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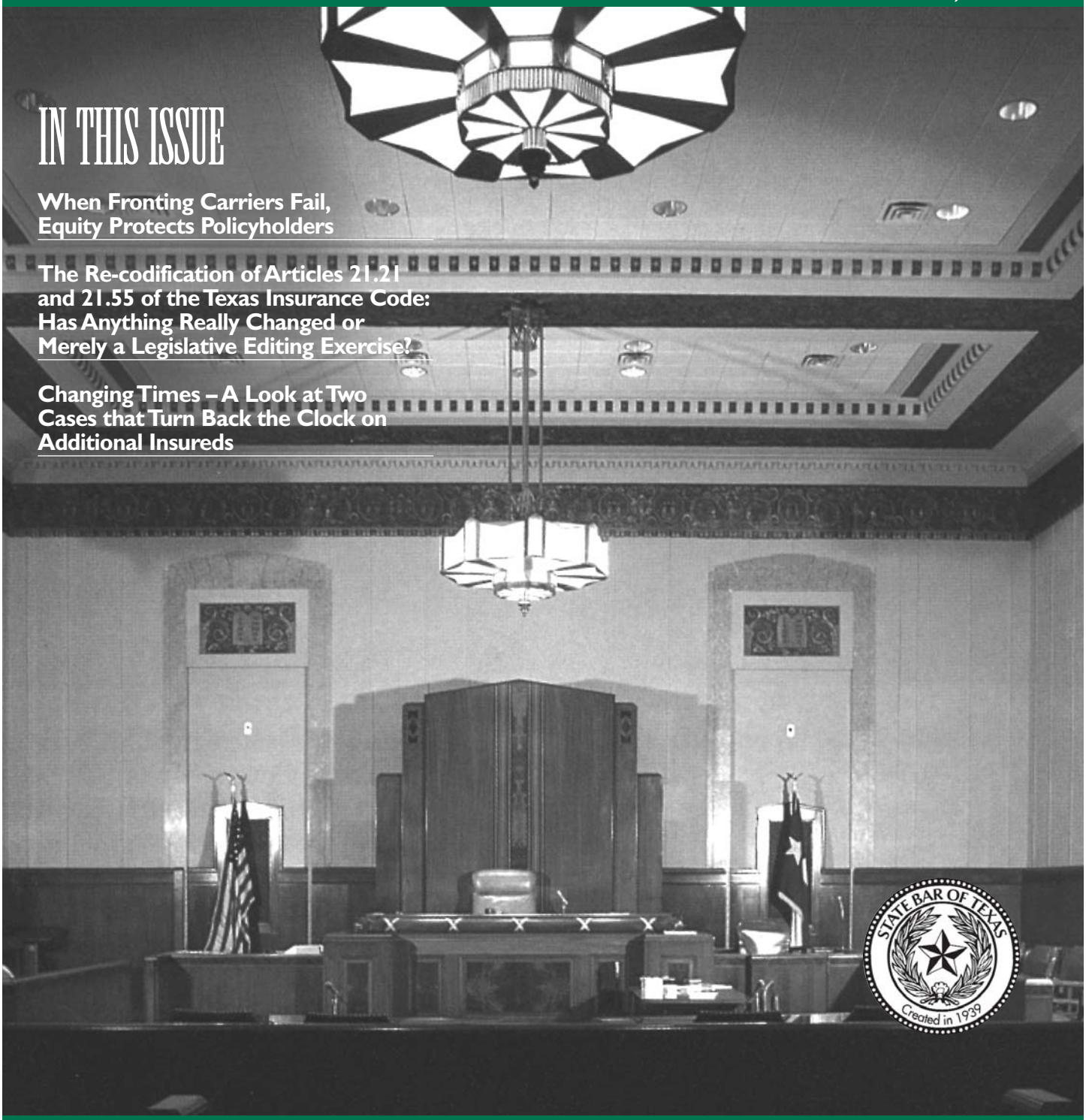

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Official publication of the Insurance Law Section of the State Bar of Texas

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Journal of Texas Insurance Law

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

Anyone interested in submitting a manuscript for publication should contact 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.

On the Cover:

This courtroom is indicative of the fine materials and craftsmanship employed in the original construction of the Jefferson County courthouse in 1931. Designed in the Art Deco style, it features terrazzo floors, doors of oak and exotic woods, ceilings of molded and painted plaster and Benedict Nickel light fixtures in abstract designs. The Beaumont building was carefully restored in 1983. Its fine exterior composition of brick, limestone, sandstone and terra-cotta were cleaned and repaired. And many of its outstanding interior appointments, neglected for years or damaged by air system ducts and office partitions, were restored.

Courtesy of *Texas Highways* magazine

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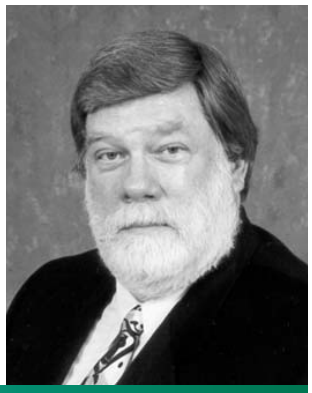

Comments FROM THE CHAIR

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

This is my first opportunity to formally thank Veronica Carmona Czuchna for her leadership of the Section during her term as Chair over the past year. Thanks!

Thanks also need to go to the Section's long-suffering editor of this Journal, Christopher W. Martin. Great job, Chris!

This issue of the Journal explores whether recodification of Articles 21.21 and 21.55 has actually changed the law. That topic is particularly apropos because the upcoming 80th Legislature is about to 'finish' the recodification process with a revision of Article 1 of the 1951 Code. A list of proposed revisions will soon appear on the Section's updated website. The actual substance of the proposed revisions will soon appear at the Texas Legislative Council's website at http://www.tlc.state.tx.us/.

Finally, I wish to encourage our membership or others who are interested in contributing to the Journal or participating in CLE presentations on insurance topics of interest to contact the Section or myself. The expression of all points of view are encouraged by our Section Bylaws and by the membership. Hopefully, our endeavors in that regard will continue vigorously during my term.

Russell H. McMains
Chair, Insurance Law Section

BY FRED A. SIMPSON

JACKSON WALKER L.L.P.

When Fronting Carriers Fail, Equity Protects Policyholders

The purpose, legality, and mechanics of a practice in the U.S. insurance industry known as "fronting" (which frequently transcends international borders) is explained rather clearly in a footnote to an Ohio court of appeals opinion:

> [A] "fronting policy" program is a legal risk management device commonly used by large corporations, operating in multiple states, in which the corporation pays a discounted premium to an insurer, which maintains insurance licensing and filing capabilities in a particular state or states, to issue and maintain an "insurance policy" covering the corporation in order to comply with the insurance laws and regulations of each state in which the corporation is required to maintain proof of insurance. However, through the use of self-insurance mechanisms, *** the corporation retains all of the risk covered under the "fronting policy." In effect, the corporation "rents" the insurer's licensing and filing capabilities in a particular state or states, and thereby becomes a self-insurer and is not subject to the requirements of [the statute].

Tharp v. Berdanier, No. Civ. A. 21473, 2003 WL 22900696 *4, n. 3 (Ohio Ct. App. Dec. 10, 2003), *appeal denied*, 808 N.E.2d 397 (Ohio 2004).

Under typical fronting schemes, the "insureds" contract with fronting insurers for what appear on the surface to be normal transfers of insurable risks. Nevertheless, under this form of fronting scheme the insureds actually "retain" responsibility for losses through "deductible" amounts of coverage, usually in amounts that are exactly equal to the "coverage" granted under the "policy."[1] These "self-insureds" then typically contract with their fronting insurers or with third-party administrators for claims handling, and with reinsurers to limit catastrophic losses under "stop loss" programs. Through variations of these arrangements, companies enjoy a lawful and cost effective way to self-insure losses without meeting the formal legal requirements to qualify as insurers (or self-insurers) in those jurisdictions where the companies do business.[2]

The normal self-insurance approach to fronting has a companion that arises from a different factual pattern. That alternate type of fronting differs where *insurers*, rather than the insureds, are the parties who elect the use of fronting methods. They do so in order to capture business in jurisdictions where those insurers are not licensed (and perhaps could never qualify for licensing). A federal court of appeals explained the mechanics and legality of this alternate practice while affirming the decision of an Illinois district court below:

> [The insurer] was not licensed to issue insurance policies directly in Illinois. [The insurer], therefore, had to use what is known as a "fronting arrangement" to insure these Illinois risks. In a fronting arrangement – a well established and perfectly legal scheme – policies are issued by a state-licensed insurance company and then immediately reinsured to 100 percent of their face value by the out-of-state unlicensed insurer. In a typical fronting arrangement, the fronting insurer issues policies on its own paper and in its own name, and the out-of-state unlicensed insurer takes over the administration of all claims as part of the reinsurance agreement.

Reliance Ins. Co. v. Shriver, Inc., 224 F.3d 641, 642 (7th Cir. 2000).

Several issues of insolvency may arise in the various forms of fronting activity.

Fred A. Simpson, a litigation partner at Jackson Walker L.L.P., Houston, Texas, is an associate editor for The Houston Lawyer.

1. Insolvent insureds become unable to reimburse fronting insurers for claims settlements and/or expenses that exceed the amount of the self-insured retentions.

2. Insolvent reinsurers cannot pay their share of reinsured losses.

3. General creditors of insolvent fronting insurers demand recovery of all claim proceeds due from all reinsurers on prior losses incurred by the insured parties.

The first insolvency risk rarely occurs because fronting insurers protect themselves with advance agreements guaranteeing repayment of anything those fronting insurers pay out in claims. This protection is accomplished in several ways, including irrevocable letters of credit, other third-party indemnity agreements, trusts, or advance deposits based on expected losses.[3]

Resolution of the second type of situation depends on the specific contractual arrangements between the fronting insurers and the insureds, and in the treaties and/or contracts between and among the various reinsurers, as well as the nature and scope of governmental regulation all of which are complexities far beyond the scope of this review which focuses on equitable relief in the third insolvency situation.

The third situation usually involves litigation by the regulatory bodies that control the business of insurance in the specific jurisdictions where the fronting insurers are registered. Courts tend to find ways to deal equitably on behalf of insureds when faced with this type of insolvency, as exemplified in a 50-plus page decision recently affirmed by the Supreme Court of Pennsylvania.[4] The insured parties, Pulte Homes, Inc.,[5] Psychiatrists' Purchasing Group,[6] Rural/Metro Corporation,[7] and American Airlines,[8] sought judicial relief from the Commissioner of Insurance of the Commonwealth of Pennsylvania after their two rather sizeable fronting insurers became insolvent. The Commissioner sued for statutory rehabilitation, insisting that anything recoverable from reinsurers belonged to the general creditors of the insurers' estates. Insureds, referred to in the opinion as "policyholders," were all permitted to intervene in the lawsuit.

The circumstances of this particular insolvency are noteworthy. Both fronting insurers had a substantial net worth, and their common parent company had poured millions of dollars into the breach in a fruitless effort to prevent intervention by the Commissioner. But the Commissioner ultimately proved technical insolvency when persistent cash flow problems prevented the fronting insurers from promptly paying claims when due. These cash flow problems were caused by lagging collections from reinsurers who owed their portion of the insured claims. As the manager for the state's rehabilitator explained, the reinsurers were unjustified in their refusals to pay losses and were "simply playing games by asserting invalid defenses."[9] According to the court's opinion, "[t]he failure of reinsurers to honor their contractual obligations is not limited to [these fronting insurers]: it is endemic to the industry."[10]

Rehabilitation under the auspices of the Commissioner proved futile, and the court ultimately granted the rehabilitator's petition requesting liquidation of the fronting insurers. Policyholders opposed liquidation, however, fearing the worst and arguing that any standard or normal statutory liquidation would be to their detriment unless all reinsurance claim proceeds were paid directly to them instead of to the estates of the insurers. The court was warmed by those arguments.

The court explained that because the insurers were merely "fronting companies" issuing insurance policies primarily reinsured by other insurers, those companies assumed neither risk nor did they provide any administrative function on behalf of their insureds. Accordingly, the court refused to allow any reinsurance proceeds to become part of the general assets of the fronting insurers' estates, unlike standard insurance company liquidations where insureds have no entitlement to any payments from reinsurers on the reinsured claims. Although some evidence showed that claims might be paid as future proceeds became available from the estates of the fronting companies, there was enough evidence to convince the court that policyholders would in fact be harmed by (a) only partial payment, and/or (b) by payment delays inherent in any standard liquidation process.[11] In other words, too little too late.

When the court granted policyholders direct access to reinsurance funds, the court explained that any such right is to be established individually, on a case-by-case basis. Accordingly, the court examined each policyholder's situation separately to determine whether each policyholder could equitably bring direct actions against the reinsurers in the policyholders' positions of third-party beneficiaries to the fronting insurers' reinsurance contracts. The court concluded that all four of the corporate policyholders were entitled to direct access to reinsurance proceeds based on their respective third-party beneficiary status. In reaching its decision, the court relied on the common law of Pennsylvania as well as the law of other jurisdictions, including the results of reported cases from New Jersey,[12] New York,[13] and Texas.[14]

The Supreme Court of Pennsylvania affirmed the lower court 5-2, *per curiam*, without any written opinion. However, the dissent filed a comprehensive opinion explaining that the controlling statute, which does not distinguish between typical insurers and "fronting companies," classifies reinsurance funds

as general assets of an insolvent insurer's estate, arguing that only statutory exceptions occur only where express "cut-through" provisions are found in the reinsurance policies so that "the reinsurance contract provided for direct coverage of an individual named insured."[15] The dissent observed, "none of the reinsurance contracts at issue contain an express provision conferring third-party beneficiary status on any of the corporate policyholder intervenors seeking direct access to reinsurance funds."[16]

However, the court below did in fact consider the above-referenced statutory provision that was raised later by the dissent in the higher court, but the lower court circumvented the statutory provision by finding power to reform the insuring agreements to reflect the parties' real intent, and that a "cut through" agreement need not be in the form of a "holy writ."[17] The court also noted that any actions in this matter must be consistent with equitable principles and serve the interests of policyholders.[18]

> The usual occasion for reinsurance has no application [here]. The Policyholder Intervenors, not the [fronting company], placed the reinsurance; [the fronting company] neither adjusted nor funded claims; and [the fronting company] did not seek to expand its underwriting capacity through reinsurance. Indeed, it sought to avoid any underwriting because its business plan called for generation of fees not underwriting profits.[19]

Traditional approaches were not useful to the lower court in "a situation where the insolvent insurer acted only as a pass-through and not as a true insurer."[20] "In short, each 'reinsurer' functioned as the direct insurer for each of the Policyholder Intervenors."[21] This case demonstrates the extremes to which courts of equity will go to protect true beneficiaries of fronting schemes, irrespective of technical barriers, including statutes.

1. A "fronting policy" is "a form of self-insurance in which the deductible is identical to the limits of liability, and the insurance company acts only as surety that the holder of the fronting policy will be able to pay any judgment covered by the policy." *Dorsey v. Federal Ins. Co.*, 798 N.E.2d 47, 51 (Ohio App. 2003) (quoting *Landers v. Lucent Technologies, Inc.*, Nos. 81506, 81531, 2003 WL 21468908 (Ohio App. 2003)). "In a fronting policy, the insured essentially rents an insurance company's licensing and filing capabilities, but the insurance company does not actually pay any claims." *Id*.

2. However, fronting is regulated or limited in some jurisdictions, such as Florida, where the statute prohibits the practice if it involves transfers to one or more unauthorized insurers substantially "the entire risk of loss on all of the insurance written by it in this state, or on one or more lines of insurance, on all of the business produced through one or more agents or agencies, or on all of the business from a designated geographical territory. . . ." Fla. Stat. Ann. § 624.404 (West 2006).

3. *See, e.g., Carns v. Smith*, No. 01-972H, 2003 WL 22881538, (Ohio Com. Pl. Nov. 7, 2003.) (General Motors' contractual duty to indemnify fronting insurer secured by a $10 million trust fund for the sole and exclusive benefit of the insurer; ConAgra's duty satisfied by a $2 million letter of credit or collateral trust); *see also Wisconsin Patients Comp. Fund v. St. Mary's Hosp. of Milwaukee*, 561 N.W.2d 797, 802 (Wis. Ct. App. 1997) (indemnity agreement and letter of credit); *Koken v. Legion Ins. Co.*, 831 A.2d 1196, 1212 (Pa. Cmmw. Ct. 2003), *aff'd Koken v. Villanova Insurance Company*, 878 A.2d 51 (Pa. 2005) (fronting insurer received $8.5 million from insured (discounted to present value) as full funding for assuming the risk, not a true underwriting risk).

4. *Koken*, 831 A.2d at 1196 .

5. Pulte builds approximately 28,000 homes per year and has over $7 billion in annual revenue. *Id*. at 1208-09.

6. This risk-purchasing group acts on behalf of the American Psychiatric Association's 35,000 members worldwide, providing economical professional liability and other types of insurance coverage unique to the practice of psychiatry which is mandatory for licensing in some jurisdictions. *Id*. at 1211-12.

7. Rural/Metro is an emergency and medical transportation company headquartered in Scottsdale, Arizona, publicly-held and employing over 10,000 paramedics. *Id*. at 1215.

8. American Airlines' September 11, 2001, infamous Flight 11 into the World Trade Center, and Flight 77 into the Pentagon were both subjects of the coverage being contested. *Id*. at 1221.

9. *Koken*, 831 A.2d at 1205.

10. *Id*. at 1205. Ironically, the fronting insurers' problems in timely collecting payment for reinsurance claims were exacerbated by its inefficient software known as "Faster." *Id*. at 1205, n. 10. Overdue reinsurance receivables exceeded $300 million at the time of proceedings. *See Villanova*, 878 A.2d 51 at 54 n. 2.

11. One of the court's considerations was the need for service to claims related to alleged psychiatric malpractice. Some such claims would perhaps not result until after patients reach majority, possibly as much as 25 years after original medical treatment. *Koken*, 831 A.2d at 1214-15. "The availability of state guaranty funds for claims that might not develop for 25 years is unlikely." *Id*. at 1214. Furthermore, the state's guarantee fund covered claims up to $300,000 only, and some types of policyholders, such as the psychiatrists, were precluded by law from access to guaranty funds, Id. at 1214, or because their net worth was too great (American). *Id*. at 1222.

12. *Id*. at 1238; *Venetsanos v. Zucker, Facher & Zucker*, 638 A.2d 1333, 1339-40 (N.J. Super. Ct. App.Div. 1994).

13. *Koken*, 831 A.2d at 1236; *Allstate Ins. Co. v. Administratia Asigurarilor de Stat.*, 948 F.Supp. 285, 307-09 (S.D.N.Y. 1996).

14. *Koken*, 831 A.2d at 1236; *Great Atl. Life Ins. Co. v. Harris*, 723 S.W.2d 329, 334 (Tex. App.—Austin 1987, writ dism'd).

15. *Villanova*, 878 A.2d at 57.

16. *Id*.

17. *Koken*, 831 A.2d at 1241.

18. *Id*. at 1242.

19. *Id*. at 1234.

20. *Id*. at 1236.

21. *Id*. at 1237.

BY CHRISTINE KIRCHNER AND STEVEN J. KNIGHT

CHAMBERLAIN, HRDLICKA, WHITE, WILLIAMS & MARTIN; HOUSTON

The Re-codification of Articles 21.21 and 21.55 of the Texas Insurance Code: Has Anything Really Changed or Merely a Legislative Editing Exercise?

INTRODUCTION AND SCOPE OF ARTICLE

In June 2003, the Texas Legislature passed House Bill 2922, which implemented a re-codification of the Insurance Code. As part of the re-codification process, the Texas Legislature has moved the substantive provisions of Articles 21.21 and 21.55 of the Insurance Code to Chapter 541 and 542, respectively, of the Insurance Code. Importantly, the Legislature's stated intent was not to effectuate any substantive changes:

> House Bill 2922, a continuation of the legislature's ongoing statutory revision program, contains non-substantive changes adding five titles and two subtitles to the Insurance Code, repealing various source laws from which the new code content is derived, and making other conforming amendments. The new titles and subtitles relate to Texas Department of Insurance fund and revenue matters, the protection of consumer interests, life and health coverage, title insurance, and the regulation of professionals.

In reviewing Chapters 541 and 542, which became effective on April 1, 2005, it is clear that many changes, were, in fact, made. The changes take a variety of different forms, generally discussed in the next section.

The purpose of this paper is to address whether any of the changes are, despite the Legislature's stated intent, substantive in nature. This paper does not address each and every change contained in the new Chapters. That task would be far too tedious and largely uneventful, as the vast majority of the changes involve word choice revisions which nonetheless capture the same substantive intent. Rather, the purpose of this paper is to first identify the types of changes that were made and to then discuss examples of changes that *may* have a substantive effect on the Code a result the Legislature did not intend.

THE GENERAL NATURE OF THE CHANGES

In reviewing Chapter 541 of the Texas Insurance Code, which contains the former provisions from Article 21.21, it appears that there are fundamentally five types of changes that have been made in the re-codification process. Those changes are: (1) word choice changes; (2) the addition of subsections to break up long sentences or long concepts contained in the old version of the statute; (3) the addition of additional sections, as opposed to subsections, to break up long sections of the prior statute; (4) changes to the language used concerning date calculation, and (5) removal of referenced to "the Board."

A. Word Choice Changes

Throughout Chapter 541 of the Texas Insurance Code, there are countless examples of situations where the Legislature changed simple words which do not appear to have any substantive impact on the meaning of the statute. These types of changes, as noted, are not the emphasis of this paper as it is unlikely such changes will give rise to substantive legal issues in future cases involving litigation of extra-contractual insurance claims.

One example of word choice changes appears in the liberal construction provision. The old version, which is found in Article 21.21, § 1(b), provides:

Christine Kirchner and Steven J. Knight practice with Chamberlain, Hrdlicka, White, Williams & Martin in Houston. Ms. Kirchner, who is a partner with the firm, represents insurers in coverage and bad faith cases in state and federal courts across Texas. Mr. Knight is an associate with the firm and also works in the firm's Insurance Practice Group.

> This article shall be liberally construed and applied to promote ***its*** underlying purposes as set forth in this section.

The new version, conversely, which appears at Chapter 541.008, states:

> This chapter shall be liberally construed and applied to promote the underlying purposes as provided by section 541.001.

These types of simple word-choice changes are found throughout Chapters 541 and 542. It does not appear as though these types of changes modify the substance of the provision. The statutes are to be liberally construed to promote its (or "the") underlying purposes.

Another example of a word choice change that does not appear to be significant from a litigation standpoint is the changing words like "making" to "to make." For example, Article 21.21 § 4(3) pertains to:

> making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement…

Section 541.053, however, describes generally the same conduct but uses different language as follows:

> It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to directly or indirectly make, publish, disseminate, or circulate or to aid, abet, or encourage the making, publication, dissemination, or circulation of a statement…

Again, it is not anticipated that this type of change will give rise to any sort of substantive legal issue for the courts to decide as they do not appear to modify the true meaning of the statute. Again, these examples are pervasive throughout the new version of the Insurance Code. They are not, however, the primary emphasis of this article, and, other than pointing out their existence generally, it is not necessary to highlight each and every such example.

B. The Addition of New Subsections

Another type of change that will not likely give rise to new legal issues to be decided has to do with the organization of the statutes. Some of the provisions of Article 21.21 contained long descriptions or paragraphs that were not subdivided in any meaningful manner. The conveyance of multiple ideas or substantive provisions in long text made the statutes difficult to read. The Legislature clearly sought to cure this by breaking up such longer paragraphs and adding subsections within the new Section.

Once clear example of this type of change is found in the immunity from prosecution provision, found in the old version at 21.21 § 12. That provision stated as follows:

> If any person shall ask to be excused from attending and testifying or from producing any books, papers, records, correspondence or other documents at any hearing on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or a forfeiture, he shall notwithstanding be directed to give such testimony or produce such evidence, he must nonetheless comply with such direction, but he shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter or thing concerning which he may testify or produce evidence pursuant thereto, and no testimony so given or evidence produced shall be received against him upon any criminal action, investigation or proceeding; provided, however, that no such individual so testifying shall be exempt from prosecution or punishment for any perjury committed by him while so testifying and the testimony or evidence so given or produced shall be admissible against him upon any criminal action, investigation or proceeding concerning such perjury, nor shall he be exempt from the refusal, revocation or suspension of any license, permission or authority conferred, or to be conferred, pursuant to the Insurance Code of this state. Any such individual may execute, acknowledge, and file in the office of the Board a statement expressly waiving such immunity or privilege in respect to any transaction, matter or thing specified in such statement and thereupon the testimony of such person or such evidence in relation to such transaction, matter or thing, may be received or produced before any judge or justice, court, tribunal, grand jury or otherwise, and if so received or produced, such individual shall not be entitled to any immunity or privilege on account of any testimony he may so give or evidence so produced.

This rather lengthy and cumbersome provision has been broken down into a new section – § 541.007 – which adds numerous sub-provisions, making it much easier to read. The new version is as follows:

(a) This section applies to a person who requests to be excused from attending and testifying at a hearing or from producing books, papers, records, correspondence, or other documents at the hearing on the ground that the testimony or evidence may

(1) tend to incriminate the person; or
(2) subject the person to a penalty or forfeiture.

(b) A person who, notwithstanding a request described by subsection (a), is directed to provide the testimony or produce the documents shall comply with that direction. Except as provided by subsection (c), the person may not be prosecuted or subjected to a penalty or a forfeiture for or on account of a transaction, matter, or thing about which the person testifies or produces documents, and the testimony or documents produced may not be received against the person in a criminal action, investigation, or proceeding.

(c) A person who complies with a direction to testify or produce documents is not exempt from prosecution or punishment for perjury committed while testifying, and the testimony or evidence given or produced is admissible against the person in a criminal action, investigation, or proceeding concerning the perjury, and the person is not exempt from the denial, revocation, or suspension of any license, permission, or authority conferred or to be conferred under this code.

(d) A person may waive the immunity or privilege granted by this section by executing, acknowledging, and filing with the department a statement expressly waiving immunity for privilege for a specified transaction, matter or thing. On filing the statement: (1) the testimony or documents produced by the person in relation to the transaction, matter, or thing may be received by or produced before a judge or justice or a court, grand jury, or other tribunal; and (2) the person is not entitled to immunity or privilege for the testimony or documents received or produced under subsection (1).

As can be seen, the re-codification of the immunity from prosecution provision becomes much simpler to read and interpret.

Another example is found in the former Article 21.21 § 4(2), which pertained to misrepresentations and false advertising of policy claims.

Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

This lengthy provision, which attempted to convey multiple substantive concepts, has now been appropriately subdivided, making the separate concepts easier to follow. The new provision is found in Section 541.051, which reads as follows:

It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to:

(1) make, issue, or circulate or cause to be made, issued, or circulated an estimate, illustration, circular, or statement misrepresenting with respect to a policy issued or to be issued:

(A) the terms of the policy;

(B) the benefits or advantages promised by the policy; or

(C) the dividends or share of surplus to be received on the policy;

(2) make a false or misleading statement regarding the dividends or share of surplus previously paid on a similar policy;

(3) make a misleading representation or misrepresentation regarding:

(A) the financial condition of an insurer; or

(B) the legal reserve system on which a life insurer operates;

(4) use a name or title of a policy or class of policies that misrepresents the true nature of the policy or class of policies; or

(5) make a misrepresentation to a policyholder insured by any insurer for the purpose of inducing or that tends to induce the policyholder to allow an existing policy to lapse or to forfeit or surrender the policy.

Again, these types of changes are found throughout the new Chapters. They do not, however, appear to give rise to new issues to be construed by courts, keeping with the stated intent to not effectuate substantive changes.

C. The Addition of New Sections (as opposed to subsections)

Another type of change that is pervasive throughout the new version of the Insurance Code is dividing up longer provisions from Article 21.21 and placing the provisions in separate Sections (as opposed to simply adding separate subsections as illustrated above).

One example of this type of change is the former Article 21.21 § 6 which pertained to hearings, witnesses, appearances and production of books. The multiple subsections have now been assigned separate Sections, appearing in the new code under Sections 541.102, 541.103, 541.104, 541.105 and 541.106.

In analyzing the re-codified provisions, it appears that the vast majority of the changes likely will not have a substantive impact…

Another example of this type of change is Sections 541.107, 541,108, 541.109, and 541.110, which contain the provisions of the former Article 21.21 § 7. The addition of the separate sections in the new version makes the construction of the hearing process simpler to read.

D. Date Calculation Language

One interesting set of changes pertains to the language used to convey deadlines and dates. For example, in Article 21.21 § 6, which described the amount of time that the insurance carrier is entitled to have prior to a hearing concerning allegations of deceptive practices, provides:

…it shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereupon to be held at a time and place fixed in the notice, ***which shall not be less than five days after the date of the service thereafter.***

The new version of this provision, codified at § 541.102(b) provides:

The Department may not hold the hearing ***before the sixth day after the day the notice is served.***

Article 21.21 § 19 concerning preliminary notice involving a class action lawsuit provides:

At least 30 days prior to the commencement of a class action suit for damages under Section 17 of this Article, this prospective plaintiff must notify the intended defendant of his complaint…

The new provision, Section 541.255 provides:

Not later than the 31st day before the date a class action for damages is commenced under this chapter…

Article 21.21 § 16(d) described the two-year statute of limitations for private causes of action under the Insurance Code as follows:

all actions under this article must be commenced ***within two years after the date on which*** the unfair method of competition or unfair or deceptive act of practice occurred…

In Section 541.162, that language was replaced with the following:

A person must bring an action under this chapter before the second anniversary of the following…

In Article 21.21 § 16, which pertained to relief available to injured parties, the 60-day notice provision required to be given to a defendant prior to filing suit, is described as follows:

As a prerequisite to filing a suit seeking damages under this section against any person, the person seeking damages shall give written notice to the other person at least ***60 days before filing suit***.

This language is now replaced and is found in Section 541.154 entitled "Prior Notice of Action." The new provision states:

A person seeking damages in an action against another person under this subchapter must provide written notice to the other person ***not later than the 61st day before the date the action is filed***.

These changes are curious as they don't appear to simplify the date calculation process.

E. Removal of References to the "Board"

Throughout the former Article 21.21, the Legislature included referenced to the Board. Chapter 541, however, removes those references, and replaces them generally with references to the "Commissioner." For example, Article 21.21 § 2 defined "Board" as "the State Board of Insurance." Chapter 541 no longer includes a definition of "Board." The reasons for this change is clear.

The 73rd Legislature passed legislation in 1993,

> giving most of the Board authority to a Commissioner to be appointed by the Governor in odd-numbered years to a two-year term and confirmed by the Texas Senate. It allows the Board to continue its authority over rates, policy forms and related matters until August 31, 1994. On November 18, 1993, however, the Board vote[d] unanimously to turn over all remaining authority to the Commissioners as of December 16, 1993.

(*See* Texas Department of Insurance website at www.tdi.state.tx.us/general/history.html). This explains the removal of the definition of "Board" from the new provisions in the Insurance Code.

POTENTIALLY SUBSTANTIVE CHANGES

The discussion above was intended to give the reader a sense of the general types of changes that were made when the Texas Legislature re-codified the former Articles 21.21 and 21.55. In analyzing the re-codified provisions, it appears that the vast majority of the changes likely will not have a substantive impact, consistent with the Legislature intent to not effectuate any "substantive" changes. However, in comparing each of the old provisions with each of the new provisions, some of the changes, it seems, could potentially be substantive in nature.

A. Chapter 541

1. "Life and Health Insurance Counselor"

The first notable change appears in the definition section. Section 541.002 defines "person" to include a "life and health insurance counselor." The definition of "person" from Article 21.21 § 2 refers to "life insurance counselors." Article 21.21 § 2 does not include a health counselor. Thus, under the new statute, the definition of "person" appears to have been expanded. This will potentially have a substantive impact on health insurance counselors. The reason for this change is not clear. The Insurance Code does not appear to provide guidance as to what qualifies as being a "health insurance counselor."

2. "Shall" versus "May"

Another notable change in word choice is found in Section 541.003 entitled "Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Prohibited." The prior version of this statute was Article 21.21 § 3. Under the prior version, the Legislature declared that:

> no person ***shall*** engage in this state in any trade practice which is defined in this Act as, or determined pursuant to this Act to be, an unfair method of competition…

The new provision, however, states:

> a person ***may*** not engage in this state in the trade practice that is defined in this chapter as or determined under this chapter to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Although it is highly doubtful that the Legislature intended to make refraining from engaging in a false or deceptive act discretionary on the part of those engaged in the business of insurance, considering what we all learn in law school concerning the difference between "shall" and "may," this change is curious. The word "may," after all, customarily connotes discretion. *See, e.g., Haig v. Agee*, 453 U.S. 280, 294, n. 26, 101 S.Ct. 2766, 69 L.Ed.2d 640 (1981)

3. Unfair Settlement Practices

Article 21.21 §10 made the following an unfair practice:

> (ii) failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim with respect to which the insurer's liability has become reasonably clear;
>
> (iii) failing to attempt, in good faith, to effectuate a prompt, fair, and equitable settlement under one portion of a policy of a claim with respect to which the insurer's liability has become reasonably clear in order to influence the claimant to settle an additional claim under another portion of the coverage, ***provided that this prohibition does not apply if*** payment under one portion of the coverage constitutes evidence of liability under another portion of the policy;

The new provision provides, in §541.060, the following:

> (2) failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of:
>
> (A) a claim with respect to which the insurer's liability has become reasonably clear; or
>
> (B) a claim under one portion of a policy with respect to which the insurer's liability has become reasonably clear to influence the claimant to settle another claim under another portion of the coverage ***unless*** payment under one portion of the coverage constitutes evidence of liability under another portion;

Interestingly, an insurance company has an obligation under these sections to attempt in good faith to resolve a claim with respect to which the insurer's liability has become reasonably clear. Article 21.21 §10(ii), and Section 541.060(2)(A). If an insurance company violates these provisions, it is potentially liable. What if an insurance company fails to attempt to effectuate a settlement of a claim with respect to which liability is clear, and it does so in order to influence a claim under another portion of the policy because "payment under one portion of the coverage constitutes evidence of liability under another portion." Under those circumstances, the insurance carrier cannot be liable for a violation under Article 21.21 §10 (iii) or Section 541.060(B). However, a carrier in this situation has still, presumably, violated section 10(ii) and Section 541.060(A) because it has not attempted to settle a claim for which liability is clear in good faith. Does the changed language ("***provided that this prohibition does not apply if***" versus "***unless***") have any impact on this issue? Only time will tell.

4. Hearings

Another potentially substantive change appears in Section 541.103, which pertains to a hearing when the Department of Insurance initiates a proceeding to investigate an insurance company which has potentially engaged in some unfair practice. The former provision, Article 21.21 § 6 entitled "Hearings, Witnesses, Appearances and Production of Books," provided the following description of the hearing:

> At the time and place fixed for such hearing, such person shall have an opportunity to be heard and to show cause for why an order should not be made by the Board requiring such person to cease and desist from the acts, methods or practices ***so complained*** of…

Notably, this provision is broad and contemplates any conduct complained of – not necessarily (or expressly limited to) just the conduct that was reduced to or being described in the notice of a hearing or of some formal complaint.

The new provision seems to remedy this. In Section 541.103, the following language is used:

> A person against whom charges are made under Section 541.102 is entitled at the hearing on the charges to have an opportunity to be heard and show cause why the Department should not issue an order requiring the person to cease and desist from the unfair method of competition or unfair deceptive act or practice ***described in the charges***.

5. "Deems" versus "Determines"

In Article 21.21 § 16, "Relief Available to Injured Parties," among other items of relief, the Legislature permitted a plaintiff to recover:

> …any other relief which the Court ***deems*** proper.

This provision was replaced and is now found in Article 541.152, entitled "Damages, Attorneys Fees and Other Relief." The relevant provision in the new statute describes:

> …any relief the Court ***determines*** is proper.

The question here is whether there is any difference between the word "deems" and "determines" for purposes of a plaintiff's remedy. There is no Legislative History to indicate one way or the other.

6. Addition of New Headings

Interestingly, where the Legislature has taken longer provisions contained in Article 21.21 and placed them in new sections in Chapter 541, it has created new headings or topics to describe the new section. Is it possible that the language chosen to describe the new section could have a substantive impact? For example, Article 21.21 § 17 addressed class action lawsuits. That is one of the longer sections in Article 21.21 that was placed in separate sections of the new Insurance Code, as opposed to a single section that kept the provisions of the former § 17 intact. Article 21.21 § 17(c) permitted a defendant to recover its attorneys fees if a lawsuit was filed "in bad faith or for the purpose of harassment." That provision has now been placed in a new Section 541.253, which, substantively, includes generally the same language. If a lawsuit was brought in bad faith or for the purposes of harassment, a defendant may recover its attorneys' fees. Interestingly, however, the Legislature entitled

Section 541.253, logically, "Frivolous Action." However, Article 21.21 § 17 does not use the word "frivolous" anywhere describing its provisions. It is unclear whether the addition of the word "frivolous" will somehow connotate additional findings of fact by the Court that must be met in order for a defendant to recover its fees or, alternatively, does the standard remain simply that the action be brought in bad faith or for the purposes of harassment?

B. Chapter 542 – Prompt Payment

1. Treatment of "Insurer"

The first notable change from Chapter 542.051, *et seq.*, which is the re-codification of the former Article 21.55, the Prompt Payment of Claims Act, is the omission of the definition of "insurer" from the new provisions. In Article 21.55, the statute defined "insurer" to mean

> any insurer authorized to do business as an insurance company or to provide insurance in this state, including: …

The definition went on to list the types of companies that would qualify as an insurer to which the statute applied.

In Section 542.051, which is the definition section of the re-codified Prompt Payment of Claims provisions, the Legislature omitted "insurer" from the definition section. Instead, the Legislature added a new section – Section 542.052 – entitled "Applicability of Subchapter." There, the Legislature captured the essence of the former definition of "insurer" by providing the following:

> This subchapter applies to any insurer authorized to engage in business as an insurance company or to provide insurance in the state, including: …

Section 542.052 then lists the types of insurance companies that would constitute an "insurer" under the former Article and, under the new Chapter 542, be subject to the statute's applicability.

2. Omission of Extra Language

The re-codification was presumably designed, in part, to eliminate extra language that was unnecessary. One example of this is Section 542.054 pertaining to liberal construction. The new provision states:

> This subchapter shall be liberally construed to promote the prompt payment of insurance claims.

This concise language replaces the language from Section 8 of Article 21.55 which provided:

> This Article shall be liberally construed to promote its underlying purpose which is to obtain prompt payment of claims made pursuant to policies of insurance.

In making many word choice modifications… the Legislature may have unintentionally effectuated a substantive change.

3. 18% as "Interest"

One important modification or variance in the new provision pertains to liability for not promptly paying a claim. The new provisions provide in Section 542.060 the following:

> (a) If an insurer that is liable for a claim under an insurance policy is not in compliance with this subchapter, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, ***interest*** on the amount of the claim at the rate of 18% a year as damages, together with reasonable attorneys' fees.

This language replaces the former Section 6 of Article 21.55 which provided:

> In all cases where a claim is made pursuant to a policy of insurance and the insurer liable therefore is not in compliance with the requirements of this Article, such insurer shall be liable to pay the holder of the policy or beneficiary making a claim under the policy, in addition to the amount of the claim, 18% per annum of the amount of such claim as damages, together with reasonable attorneys fees. If suit is filed, such attorneys' fees shall be taxed as part of the costs of the case.

The primary difference here is that the new provision, Section 542.060, describes the 18% penalty as "interest." The former provision did not characterize the 18% penalty as *interest*.

What are the legal consequences of the new characterization of the 18% penalty being interest? Some practitioners and

courts consider under Article 21.55 the 18% to be a *penalty*, allowing for pre-judgment interest under the Finance Code to be calculated on amounts due and owing. Other courts have disagreed. *E.g., Texas Farmers Ins. Co. v. Cameron*, 24 S.W.3d 386 (Tex. App. – Dallas 2000, pet. denied) (declining to apply pre-judgment interest to amounts awarded under Article 21.55, but noting contrary authority, including *Bekins Moving & Storage Co. v. Williams*, 947 S.W.2d 568, 584 (Tex. App. – Texarkana 1997, no writ). Does the reference to 18% "interest" in Chapter 542 now resolve the debate and imply no additional pre-judgment interest? The courts of Texas will be required to answer this question fairly quickly.

CONCLUSION

The re-codification of Articles 21.21 and 21.55 into Chapters 541 and 542 of the Texas Insurance Code effectuated mostly "nonsubstantive" changes, consistent with the Legislature's stated purpose. However, in making many word choice modifications, re-ordering statutes, sub-dividing provisions and assigning provisions to entirely new sections all together, the Legislature may have unintentionally effectuated a substantive change. Of course, it will be up to practitioners to argue the effect of any new language used and up to the courts to interpret the substantive effect of any new language.

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Changing Times – A Look at Two Cases that Turn Back the Clock on Additional Insureds

Up until the 1999 decision in *Admiral Insurance Co. v. Trident NGL, Inc.*,[2] many coverage attorneys in Texas would probably have thought that a typical "additional insured" endorsement on a general liability policy – i.e., an endorsement that extended coverage to the additional insured for liability arising out of the named insured's work for the additional insured – basically only gave the additional insured coverage for any vicarious liability it might face for the named insured's negligence, and not coverage for the additional insured's own negligence.[3] Beginning with *Admiral v. Trident,* and continuing through a plethora of lower court opinions over the next six years, Texas case law appeared to then instead reflexively grant additional insureds coverage for their own negligence, except to the extent policy language specifically and unambiguously indicated to the contrary. Now, two opinions in 2006 appear to turn back the clock on additional insureds:

> *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, 49 Tex. Sup. Ct. J. 589, 2006 WL 1195330 (Tex., May 5, 2006, reh'g requested); and
>
> *D.R. Horton-Texas, Ltd. v. Markel International Insurance Co.*, No. 14-05-00486-CV, 2006 WL 1766120 (Tex. App. – Houston [14th Dist.], June 29, 2006, reh'g requested).

Both cases are examined below. *ATOFINA* may reflect, and certainly is not inconsistent with, recognition of a heightened burden on a putative additional insured to actually show that status. *D.R. Horton* then limits the source of the proof one might offer in that regard, essentially requiring express allegations of the named insured's negligence. The two opinions may not go all the way back to the vicarious-liability days of yesteryear, but together they do at least bear some similarity to that era.

I. *ATOFINA*

A. Background[4]

The *ATOFINA* case arose out of a refinery construction project that led to the tragic death of a construction worker. Specifically, ATOFINA contracted with Triple S Industrial Corp. to perform maintenance and construction work at ATOFINA's oil refinery in Port Arthur, Texas. The facility included a storage tank with a badly corroded roof. As part of its work, Triple S was to construct a platform extension so that refinery employees could access the top of the storage tank without having to step on to its unsafe roof. The platform extension was designed with the participation of ATOFINA engineers and supervisors, ATOFINA gave no express warning to Triple S or its workers to not step on the roof or to use fall protection (although the roof's condition may have been common knowledge), and it did not drain the tank before Triple S began work. A Triple S employee, Matthew Todd Jones, fell through the corroded roof. One cannot swim in fuel oil, and it was likely that Mr. Jones struggled to swim for one minute or so, while his lungs filled with fuel oil.

Five days later Jones's widow sued both ATOFINA and Triple S. Triple S, however, was apparently ultimately dismissed from the suit because of the workers compensation bar. At some point, Jones's mother filed a petition in intervention. Both widow and mother, of course, asserted ATOFINA's premises defect caused the death.

ATOFINA's contract with Triple S included both contractual indemnity and insurance provisions. The indemnity provision obligated Triple S to indemnify ATOFINA for injury occasioned by its performance of the contract, "'except to the extent that any loss is attributable to the concurrent or sole negligence, misconduct, or strict liability of [ATOFINA]."[5] In other words, if ATOFINA was negligent, it was owed no contractual indemnity directly by Triple S.

As for the contract's insurance provision, that provision obligated Triple S to obtain and maintain several types of insurance policies, including a Comprehensive General Liability policy ("CGL") with "limits of not less than $500,000" and a "following form" excess policy with additional limits of not less than $500,000.[vi] Further, the contract required the Triple S CGL and excess policies to be endorsed to include ATOFINA as an additional insured:

> FINA… shall be named as additional insured in each of Contractor's policies, except Workers' Compensation…[7]

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Triple S attempted to comply with its insurance obligations by obtaining a CGL policy with limits of $1 million from Admiral Insurance, and a "Commercial Umbrella Liability Policy" with limits of $9 million from Evanston Insurance.[8] Admiral's policy included an endorsement that included ATOFINA as an additional insured, but not for ATOFINA's liability for its sole negligence:

> WHO IS AN INSURED (Section II) is amended to include as an Insured the person or organization shown above (hereinafter called the additional Insured), but only with respect to liability arising out of your [*i.e.*, Triple S's] ongoing operations performed for the additional Insured, but in no event for the additional Insured's sole negligence.[9]

Evanston's umbrella policy included two "who is an insured" provisions over which the parties argued. Section III.B.5 defined an insured as follows:

> Any other person or organization who is an insured under a policy of "underlying insurance." [I.e., the Admiral policy.] The coverage afforded such insured under this policy will be no broader than the "underlying insurance" except for this policy's Limit of Insurance.[10]

Section III.B.6, on the other hand, defined an insured as:

> A person or organization for whom you have agreed to provide insurance as is afforded by this policy; but that person or organization is an insured only with respect to operations performed by you or on your behalf, or facilities owned or used by you.[11]

When Jones's widow and mother sued, ATOFINA tendered the suit to both Admiral and Evanston. Eventually, after three mediations, the suit settled for cash and monthly installment payments with a total value of $6.75 million, $1 million of which was paid by Admiral. ATOFINA sought recovery of the remaining $5.75 million from Evanston.[12] Evanston denied coverage, and although it appeared as ordered at the mediations, it never paid any money in settlement to the Jones plaintiffs.

The trial court initially granted a partial summary judgment for ATOFINA, but later reconsidered that decision, and instead granted final summary judgment for Evanston. Beaumont's Ninth Court of Appeals reversed and remanded with instructions in a per curiam opinion.[13] Evanston petitioned to the Supreme Court of Texas, which reversed and remanded for a liability trial, as discussed below.

The parties in their briefs argued whether the insurance contemplated by the ATOFINA-Triple S contract was intended merely to assure Triple S's contractual indemnity obligation (which did not reach any negligence of ATOFINA, itself), or if it was intended as a stand-alone insurance requirement. The Supreme Court perhaps hinted that it was the former, but that in any event the crucial issue was what Evanston's policy provided:

> [T]he salient inquiry is not what the insurance purchasing agreement required Triple S to do for ATOFINA, but rather what coverage the Evanston policy actually provided. … While the indemnity agreement is relevant to determining what the parties *intended* with respect to the scope of the indemnity obligation, an insurance policy secured to insure that obligation stands on its own.[14]

In construing the Evanston policy itself, the Court in *dicta* generously observed, arguably incorrectly, that "ATOFINA qualifies as an insured under both provisions" III.B.5 and III.B.6.[15] Since section III.B.5. was expressly "no broader than the 'underlying insurance'" provided by Admiral, the Court in turn looked to the Admiral policy for its exclusion of coverage for ATOFINA's sole negligence.[16] In regards to section III.B.6, the Court acknowledged that provision did not tie its coverage to the underlying Admiral policy, but the Court nonetheless held that the exclusion for ATOFINA's sole negligence still applied:

> We recognize that ATOFINA asserts coverage under section III.B.6 of the Evanston policy, which does not limit the coverage afforded to an insured to that provided by an underlying policy. However, we believe that section III.B.5 and III.B.6 cannot be read in isolation. *See State Farm Life Ins. Co. v. Beaston*, 907 S.W.2d 430, 433 (Tex. 1995) (noting that "courts must be particularly wary of isolating from its surroundings or considering apart from other provisions as single phrase, sentence, or section of an insurance contract"). By its express language, section III.B.5 applies to the facts of this case. We cannot ignore the limitations in this section simply because section III.B.6 (which contemplates a separate, although equally applicable, set of circumstances) is also implicated.[17]

Accordingly, the Court construed the Evanston policy to insure ATOFINA as an additional insured, but not for its sole negligence. Holding that a fact issue existed as to whether ATOFINA was solely negligent in regards to Jones's accident and death, the Court remanded the matter "to the trial court for a determination of the respective liabilities" of the parties."[18]

B. The Supreme Court got *ATOFINA* right.

At first blush, the Court's construction of the Evanston

policy seems to disregard its own rules of construction. And an immediate reaction for many might well be that the Court is starting from a more principled viewpoint of what additional insureds should normally expect, versus the expansive perspective generally prevalent since *Admiral v. Trident.* Whether or not that latter take on the opinion is correct, however, upon closer examination the opinion certainly can be reconciled with our extant jurisprudence. Specifically, there is and should be a legitimate presumption against additional insured status consistent with the Court's opinion.

For one rule *seemingly* disregarded by the Court, there is the rule that words of exclusion or limitation, if ambiguous, must receive any "not unreasonable" construction proposed by the insured that would result in coverage, even if the insurer offers what appears to be a more reasonable interpretation or one that more likely reflected the true intentions of the parties.[19] On an initial reading, one interpretation of section III.B.6 could be that it does not have any words of limitation other than the requirement of "operations performed" by or on behalf of the named insured. And one "not unreasonable" construction of section III.B.5's limitation to coverage "no broader than the 'underlying insurance'" could be that the limitation applies only to section III.B.5, since it was not repeated in connection with any other provision.[20]

That said, however, keep in mind that such rules of construction are intended to guide courts in determining the rights and obligations of insurers and insureds under contracts of insurance. But what about the primal and more fundamental determination of who is an insured? Logically, should the same rules of construction apply to that inquiry?

At first blush, the Court's construction of the Evanston policy seems to disregard its own rules of construction.

Although rarely discussed in Texas as such, conceptually additional insureds are third-party beneficiaries of the policy.[21] After a person obtains the status of "insured" by becoming an "additional insured," then the litany of insured-friendly rules of construction for insurance contracts ought to apply, but not necessarily in initially achieving that status. Rather, settled Texas law mandates that to qualify as a third-party beneficiary of a contract, that intent has to clearly appear from, and be fully spelled out by, the four corners of the contract, with there being a strong presumption against such status.[22] Indeed, "any doubts must be resolved against finding a third-party beneficiary."[23] As a result, if the Court in *ATOFINA* intuitively intended to convey they were starting from a perspective that a putative additional insured initially has some greater burden of proof as to that status, then that position appears entirely consistent with Texas law.

Look again at the Evanston policy from that changed perspective. If section III.B.6 is to apply, then ATOFINA must have been an "organization for whom [Triple S] agreed to provide insurance as is afforded by [the] policy." Evanston, however, issued a commercial umbrella policy, and Triple S's contract with ATOFINA only obligated it to provide excess following form coverage. As a result, section III.B.6 does not apply, particularly when, as can be seen, it does not clearly mandate third-party beneficiary status for ATOFINA. Accordingly, consider section III.B.5 instead. Under that provision, organizations who were insured in the underlying Admiral policy also qualify as Evanston insureds, but the coverage is effectively limited to excess following form coverage – which is exactly what the ATOFINA-Triple S contract envisioned. As a consequence, starting from the presumption that additional insured/third-party beneficiary status must be clearly and fully shown from the insurance contract, with doubts resolved against rather than for such a status, then ATOFINA would seem to only qualify as an Evanston additional insured under section III.B.5. That in turn makes Evanston's coverage for ATOFINA subject to the Admiral exclusion of liability for ATOFINA's sole negligence. And that, of course, is exactly where the supreme court's opinion ended.

II. *D.R. HORTON*

A. Background[24]

In 2001, James and Cicely Holmes purchased from a third party a home that D.R. Horton had initially built in 1992. Subsequently, they allegedly discovered toxic mold in the home, and during the remediation process uncovered a number of latent defects in the design and construction of the home. The Holmeses filed suit against D.R. Horton, alleging the defects allowed water to enter the home, and that in response D.R. Horton "had made faulty, incomplete, and negligent attempts to repair these latent defects."

D.R. Horton apparently utilized independent contractor Rosendo Ramirez, both in the initial construction of the home and in the allegedly deficient repairs. A predecessor of Sphere Drake insured Ramirez from 1992 to 1999, and a predecessor of Markel insured him at the time of the repairs. The Markel policy "specifically lists Horton as an additional insured, (but only with respect to liability arising out of 'Ramirez's work' for Horton by or for Ramirez)."[25] Sphere Drake's policies were never included in the record, and there was only a letter from Sphere Drake to D.R. Horton purporting to recite policy terms. Even then, the letter was only offered in evidence to prove Sphere Drake "issued liability

policies to Ramirez for the period September 19, 1992 through September 16, 1999, with Horton listed as an additional insured under the policies."[26]

Of course, in Texas we utilize the eight-corners rule in determining whether a liability insurer has a duty to defend a suit against its insured. Specifically, a court should compare the factual allegations regarding the origin of the damages in the four corners of the pleading against the insured, with the coverage provided by the four corners of the policy.[27] A duty to defend exists if there is any potential for coverage for the alleged damages under the policy.[28] Further, if there is no duty to defend, then there also can be no duty to indemnify or pay damages on behalf of the insured.[29]

Extrinsic evidence in the form of affidavit testimony supplied by D.R. Horton apparently linked Ramirez's work to at least some of the defects or deficient repairs complained of by the Holmeses. The Holmes's petition, however, was completely silent as to Ramirez.

Applying the eight-corners rule, Houston's 14th Court of Appeals held that since the Holmes's petition made no mention of Ramirez, it did not allege D.R. Horton's liability arose out of Ramirez's work as required by the policy. As a consequence, Markel had no duty to defend, and since it had no duty to defend, it could have no duty to indemnify. As for Sphere Drake, since none of the policies were in the record, the court simply could not perform an eight-corners analysis – only four corners were available.

B. *D.R. Horton* harkens back to the days of vicarious liability coverage for additional insureds.

Step back and look at what has happened. D.R. Horton required its subcontractor to have it included as an additional insured on the subcontractor's policies. Further, the Markel policy apparently actually went so far as to identify D.R. Horton by name, rather than just "as required by contract" or some other blanket classification so often utilized. But since the Holmeses failed to mention Ramirez in their pleading, then under the court of appeals' decision D.R. Horton did not receive the protection of the Markel policy. For D.R. Horton to be protected, the Holmeses apparently would have needed to expressly identify and link named insured Ramirez to some of their claims of defective workmanship. Of course, it is doubtful that the Holmeses even knew who Ramirez was, and they plainly did not need to sue him to recover all of their damages from D.R. Horton.

Proof of intent to make someone a third-party beneficiary of a contract must appear in the four corners of the contract.[30] Since Markel's policy "specifically lists" D.R. Horton as an additional insured, then it cannot really be questioned that D.R. Horton was such a third-party beneficiary under whatever circumstances may be described in the policy. As to Markel, those circumstances were whenever D.R. Horton had "liability arising out of Ramirez's work." Prior to *D.R. Horton*, Texas's third-party beneficiary jurisprudence does not appear to have limited the beneficiary's sources of proof of those circumstances to a single piece of paper filed in a lawsuit by a complete stranger to the contract.

Further, although the question of whether an insurer has a duty to defend its insured is governed by the eight-corners rule, some Texas authority indicates that the question of who is an insured is not strictly governed by that rule. Specifically, resort to evidence extrinsic is permitted on "the fundamentals of insurance coverage," such as whether the person sued is excluded from coverage under the policy, whether a policy contract even exists, or whether some property in question is insured under the policy (*e.g.*, whether an auto involved in an accident is a covered auto).[31] As Judge McBryde has noted:

> Those decisions [applying the eight-corners rule] assume as a predicate for application of the rule they express that the person claiming a right to a defense is an insured. … The status of "insured" is to be determined by the true facts, not false, fraudulent or otherwise incorrect facts that might be alleged by a personal injury claimant ....[32]

Nonetheless, as noted, the court of appeals limited the proof available to D.R. Horton to prove its status as an additional insured for the claims it faced to the eight-corners of the pleading and policy.

III. CONCLUSION

Consciously or subconsciously, ATOFINA appears to send a message that the helter-skelter days of *Admiral v. Trident* may be over for additional insureds - there may now be once again a heightened burden of proof on a putative additional insured to actually show that status, without the benefit of the rule of construing ambiguous policy provisions in favor of coverage. On top of that, if *D.R. Horton* is correct, a putative additional insured may not be able to invoke its coverage as such unless the claimant's pleading expressly mentions the named insured and at least in some fashion links the named insured to the alleged damages.

1. Mr. Caudle is an attorney with Mateer & Shaffer, LLP in Dallas where he primarily counsels and represents insurers in insurance coverage matters. He also represents small businesses or their owners in general business litigation and raises all-natural grass-fed beef. Before becoming a lawyer, Mr. Caudle was a CPA and worked with an oil and gas company in Dallas.

2. 988 S.W.2d 451 (Tex. App. – Houston [1st Dist.] 1999, pet. denied).

3. *See Granite Constr. Co. v. Bituminous Ins. Cos*., 832 S.W.2d 427, 430 (Tex. App. – Amarillo 1992, no writ) (Granite not an additional insured when the only negligent operations in question were Granite's own negligent loading of the named insured's truck); *Northern Ins. Co. v. Austin Commercial, Inc*., 908 F. Supp. 436, 437 (N.D. Tex 1994) ("liability arising out of '[the named insured's] work'" requires some allegation of direct negligence on the part of the named insured, there must be some sort of causal connection between the named insured's own negligence and the claimant's injuries).

4. This "Background" section is compiled from the supreme court's and court of appeals' decisions, and from the parties' Briefs on the Merits that are available on-line on the supreme court's web site.

5. 2006 WL 1195330 at *1 n.2.

6. 2006 WL 1195330 at *1; Evanston's Petitioner's Brief on the Merits at 4-5, 15; Evanston's Petitioner's Reply Brief on the Merits at 8.

7. Evanston's Petitioner's Brief on the Merits at 4.

8. 2006 WL 1195330 at *1; Evanston's Petitioner's Brief on the Merits at 4-5.

9. 2006 WL 11955330 at *1 n.3; Evanston's Petitioner's Brief on the Merits at 5.

10. 2006 WL 1195330 at *1; Evanston's Petitioner's Brief on the Merits at 5. The supreme court's quotation of section III.B.5 omits the word "other," replacing it with ellipses.

11. 2006 WL 1195330 at *2; Evanston's Petitioner's Brief on the Merits at 6.

12. In its Brief on the Merits before the supreme court, ATOFINA asserted it had itself paid the $5.75 million. Evanston in reply noted that there was no record evidence of who funded the $5.75 million. ATOFINA had its own insurance, specifically, a $1 million per occurrence/$10 million in the aggregate CGL policy with Liberty Mutual (but that policy reflected a premium of only $37,559, which may indicate it was in fact only a fronted policy), and a $25 million excess policy with National Union. Liberty Mutual's role in the settlement is really never discussed in the parties' briefs; ATOFINA, however, asserted that National Union "took the position that its obligations to ATOFINA would not be triggered unless and until Evanston tendered its policy limits." ATOFINA's Respondent's Brief on the Merits at 4.

13. *ATOFINA Petrochemicals, Inc. v. Evanston Ins. Co.*, 104 S.W.3d 247 (Tex. App. – Beaumont 2003, pet. granted) (per curiam).

14. 2006 WL 1195330 at *3 (emphasis in original).

15. *Id*. at *2.

16. *Id*. at *3.

17. *Id*.

18. *Id*. at *4.

19. *Utica Nat'l Ins. Co. v. American Indem. Co.*, 141 S.W.3d 198, 202 (Tex. 2004).

20. Insurers have been issuing simple "following form" excess policies for many years, and if Evanston had intended only such coverage, it could have easily made that point clear in its insuring clause applicable to all classes of insureds.

21. *See Merced County Mut. Fire Ins. Co. v. State*, 284 Cal. Rptr. 680, 686 (Cal. App. 1991) ("an additional insured added by endorsement is a third-party beneficiary of the insurance contract"); *see also Walker v. State Farm Lloyds*, No. 3:03-CV-1514-R, 2004 WL 1462200 (N.D. Tex., June 28, 2004) ("To successfully advance a third-party beneficiary claim, Walker could have had the insured procure an endorsement adding his name to the Policy as an additional insured").

22. *MCI Telecommunications Corp. v. Texas Utils. Elec. Co.*, 995 S.W.2d 647, 651-52 (Tex. 1999) ("The intention to contract or confer a direct benefit to a third party must be clearly and fully spelled out or enforcement by the third party must be denied" and "there is a presumption against, not in favor of, third-party beneficiary agreements"); *Brunswick Corp. v. Bush*, 829 S.W.2d 352, 354 (Tex. App. – Fort Worth 1992, no writ) (to same effect).

23. *Raymond v. Rahme*, 78 S.W.3d 552, 561 (Tex. App. – Austin 2002, no pet.); *accord Ortega v. City Nat'l Bank*, 97 S.W.3d 765, 773 (Tex. App. – Corpus Christi 2003, no pet.) ("If there is any reasonable doubt as to the contracting parties' intent to confer a direct benefit on the third party by way of the contract, the third-party beneficiary claim must fail"); *IP Petroleum Co. v. Wevanco Energy, LLC*, 116 S.W.3d 888, 899 (Tex. App. – Houston [1st Dist.] 2003, pet. denied) ("Any doubt is resolved against a finding that the party was intended to be a third-party beneficiary").

24. This "Background" section is compiled from the court of appeals' opinion.

25. 2006 WL 1766120 at *3.

26. *Id*. at *8.

27. *National Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc.*, 939 S.W.2d 139, 141 (Tex. 1997).

28. *Id*.

29. *See, e.g., Collier v. Allstate County Mut. Ins. Co.*, 64 S.W.3d 54, 62 (Tex. App. – Fort Worth 2001, no pet.); *Folsom Invs., Inc. v. American Motorists Ins. Co.*, 26 S.W.3d 556, 559 (Tex. App. – Dallas 2000, no pet.); *Reser v. State Farm Fire & Casualty Co.*, 981 S.W.2d 260, 263 (Tex. App. – San Antonio 1998, no pet.); *Nutmeg Ins. Co. v. Clear Lake City Water Auth.*, 229 F. Supp.2d 668, 676 (S.D. Tex. 2002) (all recognizing that if there is no coverage for a pleading's factual allegations when liberally construed under the eight-corners rule, then there can be no duty to indemnify based on the true facts that might be proven under that pleading).

30. *Brunswick Corp. v. Bush*, 829 S.W.2d 352, 354 (Tex. App. – Fort Worth 1992, no writ) ("the party claiming third-party beneficiary status will succeed or fail according to the terms of the contract"); *accord Bass v. City of Dallas*, 34 S.W.3d 1, 8 (Tex. App. – Amarillo 2000, no pet.).

31. *See Tri-Coastal Contractors, Inc. v. Hartford Underwriters Ins. Co.*, 981 S.W.2d 861, 863 n.1 (Tex. App. – Houston [1st Dist.] 1999, pet. denied).

32. *Blue Ridge Ins. Co. v. Hanover Ins. Co.*, 748 F. Supp. 470, 473 (N.D. Tex. 1990). Other jurisdictions similarly treat the issue of who qualifies as an insured as a fundamental coverage question not subject to the strictures of the eight-corners rule. *See Transcontinental Ins. Co. v. National Union Fire Ins. Co.*, 662 N.E.2d 500, 508 (Ill. App. 1996) ("A court may look beyond the allegations of a complaint if the coverage issue involves the question of whether the party asserting coverage is a proper insured under the policy").

Comments FROM THE EDITOR

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

The new Chair of the Section, Rusty McMains, has some wonderful plans for the Section during the next several months. We have been blessed with some creative visionaries, gifted administrators, and talented lawyers as Chair of the Insurance Law Section over the past few years. Rusty continues this trend of excellence.

The Insurance Law Section will not survive without the contributions of our members. There are many ways you can get involved. If you are interested in getting more involved in the Section, please contact Rusty or any council member whose contact information is in the front inside cover of this issue. Of course, I would not be doing my job if I did not make another plea for articles or editorial assistance. We always need new articles and I could always use an extra set of eyes in helping me edit an article or two. If you are interested in either, please let me know.

Insurance remains a hot issue before the appellate courts of Texas, especially the Texas Supreme Court. The case law changes so fast that it is difficult for any practitioner to stay on top of it. As such, I want to extend another word of appreciation to Jim Cornell, a former Chair of our Section, for his tireless efforts week after week to continue to send all of us e-mail updates of the very latest insurance decisions from the appellate courts of Texas. Reviewing the cases Jim provides weekly has become a critical part of how I stay on top of the law and, without this critical service from the Section, it would be much more difficult for me to stay on top of this rapidly expanding area of the law. Because of Jim's diligent review of all the new decisions and his timely circulation of them to our members, we all benefit. Thank you Jim for your sacrificial efforts on behalf of the Section and our membership.

Christopher W. Martin,
Martin, Disiere, Jefferson & Wisdom, L.L.P.
Editor-In-Chief

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