co., Inc.*, No. 01-15-00257-CV, 2016 WL 3438243, at *5 (Tex. App.—Houston [1st Dist.] June 21, 2016, no pet.) (mem. op.); *Bernstien v. Safeco Ins. Co. of Ill.*, No. 05-13-01533-CV, 2015 WL 3958282, at *1 (Tex. App.—Dallas June 30, 2015, no pet.) (mem. op.); *Garcia v. State Farm Lloyds*, 514 S.W.3d 257 (Tex. App.—San Antonio 2016, pet. denied); *Cantu v. S. Ins. Co.*, No. 03-14-00533-CV, 2015 WL 5096858 (Tex. App.—Austin Aug. 25, 2015, no pet.); *Biasatti v. GuideOne Nat'l Ins. Co.*, 560 S.W.3d 739 (Tex. App.—Amarillo 2018, pet. filed); *Mainali Corp. v. Covington Specialty Ins. Co.*, 872 F.3d 255 (5th Cir. 2017).

40 545 S.W.3d 479, 484 (Tex. 2018).

41 *Id.*

42 *Id.* at 490.

43 *Id.* at 495.

44 *Id.* at 497.

45 *Id.* at 499.

46 *Id.* at 500–01.

47 *See, e.g.*, *Zhu*, 543 S.W.3d at 437–38; *Biasatti*, 569 S.W.3d at 743; *Turner v. Peerless Indem. Ins. Co.*, No. 07-17-00279-CV, 2018 WL 2709489, at *2 (Tex. App.—Amarillo June 5, 2018, no pet.); *Arnold v. State Farm Lloyds*, No. 4:17-CV-01520, 2019 WL 4034771, at *2 (S.D. Tex. June 14, 2019).

48 *Hinojos*, 569 S.W.3d at 311.

49 *Barbara Technologies* and *Ortiz* now mark the fourth time the Supreme Court has addressed appraisal since *Johnson* in 2009. Before that, it had only addressed appraisal five times in its entire history.

50 *Ortiz v. State Farm Lloyds*, No. 17-1048, 2019 WL 2710032, at *1 (Tex. June 28, 2019).

51 *Id.*

52 *Id.* at *2.

53 *Id.*

54 *Id.*

55 *Id.*

56 *Id.* at *3.

57 *Id.* at *4.

58 *Id.*

59 *Id.*

60 *Id.* at *5.

61 *Id.*

62 *Id.*

63 *Id.*

64 *Id.*

65 *Id.*

66 Nevertheless, the Supreme Court limited its holding because Ortiz had not sought any amounts other than those already paid. The Supreme Court chose not to express an opinion on whether other injuries, such a delays causing additional damage to a home or sums related to pre-appraisal damage assessments, could be recoverable.

67 *Barbara Techs. Corp v. State Farm Lloyds*, No. 17-0640, 2019 WL 2710089 at *1 (Tex. June 28, 2019).

68 *Id.*

69 *Id.*
70 *Id.*
71 *Id.*
72 *Id.* at *2.
73 *Id.*
74 *Id.*
75 *Id.*
76 *Id.*
77 *Id.* at *4.
78 *Id.*
79 *Id.* (citing Tex. Ins. Code § 542.060(a); *Progressive Cty. Mut. Ins. v. Boyd*, 177 S.W.3d 919, 922 (Tex. 2005) (per curiam); *Allstate Ins. v. Bonner*, 51 S.W.3d 289, 291 (Tex. 2001); *Cox Operating, L.L.C. v. St. Paul Surplus Lines Ins.*, 795 F.3d 496, 505–06 (5th Cir. 2015)*; Tremago, L.P. v. Euler-Hermes Am. Credit Indem. Co.*, 602 F. App'x 981, 983–84 (5th Cir. 2015) (per curiam)).
80 *Id.*
81 *Id.* at *5.
82 *Id.*
83 *Id.*
84 *Id.* at *6.
85 *Id.*
86 *Id.*
87 Tex. Ins. Code § 542.055(a)(3).
88 *Barbara Techs.*, 2019 WL 2710089 at *6.
89 *Id.*
90 *Id.* at *11.
91 *Id.* at * 10.
92 *Id.* at *9.
93 *Id.* at *12.
94 *Id.* at *16.
95 *Id.*

By Sarah E. Stogner

CORPORATE SUCCESSOR INSURANCE COVERAGE – IT'S NOT JUST A NAME CHANGE

Let's assume the following facts. It's October 1, 2019. A company calls its insurance broker and informs her that they have decided to change their corporate structure—maybe they are changing from an LLC to a corporation, or vice versa. Perhaps they are forming a new subsidiary and transferring certain assets from the parent to the subsidiary, or vice versa. Maybe they just bought the assets from a competitor. The broker notifies the company's various underwriters—letting them know about the change in entities (or change in risk) and requests that they endorse the policies to make sure the new or reimagined company is still a named insured under the relevant policies. The client is protected, right? It should be that simple. But it is not —particularly for long-tail claims (asbestos, environmental, *etc.*) under occurrence-based policies.

Here's another scenario—your client manufacturers widgets. It has decided to form a subsidiary and change the brand name on its widgets before ceasing business under the prior company. The client's current general liability policy is effective January 1, 2019 to January 1, 2020. The broker notified the insurer about the new entity, which endorsed the general liability policy to include the subsidiary as an additional named insured as of October 1, 2019. The endorsement does not mention pre-October 1, 2019 occurrences. The old company ceased operations on November 1, 2019. The new company calls you on February 1, 2020, and says it has been sued after someone was injured by a widget they purchased in January 2018—several months before the subsidiary was formed or added to the current policy.[1] The client tenders the lawsuit to its general liability insurer. The insurer has denied coverage—arguing that the successor subsidiary is not covered under the predecessor entity's insurance policy for any occurrences before October 1, 2019. The goal of this article is to highlight issues that arise with successor entity insurance coverage, and to suggest a resolution under unsettled Texas law.

Although there is not a significant amount of case law addressing these issues, most courts considering the problem have allowed a policyholder to assign its rights for post-sale claims arising from pre-sale injury or damage—even when the policyholder does not get the insurer's consent. But the courts are not consistent, there is no Supreme Court of Texas ruling addressing this specific issue, and the existing cases applying Texas law do not follow the majority rule.

I. Anti-Assignment Clauses

As with all insurance coverage issues, we must carefully read the policy language and apply it to the underlying facts. Most liability policies contain consent-to-assign provisions that purport to preclude the assignment of any interest under the policy without the insurer's consent. For example, the 1973 standard ISO CGL form contained the following condition:

> Assignment of interest under this policy shall not bind the company until its consent is endorsed hereon; if, however, the named insured shall die, such insurance as is afforded by this policy shall apply (1) to the named insured's legal representative, as the named insured, but only while acting within the scope of his duties as such, and (2) with respect to the property of the named insured, to the person having proper temporary custody thereof, as insured but only until the appointment and qualification of the legal representative.[2]

The question presented is whether this clause will preclude an assignment of claims under a given set of facts.

II. The Majority View: Post-Loss Assignment of Specific Claims Allowed

According to Couch on Insurance, "the great majority of courts adhere to the rule that general stipulations in policies prohibiting assignments thereof except with the consent of the insurer apply only to assignments before loss, and do not prevent an assignment after loss."[3] These courts reason that "[t]he purpose of a no assignment clause is to protect the insurer from increased liability, and after events giving rise to the insurer's liability have occurred, the insurer's risk cannot be increased by a change in the insured's identity."[4]

Although it is safe to say that most jurisdictions allow post-loss assignment of payment for a specific claim, their reasonings vary, and not all do (Texas included). "Some courts reach this result by reference to the no-assignment language. These clauses, [like the 1973 ISO-language quoted above] only prevent the assignment of the 'policy' as opposed to claims. Thus, a number of courts find that the assignment of the right to bring claims is not contrary to the

Sarah E. Stogner is an attorney with Flanagan Partners. She is licensed in Louisiana,Texas, and Colorado. She lives in Midland Texas and represents policyholders in insurance coverage litigation. She is a current Texas Insurance Coverage Council member.

no-assignment clause as a matter of contract."[5] "Other courts focus on the practical import of these clauses. These courts reason that the insurer is not harmed by the assignment of rights to claims for preassignment occurrences since the assigned risk is the same risk it initially agreed to insure."[6]

III. Texas: Where do we Stand?

There is no Supreme Court of Texas decision directly on point. However, state and federal courts applying Texas law have generally concluded that "[a]nti-assignment clauses have been enforced by Texas courts."[7] These general conclusions, however, fail to account for general principles of Texas insurance coverage law and are contrary to most other jurisdictions and the Restatement of Law – Liability Insurance.

Under Texas law, the interpretation of insurance contracts is governed by the same rules of construction applicable to other contracts.[8] Since the 1950s, "it is well settled law in this state that contracts of insurance in their construction are governed by the same rules as other contracts, and that the terms used in them are to be given their plain, ordinary and generally accepted meanings unless the instrument itself shows them to have been used in a technical or different sense."[9]

The Supreme Court of Texas, however, recognizes a difference between the standard policy forms governed by a state regulatory agency and a manuscript form. "In cases involving a standard form policy mandated by a state regulatory agency… the actual intent of the parties is not what counts (as they did not write it), but the ordinary, everyday meaning of the words to the general public."[10] "Conversely, in cases involving a non-standard form . . . our task is to determine and enforce the mutual intent of the parties to the contract. In doing so, the decisions of other courts in cases involving other parties and other circumstances are not as compelling, particularly when those decisions are themselves less than uniform."[11]

Although it is unclear what the Texas Insurance Commissioner intends by allowing anti-assignment provisions, it is safe to say the administration did not necessarily anticipate it would preclude the post-loss assignment to a successor entity. Does the general public have an "ordinary, everyday meaning of the words" in an anti-assignment provision? Probably not. However, the new Restatement of Law – Liability Insurance does a good job explaining the majority rule: a post-loss assignment does not materially change the risk assumed by the insurer when placing the policy.

Precluding a post-loss assignment as part of corporate restructuring also creates large and irrational coverage gaps. It seems inconceivable that an insurance policy assignment that accompanied the sale of a company would be unenforceable if the successor entity sought coverage under the predecessor's policy for a claim accruing before the sale.

IV. The New Restatement of Law – Liability Insurance

In 2019, the American Law Institute released its first Restatement of the Law, Liability Insurance.[12] The Restatement generally echoes the majority rule allowing assignment for specific claims already made against an insured:

> (1) Except as otherwise stated in this Section, rights under a liability insurance policy are subject to the ordinary rules regarding the assignment of contract rights.
>
> (2) Rights of an insured under an insurance policy relating to a specific claim that has been made against the insured may be assigned without regard to an anti-assignment condition or other term in the policy restricting such assignments.
>
> (3) Rights of an insured under an insurance policy relating to a class of claims or potential claims may be assigned without regard to an anti-assignment condition or other term in the policy restricting such assignments, if the following requirements are met:
>
> > (a) The assignment accompanies the transfer of financial responsibility for the underlying liabilities insured under the policy as part of a sale of corporate assets or similar transaction;
> >
> > (b) The assignment takes place after the end of the policy period; and
> >
> > (c) The assignment of the rights does not materially increase the risk borne by the insurer.[13]

The Restatement notes that modern contract law allows the owner of a contractual right (the "obligee") to transfer that right to a third party without the obligor's consent.[14] The common law used to forbid such transfers of a "chose in action."[15]But the former common law rule precluding the transfer of a "chose in action" is no longer in force.[16] Now, under general contract law, the only limitations for transferring rights are that:

> (a) The assignment not materially change the duty or increase the risk of the obligor or materially impair the obligator's chance of obtaining, or materially reduce the value of, return performance,
>
> (b) The assignment not violate a state statute or public policy, and
>
> (c) The assignment not contradict an enforceable anti-assignment provision in the contract.[17]

It is generally accepted that the policyholder's rights under a liability policy relating to a specific claim that has

already been made against the policyholder is a "chose in action" that is freely assignable without regard to any anti-assignment policy provision.[18] Complications arise when there is a delay and the claim is not immediately made against the policyholder. Claims may be brought years after a product is bought or someone is allegedly exposed to a dangerous substance. After the predecessor entity is gone —did the purchase and sale agreement purport to transfer rights under the insurance policies? Can they without the insurance company's consent?

V. The *Gandy* Decision – Different Assignment, but Still Instructive

In *State Farm Fire & Casualty Co. v. Gandy*, the Supreme Court of Texas analyzed whether a policyholder can assign its rights against its insurer to the plaintiff in a tort action.[19] This is a different scenario from a policyholder assigning its rights under its policy to a successor entity. However, the *Gandy* decision details the history of "choses in action" (which are discussed in detail by the Restatement). As a whole, the *Gandy* decision supports the argument that Texas should follow the majority rule allowing assignment of insurance policies to successor entities.

"Alienability of choses in action has its roots in equity, not law. At early common law, a chose in action could not be assigned."[20] Two rationales supported this early prohibition against assignments: 1) assignments increased disputes and litigation, and 2) the common law regarded these rights as personal. However, as early as the fifteenth century the common-law rule against the alienability of choses in action waned as parties demanded a way to enforce assigned debts.[21] "The pressures against the rule of inalienability were commercial and thus affected only debts and other contract rights that were not personal to the owner and could survive to his estate upon his death. Causes of action ex delicto for personal torts did not survive the plaintiff's death and could not be assigned."[22] "In Texas, the merger of law and equity allowed assigned rights to be enforced as fully as they would have been in chancery court."[23] *Gandy* noted that Texas adopted the common law, and then five days later enacted a statute that allowed the assignment of both negotiable and non-negotiable written instruments.[24] "But even contract rights not covered by the statute could be assigned."[25] "An 1895 Texas statute provided that personal injury claims survived to the heirs and legal representatives of the injured party" making personal injury claims assignable.[26]

The *Gandy* court then noted that "[p]racticalities of the modern world have made free alienation of choses in action the general rule, but they have not entirely dispelled the common law's reservations to alienability, or displaced the role of equity or policy shaping the rule."[27] The *Gandy* court went on to review four different cases where an assignment of a chose in action was found invalid. In each case, the court found the assignment "inoperative on grounds of public policy" as allowed by the Restatement of Contracts:[28]

1. Client could not assign cause of action for legal malpractice arising out of litigation. "Most of the authorities disallowing assignment have reasoned that to allow assignability would make possible the commercial marketing of legal malpractice causes of action by strangers, which would demean the legal profession. This is a legitimate concern. We do not relish the thought of entrepreneurs purchasing the legal rights of clients against their attorneys as an ordinary business transaction in pursuit of profit."[29] The court "concluded that the disadvantages to assignments of legal malpractice claims clearly outweighed the advantages."[30]

2. Mary Carter[31] agreements are void as against public policy.[32] "As a matter of public policy, this Court favors settlements, but we do not favor partial settlements that promote rather than discourage further litigation. And we do not favor settlement arrangements that skew the trial process, mislead the jury, promote unethical collusion among nominal adversaries, and create the likelihood that a less culpable defendant will be hit with the full judgment. The bottom line is that our public policy favoring fair trials outweighs our public policy favoring partial settlements."[33]

3. A tortfeasor cannot take an assignment of a plaintiff's claim as part of a settlement agreement with that plaintiff and prosecute the claim against a joint tortfeasor.[34] "We see no advantage in allowing defendants responsible for the plaintiff's injuries a right to, in effect, buy the plaintiff's claims and prosecute the other jointly responsible parties. It is not apparent that such settlements will result in any significant savings of time or resources. We can, however, envision that the settling defendant's unusual posture as surrogate plaintiff, co-defendant and cross-plaintiff will confuse a jury and possibly prejudice the remaining parties.... We are mindful of the general rule that a cause of action for damages for personal injuries may be sold or assigned. Our holding in the present case is an exception to this general rule. A settling defendant who is jointly responsible for personal injuries to a common plaintiff may not preserve contribution rights either by obtaining a complete release for all other parties allegedly responsible or by obtaining assignment of the plaintiff's entire claim."[35]

4. Assignment of interests in an estate are invalid when it distorts the real positions of litigants in interest.[36] Although interests in estates are freely assignable, decedents could not use an assignment to contest a will they were otherwise estopped from asserting.

The rationales precluding assignment in these four different scenarios all focused on the negative impacts of these purported assignments. "In widely different contexts, we have invalidated assignments of choses in action that tend to increase and distort litigation. We have never upheld assignments in the face of these concerns."[37] *Gandy* held that a defendant's assignment of his claims against his insurer to a plaintiff are invalid if intended to thwart the adversarial process:

> Balancing the various considerations we have mentioned, we hold that a defendant's assignment of his claims against his insurer to a plaintiff is invalid if (1) it is made prior to an adjudication of plaintiff's claim against defendant in a fully adversarial trial, (2) defendant's insurer has tendered a defense, and (3) either (a) defendant's insurer has accepted coverage, or (b) defendant's insurer has made a good faith effort to adjudicate coverage issues prior to the adjudication of plaintiff's claim.[38]

The *Gandy* court did not decide if an assignment could be invalid for other reasons. "We do not address whether an assignment is also invalid if one or more of these elements is lacking. In no event, however, is a judgment for plaintiff against defendant, rendered without a fully adversarial trial, binding on defendant's insurer or admissible as evidence of damages in an action against defendant's insurer by plaintiff as defendant's assignee."[39]

Neither *Gandy* nor the cases it relied upon support the conclusion that Texas generally disallows assignments. A big-picture review of Texas insurance coverage cases suggests that Texas should follow the majority and allow post loss assignments that do not materially change the risk originally assumed by the insurer.

For example, Texas law does not require strict enforcement of notice requirements in occurrence-based policies but does for claims-made policies. Courts have not permitted insurance companies to deny coverage on the basis of untimely notice under an "occurrence" policy unless the company shows actual prejudice from the delay.[40] In the case of a "claims-made" policy, however, notice itself constitutes the event that triggers coverage.[41] Under this same rationale, insurers should not be allowed to deny coverage because a policyholder has sold some or all of its assets to another entity without showing actual prejudice from the transfer. The majority rule recognizes this and generally allows businesses to assign rights under insurance policies as part of routine reorganizations, mergers, and acquisitions.

VI. The Majority Rule & Lessons Learned in California

For years the liabilities and rights associated with occurrence-based liability policies were routinely transferred as part of corporate transactions "apparently without significant challenge from liability insurers, at least as indicated by reported cases and the insurance trade literature, and in some cases even without an express assignment term in the asset-purchase documents."[42] "Such transfers came under challenge in the late 20th century, however, as a violation of a liability-insurance-policy term that prohibits the assignment of rights under the policy without the consent of the insurer."[43]

There is surprisingly little case law across the country addressing available insurance for successor entities. However, most cases analyzing the issue focus on two primary issues. First, whether the predecessor's liabilities will transfer to the successor. Second, whether the document effectuating transfer of the assets specifically contemplates transfer of the insurance policies. If the liabilities automatically transfer to the successor entity by a complete merger, the successor entity in most jurisdictions automatically receives the insurance as well. If, however, there is not a statutory merger, then most jurisdictions allow the successor entity the rights under the predecessor's policies if the purchase and sale agreement clearly and unambiguously transfers those rights after the injury has occurred, but before a claim is filed.

Under traditional common law, an entity buying another entity's assets usually does not become liable for the predecessor's liabilities arising before the transfer.[44] If an entity simply buys out the stock of another entity, there is no corporate predecessor or successor because the acquired corporation simply continues its existence with new shareholders. In transactions where the entities are merged together or assets are purchased, predecessor liability issues may arise. When the companies are merged, the liabilities and rights of a predecessor entity pass by law to the resulting or surviving entity. The nuances of Texas merger law are beyond the scope of this article. However, Texas law clearly states that "claims" may be made against an entity no longer in existence.[45] If a successor entity is responsible for the predecessor's tort liability, it only makes sense that it also be entitled to the predecessor entity's insurance in place when the tortious conduct occurred. Unless an insurer can show prejudice, prohibiting assignment of insurance will leave unintended gaps in insurance coverage, which will increase and distort litigation—the exact things *Gandy* tried to avoid.

Assignment of insurance to successor entities did not receive much attention until the California Supreme Court's 2003 decision in *Henkel Corp. v. Hartford Accident & Indemnity Co.* rejected the majority rule and brought uncertainty.[46] The *Henkel* court acknowledged that "a provision in a

contract or a rule of law against assignment does not preclude the assignment of money due or to become due under the contract or of money damages for the breach of the contract." However, *Henkel* held that only claims that have been reduced to money damages before assignment may be transferred without regard to a no-assignment clause, reasoning that insurers are harmed by the assignment of claims not reduced to money damages since the insurer might have to defend more than one entity.

The *Henkel* court explained that in light of the "ubiquitous potential for disputes over the existence and scope of the assignment . . ., the insurer might effectively be forced to undertake the burden of defending both parties."[47] Just as *Gandy* analyzed the overall impact of the defendant's purported assignment to the plaintiff, the *Henkel* decision revolved around public policy determinations, holding that it was unfair for an insurer to be responsible for defending more entities than originally bargained for in the policy.

The Supreme Court of California ultimately overruled *Henkel* in 2015.[48] The Restatement recognizes that the "question of what rights under a liability insurance policy can be assigned as part of a corporate sale or reorganization has proved controversial in some contexts in light of the presence of an anti-assignment condition in most liability insurance policies."[49] But the Restatement "does not take a position on whether liability insurance rights may be assigned without the consent of the insurer in other contexts in which there is no material increase in the risk borne by the insurer."[50]

Although not as important now that the Supreme Court of California has overruled *Henkel*, there is a line of "product-line" cases that give more concrete examples of why a policyholder should be allowed to assign post-loss policy benefits to a successor entity. The leading case is the 1992 decision from the Ninth Circuit in *Northern Insurance Co. v. Allied Mutual Insurance Co.*[51] In the *Northern Insurance* case, one company bought the assets for an alcoholic beverage. The trial court found that the asset purchase agreement did not assign the insurance benefits under the liability policy at issue. The Ninth Circuit, however, applied a rule of product-line successor liability, holding that regardless of any provisions to the contrary in the asset purchase agreement, a purchaser of substantially all assets of an entity assumes by operation of law, "the obligation for product liability claims arising from the selling firm's presale activities."[52] Accordingly, the benefits of the predecessor's liability policy, including the right to a defense, transferred by operation of law to the successor entity to the extent of coverage for any presale occurrences. The *Northern Insurance* court held that the right to indemnity "followed the liability rather than the policy itself."[53] The court rejected the insurer's arguments against the transfer, including enforcement of the consent to assignment provision and increased defense costs. The court held that the basis for honoring the consent-to-assign clauses disappears when liability arises from presale activity because the insurer still covers only the risk it evaluated when it wrote the policy, and substituting a different defendant would not substantially alter defense costs, as the "nature of the risk" originally insured remains the same. The *Northern Insurance* case is another example of why Texas law should allow assignment of policy benefits in accordance with the majority of other states.

Conclusion

Most states allow post-loss assignment of policy benefits to a successor entity. Although some cases purport to hold that Texas law generally allows enforcement of anti-assignment provisions, such holdings present an over-simplification of the issues. Some cases applying Texas law have enforced anti-assignment provisions. But they are fact-specific and should not be cited to support this as the general rule in Texas. Instead, the *Gandy* decision provides a roadmap for how the Supreme Court of Texas would likely analyze the issue. An insurer should not be able to enforce a non-assignment provision unless it results in the miscarriage or justice, or the insurer can prove it suffered prejudice.

1 The various occurrence policy "triggers" are beyond the scope of this article (exposure, manifestation, injury-in-fact, and continuous trigger), but will also be relevant to determine the insurance available (or not) to successor entities.

2 Insurance Services Office, 1973 CGL Policy Jacket Specimen, Cond. 9., reprinted in International Risk Management Institute Commercial Liability Insurance at IV.T.15, 18 (1990).

3 Couch on Insurance § 35:8.

4 *Id.*

5 *Elliott Co. v. Liberty Mut. Ins. Co.*, 434 F. Supp. 2d 483, 490 (N.D. Ohio), *on reconsideration*, 239 F.R.D. 479 (N.D. Ohio 2006). *But see In re Katrina Canal Breaches Litigation*, 63 So.3d 955, 964 (La. 2011) ("There is no public policy in Louisiana which precludes an anti-assignment clause from applying to post-loss assignments. However, the language of the anti-assignment clause must clearly and unambiguously express that it applies to post-loss assignments. Thus, it is necessary for the federal district court to evaluate the relevant anti-assignment clauses on a policy-by-policy basis to determine whether the language is sufficient to prohibit post-loss assignments.")

6 *Elliott*, 434 F.Supp. 2d at 490.

7 *Texas Pac. Indem. Co. v. Atl. Richfield Co.*, 846 S.W.2d 580, 583 (Tex. App.–Houston (14th Dist.) 1993, writ denied) (anti-assignment clause enforced where parties failed to specifically argue it should not apply in either trial or appellate court); *Texas Farmers Ins. Co. v. Gerdes*, 880 S.W.2d 215, 219 (Tex. App.—Ft. Worth 1994, writ denied) (enforce anti-assignment provision in health insurance policy where policyholder purported to assign policy benefits to chiropractor after receiving treatment).

8 *Massey and Fire Ins. Co. v. CBI Indus., Inc.*, 907 S.W.2d 517, 520 (Tex. 1995) ("insurance policies are controlled by Rules of

Interpretation and Construction which are applicable to contracts generally.")

9 *Western Life Ins. Co. v. Meadow*, 261 S.W.2d 554, 564 (Tex. 1953).

10 *RSUI Indem. Co. v. The Lynd Co.*, 466 S.W.3d 113, 139 (Tex. 2015), quoting *Fiess v. State Farm Lloyds*, 202 S.W.3d 744, 746 (Tex. 2006) (internal quotations omitted).

11 *RSUI Indem.*, 466 S.W.3d at 139.

12 Additional information about the ALI's restatement is available at the Institute's website: www.ali.org.

13 Restatement of the Law of Liability Insurance § 36.

14 *Id.* at Comment (a).

15 *Id.* Black's Law Dictionary defines a "chose in action" in relevant part as "[a] right to personal things of which the owner has not the possession, but merely a right of action for their possession."

16 *Id.* at Comment (a).

17 *Id.*

18 *Id.* at Comment (b).

19 925 S.W.2d 696 (Tex. 1996).

20 *Id.* at 714.

21 *Id.* at 706.

22 *Id.*

23 *Id.*

24 *Id.* (Act approved Jan. 25, 1840, 4th Cong., R.S., §§ 1–4, 1840 Republic of Texas Laws 144, 144–146, reprinted in 2 H.P.N. GAMMEL, LAWS OF TEXAS 318, 318–320 (1898) (formerly at Tex. Rev. Civ. Stat. Ann. arts. 568–571 (Vernon 1935)).

25 *Id.* citing *Kelley v. Bluff Creek Oil Co.*, 158 Tex. 180, 309 S.W.2d 208, 212 (1958); *Citizens State Bank v. O'Leary*, 140 Tex. 345, 167 S.W.2d 719, 721 (1942).

26 *Id.* at 707 (citing Act of May 4, 1895, 24th Leg., R.S., ch. 89, § 1, 1895 Tex. Gen. Laws 143).

27 *Id.*

28 *Id.* (citing Restatement (Second) of Contracts § 317(2)(b) (1981)).

29 *Id.* (citing *Zuniga v. Groce, Locke & Hebdon*, 878 S.W.2d 313 (Tex. App. – San Antonio 1994, writ ref'd)).

30 *Gandy*, 925 S.W.2d at 708.

31 A Mary Carter agreement is any settlement agreement between the plaintiff and some of the defendants in a case where the settling defendants pay the plaintiff a certain amount, participate in trial against the non-settling defendants, and the plaintiff agrees to release the settling defendants and pay back some of the money from judgment against the nonsettling defendants.

32 *Id.* at 709 (citing *Elbaor v. Smith*, 845 S.W.2d 240 (Tex. 1992)).

33 *Id.* at 250.

34 *Id.* at 710 (citing *Int'l Proteins Corp. v. Ralston-Purina, Co.*, 744 S.W.2d 932 (Tex. 1988)).

35 *Id.* at 22 (citations omitted).

36 *Id.* at 711 (citing *Trevino v. Turcotte*, 564 S.W.2d 682 (Tex. 1978)).

37 *Id.*

38 *Id.* at 714.

39 *Id.*

40 *Hirsch v. Texas Lawyers' Ins. Exch.*, 808 S.W.2d 561, 562 (Tex. App.—El Paso 1991, writ denied) (noting that the prejudice-notice requirement applies to "occurrence" policies).

41 *See, e.g., FDIC v. Mijalis*, 15 F.3d 1314, 1330 (5th Cir. 1994) (noting that "notice provisions are integral parts of claims made policies").

42 Restatement at Comment (c).

43 *Id.*

44 *W. Res. Life Ins. Co. v. Gerhardt*, 553 S.W.2d 783, 786 (Tex. Civ. App. 1977), writ ref'd n.r.e.).

45 Tex. Bus. Orgs. Code § 11.356(c)(1) (limited survival after termination); *see also* Tex. Bus. Orgs. Code §§ 11.001(1), (3)(a) (defining "Claim" and "Existing claim" under the TBOC).

46 62 P.3d 69, 75 (Cal. 2003).

47 *Henkel*, 62 P.3d at 75.

48 *See Fluor Corp. v. Superior Ct.*, 354 P.3d 302 (Cal 2015) (after injury resulting in loss occurs within the time limits of a policy, an insurer must honor an insured's assignment of the right to invoke defense or indemnification coverage regarding that loss).

49 *Id.* at Comment (c).

50 *Id.* at Comment (e).

51 955 F.2d 1353 (9th Cir. 1992).

52 *Id.* at 1357.

53 *Id.*

By Cathlynn H. Cannon

COVERAGE LITIGATION OVER THE DUTY TO INDEMNIFY? THE PARTIES' CONUNDRUM

INTRODUCTION

The Supreme Court of Texas has created a conundrum with respect to the duty to indemnify under liability insurance policies. On one hand, the Supreme Court has urged liability insurers and their insureds to pursue coverage litigation as soon as possible if significant issues exist regarding whether the insurer will ultimately have the duty to indemnify for a third-party claim. Yet, the Supreme Court has not removed the procedural barriers that prevent parties from seeking early resolution of coverage disputes.

HISTORICAL DEVELOPMENTS

Texas adopted the Uniform Declaratory Judgment Act in 1943. Following its adoption, some Texas courts, relying on the U.S. Supreme Court's construction of the Federal Declaratory Judgment Act, deemed the duty to indemnify justiciable prior to the determination of the insured's liability, at least under some circumstances.[1] It was not until 1968, however, that the question was posed to the Texas Supreme Court.[2] It then determined that the Texas Constitution would not allow Texas courts to determine the duty to indemnify prior to insured's liability being fixed by a settlement or judgment.[3]

In *Firemen's Insurance Co. v. Burch*, the underlying plaintiffs initiated the coverage litigation while their suit against the insured(s) was pending.[4] The underlying plaintiffs were Dorothy Burch and her husband Jesse. She had sustained severe injuries when the car in which she was riding collided with a car driven by Sarah Buttler.[5] At the time of the accident, Sarah was separated from her husband Larry Buttler and they subsequently divorced.[6] Prior to the separation, however, they had purchased the automobile policy, but only Larry was listed as a Named Insured. [7]

After suing Larry and Sarah Buttler, the Burches filed a declaratory judgment action against the insurer. They wanted, among other things, a declaration that Sarah's ex-husband was legally liable for any torts she committed during the marriage and that the insurance policy would provide coverage for any settlement or judgment arising out of the underlying lawsuit.[8] The insurer filed a cross action seeking a declaration that Larry was not liable for his ex-wife's torts and if he was, then the insurer's liability under the policy was limited to Larry's share of the community estate. [9]

The district court entered a declaratory judgment finding that the insurer had a duty to defend and indemnify Larry up to the policy's limits, but no duty to defend or to indemnify Sarah.[10] Ultimately, the issue reached the Texas Supreme Court. It affirmed the ruling on the duty to defend but vacated that part of the judgment finding that the insurer had a duty to indemnify Larry. [11]

According to the Supreme Court, the Texas Constitution barred the entry of judgment on the duty to indemnify because the judgment was a *de facto* advisory opinion.[12] Specifically, the Texas Constitution had not vested authority to render advisory opinions in the state's courts and the enactment of the Declaratory Judgment Act could not override the restrictions embodied in the Constitution. [13]

The Court observed that the case presented an interesting question of law on whether, under the circumstances, Larry was liable for Sarah's torts.[14] That, however, was a hypothetical question because so far, no court had found that Sarah had committed any torts. [15] Moreover, assuming Larry was liable for Sarah's torts, there was still another hypothetical question regarding the extent of the insurance coverage—would it be limited solely to Larry's community estate or would the coverage extend to the entire marital estate?[16] If the court decided those issues and the underlying jury returned a take nothing verdict for Sarah, the Court's efforts to resolve those questions would be wasted.[17]

Significantly, the Court acknowledged that a decision on those issues might facilitate settlement.[18] Nevertheless, the Court said that it would not issue such a decision because "the giving of advice as to proposed or possible settlements is not a judicial function."[19]

For more than two decades, the law was settled within the state court system. When coverage was unclear, insurers, insureds, as well as plaintiff's attorneys, had to make educated guesses regarding coverage when evaluating the settlement

Cathlynn H. Cannon, Esq. has extensive experience in federal and state trial and appellate courts with an emphasis on insurance coverage, general tort liability defense and commercial litigation. Cathlynn is a seasoned and pragmatic litigator with a well-established record of successfully defending clients in the courtroom, and has demonstrated equal finesse in meeting client objectives through arbitration or other types of dispute-resolution methods

value of a claim. That started to change in 1996 when the Supreme Court acknowledged that the inability to obtain early resolution of coverage issues under liability policies had spawned certain undesirable litigation tactics. [20]

The Supreme Court initially suggested that it was re-evaluating *Burch* in *State Farm v. Gandy*.[21] *Gandy* involved a collusive settlement intended to set up the insurer.[22] The underlying plaintiff had sued her stepfather for sexually abusing her as a child.[23] He tendered the lawsuit to his homeowner's carrier who agreed to defend under a reservation of rights. [24] While the lawsuit was pending, he entered a no contest plea to criminal charges, agreed to a six million dollar judgment in the underlying plaintiff's favor and assigned his claims against the insurer to her in exchange for her agreement not to seek to execute on his personal assets.[25] The underlying claimant subsequently obtained a judgment against the insurer, which was reluctantly affirmed on appeal by the Texarkana Court of Appeals.[26]

The Supreme Court agreed with the appellate court that the judgment was a sham and further observed that the type of collusive agreement giving rise to the judgment was not uncommon. The Court said that these agreements tended to arise in certain contexts. Specifically, when the insurance coverage was unclear and the defendant's ability to satisfy a judgment without insurance was limited. [27]

The Court noted that the catalyst for the *Gandy* settlement was the coverage issue. The Court said: "had the coverage issues been resolved early on the [underlying] litigation . . . it is doubtful that the [plaintiff] would have proposed settlement . . . on the terms that she did."[28] Therefore, "determining the insurer's obligations before the insured incurs liability benefits both the insurer and the insured by removing uncertainty."[29] Indeed, the Court suggested that plaintiff's attorneys might want to assist in the coverage litigation. [30]

The Court held that the insured's assignment of his insurance claim was void against public policy because it did not result from an actual trial.[31] The court went on to hold that such assignments were invalid if: 1) made prior to the adjudication of the plaintiff's claims against the defendants in a fully adversarial trial; 2) defendant's insurer had tendered a defense; and 3) either the defendant's insurer has accepted coverage or has made a good faith effort to adjudicate coverage prior to the adjudication of the plaintiff's claim.[32]

Although *Gandy* did not specifically overrule *Burch*, some courts opted to follow the *dictum* in *Gandy* and make early determinations on the duty to indemnify. One of those courts was the Beaumont Court of Appeals.[33] Based on *Gandy*, it issued a decision finding that an insurer had a duty to defend a pending lawsuit, but would have no duty to indemnify its insured for any future settlement or judgment arising out of the lawsuit.[34]

In G*riffin v. Farmers Texas County Mutual Insurance Co.*, the underlying lawsuit arose out of a drive-by shooting.[35] The facts set forth in the court of appeals' decision stated that the underlying plaintiff, Robert Griffin, sued James Royal alleging that Royal had negligently failed to control passengers riding in the bed of his pick up and as a result, they had shot the Plaintiff.[36] Royal's auto insurer filed a declaratory judgment action, while the underlying lawsuit was pending, seeking a declaration that it had neither a duty to defend nor a duty to indemnify.[37]

Because the insurer was seeking summary judgment on the duty to indemnify, it provided the court with evidence of the actual facts that had given rise to the claim.[38] The insurer logically assumed that since the duty to indemnify is determined based on the actual facts, it would have to put evidence into the record establishing those facts. It has long been axiomatic that while the duty to defend is based on the petition allegations, the duty to indemnify is based on the actual facts giving rise to the insured's liability.[39]

This evidence included witness statements provided to the police following the shooting[40] and showed that the shooting followed an encounter between rival gangs.[41] After the encounter, Royal and his companions left and then returned with guns.[42] As Royal drove his truck past Griffin and his companions, two people riding in the back of Royal's truck fired the guns injuring Griffin.[43]

The Beaumont Court of Appeals agreed with the insurer that based on the actual facts, it had no duty to indemnify Royal for any future settlement or judgment since Griffin's injuries did not arise out of the use of a vehicle.[44] The court, however, thought that the allegation that Royal had negligently failed to control his passengers invoked the insurer's duty to defend.[45]

When the case reached the Texas Supreme Court, the Court overturned *Burch* saying it was no longer good law because of intervening amendments to the Texas Constitution.[46] The Court explained that *Burch* was based on Article V, Section 8 of the Texas Constitution, which at that time gave the district and appellate courts jurisdiction over "all actions, proceedings and remedies" where the amount in controversy was at least $500.[47] Until a lawsuit concluded, a court could not determine if the amount in controversy would meet the minimum jurisdictional level.[48] The legislature had eliminated that obstacle in 1985 when it had amended that provision to give district courts jurisdiction over "all actions, proceedings and remedies" without regard to the amount in controversy.[49]

The Court observed that *Burch* was also in conflict with its more recent *Gandy* decision which encouraged early resolution of coverage issues:

> *Gandy* requires an insurer to either accept coverage or make a good faith effort to resolve coverage before adjudication of the plaintiff's claim, and also suggests that the plaintiff may wish to participate in the litigation . . . . If as *Burch* held, coverage issues other than the duty to defend are always nonjusticiable, it would be impossible for an insurer to make a good faith effort to fully resolve coverage before a judgment has been rendered on the underlying claim.
>
> It may sometimes be necessary to defer resolution of indemnity issues until the liability litigation is resolved. In some cases, coverage may turn on facts actually proven in the underlying lawsuit. For example, the plaintiff may allege both negligent conduct and intentional conduct; a judgment based upon the former type of conduct often triggers the duty to indemnify, while a judgment based on the latter usually establishes the lack of a duty. In many cases, however, the court may appropriately decide the rights of the parties before judgment is rendered in the underlying tort suit.
>
> We now hold that the duty to indemnify is justiciable before the insured's liability is determined in the liability lawsuit when the insurer has no duty to defend *and the same reasons that negate the duty to defend likewise negate any possibility the insurer will ever have a duty to indemnify.* Based on the facts and the rule we announce today, [the insurer] has no duty to indemnify Royal. No facts can be developed in the underlying tort suit that can transform a drive-by shooting into an "auto accident." Farmers has no duty to defend, and for the same reasons, has no duty to indemnify Royal.[50]

These three paragraphs have spawned considerable debate regarding the scope of the *Griffin* exception. Based on the italicized words in the third paragraph, some contend that the exception is strictly limited to the circumstances at issue in *Griffin*. Others point to the first two paragraphs as evidence that the Supreme Court intended to give Texas courts broad authority to rule on indemnity prior to the conclusion of the underlying lawsuit. Under this interpretation, the only time that a court may not rule on the duty to indemnify is when there is an overlap between the facts relevant to the coverage determination and the facts relevant to the insured's liability.

Initially, *Griffin*'s scope was not the focus of attention. Instead, it was the basis for the Supreme Court's ruling that the insurer had no duty to indemnify. Even though there was evidence in the record establishing the actual facts, the Supreme Court had ignored this evidence and determined the duty to indemnify based on the petition allegations. The Court disregarded the maxim that the duty to indemnify is based on actual facts, not petition allegations.

It is unclear why the Court decided to rule on the pleadings. Perhaps the Court was assuming that there would never be a situation where a plaintiff's attorney might intentionally or inadvertently plead a covered lawsuit out of coverage. While admittedly, it is far more common for plaintiffs' attorneys to artfully plead uncovered claims into coverage, the reverse can and does occur.[51] That quickly became apparent because Texas courts began determining the duty to indemnify based on the petition allegations, even if they were making this determination after the lawsuit had already concluded.[52] One of the earliest cases to follow *Griffin* in this respect was *Reser v. State Farm Fire & Casualty Co*.[53]

In the *Reser* case, the insurer had originally defended under a homeowner's policy but had withdrawn from the defense after the plaintiff amended the pleading and dropped a claim for defamation, the only covered claim.[54] After the lawsuit settled, the insured sued the insurer seeking, among other damages, indemnity for the amount he had paid to settle the lawsuit. The insured argued that the carrier was obligated to reimburse him for the settlement because even if the underlying petition had not asserted a covered claim, based on the actual facts, it could have asserted such a claim.[55]

The insurer argued that because it had no duty to defend, it could have no duty to indemnify.[56] Nevertheless, alternatively, it argued that the actual facts showed that coverage was barred and it provided the court with considerable evidence supporting its position. [57]

On appeal, the San Antonio Court of Appeals refused to consider any of the evidence that the insurer had provided to establish the "actual facts" giving rise to the settlement. Instead, relying on *Griffin*, the court held that the insurer had no duty to indemnify because the petition allegations had not invoked its duty to defend.[58]

The San Antonio Court of Appeals said that under *Griffin* the actual facts only mattered if the insurer was seeking to deny indemnity when it had a duty to defend.[59] If, however, the insurer did not have a duty to defend, then it could never have a duty to indemnify because if the petition allegations did not bring the claim into coverage, then proof of those allegations could not create coverage.[60] Numerous courts, applying Texas law, followed the San Antonio appellate court's interpretation of *Griffin*.[61]

The first of these appellate court decisions to reach the Texas Supreme Court was *D.R. Horton Texas LTD v. Markel International Insurance Co.* [62] The Supreme Court used its *Horton* decision to clear up the misconception that its *Griffin* decision had created.

This was a construction defect claim against D.R. Horton-Texas LTD ("Horton"). Horton was an additional insured under a CGL policy issued by Markel International Insurance Co. ("Markel") for liability arising out of the work of Markel's named insured, a Horton subcontractor. Although the subcontractor was responsible for the defective work, the petition never mentioned him. Accordingly, Markel refused to defend or to indemnify Horton. After Horton paid to resolve the lawsuit, it sued Markel for reimbursement.

On cross-motions for summary judgment, Markel argued that since the petition did not invoke Markel's duty to defend, under *Griffin*, Markel had neither a duty to defend or to indemnify. In contrast, Horton argued that the duty to indemnify had to be determined on the facts. It provided the court with considerable evidence showing that the defective construction was due to the work of the subcontractor. While the trial court allowed the extrinsic evidence into the record, it ruled in favor of Markel. The court of appeals affirmed, holding that because Markel had no duty to defend, it could have no duty to indemnify.

When the case reached the Supreme Court of Texas, it reversed and remanded to the trial court for a decision on Markel's duty to indemnify saying the trial court had to consider the extrinsic evidence when deciding if Markel had coverage for the settlement. The Supreme Court said that the lower courts had misunderstood the basis for its *Griffin* decision on the duty to indemnify. It was not based on a theory that a duty to indemnify could not exist in the absence of a duty to defend. Instead, it was based on the fact that under the specific circumstances of the *Griffin* claim, it would be impossible for the insured to develop evidence that could transform a drive-by shooting into an auto accident.[63] In contrast, Horton had presented the court with evidence that its subcontractor had actually performed the work, even if the petition did not mention the subcontractor. This evidence raised a fact issue sufficient to defeat Markel's motion for summary judgment on its duty to indemnify.[64]

A year later, the Supreme Court reiterated the proper interpretation of *Griffin* in *Burlington Northern & Santa Fe RY Co. v. National Union Fire Insurance Co.*[65] Here, Burlington Northern and Santa Fe Railway Co. ("BNSF") had entered into a contract with SSI Mobley ("Mobley") to control vegetation along BNSF's right-of-way. The contract, effective from 1994 through 1996, required Mobley to name BNSF as an additional insured under its CGL policy for on-going operations. Mobley complied with this requirement.

In 1995, a BNSF train hit a car, killing two people and injuring a third. A lawsuit resulted against BNSF and Mobley. The petition alleged that BNSF "had a contract" with Mobley to keep the vegetation cleared but Mobley "had not" used reasonable care in performing its responsibilities and this was the proximate cause of the accident.[66] BNSF tendered its defense to National Union, but National Union denied coverage because the petition allegations invoked the policy's completed operations exclusion.

BNSF then filed a coverage lawsuit and while the coverage lawsuit was pending, the underlying lawsuit went to trial resulting in a verdict of $27 million against BNSF. This was then settled under a pre-trial, high-low agreement under which BNSF paid eight million dollars.

Both BNSF and National Union filed motions for summary judgment. BNSF's motion included extrinsic evidence intended to establish that Mobley's operations were still on going at the time of the accident. The district court ruled in National Union's favor on both the duty to defend and the duty to indemnify. The appellate court affirmed saying that since National Union had no duty to defend BNSF based on the petition, it could have no duty to indemnify.[67] [68]

On appeal to the Supreme Court, National Union argued that the appellate court had acted properly when it failed to consider BNSF's evidence before deciding the duty to indemnify because this case fell under *Griffin*. Hence, the petition negated both the duty to defend and the duty to indemnify.[69]

The Supreme Court rejected this argument finding that the court of appeals had erred when it refused to consider BNSF's evidence. The Supreme Court again explained that in *Griffin*, the pleadings had negated both the duty to defend and the duty to indemnify because of the specific allegations. The petition—alleging that the plaintiff's injuries resulted from a drive by shooting—made it impossible for the insured to show by extrinsic evidence that the loss was within coverage; specifically, that the bodily injury was the result of an auto accident.[70] The court explained that *Griffin's* rationale did not apply to BNSF's coverage action:

> Here, the court of appeals determined that National Union did not have a duty to defend because the language in the plaintiffs' pleadings referenced Mobley's action as having happened in the past, so the policy's completed operations exclusion precluded a duty to defend . . . but unlike the situation in *Griffin* in this case the pleadings do not show that contractual provisions and other extrinsic evidence cannot possibly bring Mobley's vegetation control operations within coverage of National Union's policy for the 1995 accident when Mobley's contract unquestionably extended through 1996.[71]

In November 2014, in a mandamus action, the Supreme Court resolved an additional issue that has arisen from the *Griffin* decision; specifically, in *In re Essex Insurance. Co.*, the court considered whether the *Griffin* exception applies to

the underlying plaintiff.[72] In this case, the underlying plaintiff wanted to find out if the insurer would have coverage for any judgment prior to the conclusion of the lawsuit. The Supreme Court said that allowing the plaintiff to proceed under these circumstances would run afoul of the Texas rule prohibiting direct actions.[73]

When the Supreme Court issued its *Griffin* decision, it acknowledged that it was doing so, based on the reasoning of its *Gandy* decision. Specifically, that a coverage decision, made early in the course of the lawsuit, can benefit insureds, insurers and plaintiffs and discourage the type of collusion at issue in *Gandy*. In two decisions rendered after *Griffin*, involving the right of an insurers to be reimbursed for settling uncovered claims, the Supreme Court pointed to *Gandy* as as one of the reasons it was disallowing reimbursement observing:

> In *Gandy*, we required insurers either to accept coverage or make a good faith effort to resolve coverage before resolving the underlying claim. . . . [The insurer's] position undermines *Gandy* by reducing insurers' incentive to seek early resolution of coverage disputes.[74]

Indeed, the Supreme Court criticized one of the insurers for not making any effort to resolve the coverage issues prior to paying to settle the lawsuit, even though the lawsuit had been pending for more than a year prior to the settlement demand being made.[75] Nevertheless, if the Supreme Court intended to encourage early resolution of coverage issues, whenever possible, its *Griffin* decision, has failed to accomplish its goal.

RECENT DEVELOPEMENTS

Texas appellate courts contend that *Griffin* did not completely overrule *Burch*.[76] It only overruled *Burch* when there is no duty to defend and then only if the same thing that negates the duty to defend negates the duty to indemnify.[77] Therefore, if an insurer is defending, the court can only determine the insurer's indemnity obligation when the lawsuit concludes.[78]

As a practical matter, a great deal of the litigation between Texas citizens and insurers takes place in federal courts rather than Texas state courts. The U.S. Supreme Court resolved long ago that under the Federal Declaratory Judgment Act, the duty to indemnify is justiciable, even if the underlying lawsuit is on-going.[79] Therefore, unless, indemnification hinged on facts to be determined at trial, a federal court could rule on the duty to indemnify even if the insured's liability had not yet been determined.[80]

Paradoxically, since *Griffin* it has become harder to obtain an early ruling from a federal court on the duty to indemnify as illustrated by *Westport Insurance Corp. v. Atchley, Russell Waldrop and Hlavnika*.[81] In *Westport*, both the insurer and the insured wanted the court to rule on the duty to indemnify, even though the court had already ruled that the insurer had a duty to defend.[82]

In order to facilitate the ruling they stipulated to the facts that were necessary for the court to make a decision. They also represented to the court that there would be no overlap between the stipulated facts in the coverage action or the court's conclusions of law and the disputed facts and law at issue in the underlying legal malpractice action.[83]

Despite this, the court refused to issue an opinion. The court cited to Texas authorities holding that *Griffin* was limited to its facts and therefore, under Texas law, the duty to indemnify was not justiciable when the insurer is obligated to defend.[84] The judge criticized the earlier Fifth Circuit and Texas district court decisions concluding that justiciability should be decided based on federal law rather than state law because the court believed that justiciability should be characterized as substantive rather than procedural.[85]

The Court concluded that the practice of typically delaying decisions on the indemnity obligation until the end of the lawsuit is an integral part of a Texas scheme to place the risk on the insurer when coverage is uncertain.[86] This balance would be undermined if federal courts deviated from the practice of Texas state courts.[87]

The judge also noted that a ruling by the federal court on the duty to indemnify would give federal court litigants relief that is not available in state court.[88] The Court said it was unwilling to give the parties a quicker decision than they could have obtained in state court; particularly, since the coverage issue was one of first impression.[89]

Federal courts have also become more reluctant to rule on the duty to indemnify even when they determine that the insurer has no duty to defend.[90] Based on the panel's reasoning in *Hartford Casualty Insurance Co v. DP Engineering*, it may now be harder for an insurer to obtain a favorable ruling on its duty to indemnify in a federal court than in a state court.[91] In a decision involving the applicability of a professional services exclusion, the Fifth Circuit affirmed the district court ruling on the duty to defend, but reversed on the duty to indemnify. The Fifth Circuit said that under *Griffin,* a court can only find that the insurer has no duty to indemnify if it would be impossible for any facts to be developed during the case that might create any possibility of coverage.[92] Because it was conceivable that evidence might be developed showing general negligence, the district court had erred in granting summary judgment to the insurer on indemnity.[93]

DP Engineering did not present any evidence to support a contention that the actual facts differed from the allegations.[94] In contrast, in *Horton* and *Burlington Northern*, the

insureds provided the courts with evidence that the *Griffin* exception did not apply.[95] Similarly, in *VRV Development v. Mid-Continent Casualty,* the Fifth Circuit had indicated that the insured should present evidence if it intended to argue that the *Griffin* exception did not apply.[96] There, the petition failed to allege that any covered property damage had occurred during the policy period and based on this, the district court granted summary judgment to the insurer on both the duty to defend and the duty to indemnify.[97]

On appeal, the Fifth Circuit said that the district court had acted appropriately when it had resolved the duty to indemnify before the conclusion of the underlying lawsuit because based on the allegations, the lawsuit fell within the *Griffin* exception.[98] The court said that if the insured was aware of evidence that indicated that property damage might have occurred during the policy period, then the insured had the burden of bringing this to the district court's attention. Since the insured had not done so, the district court had properly entered judgment on both duties.[99]

No Texas state courts have considered the issue of whether the duty to indemnify is justiciable when a final judgment is on appeal. Federal courts, however, have determined the duty to indemnify when the lawsuit is on appeal.[100] They are particularly likely to entertain the coverage action if the parties will sustain a hardship if the court defers a ruling or if the issues relevant to coverage will not be affected by the appeal.[101]

CONCLUSION

Based on current precedent, it is unlikely that either the insurer or the insured can obtain a ruling from a court on the insurer's ultimate duty to indemnify if the insurer has a duty to defend. This is based on a consensus that *Griffin* should be limited to its facts.

There are some flaws in this analysis. First, this limited exception does not address the issues that the Supreme Court addressed in its *Gandy* decision that are created by the inability of parties to resolve coverage disputes at an early stage in the litigation.

Moreover, the Supreme Court's reasoning in *Griffin* does not support a restrictive interpretation of *Griffin*. Prior to *Burch*, in appropriate cases, Texas courts ruled on the duty to indemnify prior to settlement or judgment.[102] The *Burch* decision was based on a specific provision of the Texas Constitution.[103] In *Griffin*, the Texas Supreme Court overturned Burch because an amendment to the Texas Constitution had deleted that provision.[104] Therefore, there is no basis under the law to unilaterally preclude an early resolution of the duty to indemnify.

Significantly, in its opinion, the Court seemed to recognize this. The Court observed that even though it was overturning *Burch*, "it may sometimes be necessary to defer resolution of indemnity issues until the liability litigation is resolved . . . coverage may turn on facts actually proven in the underlying lawsuit."[105] Nevertheless, it is curious that the Supreme Court opted to determine the duty to indemnify based on the petition allegations, when the insurer had put evidence into the record that would have enabled the Court to make the decision on evidence and not allegations. This perhaps indicates that the Supreme Court intended for the *Griffin* exception to be narrowly circumscribed.

1 *Sheppard v. Employers Cas. Co.,* 365 S.W.2d 367, 368 (Tex. Civ. App.–Beaumont 1963, no writ) citing *Maryland Cas. Co. v. Pacific Coal & Oil Co.,* 312 U.S. 270, 273, 61 S.Ct. 510, 512, 85 L.Ed. 826 (1941)(holding duty to indemnify justiciable under the Declaratory Judgment Act prior to the insured's liability being determined).

2 *Firemen's Fund Ins. Co. of Newark, N.J. v. Burch* 442 S.W.2d 331 (Tex. 1968).

3 *See id.*

4 *See id.* at 332.

5 *Id.*

6 *Id.*

7 *Id.*

8 *See id.* Ultimately, the trial court entered a judgment finding that "the [insurer]is obligated by virtue of the [policy] to defend Larry J. Buttler in Cause No. 152,097….and that since Larry J. Buttler is liable for the torts of his wife Sarah C. Buttler committed during their marriage, the [insurer] is obligated by virtue of [the Policy] to pay on behalf of Larry J. Buttler, any judgment rendered against him….to the full extent of [the Policy.]"

9 *See id.* at 333.

10 *See id.* at 332.

11 *See id.* at 333.

12 *See id.* at 332-33 (citing Article 5, §8 of the Texas Constitution).

13 *See id.* at 333 (*citing California Products, Inc. v. Puretex Lemon Juice, Inc.*, 160 Tex. 586, 334 S.W.2d 780 (1960)).

14 *See id* at 333.

15 *See id.*

16 *See id.*

17 *See id.*

18 *See id.* at 334.

19 *See id.* Justice Smith dissented. He said that while he agreed as a general proposition that courts should not issue advisory opinions, the Texas constitution did not prohibit advisory opinions. *See id.* at 335. Here, there was a real and substantial dispute between the parties regarding the construction of a contract, the insurer was not and could not be a party to the underlying lawsuit, and the facts relevant to coverage were not at issue in the trial court. See id. at 337-338. Therefore, the court should have found the coverage issue justiciable and issued a decision on the rights of the parties under the contract. *See id.*

20 *State Farm Fire Ins. & Cas. Co. v. Gandy*, 925 S.W.2d 696,

714 (Tex. 1996).
21 *See id.*
22 *See id.*
23 *See id.* at 697.
24 *See id.*
25 *See id.* at 701-02.
26 *State Farm Fire & Cas. Co. v. Gandy*, 880 S.W.2d 129, 140 (Tex. App.–Texarkana 1994), ref'd 925 S.W.2d 696 (Tex. 1996) ("the judgment is sham because it is not what it is represented to be.").
27 *See id.* at 713 ("Settlement arrangements like the one here are not unusual in cases in which the plaintiffs' claims are arguably covered by defendants' insurance.").
28 *Id.* at 712.
29 *Id*. at 714.
30 *See id.*
31 *See id.* at 698.
32 *Id.* at 714.
33 *See Griffin v. Farmers Tex. Cnty. Mut. Ins. Co*., No. 09-95-202CV, 1996 WL 389232 (Tex. App.–Beaumont July 11, 1996), *rev'd in part, aff'd in part, Farmers Tex. Cnty. Mut. Ins. Co. v. Griffin*, 856 S.W.2d 81 (Tex. 1997).
34 *See id.*
35 *See id.*
36 *See id.* at * 2.
37 *See id*. at * 1.
38 *See id.*
39 *See E&L Chipping Co., Inc. v. Hanover Ins. Co.,* 962 S.W.2d 272, 274-75 (Tex. App.–Beaumont 1998, no pet).
40 *See Griffin*, 1996 WL 389232 at *2.
41 *See id.*
42 *Id.*
43 *Id.*
44 *See id* at *2.
45 *See Griffin*, 1996 WL 389232 at *2.
46 *See Griffin*, 955 S.W.2d at 81.
47 *See id.* at 83.
48 *See id.* at 84.
49 *See id.*
50 *Id.* at 84 (emphasis original).
51 *See* M. Kincaid & Z Wolfe, Insurance Issues for Trial Lawyers, 37 The Advocate (Texas) 81 (identifying reasons that a plaintiff may not want to plead a lawsuit into coverage).
52 *See Reser v. State Farm Fire & Cas. Co.*, 981 S.W.2d 260 (Tex. App–San Antonio 1998, no pet.).
53 *See id.*
54 *See id.*
55 *See id.* at 262-263.
56 *See id.* at 262.
57 *See id.*
58 *See id*. at 264 ("Using the Supreme Court's test in *Griffin,* even if all the factual allegations in the counterclaim were proven, such proof would not invoke [the insurer's] duty to indemnify.").
59 *See id.* at 264.
60 *See id*.
61 *See D.R. Horton–Texas, Ltd. v. Markel Intern. Ins. Co., Ltd.,* 300 S.W.3d 773 (Tex. App.–Houston [14th Dist] 2006, pet. granted)*; Transport Int'l Pool, Inc. v. Continental Ins. Co.*, 166 S.W.3d 781, 788 (Tex. App.–Fort Worth 2005, no pet.)(liability insurer owed no duty to indemnify insured in absence of a duty to defend); *Utica Lloyd's of Tex. v. Sitech Eng'g Corp*., 38 S.W.3d 260, 263 (Tex. App.–Texarkana 2001, no pet.) (if there is no duty to defend, there can be no duty to indemnify); *State Farm Lloyds v. CMW*, 53 S.W.3d 877, 889 (Tex. App.–Dallas 2001, no pet) (the duty to defend is broader than the duty to indemnify and where there is no duty to defend under the policy, there can be no duty to indemnify); *Folsom Inv. Inc. v. Am. Motorists Ins. Co.*, 26 S.W.3d 556, 559 (Tex. App.–Dallas 2000 no pet.) (if underlying complaint does not state facts that are sufficient to bring the claim into coverage, then even proof of those allegations cannot invoke the insurer's duty to indemnify); *Travelers Indem. Co. v. Citgo Petroleum Corp*., 166 F.3d 761, 768 (5th Cir. 1999)(While a party may have a duty to defend but ultimately no duty to indemnify, without a predicate duty to defend, indemnity cannot arise).
62 *See D.R. Horton-Texas LTD v. Markel Int'l Ins. Co.,* 300 S.W.3d 740 (Tex. 2009).
63 *See id. at 744*.
64 *Id.* at 745.
65 *See* 334 S.W.3d 217, 220 (Tex. 2011).
66 *See id.* at 218.
67 The appellate court issued its opinion in *Burlington Northern* a few days prior to the Supreme Court issuing its opinion in *Horton*.
68 *See Burlington N. and Santa Fe Ry. Company v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa*., 334 S.W.3d 235 (Tex. App.–El Paso 2009) *aff'd in part, rev'd in part;* 334 S.W.3d 217 (Tex. 2011).
69 *See Burlington*, 334 S.W.3d at 219.
70 *See id.* at 220.
71 *Id.*
72 450 S.W. 3d 524 (Tex. 2014)(per curiam).
73 *See id.* (*citing Angus Chem. Co. v. IMC Fertilizer, Inc.,* 939 S.W.2d 138, 138 (Tex. 1997) (per curiam)).
74 52 S.W.3d 128, 135 (Tex. 2000).
75 *See id.* n.6. ("we note that in this case, almost two years elapsed between the time TAC filed its declaratory judgment action and the dte it settled the [underlying] suit. The record reflects no effort by TAC during that time to resolve the coverage dispute.").
76 *Foust v. Ranger Ins. Co*., 975 S.W.2d 329 (Tex. App.– San Antonio 1998, pet denied).
77 *See id.*
78 *Warrantech Corp. v. Steadfast Ins. Co.,* 210 S.W.3d 760, 768 (Tex. App. – Fort Worth pet. denied).
79 *Maryland Cas. Co. v. Pacific Coal & Oil Co.*, 312 U.S. 270, 273, 61 S.Ct. 510, 512, 85 L.Ed. 826 (1941).
80 *Central Sur. & Ins. Corp. v. Hampton*, 179 F.2d 261, 264 (5th Cir. 1950) (district court should have ruled on duty to indemnify as well as duty to defend, even if the duty to indemnify was not justiciable under the Texas Declaratory Judgment Act because the federal act applies); *Ohio Cas. Ins. Co. v. Cooper Mach. Corp*., 817 F.Supp. 45, 48 n. 1 (N.D. Tex. 1993) (insurer would not be able to obtain a ruling in Texas state court on its duty to indemnify because the underlying lawsuit was still pending but federal courts have a more sensible view of the goal of declaratory judgment

practice and have approved declarations on those subjects that are necessary for a full resolution of coverage issues)

81 *See Westport Ins. Corp. v. Atchley*, *Russell Waldrop & Hlavinka, LLP*, 267 F.Supp.2d 601, 625-26 (E.D. Tex. 2003).

82 *See id.* at 626.

83 *See id.*

84 *See id*. at 634.

85 *See id*. at 629-31.

86 *See id.* at 630.

87 *See id.*

88 *See id*. at 634.

89 *See id.*

90 *See Hartford Cas. Ins. Co. v. D.P. Eng'g LLC*, 827 F.3d 423 (5th Cir. 2016) (although the petition alleged only professional negligence and therefore, insurer had no duty to defend, this did not foreclose the possibility that the plaintiff might establish general negligence at trial); *Solstice Oil Gas I, LLC v. Seneca Insurance Co*., 656 Fed. App'x. 221 (5th Cir. 2016).

91 *See DP Eng'g*, 827 F.3d at 431.

92 See *Id.*

93 *See id.*

94 *See id.*

95 *D.R. Horton*, 300 S.W.3d at 773; *Burlington Northern*, 334 S.W. 3d at 217.

96 *VRV Dev. L.P. v. Mid-Continent Cas. Co*., 630 F.3d 451 (5th Cir. 2011).

97 *See id.* at 453.

98 *See id.* at 459.

99 *Id.* at 459. *See also City of College Station, Tex. v. Star Indem. Co.*, 735 F.3d 332 (5th Cir. 2013) (a court can make a determination solely on the pleadings if the allegations negate the duty to defend and likewise negate any possibility that the insurer will have a duty to indemnify).

100 *See Ironshore Specialty Ins. Co. v. Tractor Supply Co.,*. 624 Fed. App'x 159, 163–64 (5th Cir. 2015).

101 *See Federal Ins. Co. v. COMPUSA, Inc.,* o. Civ.A.3:01CV0593–D, 2001 WL 1149109 at *1 (N.D. Tex. Sept. 26, 2001) (Sidney A. Fitzwater).

102 *See e.g.*, *Sheppard*, 365 S.W.2d at 368.

103 *See Burch*, 442 S.W.2d at 333.

104 *Griffin*, 955 S.W.2d at 83.

105 *See id.* at 84.

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