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Anyone interested in submitting a manuscript for publication should contact Christopher W. Martin, Editor of ***The Journal of Texas Insurance Law***, at 713-632-1701 or by email at martin@mdjwlaw.com. Manuscripts for publication must be typed double-spaced with endnotes (PC-compatible disks are appreciated). Replies to articles published in the ***Journal*** are welcome.

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Cover: Jefferson Countty Courthouse. This beautiful courthouse was built in 1931 and is located in Beaumont, Texas.
Photo by Bob Weston.

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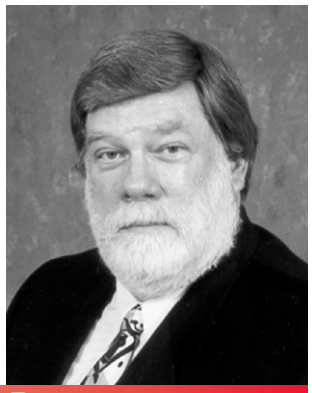

Comments FROM THE CHAIR

BY RUSSELL H. McMAINS
Law Offices of Russell H. McMains

The Spring CLE program co-sponsored by the Insurance Section and the Texas Bar CLE was a great success. More than 140 attended and were treated to both a feast of ideas and food at the Adolphus Hotel in Dallas. The same venue has been chosen and booked for next spring. I hope to see many of our 1500 members there next year.

As previously promised, the Section's annual meeting was held at the Spring CLE program and the Section bylaws were amended to provide for the annual business meeting to be held at different times upon vote of the Council and at least 30-days notice to the membership.

The Section also hosted a CLE program at the State Bar Annual Meeting in June including offsite reception for the membership with the Construction Law Section following the CLE presentations. It was a great success and we hope to do more events withe Construction Law Section in the future.

I have enjoyed serving as Chairman this year and I hope to continue service to the Section and its members in the future. The Chair-elect is Karen Keltz, who many of you know has served tirelessly as head of the Section's CLE committee for the last several years. I leave the Section leadership in capable hands.

Russell H. McMains
Chair, Insurance Law Section (2006-2007)

BY: MICHAEL SEAN QUINN

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"AGENTS" AND "BROKERS": TEXAS STATUTORY DEFINITIONS AND RULE-ENTAILING CHARACTERIZATIONS

THIS ESSAY CALLS FOR A REACTIONARY REVOLUTION IN TEXAS INSURANCE LEGAL THINKING. ITS PROPOSAL IS "REACTIONARY" IN FOUR SENSES. EACH OF THEM IS IMPORTANT.

First, it requires that we focus literalistically upon the established and clear language of the relatively old text of statutory law. Second, it requires that we comprehend and react to it——and it alone—as is appropriate in interpreting clear statutes. In interpreting statutes, everyone agrees that text is of central importance, even if context is also important and that even legislative purpose, if it is reliable and knowable, is sometimes also important.[1] Then again, one wonders how to embrace legislative intent when there are no legislative records at the time of passage, when actual testimony from legislators present is impossible—since they are all dead—or not terribly believable, since each of them had political, not to mention immediate financial motivation. Texas legislative intent is almost impossible to find and determine.

Third, the deepest and most mysterious theme and focus of this entire enterprise is the word "solicit," and the concept it expresses. We shall see why this is so important as the essay progresses. How we react to the word "solicit" under various circumstances in thinking about insurance intermediaries is crucial and—believe it or not—complex. Right here, in this area, facts and meaning are and crucially connected.

Fourth and finally, it is called "reactionary" because it demands that we react to some established desires, wishes, attitudes and perceptions in negative ways. (The proposal is not reactionary, however, in the sense that it wants to re-establish a once established rule which is now ancient and completely unused, or which was explicit, unquestionably unambiguous, well-understood, and widespread, but which is now an ignored, ill-understood, opposed, or abandoned rule, principle, norm, view or theory).

In contrast to what has been said so far, some of the proposals herein are "revolutionary"—in an orthodox sense of that word——because they require that we radically change how many think about and conceptualize one of the important low hanging and supporting branches—or perhaps event roots——of the tree of insurance law. So, let us begin. Remember! Keep the ideas of *solicit, solicited, soliciting, solicitation,* and *solicitor(s)* in mind as we go.

I. STARTING POINT

The discussion here concerns how to think about the law of "insurance agents" and "insurance brokers."[2] These two phrases can be explicated and better understood together with—or, as it were, inside——the phrase "insurance intermediaries." Insurance intermediaries are middle-persons between insurers and policyholders, policy buyers, and/or insurance policy "wannabes," (i.e., want-to-"bes"). There are many uses of the terms "agent" and "broker" in the insurance sector of life. Brokers are sometimes thought of as middlepersons at "big agencies." Big-time sellers at Marsh-Mac or Aon are often referred to as "brokers," and hardly ever as agents. Often they are thought of as middlepersons involving business insurance and specialized insurance. Some people know that there are whole chains of brokers between an insurer and those buying insurance. Agents are often thought of as selling to individuals and families. People ordinarily speak of the "State Farm agent" but

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never of the "State Farm broker." Allstate is the same. Given these usages, neither agents nor brokers are necessarily the legal agents of anyone—and certainly not either an insurer or a policyholder or policy-customer.

Occasionally, in some courts and some states, brokers are thought of as the legal agents of insurers, while agents are thought of as legal agents of customers and policyholders.[3] This usage is elegant, since it divides up the world in a sharply distinguishable way, but the usage does not fit with ordinary usage, so it must have either a statutory basis, or a basis in common law. Sometimes it does in some states; sometimes it does not. Thus, to some degree, the terms "agent[s]" and "broker[s]" are used differently in different contexts, and they are—in some ways——ambiguous, although not through and through, or in all contexts.

In discussing these matters it is important to keep in mind that there is a difference between the idea of *being an agent* (like a guy selling bus tickets), *being an agent of someone,* and *being someone's* [or *something's*] *legal agent.* (And, of course, there are many more combinations of relevant phraseology.) What we need to keep in mind more than anything else is the idea of *legal agency*. This idea always involvesd two or more persons or entities. At least one is the *agent*, and at least one is the *principal*. Agents act *for* principals; principals instruct and/or authorize agents. The agency relationship has a scope, since an agent may be authorized to do this, but not that. The relationship can have a time frame, as well as a topical frame and/or a geographic frame. If an agent is acting within the scope of his agency relationship with his principal, he can bind the principal, for example, by contract or by deed. If an agent, while acting within the scope of the agency relationship, harms some third person or entity, the principal may be responsible to the injured third party. This is called "vicarious liability"; in theory, at least, the principal could then recover from the agent. After all, it was the agent who fouled up. Interestingly, agents are frequently classified as the fiduciaries of their principals.[4]

Here are some important legal questions about insurance intermediaries. These questions are coming up more and more often in suits against intermediaries, and these appear to be becoming more common. In this essay, all of these questions are asked with respect to Texas only:

- Is an insurance intermediary always the legal agent of somebody—insurer, policyholder, policy customer, and/or another intermediary? Why? When?
- Is an insurance intermediary ever the legal agent of an insurer? When? Why?
- Is an insurance intermediary ever the legal agent of a policyholder? When? Why?
- Is an insurance intermediary ever the legal agent of a policy customer? When? Why?
- Is an insurance intermediary ever the legal agent of both the insurer and the policyholder (or customer)? When? Why?

Of course, in theory, these questions could differ as between insurance agents and insurance brokers, but that is not true in Texas, as we shall see, and so that potential difference will be ignored for here and now.

Before going further, it might be helpful to observe that insurers want middlepersons to be classified as their legal agents as infrequently as possible. Agency cannot be avoided anywhere where the middleperson is a managing general agent. These people and/or entities have the authority to issue policies for insurers, so they cannot not be agents of them. It is impossible. However, such insurers try to keep the scope of the agency as narrow as possible. Indeed, with respect to most middlepersons who—in some sense—represent, service, and/or produce for insurers, there are signed contracts containing clauses stating that the middle person is not the legal agent of the insurer. Ask yourself about the extent to which such clauses of such contracts are enforceable in Texas given the law which is about to be outlined and then discussed.

II. TEXAS STATUTE(S)

A long-lasting Texas statute—or group of statutory provisions—in the Insurance Code establish(es) at least some of the circumstances under which an insurance intermediary is the legal agent of the insurer. This statute, now §§4001.003 and 4001.051-053, will be discussed presently. It does not, by its own terms, exhaust the *ways* in which an intermediary can become a legal agent of an insurer, and it does not restrict the *scope* of this agency relationship.

The statute is not well-known in the insurance industry, and this is true not only nationally, but in Texas as well. Of course, this lack of knowledge is a great surprise. However, the statute is not well-understood by those who know of it either, and this is not so surprising. (Wishful thinking often determines interpretative belief and therefore undermines legal knowledge.). Probably most in the

insurance industry—even those who are genuinely knowledgeable——do not realize how powerful its language really is, when interpreted simply, straightforwardly, and clearly. Many judges do not like the statute and prefer avoiding, ignoring, or even misreading it. Many who do know of its existence and invoke it, usually on behalf of policyholders, misinterpret it and do not appreciate its complexity. In any case, the present version (or printing) of this statute will be discussed presently. It is of importance in contemporary Texas legal thought, but it is of even more importance—indeed, it is of enormous importance—when it is understood correctly. Toward this end, we must begin with its language in isolation.

All states have statutes regulating some insurance intermediaries, and virtually all do so extensively.[5] Many have statutes classifying and characterizing them as well. Significantly, these statutes change over time,[6] and this occasionally produces confusion among participants in the insurance industry, as well as the courts. This has not happened in Texas, to any great extent, even though there has been a substantial revision in the way in which Texas statutory law regarding insurance is designed, devised, worded, and presented.

"After all, the word 'Agent' in ordinary usage is ambiguous . . . "

With respect to agents, for example, before 2005, the most significant part of the Insurance Code was Chapter Twenty-One, Subchapter A, which was entitled, "Agents and Agent's Licenses." Art. 21.02, entitled "Who Are Agents?" and Art. 21.04, entitled "Solicitor Deemed Company's Agent" were among the most important provisions regarding the characterization of insurance intermediaries. These sections have been physically revised, reorganized a little, and very slightly altered in the new Texas Insurance Code. The relevant parts to our discussion are to be found in Chapter 4001, which is entitled "Agent Licensing in General." The two most significant of the old provisions are to be found first in §4001.051, which is entitled "Acts Constituting Acting as Agent," and which is nearly the same, except in physical configuration, as Art. 21.02,; and second in §4001.052, which is entitled, "Solicitor of Application for Insurance Considered Agent of Insured," and which is substantially the same as Art. 21.04. In addition, the new Code contains §4001.003, which is entitled, "Definitions," §4001.053, which is entitled, "Personal Liability for Acting as Agent," and §4001.001, which is entitled, "Purpose," and which is potentially extremely important to judicial reasoning.

The next sections of the paper focus on these portions of the new Insurance Code. Necessarily, much of what is said here is quotation, and only some of it is commentary. Some terms in the statutory quotes are emphasized. This is the author's addition to the statutes. There are not italics, underlinings, or emboldened letters in the statutes themselves. For reader guidance, some asterisks have been added here and there to coordinate multiple texts, i.e., statutes stating rules and statutes stating definitions. They too are not to be found in the original, official, and authoritative text.

DEFINITIONS

Section 4001.003 contains a number of significant definitions. The crucial definition is that of the word "agent," and it is to be found in §4001.003. Much of it is about to be quoted. I have added asterisks immediately following those words which are defined elsewhere in §4001.003. Neither the asterisks, nor the underlining are in the original. Here is the quotation of §4001.003(1):

> "Agent" means a person* who is an authorized agent of an insurer. . . . , a subagent,* and any other person* who performs the acts of an agent,* whether through an oral, written, electronic, or other form of communication, by *soliciting, negotiating, procuring,* **or** *collecting* a premium on an insurance … contract. [Emphasis—italics and boldness added, along with the asterisks.]

The definition also concerns representing health maintenance organizations, and it contains a list of those who or which work in the insurance industry who or which are not "agents."

The key defined term is "person." It is defined in §4001.003(8), as follows:

> "Person" means an individual,* partnership,* corporation,* or depository institution. [Asterisks added.]

The terms "individual," "partnership," and "corporation" are all themselves defined in §4001.003. The terms "insurer" and "subagent" were also used in the definition of "agent," and they are defined. The definition of corporation is a lengthy list, and – no doubt – there are hidden features in this definition.

The definition of the term "subagent" is in §4001.003(9), and it is relatively straightforward:

> "Subagent" means a person engaged in activities described under Subdivision (1)[, the definition of "Agent,"] who acts for or on behalf of an agent,* whether through an oral, written, electronic, or other form of communication, by soliciting, negotiating, or procuring an insurance … contract …, or collecting premiums or charges on an insurance … contract …, without regard to whether the subagent is designated by the agent* as a subagent or by any other term. A subagent is an agent* for all purposes of this title, and a reference to an agent in this title …, or a provision listed in Section 4001.009 includes a subagent without regard to whether a subagent is specifically mentioned. [Asterisks added.]

But Section 4001.009 is a reference to other laws, while Chapter 21, which is entitled "General Provisions," is really the numbering system taken over from the previous Insurance Code, most of which has been repealed. (One exception is Art. 21.11–2, which is entitled, "Agency Contracts with Insolvent Insurers," and there are some others, but they will not be discussed here).

WHAT MAKES AN INTERMEDIARY AN AGENT BY STATUTE?

Obviously, if someone meets the definition of "agent" found in §4001.003, then that person is an agent. It is still not clear, however, precisely what an agent is. This is especially true, given the diversity of usages that exist for the term "agent" in the insurance industry, as well as in language more broadly considered. After all, the word "agent" in ordinary usage is ambiguous, so disambiguation in the law will require, as it were, "going beyond." Above all, the definition found in §4001.003 does not identify the principal of the agent as defined in that section.

Then again, some *acts* by themselves—through their very nature——constitute the acts of a legal agent, whether the *definition* in the statute is met or not—whether the statutory definition is unambiguous or not. Miracle or miracles, at least some of these acts are to be found listed in §4001.051(b) of the statute, along with some explanations. Sound statutory interpretation virtually requires that if there are obvious examples in a statute, then this fact helps interpret, understand, and, apply the general language of a related definition. In particular, §4001.051(b) states that one who performs the listed acts is an agent *of* the insurer. Here are the key portions of this statute:

> Regardless of whether the act is done at the request of or by the employment of an insurer, broker, or other person, *a person is an agent* of the insurer** for which the act is done or risk is taken for purposes of the liabilities, duties, requirements, and penalties provided by this statute … ,[7] if the person*:
>
> (1) *solicits insurance* on behalf of the insurer;
>
> (2) receives or transmits other than one the person's own behalf *an application* for insurance **or** an insurance *policy to or from* the insurer;
>
> (3) *advertises* or otherwise *gives notice* that the person will receive or transmit an application for insurance or an insurance policy;
>
> (4) receives or transmits *an insurance policy* of the insurer;
>
> (5) examines or *inspects* a risk;
>
> (6) receives, collects, or transmits an insurance *premium*;
>
> (7) makes or forwards a *diagram* of a building;
>
> (8) takes *any other action* in the making or consummation of an insurance contract for or with the insurer other than on the person's own behalf; or
>
> (9) examines into, *adjusts*, or aids in adjusting a loss for or on behalf of the insurer. [Asterisks, italics, and bold added.]

To repeat, the aforementioned quotation is most of what is to be found in §4001.051. Remember what has been emphasized, to wit: the concepts built into the term "solicit" and its semantic relatives. Is there any signifi-

cance that it is first on the list? One cannot help but think so. Surely one would not look stupid if one mentioned this fact in argument.

Of course, this statute is not an absolutely complete account of all one would like to know about the intermediary-to-insurer agency relationship. This is true for several reasons.

First, it does not explicitly specify any duties, and it does not provide a list thereof. Of course, it is natural to look for them in the common law of legal agency. This might well be expected by the legislature under the circumstances. It would be natural especially to infer this vis-à-vis the recent legislative reorganization of this statute, since the Texas Supreme Court has done exactly this with the earlier version of the statute, at least twice.[8]

Second, it does not specify the scope of the agency relationship arising from the various functions. Clearly, someone who made a diagram of a building for an insurer would not be an agent of anyone in the same way as the someone who offered policies, solicited customers, constructed the policies, and transmitted premiums would be. Thus, the question is, g*iven that someone is statutorily the agent of an insurer, what is the scope of his agency?*

Third, to what extent can a contract between an insurer and a statutory agent control the scope of the agency? Presumably, if a contract says that the non-insurer party to the contract is not the agent of the insurer party to that contract, and the statute says he is, the statute controls. But by how much? To what extent? And why has this not been hitherto litigated? So much for summarizing and wondering about 4001.051(b). What about the other subsections?

Section 4001.051(a) states that the section applies regardless of whether the insurer is incorporated in Texas or elsewhere. Section 4001.051(e) states that if an unlicensed person refers another person to someone who conforms to §4001.051(b), this referral does not make the referring person an agent, "unless the unlicensed person discusses specific insurance policy terms or conditions with the potential customer." These two subsections are probably not terribly important for most purposes.

Section 4001.051(c) is another story. This section, which is taken over from the preceding Code, but presented more prominently, and which appears in many state statutes, is extremely important. That section states as follows:

> This section[, §4001.051,] does not authorize an agent to orally, in writing, or otherwise alter or waive a term or condition of an insurance policy or an application for an insurance policy.

In other words, insurers determine what are in the policies, either by themselves or in negotiation with an insured-to-be. Section 4001.051 never expands the scope of an insurance agent's agency so that the insurance agent can alter either the content of an insurance policy or the content and requirements of an application for insurance.

Another set of acts which constitute acting as an agent is to be found in §4001.052, entitled, "Solicitor of Application for Insurance Considered Agent of Insurer." Section 4001.052 contains, roughly speaking, the same limitations that are found in §4001.051(c). Thus, the crucial language of this section is to be found in §4001.052(a), which states as follows:

> A person who *solicits* an application for life, accident, or health insurance or property or casualty insurance *is considered the agent of the insurer issuing a policy* on the application *and not the agent of the insured in any controversy between* the insurer and the insured, the insured's beneficiary, or the insured's dependents. [Italics added.]

This section, §4001.052, is pretty much identical to Art. 21.04 found in the old Code.

COMMENTARY

Of course, there has already been some commentary built into the preceding paragraphs. Now we turn to big-time stuff. The number of cases explicating the meaning of the earlier versions of these statutes is not large, and thus are not much help in understanding the new version. Consequently, some of the commentary set forth here is based upon language, argument, prediction, and guesswork. It is not based on established case law, and, it does not say, "Here is what this statute means, since the Texas Supreme Court has said so, and that's the end of that." There is not a broad and fixed judicial or legal consensus as to the meanings of these statutes. In fact, people in the insurance industry do not understand them very well, as has already been stated, and many lawyers try to ignore them, for reasons which will become clear presently.

A. §4001.052(a): Meaning.

Start with Section 4001.052(a), just quoted above. Basically, it says that if a person "solicits" an application for various kinds of insurance, that person will be, by the courts, "considered an agent of the insurer issuing [the] policy" which is based upon the application and that soliciting person shall not be "considered an agent of the insured in any lawsuit between the insurer and the insured." It seems to the author that the term "agent" in this definition means, or expresses the idea of, *legal agent*. Thus, if someone solicits an application for insurance, that person is the legal agent of the insurer and not thereby the legal agent of the insured. This rule applies only if the insurer issues the policy.

Turn now to the other words in the statute. The term "person" is defined in Section §4001.003(8) to mean virtually any kind of human being or entity involved in the solicitation. All of the ideas of the types of insurance involved are clear enough, except for the term "casualty insurance." It is not defined in the statutes, and there is slight disagreement as to what it means. Virtually everyone agrees that it means liability insurance. One leading insurance dictionary, however, defines it as liability insurance involving bodily injury or injury to property,[9] whereas another dictionary defines "casualty insurance" as involving all insured liability whatsoever.[10] Texas insurance cases regarding liability insurance do not seem to turn on this definition.[11]

"The word 'solicit' does require that the person soliciting do something. Sitting or standing . . . and then handing over whatever is requested does not constitute 'solicitation,' in common usage."

This leaves us with the word "solicit." There are no civil cases in Texas defining this term in the insurance context. The term "solicit" appears in §7.02(a)(2) in the Texas Penal Code, which is the law against conspiracy, but it is not itself defined there.[12] Thus, the definition of "solicit" should probably be understood as it is usually used, since it does not have any kind of specialized use in the insurance industry.

Broadly understood, the verb "to solicit" means a whole range of things. At the one hand, it means *inviting somebody to do something*, while at the other end of the range it means *trying to get somebody to do something*. The word "solicit" does require that the person soliciting do something. Sitting —or standing—more or less silently and waiting for someone else to suggest something, and then handing over whatever is requested does not constitute "solicitation," in common usage. For example, tending bar does not make a person a solicitor of anything. Although this might change if the customer begins by saying, "What's a good gin drink?"

What is to be said about the following situation? An insurance intermediary has an office. A person walks into the office and says that he'd like to buy auto insurance. The intermediary says, "You've come to the right place. Here is an application." Did the intermediary solicit the sale to the person who walked in off the street? Did the intermediary solicit the application? After all, he handed it to the customer.

What about this situation? Suppose an insurance intermediary selling life insurance calls on the Smith family and suggests that they ought to buy some life insurance. Unquestionably, this is a solicitation in the context of sales. Now suppose the family agrees that they should buy life insurance, and asks "from whom should we buy it?" Now, if the agent responds and says, "I represent Jones Insurance, and I recommend them; here is an application." Unquestionably, the intermediary has solicited both business and an application. Now supposed the intermediary says, "I represent five different companies. They're all good. The prices are all about the same. Here they are. Pick the one you want. I'm pretty sure all of them will issue coverage to people as splendid as you are." Thereafter, Smith's family picks Jones Insurance Company, and they go forward.

B. §4001.053(a): Dual Agency.

Now we come to the key portion of §4001.053. Does this section contain a statutorily based legal rule that legal agents of insurers are not also—ever— the legal agents of policyholders or those seeking to buy policies? The fact is the section does not really say that.

First, the passage is restricted to certain types of insurance: life, accident, health, property, and casualty insurance. Of course, these are most all types of insurance, but they are not necessarily the only ones. What is credit risk insurance, for example?

Second, and more significantly, the statute does not say what is or is not true under Texas law. What it says is

what may be *considered* to be the case in legal controversies between insurers and insureds, insurers and the beneficiaries of insureds, insurers and the dependants of insureds. This is a legal rule about what may be done and what may not be done in the contexts of some types of litigation.

In effect, what this provision does is to forbid an insurance intermediary from being counted as a dual legal agent——once for the carrier and once for the policyholder——in controversies between the insurer and the insured. Does the statute establish that an insurance intermediary is the legal agent of the insurer, or does it establish that the intermediary is to be treated as some other type of agent of the insurer's some-other-type-of-agent, albeit an unknown and undescribed one, for some purposes at some times?

The net effect of this statute, at least in Texas, is: (1) Insurers may not argue in lawsuits, arbitrations, or what have you, that the insurance intermediary who or which solicited for it was also automatically and always the agent of the insured, when it submitted an application for the policyholder-to-be, (2) Nor, obviously, can it deny that such a person was never, in any sense, its agent. This might depend on the meaning of "solicit" and the facts surrounding the transaction, —facts which may be old, undocumented (or only partially so), or difficult to remember. (3) Of course, Texas insureds may not argue successfully in any context that all insurance intermediaries assisting them are automatically to be considered their legal agent. (Note that in three party lawsuits, where policyholders have sued both their insurers and the intermediaries it is difficult to see why this might happen, but it might).

Curiously, given the first of these Texas propositions, a leading, well known systematic, national, ABA published "textbook" account of insurance agent malpractice creates the following paradox when it begins its discussion of Texas law with the following sentence: "an insurance agent is an agent of both the insurer and the insured."[13] The article does not say "sometimes"; it does not say "occasionally"; it does not say "often, as a matter of fact." Its language implies "always."

Clearly, "duality" as to agency is possible under the statute, under some circumstances. Equally clearly, it is not universal. Over the years, precisely this "doubling" or "dualization" of legal agency for insurance intermediaries has been done repeatedly around the country, and courts of review here and there have both recognized it as reasonable and have accepted it.[14] The doubling of agency relationships for insurance intermediaries through successful legal argument in Texas, however, is extremely rare, as well as rather odd-sounding, and so many jurists and lawyers are uncomfortable about it, because precisely this idea is so clearly contrary sounding when it comes to the literal and obvious meaning of a long-established statute. If the common law of agency is supposed to be used in deciding whether a soliciting intermediary is the agent of the person purchasing insurance, as well as the insurer itself, many guess, and hence believe, that the statute would say this. Statutory silence under this condition, therefore, is often taken not to be consent, but to be prohibition. Fallacious reasoning this may be, but a socio-cultural fact, it is.

The statute does not prevent related classifications under all circumstances. Obviously, whether there is *soliciting* is or should be extremely important. Here is a situation in which meaning and facts are intrinsically connected. But there is more.

Consider the situation in which there is a controversy between and insurance intermediary and an insured, near-insured, or non-insured who was a customer/client of the intermediary. In this schema, no insurer is a party. The statute under discussion does not forbid one or both of those parties from classifying the intermediary as the legal agent of the insured in this type of controversy. Thus, an insured might have, for example, a breach of fiduciary duty action against the intermediary, if it can classify the intermediary as its legal agent, and nothing in §4001.052(a) prevents this.[15] It will do the intermediary no good to claim that he was the legal agent of the insurer, and, therefore, that under §4001.052(a) he could not be the legal agent of the insured. This statute simply does not say that. No Texas cases that say that, either and the lawyer instructional textbooks and the legal treatises regarding Texas law do not discuss it.[16]

As a matter of logic and conceptual analysis, with respect to a middleperson, if a statute says that the middleperson is the legal agent of sellers of some knowledge based product, but says nothing at all about buyers, does is follow that statutory silence entails that the middleperson is never the legal agent of the buyer? Surely not! The nature of this relationship could be determined by facts and the common law, without reference to the statute. Probably, the existence the relation of legal agency running from the middleperson to the buyer would be much less likely and much harder to establish than the relationship running from the middleperson to the seller. Has traditional doubt and confusion permanently trumped literal meaning? If this false impression has existed in the

legal community, perhaps the passage of a slightly revised Insurance Code makes it more possible to get the statutory interpretation right.

What should be done now in lawsuits where the insured has sued both the insurer and the intermediary? What is to be done and what can be said about the intermediary's relationship with the insured under these circumstances? Can the intermediary be counted as the legal agent of the insured, as well as the insurer for any purpose whatsoever? What if the insured takes the position that the intermediary did not solicit for the insurer? What if the insurer-intermediary contract stipulates that the intermediary is not the insurer's agent and/or that the intermediary does not in any sense *solicit* for the insurer. The answers to these questions are uncertain, and as usual in the law, whatever the answers are, there are pluses and minuses therein.

Of course, this second option, which is more logical given the wording of the statute after all, the word "controversy" does not mean the same thing as the word "suit" there would be practical problems galore. It would be extremely difficult to have a jury think of the intermediary in one way when it was hearing evidence about and pondering the case the insured has brought against the insurer, and then to do the opposite in the case the insured has brought against the intermediary. Therefore, for practical reasons, we suspect that the first meaning is the one that would be used in interpreting the statute. Of course, it is becoming more common to sue both insurers and intermediaries in the same lawsuit. Sometimes this is done in order to make sure that recovery is ultimately possible from the insurer. After all, principals are vicariously responsible for the actions of their legal agents, so long as their actions are within the scope of their agency. This is as true for insurance companies and intermediaries as it is for any principal, together with its legal agent.[17]

C. §4001.051(b): "The List."

Turn now to §4001.051(b). This statute provides a variety of conditions under which an intermediary is considered the agent of the insurer. In its previous version, this statute contained no reference to brokers. The fact that the word "broker" did not occur in §21.02 of the previous statute is part of the reason why people used to say that there were no brokers in Texas. Significantly, the nine (9) antecedent conditions under which a person is the agent of an insurer are *disjunctively joined*. The word "or" is the last word in Item (8) in the list of §4001.051(b). In other words, any one of the specifications which occurs anywhere on the list of (1)-(9), by itself and alone, is sufficient to make a person an agent of an insurer. Presumably, the word "agent" here means "legal agent." The list of activity which makes a person the legal agent of an insurer is immense. Consider the following characteristics of intermediaries for Zebra Insurance Company ("ZIC"):

- solicits insurance on behalf of ZIC;
- receives from a customer an application for insurance from ZIC;
- transmits to ZIC an application received from a customer;[18]
- receives an insurance policy from ZIC insuring an applicant;
- advertises that he will do any of the first four bullet points above;
- transmits to the applicant an insurance policy from ZIC insuring the applicant;
- advertises that he will do any of the first four of the above bullet points;
- gives notice that he will do what was described in the fifth bullet point;
- receives an insurance policy issued by ZIC for some insured, but physically receives it from someone other than ZIC (e.g., a wholesale broker);
- transmits a ZIC insurance policy for some applicant, but sends it to someone other than the applicant (e.g., a retail broker);
- examines a risk;
- inspects a risk;[19]
- receives insurance premium for ZIC;
- collects an insurance premium ultimately going to ZIC;
- transmits an insurance premium ultimately going to ZIC;
- diagrams a building;
- forwards to ZIC a diagram of a building made by someone else;
- does anything in the context of "making or consummating an insurance contract" involving ZIC;[20]
- adjusts a loss for ZIC;
- is an intermediary adjusting a loss for ZIC;[21]
- "examine into" a loss for ZIC.[22]

Obviously, not all of these activities are characteristic of intermediaries. The final three bullet points, for example which constitute a list of §4001.051(b)(9) are characteristic of claims adjusters, not intermediaries.

This is true even though intermediaries are often involved in claims to some extent. Local intermediaries

are often the first to know about a building catastrophe, and they sometimes phone it in. Intermediaries often try to straighten out adjustment controversies. This is particularly true as intermediary firms get larger. Some larger intermediaries have whole adjustment departments.[23]

Intermediaries seldom truly examine or inspect risks, an activity which is covered by §4001.051(b)(5). Usually, this is done by engineers or other specialists. At the same time, intermediaries will drive by buildings to see if they are really made out of brick and to express and opinion as to what kind of shape the roof is in. Intermediaries do not usually make serious diagrams of buildings, as is described in §4001.051(b)(7). This is usually reserved for specialists. Of course, the word "diagram" might include a *rough sketch*. Intermediaries might do this with respect to a smaller, simpler building, during the sales process. And so on. Obviously, to some extent, §4001.051(b) pertains to the scope of legal agency, although it is not dispositive. (The agreement between the insurer and the intermediary –or whoever –would be relevant, as would habit and established custom).

Nevertheless, if one focuses on §4001.051(b)(1)-(4), (6), and (8), it is perfectly clear that virtually all of the activities of any intermediary make it a legal agent of the insurer, for at least some purposes. There are significant questions, some of which concern clarity. The most significant question is whether the performance of a specified activity for example, receiving from an applicant and sending off to an insurer an application for insurance restricts the scope of the intermediary's being an agent to that activity alone, or whether the intermediary's engaging in that activity constitutes evidence of a more general scope of agency. (The author would bet the latter.) Then again, how general would the scope of that agency be? Probably this truth depends upon what the intermediary has done, and how it is usually viewed and understood by those involved and the industry in general.

Another question about clarity is to be found in §4001.051(b)(1). According to it, person *A* is an agent of insurer *B* if he "solicits insurance on behalf of" *B*. Suppose *A* sells insurance to customer *C*. Suppose further that *A* does not tell *C* whose insurance he is trying to sell, i.e., whose insurance he is trying to get *C* to buy. Has *A* solicited the purchase of insurance from *C* for *B*? What if *A* represents five insurers, and he tries to sell *C* a type of policy sold by each of them, but *A* makes no reference to which insurers he represents, or how many there are? Or, suppose *C* agrees to buy insurance through *A*, and *A* hands *C* a list of five insurers, and tells *C* to pick one. With respect to which of the insurers on the list is *A* an agent under §4001.051(b)(1), if any?

The well known case of *Lexington Ins. v. Buckingham Gate*[24] is instructive. Buckingham recovered from the intermediary after a jury trial for misrepresentation. The question on appeal relevant to the topic of this essay was whether the intermediary was the legal agent of the insurer, and if so, with respect to what? The court found that the intermediary was the legal agent of the insurer with respect to some activities, but not with respect to at least one other activity, namely, representations made regarding the policy. It would, however, automatically have been a legal agent of the insurer in the relevant respects, had it been what used to be called in Texas a "local recording agent," the opinion of the appellate court implied.[25]

We need to take a little closer look at a few features of the case, namely to wit: how the court described the legal relationship between the insurer and the intermediary. Unquestionably, the facts of the case established that the intermediary *solicited* insurance business from Buckingham for Lexington. This is not what the Court held, however. What it held was that the testimony of the intermediary:

> showed that he (1) examined the risks involved with the property, (2) [his agency] received the policy from Lexington and sent it to Buckingham, (3) collected the premium from Buckingham and sent it to Lexington, and (4) aided in adjusting the loss of the dock. Therefore, [the agency] was Lexington's agent for purposes of article 21.02.

Remember, Art. 21.02 contains roughly the same provisions as §4001.003 and §4001.051(b).

If the Court had found that the intermediary was involved in *soliciting* insurance on behalf of Lexington, it is difficult to see how the intermediary would not have had at least implied authority with respect to making statements about the content of the policy. It would not have the authority to change the terms of the policy, but its authority would be such that its principal would be financially responsible for the legal misrepresentations of its legal agent in the context of soliciting insurance. Of course, the intermediary would itself be liable. (It would, after all, have been the one to make the mistake.) If nothing else this liability might have been established by

the doctrines of promissory or equitable estoppel, as the Utah Supreme Court observed recently.[26] Probably, the term "solicit" should be broadly understood, from which it would follow that any explanation of what was contained in the policy which might have a role in discouraging the insured from moving on to a different carrier or indicating to the insured that it did not need to buy additional coverage would be within the area of *soliciting coverage* or *soliciting business*.

How could the Court possibly have impliedly held, through its silence, that the intermediary did not have responsibilities or activities with respect to soliciting business? Only two explanations seem plausible. The first one is the more likely. (1) The lawyers presenting the case simply failed to include testimony about this. This explanation is hard to believe, since need for precisely this is so obvious. (2) The appellate court did not "like" the genuine implications of what was then the controlling statute, namely Article 21.02 of the then and older Texas Insurance Code, so it wrote in such a way to avoid its implications.

". . . the statute creating local recording agencies and soliciting agencies has disappeared."

It would seem harder to do today what the *Buckingham Gate* court did in 1999. The reason is that the statute creating *local recording agencies* and *soliciting agencies* has disappeared. The word "solicit," when found in the Insurance Code, should not be thought of in terms of old, if not ancient, and now extinct, statutory terms and concepts. (By the way it should be emphasized somewhere along the line, that many jurisdictions other than Texas have over time used the categories of *local recording agent* and *soliciting agent*. These categories were not peculiar to Texas law, and some years ago they were standard vocabulary throughout large parts of the industry.[27] They are dying everywhere if they are not already dead. Of course, the term "managing general agent" is still alive and well, and it has some similarity to the idea of a *recording agent*. This fact of business language usage is completely irrelevant to the main point here.)

D. §4001.052: Intermediaries and Other Agents.

It has already been pointed out that §4001.052 forbids dual agency classification of intermediaries remember, these are agents and brokers in controversies between insureds and insurers. Significantly, this prohibition is restricted to those who *solicit applications* for various types of insurance. Section 4001.052(a) does *not* prohibit dual-agency classification for anyone else governed by §4001.051(b). This list includes inspectors, engineers, technicians of various sorts, accountants perhaps, architects, architectural technicians, and perhaps most importantly claims adjusters. These people can—legally speaking be classified as agents of the insurer, and also be classified as agents of the insured. This is seldom true with respect to adjusters, although sometimes it might be. (Large companies, for example, sometimes have their own staff of adjusters. They may have subsidiaries which perform adjustment services for the other corporate members of the group. Sometimes, insurance companies send adjusters to the facilities of large companies and work out of them, at least somewhat under the supervision of some of the insured's risk managers).

The fact that Texas courts tend to ignore the implications of §4001.051(b), and its predecessor, has already been mentioned. Since adjusters are being discussed here, this might be a good place to mention one of the most significant cases in which this statute is ignored. The case is *Natividad v. Alexsis, Inc.*,[28] a case about adjustment problems. This case is mainly about whether the tort of common law bad faith reaches adjusters who are not employed by the insured, but are retained by the insurer, or are retained by someone retained by the insurer, as were the facts were here. The principal ruling in the case was as follows:

> [t]he duty of good faith and fair dealing emanates from the special relationship between the parties and not from the terms of the contract, therefore its breach gives rise to tort damages and not simply and not simply to contract liability. . . . [T]he 'special relationship' exists only because the insured and the *insurer* are parties to a contract that is the result of unequal bargaining power, and by its nature allows unscrupulous insurers to take advantage of their insureds. Without such a contract, there would be no 'special relationship' and hence, no duty of good faith and fair dealing.[29]

This is not necessarily a genuine deprivation with respect to an injured insured, since, under this case, "[w]hen the insurance carrier has contracted with *agents*

or contractors for the performance of claims handling services, a carrier remains liable for actions by those *agents or contractors* that breach the duty of good faith and fair dealing owed to the insured by the carrier."[30] In other words, an insurer's duty of good faith and fair dealing is "non-delegable."

Thus, notice that adjusters are counted as either agents or contractors. Under §4001.051(b)(9), and its statutory predecessor, adjusters are the agents of the insurer. Clearly, the court has ignored the message of the statute. This is true in several passages of the *Natividad* majority opinion. At the same time, it must be admitted that not every passage is inconsistent in this way. Here is a different one: "By imposing a non-delegable duty of good faith and fair dealing on insurance companies[,] we are sending a clear message–the buck stops with them. The insurance companies must answer for the 'sins' of their agents."[31] This passage appears to imply that adjusters are agents. This implication is present because the court has already held that insurers are vicariously liable for acts or omissions of outside adjusters working on a claim involving an insurance policy issued by the defendant insurer.

E. §4001.003(1): The Definition of "Agent."

Relevant parts of the definition of "[insurance] agent" are found in §IIA above. There are several things to notice about this definition. The most important of these is that the idea of an *agent* is conceptually tied to the idea of an *insurer*. The "tie" can be immediate, or it can be removed by one, two, or even more steps. Thus, a person is an agent if he is the "authorized agent of an insurer." A person can be an *insurance agent* if he is a subagent of "an authorized agent of an insurer." A person can be an *agent of an insurer* if he performs the act of an agent of an insuret. It does not matter whether he performs these acts orally or in writing. They may be done face to face; they may be done over the phone; or they may be done over the internet. Thus, the people who are portrayed in television insurance ads for Progressive Insurance as those who take incoming calls, sit at computers, and share data, are agents of Progressive. (One could also wonder whether the actors who appear in those commercials are also agents for Progressive, since they are soliciting insurance business on behalf of Progressive, but that inventive question can be left for another day.) The person may also be an agent if he solicits insurance contracts, negotiates insurance contracts, procures insurance contracts, or collects premiums on insurance contracts. The author confesses that he is not entirely clear about each term of this definition. What, for example, is the difference between *soliciting* and *procuring* insurance contracts? Is one of these to be done for an insurer while the other one is to be done for an insured?

CONCLUSIONS

(1) The word "agent" in the relevant statutes frequently means "legal agent." It would be hard to see how it could mean anything else. Why would it be so elaborately explicated if it meant something else? It is as if the statute is saying, "Get this straight." Then again, the statute could be clearer.

(2) Determining the meaning of the term "agent" in the statute depends not just upon language and statutory terms, but upon facts, actual beliefs at relevant time among the disputing parties, and the true nature of the contexts.

(3) This last point applies with special force to two typical features of insurance markets: (a) the meaning of *solicitation,* and related terms; and (b) the scope of a legal agency relationship if the intermediary is the legal agent of the insurer.

(4) Insurance intermediaries are quite often the legal agents of the insurers which they serve. This sort of thing does not matter when the intermediary is a large company with plenty of money (as it were, a "brokerage house"), but it does or may well matter if the intermediary is a small firm or solo person.

(5) Under some circumstances, the intermediary can be the legal agent of both the insurer and the insured. In any coverage lawsuit where both the insurer and the insured are parties, along with the intermediary, a finding of duality will turn closely on the facts, as well as the meaning of concepts grouped together as *soliciting.* Usually, insureds will want the intermediary to be the legal agent of the insurer because of his soliciting business. If the insured is trying to establish duality, the opposite will be true, but he will still want the intermediary to be the insurer's agent in some relevant way. This is not an easy argument. Only a professor of rhetoric could love this last maneuver.

(6) The judiciary needs to be cured of its aversion to thinking of insurance intermediaries as legal agents, as do others. Alas, it is not easy to see how to achieve this reform in widespread legal impressions, if not actual idea.

[1] *Index of Abbreviations.* To simplify citations and convey judgment if not information, I have grouped most of the works cited together here. The most straightforward is Part IV, entitled "Insurance Agents and Brokers," of the chapter entitled "Insurance" found in 43 AM. JUR.2d §§122-182 2003, hereinafter cited as "AJ2§ ___." Less helpful is the state legal encyclopedia, TEXAS JURISPRUDENCE (THIRD). Two volumes are devoted to insurance, and the whole section is entitled *Insurance Contracts and Coverage.* The appropriate part of the 1343 sections is Chapter IV, entitled "Agents and Brokers," found in 45 TEX. JUR.3d §§ 271-394 (2006), hereinafter cited as "TJ3§ ___." Also very important, as an encyclopedic-in-scope genuinely learned -treatise, is Lee R. Russ & Thomas F. Segalla, COUCH ON INSURANCE 3D (2005), hereinafter cited as "C3d§ ___." One of the most important single-volume insurance treatises is Robert E. Keeton and Alan I. Widiss, INSURANCE LAW; A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES (1988), hereinafter cited as "K&W§ ___." Interestingly, the authors entitle their central section on this topic, "Intermediaries in Insurance Marketing." Id at § 2.5. Another helpful volume is Mark L. Kincaid and Christopher W. Martin, INSURANCE LITIGATION (2005), hereinafter cited as "K&M §____." Another significant textbook is a very thick paperback. Robert H. Jerry II, UNDERSTANDING INSURANCE LAW (1986), hereinafter cited as J2. A significant article on Texas law is Nancy Manderson, *Insurance Agent Malpractice: The Texas Experience*, 29 TORT AND INS. L.J. 623 (1994), hereinafter cited as "M at ___. A little bit will be said about English law regarding insurance intermediaries here and there in this paper. We will rely upon Malcolm Clarke, POLICIES AND PERCEPTIONS OF INSURANCE: AN INTRODUCTION TO INSURANCE LAW (Oxford University Press: Clarendon Law Series, 2003), hereinafter cited as "C at ___." This is a high prestige series of legal treatises. Some of them are among the most famous and influential legal treatises of the 20th century. Indeed, this book was first published in 1997. *See* Martin S. Schexnayder, *Insurance Agent Liability in Texas*, 64 TEX. B.J. 458 (May 2001) hereinafter cited as "S at ___."

[2] Jonathan T. Molot, *The Rise and Fall of Textualism,* 106 COLUMBIA L. REV. 1, 35, n. 50 &c. (2006) (arguing at length for moderate and modest textualism in opposition of Justice Scalia and Judge Easterbrook, among others).

[3] S at 462.

[4] For a general account of the complexities here see C3d§45 and for an overview of confusions and vagaries see K&W§2.5(a)-(b), esp. §2.5(b)(3)-(4). See also J2§35[e] for a screaming error: "Agents are usually employees of the insurer. . . ." See also S at 458.

[5] For a statement of the general law of agency, the following is about as good as it gets: RESTATEMENT OF THE LAW GOVERNING AGENCY (THIRD) (2006). This latest relevant restatement is shorter than its immediate predecessor and perhaps more concise. Still, AGENCY (SECOND) is a good research tool, since it has so many cases collected over the years, since its 1958 publication.

[6] C3d§47:3.

[7] *See Country Mut. Ins. Co. v. Carr*, 852 N.E.2d 907, (Ill. App. 2006, appeal pending).

[8] As well as those provided by the unrepealed articles of Chapter 21 of the Code, which is Chapter 21 from the old Code, most of which has been repealed, or which are provided by the other laws set forth and listed in §4001.009 of the new Code.

[9] See *Celtic Life Ins. Co. v. Coats,* 885 S.W.2d 96 (Tex. 1994) and the case it relied upon *Royal Globe Ins. Co. v Bar Consultants, Inc.,* 577 S.W.2d 688 (Tex. 1979).

[10] Thomas A. Green, GLOSSARY OF INSURANCE TERMS, 40 (5th Ed. 1994).

[11] Michael C. Thomsett, "Compiler," INSURANCE DICTIONARY 25 (1989).

[12] In fact, the author has not located a Texas insurance case which defines these terms.

[13] The earlier concept of *soliciting agent* utilized the definition of the term "solicitor." was It was found in Art. 21.14 §2 of the old Texas Insurance Code.

[14] M at 623-24. ("[T]he agent is often in a difficult position and [that is] why an important threshold question in many agent malpractice actions is 'for whom was the insurance agency acting?'" [T]he agent's dual roles and the lack of firm, specific legal guidelines have combined to increase dramatically the agent's exposure to malpractice liability."

[15] C3d§45:21

[16] One wonders what fiduciary duties an insurance intermediary might owe a policyholder. As far as we are aware, there is no systematic study of what they might be. Here are some possibilities: undivided loyalty, trustworthiness, fairness, good faith, integrity, scrupulousness, full and complete disclosure of material facts, candor, openness, honesty, an absence of concealment, an absence of deception, confidentiality to the extent the customer might desire it, reliability, disclosure of any possible conflicts, and the placing of the client's interests ahead of his own. This list has been deliberately constructed so that it is not quite as high as the fiduciary duties lawyers owe their clients, but it is still recognizably higher than a simple routine commercial relationship. For a summary and bibliography of fiduciary duties attorneys owe their client under Texas law, see www.michaelseanquinn.com, in the "Articles" section.

[17] For example, see K&M§274&307.

[18] *Celtic Life Ins. Co. v. Coats*, 885 S.W.2d 96, 98-99 (Tex. 1994); *Royal Globe Ins. Co. v. Bar Consultants, Inc*., 577 S.W.2d 688, 693-94 (Tex. 1979).

[19] The last two items exclude applications the person in question is submitting on his own behalf.

[20] The ideas of *examining* and *inspecting* are slightly different. Usually, it is physical, real property which is inspected. Financial documents and internal organizational schemes are not inspected, they are examined. (The usages we are deploying here are not completely universal, and they are certainly not rigid).

[21] Again, other than a contract of which the person is a party.

[22] According to Professor Clarke, in England, intermediaries often get involved in loss adjustments. C at 56-57. It is less common today in the United States that intermediaries would be in charge of or have control over claims adjustment, but years ago, it was quite common. It still happens occasionally as to small claims, e.g., small personal household and auto claims of no particular controversy. (One sees this occasionally when stuff is stolen out of a car, and the history between the company and the claimant is without suspicion).

[23] What do you suppose it is to "examine into" a loss?

[24] On its website, for example Marsh advertises that it helps with claims advocacy and claim documentation preparation, at least for large businesses with specialized problems, e.g., the chemical industry.

[25] *Lexington Ins. Co. v. Buckingham Gate, Ltd., Inc.*, 993 S.W.2d 185 (Tex. App.—Corpus Christi 1999, pet. denied).

[26] *See* C §45:22. *See also* S at 460.

[27] *Youngblood v. Auto-Owners Insurance Co.,* ___ P.3d ___, 2007 WL 861157 (Utah March 23, 2007).

[28] AJ2 §146-47.

[29] *Natividad v. Alexsis, Inc.*, 875 S.W.2d 695 (Tex. 1994).

[30] *Id*. at 697-98. [Emphasis added.]

[31] *Id*. [Emphasis added.]

[30] *Id*. at 698. n. 7.

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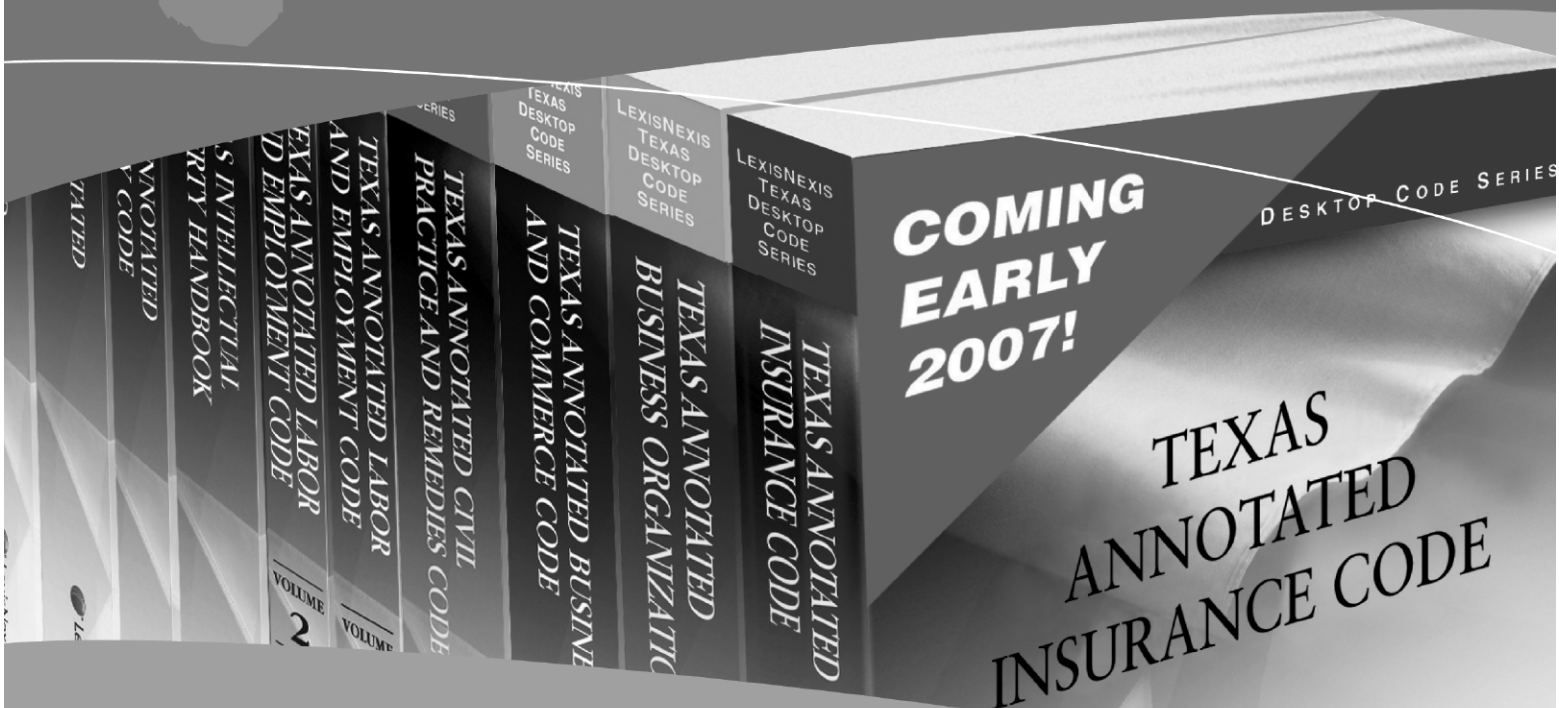

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A PRIMER ON "KNOWN LOSS" AND "LOSS-IN-PROGRESS"

In recent years, the fortuity doctrine's known loss and loss-in-progress rules have become potent affirmative defenses in coverage litigation that carriers have turned to with increasing frequency. Today, the two rules often receive consideration any time the conduct of an insured or its principal, which gave rise to claimed injury or damage, pre-dated the issuance of the insurance policy. At the same time, practitioners and courts should not lose sight of the moral underpinnings for the rules, as judicially-crafted tests for minimum honesty and good faith by insureds when contracting with insurers; neither should they unnecessarily frustrate the intent of the contracting parties to shift risk.

I. HISTORICAL DEVELOPMENT

A. Pre-*Burch*

The current known loss and loss-in-progress rules have considerable ancestry. For example, in 1828 the Supreme Court discussed some of the rationale underlying them, as follows:

> The contract of insurance has been said to be a contract *uberrimae fidei*,[1] and the principles which govern it, are those of an enlightened moral policy. The underwriter must be presumed to act upon the belief, that the party procuring insurance, is not, at the time, in possession of any facts, material to the risk which he does not disclose; and that no known loss had occurred, which by reasonable diligence might have been communicated to him. If a party, having secret information of a loss, procures insurance, without disclosing it, it is a manifest fraud, which avoids the policy. If, knowing that his agent is about to procure insurance, he withholds the same information for the purpose of misleading the underwriter, it is no less a fraud ….

McLanahan v. Universal Ins. Co., 26 U.S. 170, 185 (1828).

Early Texas cases mentioning the known loss or loss-in-progress rules, or applying their rationale, arose under diverse lines of insurance, including workers compensation,[2] auto collision or liability,[3] fire insurance[4] and life insurance.[5] Probably the most noteworthy early case was *Alliance Insurance Co. v. Continental Gin Co.*, 285 S.W. 257 (Tex. Comm'n App. 1926). The court in that matter reiterated the prevention of insured fraud in contracting for insurance as illustrated by *McLanahan*, *supra*, but then also introduced the concept of the harm to the common-good wrought by improper loss payments:

> Property in *esse* … is the basis of a contract of or for fire insurance. A substantial element is the chance of loss. If either thing be absent (*i.e.*, if there be no property originally or chance of loss be precluded by the certainty incident to pre-occurring fire), the insurance company is in the absurd position of freely offering to pay a large and certain sum … if the insured will pay to it the comparatively insignificant amount of the premium …. When good faith of both parties is assumed and the property does not exist, there is a mutual mistake of fact as to the very subject-matter of the agreement; if the insurer acts in good faith, but the insured knows of the previous destruction, there is present avoiding fraud. The business of fire insurance has acquired quasi public aspects. Rate regulation has proceeded to the point where improper payment of losses substantially affects the well-nigh common burden. And because of these things, it is our opinion that public policy would inhibit the making or enforcement of an insurance contract in relation to imaginary property, even where both parties so intend.[6]

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B. *Burch v. Commonwealth County Mutual*

The most recent Supreme Court of Texas opinion to address either the known loss or loss-in-progress rule is *Burch v. Commonwealth County Mutual Insurance Co.*, 450 S.W.2d 838 (Tex. 1970).[7] Discussing the above-quoted analysis from *Alliance*, the court in *Burch* observed that "[s]ome of these statements are too broad."[8] The *Burch* court did agree with the proposition that an insured that procures an antedated policy, knowing a loss has already occurred during the policy period, commits a "fraud that would enable the insurer to set aside the contract."[9] And the court further agreed that "it is contrary to public policy for an insurance company, the business of which is affected with a public interest, knowingly to assume the burden of a loss that occurred prior to making the contract."[10] The court, however, disagreed with the suggestion from *Alliance* that a contract of insurance was impossible when both applicant and insurer in good faith mistakenly did not know a loss had occurred.[11]

"It is contrary to public policy for an insurance company . . . knowingly to assume the burden of a loss that occurred prior to making the contract."

In that regard, it appears Burch had previously insured another auto with Farmers through agent Bobby Hardin. At approximately 6:00 p.m. on July 18, 1967, he asked Hardin for insurance on a Chevrolet. Hardin figured the premium; Burch signed an application, gave a check for the premium, and left, thinking he had coverage. He knew, however, that Hardin wrote coverage for several companies, and did not necessarily expect to receive a Farmers' policy. The Chevrolet was undamaged at the time.

Early the next morning, Hardin, believing that Farmers would not accept the risk, took the application and premium check to Jack Barron with the Ideal Insurance Agency. Ideal had previously placed policies for Hardin on a case-by-case basis. In this instance, Barron wrote Commonwealth at the top of the application, completed a Commonwealth policy with a policy period beginning the previous day, July 18, 1967, at 12:01 a.m., and mailed the policy to Burch. Hardin delivered the premium check, which was cashed by Ideal.

Unbeknownst to either Hardin or Barron, Burch had an accident in the Chevrolet earlier that morning. Burch unsuccessfully attempted to report the accident to Hardin that morning, and successfully gave notice two or three days later. Accordingly, at the time the policy issued, a loss had occurred that the insured knew about (but he thought he had coverage in place), but of which both Hardin, as applicant, and Barron, as the agent for the insurer, were ignorant.

Against that backdrop, the court recognized coverage notwithstanding the prior loss:

> Most courts that have considered the question hold that recovery may be had on a policy antedated to include the time at which a loss occurred provided neither the applicant nor the insurer knew of the loss when the contract was made. We approve and adopt this as a general rule, because in our opinion it is entirely sound as applied to the facts of this case. Aside from any question of protecting insurance companies against possible fraud on the part of their customers or agents, we can think of no reason for holding that the parties may not effectively contract for the insurer to assume the risk of a loss that may or may not have occurred when the contract is made. If that is their intention, they are not mistaken in any material respect even though the insured property has, in fact, been damaged or destroyed. When neither of them knows of the loss, there is no basis for charging the insured with fraud and the company is not in the position of promising unconditionally to pay a substantial amount of money in exchange for a much smaller sum.
>
> We hold that the general rule applies under these circumstances where the person arranging the insurance does not know, and there was no conscious or negligent failure to advise him, of the loss.[12]

Some observations from *Burch*:

- The court appears to have focused on the subjective mental states of the actors;
- The known loss rule at that time appears primarily designed to foreclose [1] insured fraud in contracting for coverage, and [2] an insurer's unconditional (no remaining contingency) promise to pay a substantial amount under its policy in exchange for a much smaller premium.

II. TRANSITION TO THE MODERN LINE OF CASES

A. *Two Pesos*

Twenty-five years after *Burch*, the Fourteenth Court of Appeals revisited the fortuity doctrine and its known loss and loss-in-progress rules in *Two Pesos, Inc. v. Gulf Insurance Co.*, 901 S.W.2d 495 (Tex. App. – Houston [14th Dist.] 1995, no writ), with an opinion that has animated much of the recent fortuity doctrine litigation.

Taco Cabana sued Two Pesos for misappropriation of trade secrets and trade dress infringement, claiming that the appearance of Two Pesos' restaurants was confusingly similar to those of Taco Cabana. After a jury trial, a federal court entered a judgment against Two Pesos awarding Taco Cabana over $2 million in damages, and permanently enjoining Two Pesos to change the appearance of its restaurants. That judgment was affirmed by both the Fifth Circuit and the Supreme Court.[13] On August 6, 1991, Taco Cabana filed a motion in district court for supplemental damages for Two Pesos' continued trade dress infringement during the appeals.

Two Pesos had obtained a general liability policy from Gulf, after the judgment was rendered and while the appeals were ongoing. Two Pesos had disclosed the litigation to Gulf on its insurance application, which issued a policy effective from March 1, 1990 through March 1, 1991. Two Pesos tendered the supplemental damage claim to Gulf for coverage under the policy's advertising injury provisions. Gulf denied coverage and filed the coverage suit.

The court first held that the advertising injury "offense" was not committed during Gulf's policy period as required by the policy. However, the court alternatively held coverage was also precluded by the fortuity doctrine's known loss and loss-in-progress rules:

> Generally, fortuity is an inherent requirement of all risk insurance policies. "The concept of insurance is that the parties, in effect, wager against the occurrence or non-occurrence of a specified event; the carrier insures against a risk, not a certainty."
>
> The fortuity doctrine not only concerns whether the offending conduct is accidental or intentional, but also incorporates the "known loss" and "loss in progress" principles. These aspects of the fortuity doctrine focus on the proposition that insurance coverage is precluded where the insured is, or should be, aware of an ongoing progressive loss or known loss at the time the policy is purchased. The "loss in progress" principle is recognized as part of standard insurance law. An insured cannot insure against something that has already begun and which is known to have begun. Texas has long recognized that it is contrary to public policy for an insurance company knowingly to assume a loss occurring prior to its contract.
>
> [C]overage for Two Pesos' continued trade dress infringement is precluded because the claim constitutes a known loss or loss in progress.… [T]he risk of liability was no longer unknown because injuries resulted when Two Pesos first copied Taco Cabana's trade dress. The risk of injury from continued infringement was readily apparent, or should have been. Moreover, affording coverage to Two Pesos would violate public policy by allowing protection for a known loss and permitting an insured to benefit from its wrongdoing.[14]

Several observations are in order regarding *Two Pesos*: The quoted "should be[,] aware of an ongoing progressive loss" language appears to implement a new objective test for the insured's knowledge of pre-existing loss.[15] At the same time, keep in mind what Two Pesos was aware of – a jury had already determined the appearance of its restaurants infringed Taco Cabana's trade dress, and a judgment had already imposed substantial damages on Two Pesos for the infringement, but it did nothing thereafter to stop the infringement.[16]

Although Gulf's policy was a policy of liability insurance, and although the purpose of insurance is to "insure against a risk,"[17] the fact that Two Pesos' *risk of liability* via judgment or court order for the continued infringement might have been theoretically uncertain does not appear to have factored into the court's analysis; rather, the known loss or loss-in-progress rules were stated to apply because "[t]he *risk of injury* from continued infringement was readily apparent, or should have been." In a similar vein, the Houston court quoted approvingly from a Third Circuit opinion that "the purpose of insurance is to protect against unknown risks,"[18] arguably inferring that insurance is not intended to protect from identified risks, even if contingent.

The *Two Pesos* court appears to have added a third justification for the known loss and loss-in-progress rules – public policy prevents coverage when it would permit

"an insured to benefit from its wrongdoing."

If somehow not clear before, the court made explicit that the known loss and loss-in-progress rules applied "as part of standard insurance law," and not by virtue of any specific policy language.[19]

B. *Franklin v. Fugro-McClelland.*

Judge Atlas in *Franklin v. Fugro-McClelland (Southwest), Inc.*, 16 F. Supp.2d 732 (S.D. Tex. 1997) quoted from and applied *Two Pesos'* reasoning in an opinion that basically held the loss-in-progress rule applied whenever an insured knew before policy issuance that it was engaging in wrongful conduct or conduct for which it could potentially be found liable:

> In the case at bar … the insureds began their alleged infringement…, voluntarily continued these activities even after receiving accusations of patent infringement, and then entered into the insurance policy. The loss in progress doctrine was designed for cases just like the one before the Court and is based on equitable principles. The doctrine precludes a party from voluntarily engaging in an activity that gives rise to an accusation of wrongdoing and potential legal liability, and then purchasing insurance so that it may shift financial responsibility for its conduct and then continue to engage in the offending activity.[20]

Although the insureds had received an accusation of wrongdoing from the claimants via a "cease and desist" letter, application of the loss-in-progress rule did not turn on their knowledge of that accusation, but rather on their knowledge of their own actions:

> [T]here can be no question that Defendants knew of their own activities and therefore knew all the operative facts giving rise to Koenig's claims. … The relevant inquiry is whether they knew at the time they entered the insurance policy that they were engaging in activities for which they could possibly be found liable.[21]

Extending the logic of the *Two Pesos* opinion, Judge Atlas expressly disagreed with the suggestion that an insured could have no known loss in response to a third-party liability claim until its liability for the claim had actually been adjudicated.[22] The court, however, arguably might have left open the possibility that one potentially could contract for insurance for claimed but not fully adjudicated liability for past, non-recurring, conduct, if the insured informs the insurer when contracting that its policy is meant to cover such litigation.[23]

Finally, the court rejected the insured's assertion that its attempts, which it allegedly thought were successful, before the policy issued to mollify the claimants, in turn excused it from advising the insurer of the potential litigation when applying for the policy.[24]

III. WHERE WE CURRENTLY STAND

The combination of *Two Pesos* and *Franklin* provide much of the logical framework for most of the subsequent Texas cases that have applied either the known loss or loss-in-progress rule, including the following selections:

The court in *E&L Chipping Co. v. Hanover Insurance Co.*, 962 S.W.2d 272 (Tex. App. – Beaumont 1998, no pet.) emphasized that the fortuity rules were, in a duty to defend context, analyzed under the eight-corners rule. In other words, information about the insured's knowledge of loss came from the pleadings as framed by the claimants, liberally interpreted with doubts regarding coverage resolved in the insured's favor.[25] At the same time, the court seemed to disregard the admonitions from *Two Pesos* and *Franklin* to look to the insured's knowledge of its wrongful conduct when contracting for the insurance. Unlike *Two Pesos* and *Franklin*, however, *E&L Chipping* did not involve allegations of the insured's ongoing wrongful conduct; rather, the matter involved the insured's putting out a fire in a wood chip pile by spraying water on the pile. That limited duration act allegedly caused runoff that contaminated various water sources, and the court held the known loss rule did not apply since the claimants' pleadings alleged runoff damage-contamination continued to occur during the policy period.

The court in *Matagorda Venture, Inc. v. Travelers Lloyds Insurance Co.*, 203 F. Supp. 2d 704, 716-17 (S.D. Tex. 2000) addressed the wrinkle of a newly formed entity owned by individuals tainted with prior knowledge of claimed wrongdoing and injury. Owner 1 owned a predecessor company that had received a demand letter alleging its operations infringed the claimant's trademarks. Owner 1 and Owner 2 formed a new company that assumed the operations of the predecessor, and Owner 2 had the new company added as an insured on an already existing liability policy. The court held the known loss

rule applied and barred coverage for the claimant's later filed suit.

Similarly, the court in *Scottsdale Insurance Co. v. Travis*, 68 S.W.3d 72 (Tex. App. – Dallas 2001, pet. denied) held the known loss rule applied to allegations that the principal of a newly-formed corporation conspired with others to, *inter alia*, tortiously interfere with the claimant's contracts at a time when the principal had been the president and a director of the claimant, and previous to the new corporation's formation (as part of the alleged conspiracy) or its purchase of insurance.

RLI Insurance Co. v. Maxxon Southwest, Inc., 265 F. Supp. 2d 727 (N.D. Tex. 2003), *aff'd*, 2004 WL 1941757 (5th Cir. 2004) drives home the point that *Two Pesos'* objective test operates notwithstanding the insured's lack of recognition of any potential liability. In that matter, the insureds had not received "any pre-policy notice" from the claimant such as a cease and desist letter, and did not have "any independent knowledge of the subject loss."[26] Nonetheless, since they knew different gypsum cement dealers paid different prices for their cement, then "[t]he risk of potential injury … was, or should have been, readily apparent to the defendants from the moment they formulated and employed the various dealer price lists."[27] On appeal, the Fifth Circuit rejected the contention that the fortuity doctrine required "some sort of 'watershed event' … to give an insured sufficient notice that he or she is subject to potential liability."[28] The court held the critical issue instead was "whether the party knowingly acted in a manner in which it 'could possibly be found liable.'"[29] In so holding, the court appears to have stepped beyond the concerns that initially gave rise to the known loss and loss-in-progress rules – mandating insured honesty when contracting for coverage. Also, the court's decision seems at-odds with the Texas Supreme Court's decision in *Burch*, which allowed coverage notwithstanding the good faith but mistaken belief that no loss had occurred prior to policy issuance.

"The known loss and loss-in-progress rules serve the noble purposes of requiring basic honesty and good faith on the insured's part in contracting for the insurance and of preventing an insured from improperly profiting from its own wrongdoing."

Lennar Corp. v. Great American Insurance Co., 200 S.W.3d 651 (Tex. App. – Houston [14th Dist.] 2006, pet. filed) seems to backtrack somewhat on *Franklin's* distinction between risk of liability versus risk of injury. The case arose out of Lennar's decision to remove the EIFS or synthetic stucco on approximately 400 homes in the Houston area, and its attempts to recover the costs of repair from its insurers. Lennar knew of identified damage to some of the homes, or of repairs it had already performed, prior to the purchase of policies from American Dynasty and Markel. However, there was a fact issue as to whether Lennar knew that the EIFS was an inherently defective product that "had damaged, or was in the process of damaging, all the homes on which it installed." In the process, the court of appeals approvingly cited the Second Circuit's *Stonewall Insurance Co. v. Asbestos Claims Management Corp.*[30] for its holding that the:

> "[K]nown loss" doctrine did not bar coverage for asbestos claims, except claims for which [the] insured had been sued, or received pre-suit demand, before [the] policy incepted; although insured knew before [the] policy incepted that its product risked causing diseases and had received [a] large number of claims, it was uncertain as to prospective number of injuries and claims, likelihood of successful claims, and amount of ultimate net losses.[31]

The known loss rule as apparently viewed by the court of appeals in *Lennar* appears to have less force than as articulated by Judge Atlas in *Franklin*, or even by the same court in *Two Pesos.*

Although the known loss rule had previously been applied in conjunction with claims-made liability policies, *Warrantech Corp. v. Steadfast Insurance Co.*, 210 S.W.3d 760, 767 (Tex. App. – Fort Worth 2006, pet. filed) expressly rejected an argument that it did not apply to such policies. Also, seemingly forgetting that the rule applies irrespective of the contents of the insurance policy, the court sought to reason around an exception to an exclusion that affirmatively obligated the insurer to defend an insured against claims of a "dishonest, fraudulent or criminal act" until such was established by a judgment against the insured. In the process, the court articulated a known loss rule stripped of any requirement of knowledge of wrongdoing, holding instead it only required the insured to know before the inception of coverage "that an act – knowingly wrongful or otherwise – resulted in a loss." Of course, businesses routinely engage in acts that cause "loss" to competitors, but only limited categories of such acts should ever expose the business to any potential liability for those losses. Stated differently, does the known loss rule apply to knowledge of any loss whatsoever, no matter what its cause, or does

it apply only to known losses for which the insured knows it could conceivably be liable? Depending on the answer to that question, it may be that the *Warrantech* court's reasoning, if applied literally, could in isolated instances result in unwarranted application of the rule.

Finally, the court in *Sentry Insurance v. DFW Alliance Corp.*, 2007 WL 507047 (N.D. Tex., Feb. 16, 2007) effectively held that acts of an insured's principals before policy issuance in preparation for the insured's causing actionable injury subsequent to policy issuance would trigger application of the known loss rule. The case presented a duty to defend issue where the pleaded facts are accepted as true, and the insurer must defend if the allegations, liberally construed, give rise to even one potentially covered claim. A chronology of allegations and coverage in the case follows:[32]

- By 6/30/2000 – A, B, C and D had "embarked on a program of subterfuge to prepare themselves to unfairly compete with NDS including, but not limited to, creating molds to manufacture parts bearing marks and part numbers confusingly similar to NDS's registered trademark 'DFW,' the unregistered mark 'NDS' and the unregistered trademark 'DFW/HPI."

- By 1/1/2001 – A, B, C, D and DFW, the insured, had "manufactured, distributed and sold plastic goods under the name 'DFW' and 'DFW Plastics.'"

- Also by 1/1/2001 – the assets of A, C and D were transferred to DFW, and "DFW was liable, as a successor-in-interest, for the wrongful conduct" of A, C and D.

- 5/1/2002 – inception of Sentry's coverage for DFW.

- 6/19/2002 – a cease and desist letter from NDS's attorney advised DFW and the other defendants of its ownership of the trademarks.

DFW argued that liberally construed, NDS's pleading did not allege infringement of the NDS and DFW/HPI marks until after the policy issued, and if Sentry had a duty to defend those claims, then it had a duty to defend the whole suit. The court disagreed, characterizing the pre-6/30/2000 preparatory acts by A, B, C and D of "creating molds" to be used in infringing the marks as "infringing activity" that sufficed for the known loss rule as to all of the marks.[33] The court then accepted as true NDS's allegation that since DFW, the insured, "is not an independent, lawful corporation," NDS "is entitled to pursue against DFW any claims it may have against" A, C and D, resulting in application of the rule to DFW for the earlier "infringing activity" of its principals.[34] The court further refused to recognize a duty to defend DFW for the judicial proceedings it continued to face after obtaining a favorable jury verdict in the underlying suit.

IV. CONCLUSION

The known loss and loss-in-progress rules serve the noble purposes of requiring basic honesty and good faith on the insured's part in contracting for the insurance, and of preventing an insured from improperly profiting from its own wrongdoing. Recent cases, and particularly the holdings of the courts in *RLI* and *Sentry*, and the analysis of the court in *Warrantech*, have pushed the envelope on the scope of the rules. It may be that we are now close to the outer-limits of the potential application of the rules, at least as justified by their historic rationale and purpose. Our courts should proceed cautiously, and illustrate the good faith intent of both contracting parties to transfer risk.

[1] BLACK'S LAW DICTIONARY (5th ed. 1979) defines *uberrima fides* in part as follows:

The most abundant good faith; absolute and perfect candor or openness and honesty; the absence of any concealment or deception, however slight. A phrase used to express the perfect good faith, concealing nothing, with which a contract must be made; for example, in the case of insurance, the insured must observe the most perfect good faith towards the insurer.

[2] *See, e.g., United States Casualty Co. v. Rodriguez*, 288 S.W. 487 (Tex. Civ. App. – San Antonio 1926, writ ref'd Jan. 12, 1927) (policy that was bound and issued after employee's injury, but with a prior inception date, would not provide compensation benefits for that injury, but the policy was not void since it did protect the insured for injuries to other employees); *Bankers Lloyds v. Montgomery*, 60 S.W. 201 (Tex. Comm'n App. 1933) (policy requested by insured before employee's injury from agent without binding authority, and thereafter issued by insurer without knowledge of the injury with an effective date prior thereto, and delivered to agent – who then knew of the intervening injury – for delivery to insured, would not provide compensation benefits for the injury).

[3] *Trinity Universal Ins. Co. v. Rogers*, 215 S.W.2d 349 (Tex. Civ. App. – Dallas 1948, no writ) (renewal of auto liability policy issued roughly 7 weeks before accident, but undelivered to insured and not paid for or otherwise accepted by the insured until after accident, afforded no protection for liability resulting from accident); *Mallard v. Hardware Indem. Ins. Co.*, 216 S.W.2d 263 (Tex. Civ. App. – San Antonio 1948, no writ) (owner of vehicle who never accepted renewal policy thereon could not accept the policy after the vehicle was totaled, even when the insurer sent him an unenforceable demand for supposedly earned (through a date inclusive of the date of loss) but unpaid premium).

[4] *Blake v. Hamburg-Bremen Fire Ins. Co.*, 67 Tex. 160, 2 S.W. 368 (1886) (insured failed to effectively request increase in insurance before fire by failing to place a postage stamp on letter to agent requesting same, and court correctly charged jury that a second such request to the agent – apparently in person – after fire was in progress, was insufficient to bind insurer); *Alliance Ins. Co. v. Continental Gin Co.*, 285 S.W. 257 (Tex. Comm'n App. 1926) (agent's attempt to honor first insurer's request to get off risk by immediately issuing replacement policies with another insurer was ineffectual since agent was not able to then communicate with insured to obtain his assent, first insurer's policies had not been formally canceled pursuant to their terms, the property was destroyed before insured could surrender first insurer's policies, and he could not lawfully accept the second insurer's offer of insurance after the loss had occurred); *H. Schumacher Oil Works, Inc. v. Hartford Fire Ins. Co.*, 239 F.2d 836 (5th Cir. 1956) (dealing with apparent context of a smoldering fire deep within a 1000 ton pile of cottonseed, whose existence became suspected at one point and confirmed, according to experts, at another point, and with various policies continuing, incepting, renewing or expiring throughout the period).

[5] *Dickey v. Continental Casualty Co.*, 40 Tex. Civ. App. 199, 89 S.W. 436 (1905, writ ref'd) (life insurance not effective, decedent had expressed to agent desire to procure life insurance after December 18th when the premiums could be taken out of his January earnings with his employer, but the application for insurance was not completed by agent until December 20th, after decedent had died earlier that morning, and when agent had been advised that decedent was either injured or killed).

[6] 285 S.W. at 258 (citations omitted).

[7] CAVEAT: At the time this article was written, issues regarding the known loss and loss-in-progress rules were pending before the Supreme Court of Texas in several matters, including via the petitions of Markel and American Dynasty in *Markel American Insurance Co. v. Lennar Corp.*, No. 06-0287.

[8] 450 S.W.2d at 840.

[9] *Id.*

[10] *Id.* at 840-41.

[11] *Cf. U.S. v. Patryas*, 303 U.S. 341, 345 (1938) ("No legal obstacle prevents parties, if they so desire, from entering into contracts of insurance to protect against loss that may possibly have already occurred. Marine insurance and antedated fire insurance policies frequently afford protection against risks which, unknown to the parties, have already attached.")

[12] 450 S.W.2d at 841 (citations omitted).

[13] *Taco Cabana, Inc. v. Two Pesos, Inc.*, 932 F.2d 1113 (5th Cir. 1991), *aff'd*, 505 U.S. 763 (1992).

[14] 901 S.W.2d at 501-02 (citations omitted).

[15] Some courts appear to only link *Two Pesos'* objective test with loss-in-progress, while maintaining a subjective test for known loss. *Burlington Ins. Co. v. Texas Krishnas, Inc.*, 143 S.W.3d 226, 230 (Tex. App. – Eastland 2004, no pet.) ("A 'known loss' is one that the insured knew had occurred before the insured entered into the contract for insurance. … A 'loss in progress' involves those situations in which the insured knows, or should know, of a loss that is ongoing at the time the policy is issued."); *Lennar Corp. v. Great Am. Ins. Co.*, 200 S.W.3d 651, 687-88 (Tex. App. – Houston [14th Dist.] 2006, pet. filed); *Warrantech Corp. v. Steadfast Ins. Co.*, 210 S.W.3d 760, 766-67 (Tex. App. – Fort Worth, pet. filed); *Certain Underwriters v. KKM Inc.*, 215 S.W.3d 486, 495 (Tex. App. – Corpus Christi 2006, pet. filed). The First Court of Appeals appears to apply the objective standard to both,. *Westchester Fire Ins. Co. v. Gulf Coast Rod, Reel & Gun Club*, 64 S.W.3d 609, 613 n.2 (Tex. App. – Houston [1st Dist.] 2001, no pet.) ("A 'loss in progress' is an ongoing progressive loss that the insured is or should be aware of at the time the policy is purchased. … A 'known loss' is a loss that has already occurred and that is known or should be known by the insured when the policy is purchased."), and the Dallas Court of Appeals appears to have taken both positions. *Compare Roman Catholic Diocese v. Interstate Fire & Casualty Co.*, 133 S.W.3d 887,895-96 (Tex. App. – Dallas 2004, pet. denied) ("The doctrine of fortuity precludes coverage for losses of which the insured knows at the time the insurance is purchased. … Coverage is also precluded when the insured is also aware or should be aware of ongoing progressive losses") *with Scottsdale Ins. Co. v. Travis*, 68 S.W.3d 72, 75 (Tex. App. – Dallas 2001, pet. denied) ("Insurance coverage is precluded where the insured is or should be aware of ongoing progressive or known loss at the time the policy is purchased").

[16] *Compare Two Pesos with RLI Insurance Co. v. Maxxon Southwest, Inc.*, 265 F. Supp. 2d 727 (N.D. Tex. 2003), *aff'd*, 2004 WL 1941757 (5th Cir. 2004). In the latter matter, the insureds had not received "any pre-policy notice" from the claimant such as a cease and desist letter, and did not have "any independent knowledge of the subject loss." 265 F. Supp. 2d at 731. Nonetheless, since they knew different gypsum cement dealers paid different prices for their cement, then "[t]he risk of potential injury … was, or should have been readily apparent to the defendants from the moment they formulated and employed the various dealer price lists." *Id.* at 732; *see also* 2004 WL 1941757, *4 (5th Circuit rejecting contention that the fortuity doctrine required "some sort of 'watershed event' … to give an insured sufficient notice that he or she is subject to potential liability," and holding that the issue was instead "whether the party knowingly acted in a manner in which it '"could possibly be found liable."')

[17] *Id.* at 501 (quoting *Bartholomew v. Appalachian Ins. Co.*, 655 F.2d 27, 29 (1st Cir. 1981)).

[18] 901 S.W.2d at 502 (quoting *Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56, 63 (3rd Cir. 1982)).

[19] Hence, the fact the known loss and loss-in-progress rules are largely written expressly into the "Coverage A" insuring agreement for bodily injury and property damage liability in standard CGL policies after October 2001, but not nearly so expressly for "Coverage B" for personal and advertising injury liability, should in no sense negate their potential application to Coverage B in current CGL policies.

[20] 16 F. Supp. 2d at 736.

[21] *Id.* at 737.

[22] *See id.* at 735-37; *see also Matagorda Ventures, Inc. v. Travelers Lloyds Ins. Co.*, 208 F. Supp. 2d 687, 690-91 (S.D. Tex. 2001); *Scottsdale Ins. Co. v. Travis*, 68 S.W.3d 72, 77

(Tex. App. – Dallas 2001, pet. denied) (rejecting similar "not legally adjudicated" arguments).

[23] *Id.* at 736

[24] *Id.* at 736, n.6; *see also Matagorda Ventures, Inc. v. Travelers Lloyds Ins. Co.*, 208 F. Supp. 2d 687, 691-92 (S.D. Tex. 2001); *Essex Ins. Co. v. Redtail Prods., Inc.*, 1998 WL 812394 (N.D. Tex., Nov. 12, 1998) (both addressing similar unsuccessful remedial actions, with no related disclosure when thereafter applying for insurance).

[25] *See also Westchester Fire Ins. Co. v. Gulf Coast Rod, Reel & Gun Club*, 64 S.W.3d 609, 614 (Tex. App. – Houston [1st Dist.] 2001, no pet.) (pleading avoided the fortuity doctrine's rules in duty to defend context by alleging both the insured's knowledge "for at least twenty years" of beach erosion its actions caused, and its negligence "in failing to ascertain the consequences … of dredging 'The Cut'"); *Burlington Ins. Co. v. Texas Krishnas, Inc.*, 143 S.W.3d 226, 231 (Tex. App. – Eastland 2004, no pet.) (pleading in the alternative regarding "no knowledge" or "actual or apparent knowledge" of abuse of children, when liberally construed, did not preclude a duty to defend under the known loss and loss-in-progress rules); *but cf. Essex Ins. Co. v. Redtail Prods., Inc.*, 1998 WL 812394 (N.D. Tex., Nov. 12, 1998) (considering 9/27/96 demand letter since allegation that trademark violations had occurred "recently," even if accepted as true, was insufficient to determine if violations occurred during policy period incepting on 10/14/96).

[26] 265 F. Supp. 2d at 731.

[27] *Id.* at 732.

[28] 2004 WL 1941757, *4.

[29] *Id.* (quoting *Matagorda Ventures*, which in turn quoted *Franklin*).

[30] 73 F.3d 1178, 1214-15 (2nd Cir. 1995).

[31] 200 S.W.3d at 689.

[32] Taken from 2007 WL 507047 at *1 and *6.

[33] *Id.* at *8.

[34] *Id.*; *but cf. Heyden Newport Chem. Corp. v. Southern Gen. Ins. Co.*

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BY LEAH S. FISCHER[1] AND FRED A. SIMPSON[2]

Evolution of the Texas Health Insurance Risk Pool

In an ideal world, all Texans would have reasonable and equal access to low cost health insurance coverage, regardless of any pre-existing medical conditions. However, the realities of health insurance coverage are not ideal. A 1990 study shows that, at that time, more than 60% of group health insurance plans excluded coverage for preexisting medical conditions.[3] However, the marketplace for group and individual health coverage changed in a number of significant ways in 1996 when the Health Insurance Portability and Accountability Act (HIPPA)[4] became the law of the Land. HIPPA not only restricts the time period for which insurance companies can deny coverage for preexisting illnesses, the Act contains certain other provisions that led the Texas Legislature to vitalize the Texas Health Insurance Risk Pool ("THIRP") and provide a "safety net" for any claims paid in excess of premiums collected. Today, almost 30,000 Texans obtain their medical insurance coverage under THIRP, paying premiums generally higher than in the private sector, but still below actual cost, with annual claims aggregating nearly $230 million and premiums received of far less than $200 million.

THIRP, now in Texas Insurance Code at Chapter 1506, originated in Tex. S.B. 832, 71 Leg. R.S. (1989) ("S.B.832"),[5] and was substantively amended by Tex. H.B. 710, 75 Leg. R.S. (1997) ("H.B.710").[6]

I. LEGISLATIVE HISTORY

Creation of THIRP

THIRP was created in 1989 with no funding mechanism. However, HIPPA changed that. In 1997, the Texas Legislature amended the law to cause THIRP to become operational through passage of H.B. 710. The bill analysis on certain 1999 Texas legislation succinctly explains the situation:

> Created in 1989, the Texas Health Insurance Risk Pool (pool) became operational when the Texas Legislature provided startup funding in 1997. The legislature provided the startup funding to ensure that Texas complied with a federal law that reformed the marketplace for health insurance. Commonly called HIPAA (the Health Insurance Portability and Accountability Act), the federal legislation limits the imposition of preexisting condition requirements in any group health plan or group health insurance, and requires every health insurance issuer offering individual health insurance coverage in a state to accept every eligible individual wanting to purchase such coverage without imposing such requirements. The law required the states to conform to the minimum federal standards or to develop an acceptable alternative mechanism. Those alternatives included the following: providing guaranteed individual health insurance (with no rate constraints by law); enacting or modifying laws to implement a health insurance risk pool according to the new law (with rates capped at a maximum of 200 percent of average); or enacting another type of risk-spreading mechanism.

House Comm. On Insurance, Bill Analysis, Tex. H.B. 1431, 76th Leg., R.S. (1999). The same bill analysis explains the State's chosen alternative under HIPPA and gives further insight to the construction of THIRP:

> Texas chose to implement the health risk insurance pool it had created in 1989. The purpose of the pool is to provide uninsurable individuals access to health insurance for medical conditions or diagnoses that result in ineligibility for private insurance coverage. The pool funds itself by charging premiums for the policies that it issues. If claims and expenses for the pool's

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operation exceed collected premiums, state law authorizes the board of directors of the pool to collect additional funds by charging an assessment to licensed insurers providing health insurance coverage in this state. It has been anticipated that assessments will be required each year. *Id.*

S.B. 832 provided the blueprint for THIRP as initially envisioned by the Texas Legislature, establishing guidelines for the pool's management and operational structure by: (a) describing the pool's authority to act as an insurance company; (b) defining a competitive bidding process through which to select an administrator; (c) establishing rules for governance of the pool, including rate settings and schedules; (d) outlining criteria for pool eligibility, (e) setting minimum pool benefits and preexisting conditions; and (f) addressing complaint procedures for applicants or participants.[7]

But it was H.B. 710 in 1997 that provided a funding mechanism and such management features as annual financial, economy and efficiency audits to be performed and reported to THIRP's Board of Directors and the State Comptroller. H.B. 710 provided a mere $50,000 to cover the start-up expenses, however. S.B. 832 has undergone a series of other revisions since its enactment in 1989, particularly to sections of the bill related to eligibility for coverage and funding.

THIRP determines the "standard risk rate" by considering the premium rates charged by other insurers offering health insurance coverage to individuals.

Structure and Operations

Although THIRP's creators envisioned a twelve-member Board of Directors under S.B. 832, THIRP is governed today by a nine-member Board of Directors appointed by the Commissioner of Insurance for staggered six-year terms.[8] The nine-member Board is composed of: (a) at least two (but no more than four) persons affiliated with an insurer who are authorized to write health insurance in Texas; (b) at least two persons who are insureds or parents of insureds, or who are reasonably expected to be eligible for pool coverage; and, (c) the remainder of Board members selected from individuals such as a physician licensed to practice in Texas, a hospital administrator, an advanced nurse practitioner, or a representative of the public who has no conflicting interests.[9] The Commissioner appoints a chairperson from among the Board members.[10] Board members are immune from civil lawsuits when performing their duties in good faith.[11]

THIRP's initial Board of Directors was responsible for developing a plan of operation that would "assure the fair, reasonable, and equitable administration of the pool."[12] The Commissioner approved the plan if it appropriately fit the criteria. The plan included procedures for the operation of the risk pool, selection of a pool administrator, creation of a fund for administrative expenses, the management of the pool's money and assets, and the development of a program to publicize the existence of the pool, its eligibility requirements and enrollment procedures. Additionally, the plan was to establish procedures for creating a grievance committee to review applicant and participant complaints. The initial Board also was responsible for generating a list of medical or health conditions for which a person would be eligible for pool coverage without applying for private health insurance.[13] This list of medical conditions, effective from the first day the risk pool became operational, is occasionally amended and is posted on the THIRP website.[14]

The Board sets rates and rate schedules that reflect "appropriate risk factors including age and variation in claim costs. The Board may consider appropriate risk factors in accordance with established actuarial and underwriting practices."[15] S.B. 832 established that premiums may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.[16] Similar to most commercial health plans, "separate schedules of premium rates based on age, sex and geographic location may apply for individual risks".[17] THIRP determines the "standard risk rate" by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The risk rate is established using "reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage."[18] H.B. 710 provided that "initial pool rates may not be less than 125% and may not exceed 150% of rates established as applicable for standard rates."[19] H.B. 710 also determined that subsequent rates would be set to cover the expected costs of claims, but would not exceed 200% of rates applicable to individual standard rates.[20] However, legislation passed in 2003 repealed the minimum and maximum initial premium rates, leaving in place the 200% maximum increase in premium rates over market cost.[21]

THIRP's Administrator

Administrator(s) are selected by the Board through a competitive bidding process.[22] The Board reviews the bids submitted against a set of evaluation criteria. These criteria relate to past performance in managing individual accident and health insurance programs, efficiency of claims paying procedures, the estimated total charges for administering THIRP, the candidate's ability to administer in a cost-efficient manner, and the financial health and stability of the candidate administrator.

Once selected, THIRP"s insurer/administrator(s) serves a three-year term. The administrator's main functions are: (a) to perform eligibility and administrative claims payment procedures for the pool; (b) to establish a billing procedure for collection of premiums from; (c) to perform functions necessary to assure timely payment of benefits; (d) to submit regular reports to the Board relating to the operation of THIRP; and (e) to submit annual reports to the Board disclosing net written and earned premiums, administrative expenses and paid and incurred losses. THIRP pays the administrator's expenses incurred while performing duties listed above. The total amount of administrative costs and fees paid to all administrators in a given year "may not exceed 12.5 percent of the gross premium receipts for the calendar year."[23]

Eligibility

Two areas of THIRP legislation that have undergone significant revision subsequent to 1989 are: (a) eligibility for coverage; and (b) minimum pool benefits. The following delineates the eligibility and non-eligibility criteria as they were first written in S.B. 832, and what they are today. S.B. 832 established that a person who is a Texas resident and is diagnosed as having a condition designated as uninsurable by the Board or who provides proof acceptable to the Board from his insurer that he has been determined to be a substandard risk for whom the insurer's premium would exceed the premium charged by the pool is entitled to coverage from the pool.[24]

Over time and through passage of a number of House and Senate bills, these rather straightforward eligibility criteria grew to be more complex. Today, an individual is eligible if under age 65 and has been for at least 30 days and remains a legal resident of Texas and a United States citizen, or a permanent resident of the United States for at least 3 continuous years, and if the individual provides the Health Pool's administrator evidence of one of the following:[25]

1. Notice of rejection or refusal by an insurance company to issue substantially similar individual health insurance due to health reasons;

2. A certification from an agent or salaried representative of an Insurance Company, on the Pool's Application form, that states the agent or representative is unable to obtain substantially similar individual Health insurance with any state-licensed Insurance Company, which the agent or representative represents, that coverage will be declined as a result of a medical condition, under the underwriting guidelines of the Insurance Company;

3. An offer by an Insurance Company to issue substantially similar individual health insurance that excludes a medical condition or conditions; and

4. The individual has been diagnosed with one of the Qualifying Medical/Health Conditions.

Additionally, an individual is eligible if under age 65, remains a legal resident of Texas, and if the individual has maintained health insurance coverage for the 18 months preceding application for coverage to the Health Pool, with no gap in coverage of greater than 63 days, provided the last health insurance was through an employer sponsored plan, church plan, government plan, or another state's high risk pool (known as "HIPPA eligibility"). (United States citizenship or permanent residency is not required for this eligibility category only.) Dependents are also eligible for Health Pool coverage. If the eligible individual is a child, family members of the child who have been for at least 30 days and remain legal residents of Texas and United States citizens and who reside with the child are also eligible for Health Pool coverage.[26]

THIRP legislation also stipulates non-eligibility criteria for coverage. Under S.B. 832, an individual is not eligible if he/she:

1. had health insurance coverage in effect on the date Health Pool coverage would otherwise be effective;

2. was eligible for other health care benefits at the time application is made to the pool;

3. had terminated coverage in the pool within 12 months of the date that application is made to the pool, unless the person demonstrates a good faith reason for the termination;

4. had had benefits paid by the pool on his behalf in the amount of $500,000;

5. was confined in a county jail or imprisoned in a state prison; or

6. was eligible for Medicare benefits.[27]

However, similar to criteria for coverage eligibility, the above non-eligibility criteria were modified over time. As presented on the THIRP website, an individual is not eligible if the individual:

1. has other health coverage in effect on the date Health Pool coverage would otherwise be effective;

2. is eligible for or covered by employer-sponsored health coverage (including a self-insured health benefit plan), including eligibility for continuation of coverage under state or federal law;

3. has terminated Health Pool coverage within 12 months prior to application for Health Pool coverage, unless there's a good faith reason for such termination;

4. is confined to county jail or imprisoned in a state or federal prison;

5. had prior Health Pool coverage terminated for fraud;

6. had prior coverage by the Health Pool that was terminated for nonpayment of premiums within 12 months prior to application for subsequent coverage;

7. has received $1,500,000 in benefits from THIRP; or

8. will have premiums paid or reimbursed by or under a government sponsored program or government agency or by a health care provider.[28]

Eligibility criteria for coverage under THIRP has become more complicated over the years, as have the eligibility criteria for all other health insurance coverages. Furthermore, HIPAA affected health coverage plans across the board with respect to their treatment of preexisting conditions. THIRP under S.B. 832 was no exception; language related to preexisting conditions was amended to comply with HIPPA regulations.

Minimum Benefits

Substantial changes to minimum benefits occurred between THIRP's creation and its implementation. S.B. 832 contains an itemized list of specific minimum benefits and exclusions. When H.B. 710 was later passed, the section on minimum benefits was rewritten to reflect a broader perspective. THIRP is required to offer coverage consistent with major medical health coverage to each eligible person who is under 65 years of age. With the approval of the Commissioner, the board must establish coverages; the applicable schedules of benefits; and any coverage exclusions and other limitations.[29] The benefits provisions must include: (a) all required or applicable definitions; (b) a list of any exclusions or limitations; (c) a description of covered services required under the pool; and (d) the deductibles, coinsurance options, and co-payment options required or permitted under the risk pool. This section also gives the Board authorization to adjust deductibles, the amounts of stop-loss coverage and the time periods governing preexisting conditions to preserve the financial integrity of THIRP.[30]

THIRP's Funding

Legislators did not foresee the substantial monetary resources required to operate a health insurance risk pool. As mentioned above, H.B. 710 included a provision for only $50,000 of state appropriated funds to cover the start up expenses of the risk pool. Additionally, the bill requires that the Office of the State Auditor conduct an annual "special" audit of the pool, the cost of which is to be reported to the Board of Directors and the Comptroller. The Board remits this amount to the Comptroller for deposit to the general revenue fund.[31] In fact, the fiscal note of H.B. 710 indicates that the THIRP would have a positive impact on state revenue. Gains to the revenue fund were estimated to be $50,000 in 1998, $70,000 in 1999 and $100,000 in years 2000, 2001 and 2002. The Legislative Budget Board anticipated that "revenues would increase as the program reaches full capacity."[32] In simple terms, policy makers initially believed THIRP would fund itself through the premium payments of individuals with THIRP coverage.

However, in the event of funding shortages, S.B. 832 authorized the Board of Directors to appeal to the Insurance Commissioner for additional funding via the imposition of assessments on each commercial insurer licensed to write health insurance in Texas.[33] Two years after passage of H.B. 710, in an atmosphere of rising health care costs, it was apparent that THIRP would require additional funding and that assessments would

likely be imposed each year on commercial providers of health insurance coverage. A 1999 amendment concerning administrative payments to the risk pool administrator also reflects the rising costs of health care. H.B. 1431 authorizes the Commissioner to approve an increase in payments to THIRP administrators from a previous cap of 12.5 percent to a new amount not to exceed 15% of premium receipts.[34]

THIRP's creators had the foresight to include a 'safety net' provision for funding the risk pool through assessments on commercial insurers doing business in Texas should THIRP's premium collections not cover claims and expenses. The policy makers determined that assessments would be calculated from "a ratio of the gross premiums collected by the insurer for health insurance policies in Texas during a calendar year to the gross premiums collected by all insurers for health insurance in Texas during the same calendar year."[35] Over time, legislators modified the policy concerning assessments to accommodate the financial needs of commercial health insurers. For example, H.B. 2191 allows insurers to petition the Commissioner for an abatement or deferment of all or part of an assessment and allows the Commissioner to grant an abatement or deferral on a finding that payment would jeopardize the insurer's fulfillment of contractual obligations. The legislation provides that if an abatement or deferment is approved, the amount is reallocated and assessed against other insurers in a manner consistent with the basis for computing the original assessment, but the insurer receiving financial accommodation remains liable to THIRP for the deficiency.[36]

Another bill that would have helped private insurers died in committee during the same 77th legislative session. H.B. 1709 would have provided full credit for any assessment paid during any calendar year against the private insurer's premium tax liability to the State of Texas. (This proposed tax credit would have allowed a 10 percent credit per year for ten years following the assessment date.)[37] In the fiscal note to H.B. 1709, the Legislative Budget Board reported that the premium tax credit bill would have had an estimated negative impact on the General Revenue-Related Funds ranging from $8 million in the first year to $76 million in the fifth year, for a total five-year negative impact of $204 million .[38]

As health care costs (and THIRP's deficit) increased, the Legislature sought additional measures to address THIRP's funding requirements. Tex. S.B. 809 79th Leg. R.S. (2005)[39] addresses THIRP's budgetary/financial issues in two ways. First, the bill established a policy regarding cost containment measures; and second, consistent with bills discussed above, S.B. 809 created legislation for further study of THIRP's deficit. A provision in S.B. 809 requires THIRP to offer coverage that is "more cost-effective," utilizing cost containment measures that must include individual case management and disease management. S.B. 809 requires the legislature to form a joint interim committee "to study the deficit resulting from the net losses of THIRP and to recommend a method or formula for recouping any deficit that apportions the cost of these losses among the largest possible number of users of the health care system."[40] The bill stipulates that the committee report its findings and recommendations to the Governor, the Lieutenant Governor, and the Speaker of the House of Representatives by September 1, 2006. Additionally, the bill sets new guidelines for the computation of the annual assessment paid by each insurer authorized to write insurance in Texas. The revised formula is based on an insurer's number of enrollees rather than on the amount of gross premiums collected, as discussed above.[41] Reasons behind the modification to the assessment formula are not provided, but the affect of such a revision on increased revenue, if any, appears unlikely.

II. SNAPSHOT OF THIRP AS IT IS TODAY

The following information appears in THIRP's 2005 Annual Report[42] concerning THIRP's recent performance, including: (a) demographic information concerning the risk pool population, (b) THIRP's financial condition and (c) several accomplishments toward making health coverage more cost-efficient for its enrollees while offering coverage consistent with major medical insurance available in the commercial market.

Demographics

During 2005, THIRP's Administrator, Blue Cross Blue Shield of Texas (BCBSTX), received 8,210 applications for coverage; of these, 6,665 applications were approved, a 5% decrease from 2004. Enrollment grew to 28,132 at year-end, a 6% increase. Enrollment increased during the year at an average rate of 130 insureds per month. Of those enrolled at the end of the year, 6% selected the $500 deductible plan, 17% selected the $1,000 plan, 47% selected the $2,500 plan, and 30% selected the $5,000 plan. The $500 plan was eliminated at the end of the year, due to diminished enrollment. Table 1 shows the increasing trend towards high deductible plans, similar to what occurred in the commercial market. THIRP's highest deductible ($5,000) plan experienced the greatest amount of growth during 2003-2005,

although the $2,500 deductible plan is the most popular (See Appendix, Table 1). In other words, to lower monthly premiums set at 200% above the "standard risk rate," a growing percentage of insureds who can afford to cover all their out-of-pocket medical expenses (or those who do not have many medical expenses) are opting for the highest deductible plan.

During 2005, the average monthly premium paid was $490, as compared to an average monthly premium in 2004 of $480. (The average market cost of employer-sponsored health insurance in 2004 was $315/month for an individual employee in Texas.)[43]

Of those insured by THIRP at the end of 2005, 46% were enrolled as HIPAA eligibles, 16% were enrolled for being refused individual insurance policies from private insurers, 13% were enrolled with agent certifications, 9% had automatic qualifying medical conditions, and 4% were enrolled because they had been offered individual insurance policies with medical condition waivers or at premium rates higher than the THIRP's rates. An additional 12% of insureds were covered as eligible dependents (See Appendix, Table 2). The average enrollee age was 50 years, and 66% were between the ages of 50 and 65.[44] The age distribution of the population covered by THIRP is interesting. With the exception of individuals younger than nineteen years of age, the proportion of enrollees increases with every four-year incremental increase in age. The small proportion of dependents may be explained by the relatively small proportion of enrollees with minors in their households.

Those enrolled in THIRP at the end of 2005 have coverage for an average of 32 months. Of THIRP's insureds who left the Pool, 26% did so because they obtained replacement health coverage. Perhaps this is a positive reflection of the job market, but 27% of enrollees lost coverage due to non-payment of premiums.[45]

Financial Highlights From THIRP's 2005 Annual Report[46]

THIRP is funded by premiums and assessments. In 2005, the Pool charged $161,596,890 in premiums, collecting $160,044,940. In the same year, the Pool assessed 380 health insurers and HMOs for a total of $98,371,720. There was a refund of $739,140 to companies with assessment credit balances. (The total Texas private-sector health insurance premium base subject to assessment was $8.7 billion.)

THIRP's costs are principally claims and administrative fees. Claims paid by THIRP during 2005 totaled $229,974,000. Claims for outpatient prescription drugs were 32% of that amount. A total of 597,187 medical claims and 1,051,092 prescription claims were paid during the year. As of December 31, 2005, the total claims reserve was $31,930,000, an increase of $4,630,000 from the prior year-end. The 2005 average incurred annual claims expense per insured was $8,510, a 2% increase over the 2004 figure of $8,365. The prior year's increase was 10%. Third-party administrator fees in 2005 totaled $15,063,063. All other operating expenses, including professional fees, employee expenses, and agent referral fees, totaled $971,419.

The 2005 actuarial loss ratio was 145%, compared to the 2004 loss ratio of 146%. The loss ratio represents the relationship of incurred claims to earned premiums. THIRP's net loss for 2005 was $86,844,495, including claim reserves.

To cut its losses, THIRP seeks ways to improve its cost-effectiveness. One such way is to provide insureds with a large network of pharmaceutical and medical providers. The WellPoint pharmacy network in Texas consisted of 4,000 pharmacies at the end of 2005. WellPoint network contract pricing lowered the THIRP's drug costs for the year to $37 million below ordinary pharmacy pricing. This may explain the reduction in the average incurred annual claims from 2004 to 2005.

Additionally, THIRP utilizes BCBSTX's BlueChoice® preferred provider network. At the end of 2005, the BlueChoice® statewide network included approximately 420 general hospital facilities and approximately 40,000 physicians and other providers. A large majority (97%) of the Pool's total medical claims were paid to preferred providers. Eligible charges were discounted by an average of 45%, under preferred provider contracts. These negotiated provider discounts reduced the Pool's medical claim costs by $219 million. Case management and utilization review programs resulted in additional medical claim cost savings for THIRP of $3.3 million. These cost-containment measures became mandatory with the passage of S.B. 809 in 2005.

Achievements Shown in THIRP's 2005 Annual Report[47]

In addition to the successful cost-containment strategies shown above, THIRP achieved improved cost-effectiveness during 2005 in three other noteworthy areas. First, THIRP significantly expanded several clinical pharmacy programs designed to control costs while protecting the health of insureds. This effort reduced THIRP's drug costs by $2.1 million. Moreover, THIRP

insureds and their physicians were introduced to the Half-Tab program, which was implemented in July 2005 for several cholesterol and depression management medications that are safely "split." THIRP provided free tablet splitters to insureds whose physicians prescribed half the medication at a doubled strength, for half the copay. In just its first few months of operation, this program reduced THIRP's drug costs and "copays" by $100,000.

Second, in October in 2005, THIRP introduced two WellPoint web-based programs, MyRxBenefits and HealthEnvelope, as complements to BlueAccess for Members, the medical benefit management and wellness site offered by BCBSTX. These programs promote better management of prescription drug benefit and provide access to useful health and wellness information. Also, BCBSTX launched Treatment Cost Advisor, which provides insureds with cost data for common health services, helping them to become better informed health care consumers.

Finally, THIRP worked with the other state risk pools to actively support passage of the State High Risk Pool Funding Extension Act (H.R. 4519) signed by President Bush on February 10, 2006. Congress authorized $75 million in risk pool funding for each year through 2010 under the new act. Of this amount, THIRP was awarded $9.2 million, the largest award to any state risk pool. THIRP's share of these federal funds was not allocated on a ratio of state to federal population. (Texas has only 8% of the total U.S. population, but received approximately 12% of the total $75 million appropriation.) The federal subsidy will reduce premiums charged by THIRP to Texas insureds. Therefore, the average January 1, 2007 premium increase will likely be only 1.7% rather than 5.3%, eliciting a collective sigh of relief from the 28,000 individuals who are covered by THIRP.

III. CONCLUSION

THIRP's objectives are expressly stated in the Texas Insurance Code, along with the admonishment that THIRP "is not intended to diminish the availability of traditional health care coverage to consumers who are eligible for that coverage."[48] The purposes of THIRP are said to be these, according to section 1506 of the Insurance Code:

1. provide for access to quality health care at minimum cost to the public;

2. relieve the insurable population of the disruptive cost of sharing coverage, and

3. maximize reliance on strategies of managed care proven by the private sector.

The State of Texas is modestly in the business of providing health care insurance. Although THIRP consistently operates at a deficit and has never realized the revenue potential originally envisioned by its creators, THIRP continues to serve a public need.

Appendix

Table 1*

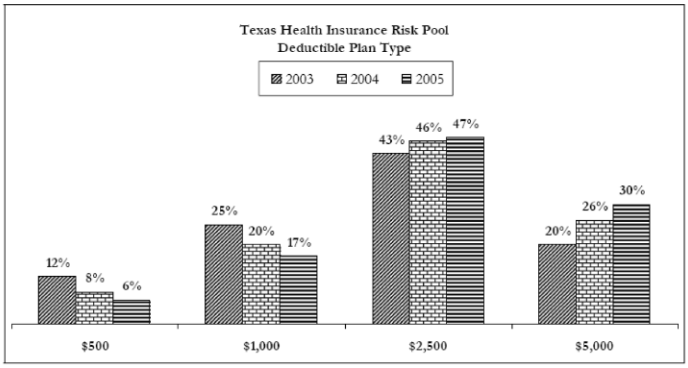
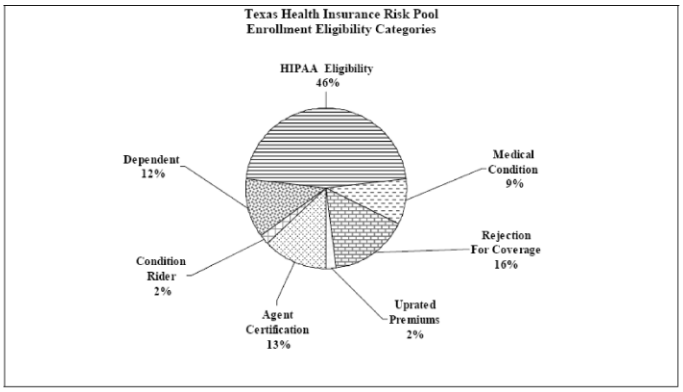


Table 2*



*S

Table 3*

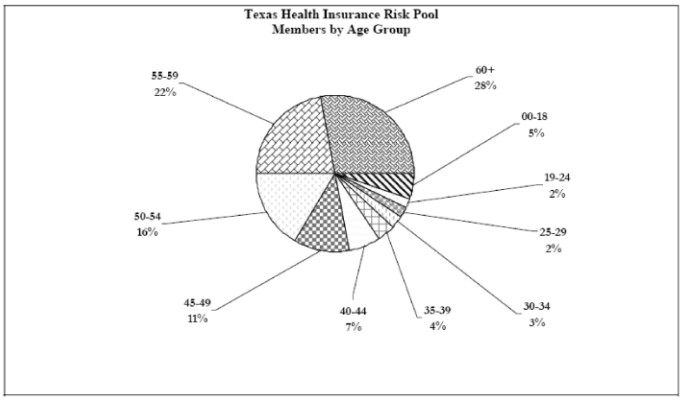
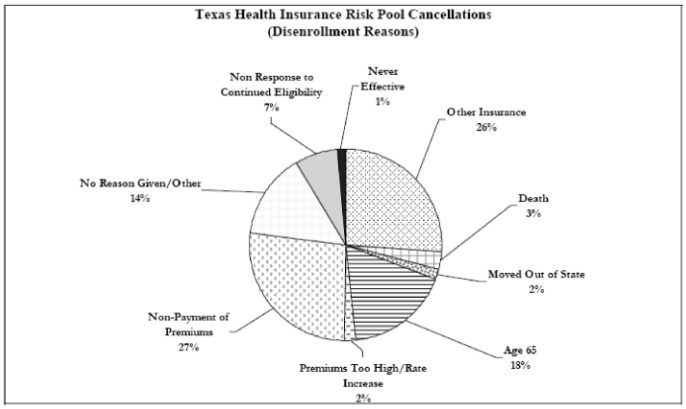


Table 4*



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2 Fred A. Simpson is a partner in the Houston Litigation Section of Jackson Walker L.L.P.

3 Thomas. S. Bodenheimer & Kevin Grumbach, Understanding Health Policy: A Clinical Approach 22 (McGraw Hill 2005).

4 Health Insurance Portability and Accountability Act (1996), Pub. L. 104-191, 110 Stat.1936 (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.).

5 Act of May 27, 1989, 71st Leg. R.S., ch. 1094, 1989 Tex. Gen. Laws 4477-4491.

6 Act of May 24, 1997, 75th Leg. R.S., ch. 837, 1997 Tex. Gen. Laws 2679-2694.

7 Acts 1989, 71st Leg., ch. 1094 §1 *et seq.*

8 Tex. Ins. Code Ann. §1506.051.

9 Tex. Ins. Code Ann. §1506.051.

10 Tex. Ins. Code Ann. §1506.052.

11 Tex. Ins. Code Ann. §1506. 055.

12 Acts 1989, 71st Leg., ch. 1094 §1 *et seq*.

13 Tex H.B. 710, 75th Leg., R.S. (1997), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=75R &Bill=HB710.

14 http://www.txhealthpool.org/eligibil.html.

15 Acts 1989, 71st Leg., ch. 1094 §1 *et seq*.

16 Acts 1989, 71st Leg., ch. 1094 §1 *et seq.*

17 Acts 1989, 71st Leg., ch. 1094 §1 *et seq*

18 Tex. H.B. 710, 75th Leg., R.S. (1997), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=75R&Bill=HB710.

19 Tex. H.B. 710, 75th Leg., R.S. (1997), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=75R&Bill=HB710.

20 Tex. H.B. 710, 75th Leg., R.S. (1997), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=75R&Bill=HB710.

21 Tex. S.B. 467, 78th Leg., R.S. (2003), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=78R&Bill=HB467.

22 Tex. Ins. Code Ann. §1506.203.

23 Tex. Ins. Code Ann. §1506.205(b). However, the Commissioner may approve a higher percentage, up to 15%. *See* Tex. Ins. Code Ann. §1506.205(c).

24 Acts 1989, 71st Leg., ch. 1094 §1 *et seq*

25 http://www.txhealthpool.org/eligibil.html.

26 http://www.txhealthpool.org/eligibil.html. Note: Because the THIRP website is intended for use by the general public, eligibility criteria presented on the website do not track Tex. Ins. Code Ann. §1506.152 verbatim.

27 Acts 1989, 71st Leg., ch. 1094 §1 *et seq*

28 http://www.txhealthpool.org/eligibil.html.

29 Tex. H.B. 710, 75th Leg., R.S. (1997), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=75R&Bill=HB710.

30 Tex. H.B. 710, 75th Leg., R.S. (1997), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=75R&Bill=HB710.

31 Tex. H.B. 710, 75th Leg., R.S. (1997), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=75R&Bill=HB710.

32 Tex. H.B. 710, 75th Leg., R.S. (1997), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=75R&Bill=HB710.

33 Acts 1989, 71st Leg., ch. 1094 §1 *et seq.*

34 Tex. H.B. 1431; 76th Leg.. R.S. (1999), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=76R&Bill=HB1431.

35 Acts 1989, 71st Leg., ch. 1094 §1 *et seq*

36 Tex. H.B. 2191, 77th Leg., R.S. (2001), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=77R&Bill=HB2191.

37 Tex. H.B. 1709, 77th Leg., R.S. (2001), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=77R&Bill=HB1709.

38 Fiscal Note, Tex. H.B. 1709, 77th Leg. R.S. (2001), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=77R&Bill=HB1709.

39 Act of April 26, 2005, 79th Leg. R.S. ch. 824, § 3,8,11(e); 11(f), 2005 Tex. Gen. Laws 2824.

40 Tex. S.B. 809, 79th Leg., R.S. (2005), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=79R&Bill=SB809.

41 Tex. S.B. 809, 79th Leg., R.S. (2005), *available at* http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=79R&Bill=SB809.

42 Texas Health Insurance Risk Pool 2005 Annual Report, *available at* http://www.txhealthpool.org/index.html.

43 http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Health+Costs+%26+Budgets&subcategory=Employer%2dBased+Health+Premiums&topic=Single+Coverage&link_category=&link_subcategory=&link_topic=&viewas=table&showregions=0&sortby=&printer-friendly=0&datatype=currency.

44 *See* Appendix, Table 3.

45 *See* Appendix, Table 4.

46 Texas Health Insurance Risk Pool 2005 Annual Report, *available at* http://www.txhealthpool.org/index.html.

47 Texas Health Insurance Risk Pool 2005 Annual Report, *available at* http://www.txhealthpool.org/index.html.

48 Tex. Ins. Code Ann. § 1506.101.

Comments FROM THE EDITOR

BY CHRISTOPHER W. MARTIN
Martin, Disiere, Jefferson & Wisdom, L.L.P.

I want to express a word of thanks to Pat Wielinski and Kelly Shoulders of Cokinos, Bosien & Young in Arlington for their assistance in editing articles for this issue of the *JTIL*. I also want to thank Leslie Thorne of Haynes & Boone who also provided editorial assistance for this issue of the *JTIL*. Editing is a thankless job and I appreciate each of them for their hard work that made this issue possible.

We still have two openings for articles in our winter 2007 issue. If you would like to submit an article for publication, please call or email me.

I anticipate that we will see several significant insurance decisions from both the Texas Supreme Court and the Fifth Circuit over the next few weeks. Jim Cornell will circulate those decisions through the Section's email service as soon as they are released. Watch for the emails of recent decisions because several big decisions should be coming out soon.

If any aspect of your practice touches on insurance law, I believe the benefits the Section provides in cutting-edge information, substantive education, CLE opportunities, and professional networking far exceeds the nominal annual membership fee. Maintaining a large, vibrant and healthy Section is key to being able to continue to do what the Section does so well. Thank you for your continued membership in support of the Insurance Section of the State Bar of Texas.

Finally, I want to thank Rusty McMains for his strong leadership of the Insurance Law Section over the past year. He brought new ideas to the Council, encouraged our leadership, and implemented several new initiatives. His support for this publication is strong and I want to publicly thank him for his hard work, great ideas, and constant encouragement. The reigns of leadership have now been turned over to Karen Keltz who has been active in the leadership of the Section for many years. The Section remains in very good hands as we continue to strive to meet the needs of our membership.

Christopher W. Martin
Editor-in-Chief

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