

Journal of Texas Insurance Law

Fall 2005

Volume 6, Number 2

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OTHER NEW INSURANCE LEGISLATION
A. H.B. 160: Relating to recording devices.

A manufacturer of a vehicle equipped with a recording device must obtain a court order, consent of the driver, or consent of the driver's insurer before recording the driver's response in the vehicle.

B. H.B. 200: Relating to health care providers.

IN THIS ISSUE

**Be Careful What You Wish For
The Potential Pitfalls Facing
Insurers after Frank's Casing**

The Insured's Duty to Cooperate

**Insurance/Litigation, Including
Overhaul of Workers' Comp and
Asbestos/Silica**

III. ASBESTOS/SILICA REFORM:

S.B. 15, the asbestos reform bill, passed by the Texas Legislature on May 11, 2005. The bill amends both

Section 22.225(d) of the Texas Civil Practice and Remedies Code to allow for an appeal to the State Court of Appeals from an interlocutory order denying a motion for summary judgment.

Section 7: Trial settings

Section 101(a) of the Texas Civil Practice and Remedies Code



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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.

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Cite as:

6:2 J. TEX. INS. L. ____ (Fall 2005)

Journal of Texas Insurance Law

FALL 2005, VOLUME 6, NUMBER 2

TABLE OF CONTENTS

Comments from the Chair

Veronica Carmona Czuchna

1

Be Careful What You Wish For The Potential Pitfalls Facing Insurers after Frank's Casing

Jim Perschbach

2

The Insured's Duty to Cooperate

Rick Virnig

11

2005 Legislative Update on Insurance

Brian S. Martin

23

Comments from the Editor

Christopher W. Martin

35

Comments

FROM THE CHAIR



BY VERONICA CARMONA CZUCHNA
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One of the most important goals of the Insurance Law Section is to keep our members informed of emerging issues and significant developments in insurance, whether in the substantive law or in procedural aspects of insurance litigation. The Section has sought to accomplish this through several means, including CLE programs, the website, and the weekly “Right Off the Press” case updates. Of course, publication of *The Journal of Texas Insurance Law* is, without a doubt, the principal means through which the Section achieves this goal. Toward that end, this issue of the *Journal* includes an informative article on the recent Texas Supreme Court decision in *Frank’s Casing*. *Frank’s Casing* is an important case for all of us, insurer and policyholder lawyers alike (and defense attorneys), in that it alters the law on reimbursement as we have known it (or thought we knew it) since *Matagorda*, has implications in the settlement and *Stowers* contexts, and raises a new spectrum of rights and risks for those involved.

There is every indication that we will continue to see exciting developments in insurance law in 2005 – 2006. There are several cases presently pending before the Texas Supreme Court on significant insurance issues, including the insurability of punitive damages, whether the ensuing loss provision in a homeowners policy establishes coverage for loss caused by mold despite an exclusion of such coverage, whether the use of captive or staff counsel by an insurance company constitutes the unauthorized practice of law, and whether and to what extent a settling insurer that underpays owes an actionable duty to one that overpays the settlement. The Section plans to continue providing our members with updates, articles and analyses regarding these and other emerging insurance issues.

Each Section member soon should receive, or recently may have received, a Member Survey. We ask that each of you please spend a few minutes responding to the survey and return it to our Executive Director, Donna Passons. The survey seeks your input concerning member benefits, and we very much would like to hear your comments and ideas. Among many other things, we are trying to determine the level of interest, if any, in receiving the *Journal* in electronic format.

I would like to thank Chris Martin, our Publications Officer and Editor-in-Chief, who, since 1999, has continued to produce an exceptional *Journal*. His continuing dedication to publication of the *Journal* is a benefit to each and every one of us. Of course, the *Journal* would not be possible without the articles and editing contributions from the Section and Council members. Thank you for your many contributions.

Veronica Carmona Czuchna
Chair, Insurance Law Section

Be Careful What You Wish For The Potential Pitfalls Facing Insurers after *Frank's Casing*

The Texas Supreme Court's opinion in *Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc.*, 48 Tex. Sup. Ct. J. 735, 2005 WL 1252321 (Tex. May 27, 2005) significantly and importantly changed Texas law regarding an insurer's ability to seek reimbursement for indemnity payments made on its policyholder's behalf. While it is easy to see the problems that this decision will create for policyholders, this paper takes the position that the decision will also present dangers to insurers. Specifically, it seems that an insurer's ability to control the defense in liability cases may have been significantly compromised. Additionally, insurers may be without some important defenses in later bad faith or Stowers suits. The bottom line is that reservations of rights have suddenly become much more important to both insurers and their policyholders.

THE OLD REIMBURSEMENT RULE – MATAGORDA COUNTY

Until recently, there was little danger to either the insurer or the policyholder from "form" reservations. While the reservation created a potential conflict of interest, the insurer had the burden of either immediately challenging coverage in a contemporaneous declaratory judgment action, *Farmers Texas County Mut. Ins. Co. v. Griffin*, 955 S.W.2d 81, 84 (Tex. 1997), providing a qualified defense and basing any ultimate indemnity decision on the underlying fact-finder's decision in the liability suit, *Id.*, or settling the claim against the policyholder before the coverage dispute was resolved, thereby waiving the coverage dispute, *Texas Ass'n of Counties Risk Mgmt. Pool v. Matagorda County*, 52 S.W.3d 128 (Tex. 2000).

In *Matagorda County*, the insurer timely reserved rights and tendered a qualified defense to the policyholder. The plaintiffs made a settlement demand that the policyholder agreed was reasonable. *Id.* The insurer agreed to pay the demand but sent a letter purporting to reserve its right to seek

reimbursement from the policyholder if the claim was later found outside coverage. *Id.* at 130. The policyholder did not respond to the insurer's letter, the settlement was funded, and the insurer sought reimbursement through a declaratory judgment action. *Id.*

Reasoning that the subject insurance policy did not contain an implied right to reimbursement, the Texas Supreme Court held that the insurer was not entitled to reimbursement. *Id.* at 133. In fact, *Matagorda County* strongly implied that the only way that an insurer could obtain reimbursement after funding a settlement, despite reserved rights, was where the policyholder had expressly agreed to allow the insurer to pursue a reimbursement action. *Id.* at 133-134. Therefore, the *Matagorda County* rule was essentially this: "An insurer may reserve rights and may then elect to challenge coverage in a declaratory judgment action (or later Stowers suit). However, if the insurer elects to settle its policyholder's liability before its coverage dispute has been resolved, then it has waived its right to dispute coverage absent the policyholder's consent to suit."

THE NEW REIMBURSEMENT RULE – FRANK'S CASING

Insurers were not willing to let the reimbursement issue rest after *Matagorda County*. Many insurers argued that the *Matagorda County* rule was unfair because a Stowers demand could force them to either pay a disputed indemnity claim without recourse or risk much larger liability in the form of a bad faith or Stowers suit. The Texas Supreme Court agreed and issued the *Frank's Casing* opinion almost exactly four and a half years after *Matagorda County*.

The policyholder in *Frank's Casing* received a settlement demand from the plaintiff. 2005 WL 1252321 at *1. Its general counsel forwarded the demand to its excess insurer together with a demand to settle the case within policy limits. *Id.*

While the insurer had issued a timely reservation of rights, it had not filed a declaratory judgment action. In fact, the insurer first gave its policyholder notice of its intent to seek reimbursement after receiving the settlement demand. *Id.* The excess insurer then filed its declaratory judgment action and obtained a summary judgment that all of the claims asserted against the policyholder were outside coverage and awarding it reimbursement of the over \$7 million that it had paid to settle the underlying lawsuit. *Id.* at *2. However, the Texas Supreme Court issued *Matagorda County* shortly after the summary judgment was rendered. In response, the trial court vacated the summary judgment in the excess insurer's favor and entered summary judgment in the policyholder's favor on the ground that the policyholder did not expressly agree to allow the excess insurer to seek reimbursement. *Id.*

The Supreme Court in *Frank's Casing* held that the insurer's right to seek reimbursement is implied in law and is quasi-contractual at least in cases where the policyholder demands settlement or expressly agrees that a case against it should be settled. *Id.* at *5. Although *Frank's Casing* purports to do nothing more than clarify *Matagorda County*, Justice Hecht correctly noted in his concurrence that it effectively overrules *Matagorda County* since any factual distinctions between the decisions are immaterial to the ultimate hold. *Id.* at *8 (Hecht, J., concurring).

Frank's Casing holds that an insurer has the right to seek reimbursement from its policyholder if it timely reserves rights, notifies the policyholder of its intent to seek reimbursement, and pays to settle claims that are not covered in at least three situations (two of which are new following *Frank's Casing*):

1. Where the policyholder has expressly agreed to allow the insurer to seek reimbursement (the *Matagorda County Rule* presumably still applies since the Court did not expressly overrule that decision);
2. Where the policyholder has demanded that the insurer accept a settlement demand that is within policy limits; or,
3. Where the policyholder expressly agrees that the settlement demand should be accepted.

Id. at *3

The Court then went on to hold that the policyholder admits, for the purpose of any later reimbursement and coverage suit, that the settlement amount paid to the underlying plaintiff is reasonable by demanding that an insurer accept a settlement demand or by agreeing that the insurer should accept a settlement demand:

When there is a coverage dispute and an insured demands that its insurer accept a settlement offer within policy limits, the insured is deemed to have viewed the settlement offer as a reasonable one. If the offer is one that a reasonable insurer should accept, it is one that a reasonable insured should accept if there is no coverage. The insured knows that if the case is not settled, a judgment may be rendered against it for which there is no insurance coverage.

. . .

The insurer should be entitled to settle with the injured party for an amount the insured has agreed is reasonable and to seek recoupment from the insured if the claims against it were not covered. From the insured's point of view, it is in precisely the same position in it would have been absent any insurance policy, except that the insurer is now the insured's creditor rather than the injured party.

Id. at *4

Therefore, the Court has essentially imposed a duty to determine coverage and evaluate liability onto the policyholder. By making a demand to settle, or by expressly agreeing that a case should be settled, the policyholder subjects itself to reimbursing the carrier if a later declaratory judgment action finds that the claims were outside coverage. Additionally, the Court has held that the policyholder admits that the settlement award is reasonable by demanding or accepting a liability settlement. *Id.* at *3. Before *Frank's Casing*, neither duty was imposed on the policyholder. Now, however, the policyholder and the insurer both face risks when faced with settlement demands in cases where the insurer has reserved coverage rights.

Frank's Casing clearly and dramatically expands an insurer's ability to seek reimbursement from its policyholder. However, while at first glance this holding appears to favor insurers by preserving their reimbursement rights after settlement, there is reason to believe that it may also present some concerns for insurers.

THE INSURER'S RIGHT TO CONTROL THE DEFENSE – DAVALOS

Frank's Casing must be read in conjunction with *Davalos v. Northern County Mut. Ins. Co.*, 140 S.W.3d 685 (Tex. 2004). There, the Court was faced with a dispute between an insurer and its policyholder over venue of a third-party claim. The *Davalos* facts are well-known. *Davalos* (interestingly, a

Matagorda County resident) was involved in a multiple car accident in Dallas. *Id.* at 687. Davalos filed suit in Matagorda County. *Id.* Another driver then sued Davalos in Dallas County. Davalos' Matagorda County lawyers answered the Dallas suit and filed a motion to transfer venue to Matagorda County before notifying Davalos' insurer of the lawsuit against him. *Id.* The insurer, Northern County Mutual, agreed to defend Davalos provided that he both withdrew his motion to transfer venue and further agreed to accept representation from the insurer's panel counsel. *Id.* Ultimately, the Matagorda County suit was transferred to Dallas on another party's motion, and Northern settled all claims against Davalos without any contribution from him. *Id.* at 687-88. However, prior to this settlement Davalos filed suit alleging that Northern acted in bad faith and in violation of the Texas Insurance Code. *Id.* at 688.

The Court noted that the insurer typically acquires the right to control its policyholder's defense as part of the insurance policy where no conflict of interest exists. *Id.* (Citing *State Farm Mut. Auto. Ins. v. Traver*, 980 S.W.2d 625, 627 (Tex. 1998)). However, the insurer loses its right to control its policyholder's defense when a conflict arises between them. The Court in *Davalos* set the following standard for control of a policyholder's defense:

Ordinarily, the existence or scope of coverage is the basis for a disqualifying conflict. In the typical coverage dispute, an insurer will issue a reservation of rights letter, which creates a potential conflict of interest. And when the facts to be adjudicated in the liability lawsuit are the same facts upon which coverage depends, the conflict of interest will prevent the insurer from conducting the defense. On the other hand, when the disagreement concerns coverage but the insurer defends unconditionally, there is, because of the application of estoppel principles, no potential for a conflict of interest between the insured and the insurer.

Other types of conflicts may also justify an insured's refusal of an offered defense. One authority lists four separate circumstances in which the insured may rightfully refuse to accept the insurer's defense: (1) when the defense tendered "is not a complete defense under circumstances in which it should have been," (2) when "the attorney hired by the carrier acts unethically and, at the insurer's direction, advances the insurer's interests at the expense of the insured's," (3) when the "defense would not, under the governing law, satisfy the insurer's duty to defend," and (4) when, though the defense is otherwise proper,

"the insurer attempts to obtain some type of concession from the insured before it will defend."

Davalos, 980 S.W.2d at 689 (citations omitted).

The *Davalos* Court found that only a venue dispute existed between the parties. *Id.* Since venue disputes are strategic and do not affect a party's rights under an insurance policy contract, the Court held that Northern had not violated either its duty of good faith to Davalos or its duties to him under the Texas Insurance Code. *Id.* at 689-90.

***Davalos* Applied**

Most practitioners are very familiar with how *Davalos* was later applied in *Dallas Housing Authority v. Northland Insurance Co.*, 333 F. Supp. 2d 595 (N.D. Tex. 2004) (appeal pending). The insurer in that case reserved rights advising DHA that it was providing DHA with a qualified defense but:

Reserving its rights to later disclaim coverage if it is determined that (1) DHA interfered with its right to defend by failing to provide it with all information, assistance and cooperation that it requests, or DHA otherwise prejudices [the insurer's] position; (2) the claim is based upon, arises from or is in consequence of any fraudulent act or omission or any willful violation of any statute or regulation; (3) the claim is based upon, arises from or is in consequence of any conduct that DHA knew was wrongful; or (4) the claim is for damages due in any part for actual or alleged bodily injury, sickness, disease, or mental or emotional distress. [The insurer] also disclaimed coverage for punitive damages contending that insurance coverage for such damages is against public policy in Texas.

DHA, 333 F. Supp. 2d at 600.

The DHA court found that the insurer's reservation of rights to disclaim coverage for any willful statutory violation was a reservation based on the same facts at issue in the underlying lawsuit. *Id.* at 601. Therefore, despite the fact that DHA's only complaint with the insurer's panel counsel was an ambiguous assertion that such counsel did not move cases as quickly as DHA would like, the Court found that the insurer was disqualified from controlling the insured's defense. *Id.* at 601-02.

The DHA court went on to hold in a later order that not only was DHA entitled to recover the fees that it paid to its independent counsel, that the insurer was obligated to pay the statutory interest penalty imposed by the Prompt Payment of

Claims Act by virtue of its failure to pay such counsel when retained. *Id.* at 602-03.

CONCERNS FOR INSURERS

Losing the Right to Control the Defense by the Reservation of Rights

The Duty to Timely Reserve Rights

An insurer must reserve rights before it can seek reimbursement. *Frank's Casing*, 2005 WL 1252321 at *3. Obviously, the reservation must be made within a reasonable time after the insurer has reason to believe that one or more claims against its policyholder are not covered. See TEX. INS. CODE §541.060(a)(4)(B) (Vernon 2005) (making it an unfair settlement practice for an insurer to fail to timely reserve rights); *Tull v. Chubb Group of Ins. Cos.*, 146 S.W.3d 689, 694 (Tex. App.—Amarillo 2005, no pet.) (noting that an insurer that fails to timely reserve rights after learning of facts that may put the claims outside coverage may be found to have waived any coverage defenses).

A policyholder is not obligated to accept a qualified defense after the insurer reserves rights. *Arkwright-Boston Mfrs. Mut. Ins. Co. v. Aries Marine Corp.*, 932 F.2d 442, 445 (5th Cir. 1991). However, if it does not object to the reservation and accepts the qualified defense, then it may be found to have consented to the insurer's reservation. *Western Cas. & Sur. Co. v. Newell Mfg. Co.*, 566 S.W.2d 74, 76 (Tex. App.—San Antonio 1978, writ ref'd n.r.e.).

Of course, an insurer that reserves rights and offers a qualified defense is almost always acknowledging that there is at least one potentially covered cause of action asserted against its policyholder. This is because the policyholder is entitled to a defense as to all causes of action asserted against it if any allegation is potentially covered under the insurance policy contract. *St. Paul Ins. Co. v. Texas Dep't of Transp.*, 999 S.W.2d 881, 884 (Tex. App.—Austin 1999, pet. denied); see *Heyden Newport Chem. Corp. v. Southern Gen. Ins. Co.*, 387 S.W.2d 22, 26 (Tex. 1965). Only the "eight corners" of the petition and the insurance policy are considered in determining the duty to defend. *National Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc.*, 939 S.W.2d 139, 141 (Tex. 1997). Therefore, an insurer that does not believe that there is any potentially covered

cause of action asserted against its policyholder should deny coverage rather than provide a defense subject to a reservation of rights.

In order to preserve its right to later seek reimbursement, the insurer must timely reserve rights. But, by timely reserving rights the insurer has created a potential conflict. *Davalos*, 140 S.W.3d at 689. Insurers will certainly argue that not every reservation results in a disqualifying conflict. However, as discussed below, *Frank's Casing* seems to give policyholders some very strong arguments that they are entitled to independent counsel whenever an insurer reserves rights in a liability case given the *Davalos* standard.

The Duties Owed by Panel Counsel to the Policyholder

An important part of the insurer's right to control its policyholder's defense is the right to select the policyholder's counsel. This counsel is almost always panel counsel – an attorney that regularly accepts assignments from insurers subject to the insurer's negotiated rates and litigation guidelines. Of course, while panel counsel is retained, usually as part of an ongoing relationship with the insurer, the panel counsel representing the policyholder acts as the policyholder's lawyer. *Employers Cas. Co. v. Tilley*, 496 S.W.2d 552, 558 (Tex. 1973). As such, panel counsel owes the policyholder the same duties of loyalty that are owed to any client. *Id.* Therefore, panel counsel must protect the policyholder's interests if such interest would be compromised by the insurer's instructions. *State Farm Auto. Ins. Co. v. Traver*, 980 S.W.2d 625, 628 (Tex. 1998).

The Texas Supreme Court has held that an insurer is not liable for panel counsel's professional malpractice. *Traver*, 625 S.W.2d at 628-29. And, courts have correctly noted that most Texas attorneys zealously protect their clients even when their business is largely dependent upon an insurer's continuing referrals. But what can be done when the insurer's need to know the facts of the case in order to control the defense put the panel counsel in the position of providing factual details and legal analysis that the insurer must use to determine coverage?

It is common knowledge that insurers often require panel counsel to comply with litigation guidelines. While these guidelines will certainly include billing standards and other procedures for controlling defense costs, they will also generally include reporting requirements. And these reporting

*An insurer must
reserve rights
before it can seek
reimbursement.*

requirements, in fact any reporting requirement necessary to allow the insurer to control the policyholder's defense, will almost certainly create a disqualifying *Davalos* conflict given the *Frank's Casing* reimbursement rule.

How the *Davalos* Conflict is Exacerbated by the *Frank's Casing* Reimbursement Rule

Virtually every Texas lawyer is familiar with the *Stowers* doctrine. An insurer may become obligated to pay an amount above its policyholder's contractual policy limits if it fails to pay a proper *Stowers* demand. Before *Frank's Casing*, the elements of a proper *Stowers* demand were:

1. A covered claim against the policyholder is at issue.
2. The demand is within policy limits.
3. The demand is accompanied by an offer to fully and finally release the policyholder in consideration of the insurer's acceptance of such demand.
4. The demand's terms are such that an ordinarily prudent insurer would accept it given the likelihood and potential of an excess judgment against the policyholder.

American Physicians Ins. Exch. v. Garcia, 876 S.W.2d 842, 848-49 (Tex. 1994) (clarifying that the *Stowers* standard was viewed from the position of a reasonable "insurer" rather than a reasonable "person").

However, *Frank's Casing* modified the fourth element. The policyholder now has a duty to determine coverage and evaluate liability. Justice Owen wrote:

We have said that the duty imposed by *Stowers* is to "exercise that degree of care and diligence which an ordinarily prudent person would exercise in the management of their own business." We have also said that the *Stowers* duty is viewed from the perspective of an insurer: "the terms of the demand are such that an ordinarily prudent insurer would accept it." Both statements are correct.

Frank's Casing 2005 WL 1252321at *3.

After *Frank's Casing*, a policyholder that demands that its insurer settle a liability claim or who agrees that a liability claim should be settled in the face of disputed coverage faces the risk of a subsequent reimbursement suit. Of course, the subsequent reimbursement suit will involve essentially liquidated damages since the policyholder admits that the settle-

ment amount is reasonable by making the demand for settlement or agreeing to the settlement in the face of disputed coverage. *Id.* at *3.

Frank's Casing accepts the insurers' argument that it is unfair for them to be forced into a "Catch 22" of either paying a disputed claim and waiving coverage defenses or facing a later bad faith or *Stowers* suit that could result in payment obligations beyond the policyholder's contractual limits.

Whether the insurer or the insured ultimately bears the cost of a reasonable settlement with a third party should depend on whether there is coverage. As pointed out by the California Supreme Court and our own Court of Appeals in the present case, denying a right of reimbursement once an insured has demanded that an insurer accept a reasonable settlement offer from an injured third party can significantly tilt the playing field. The insurer would have only two options. It could refuse to settle and face a bad faith claim if it is later determined there was coverage. Or it could settle the third party claim with no right of recourse against the insured if it is determined that there was no coverage which effectively creates coverage where there was none. As the California Supreme Court concluded, "[R]eimbursement should be available because the insurer had not bargained to bear these costs and the insured had not paid the insurer premiums for the risk."

Id. at *4.

But this argument ignores the fact that insurers are simply in a far better position to determine coverage and evaluate liability than the vast majority of their policyholders. *Matagorda County*, 52 S.W.3d at 135; see also *Gonzalez v. Mission Am. Ins. Co.*, 795 S.W.2d 734, 737 (Tex. 1990) (the insurer, as the policy drafter, bears the fault for any vague or ambiguous policy provision). Insurers are in the business of evaluating risk. Policyholders are typically strangers (or at least relative strangers) to litigation. While policyholders may not face statutory penalties, after *Frank's Casing* they do face the risk of defending, at their own expense, a coverage suit against a more sophisticated insurer. In fact, as discussed below, they may also have *Stowers*-type duties to their insurer.

Like insurers, policyholders certainly cannot afford to "gamble" with their coverage issues. See *Frank's Casing*, 2005 WL 1252321at *8 (Hecht, J., concurring) (noting that insurers faced with *Stowers* demands cannot afford the "gamble" imposed upon them if they are wrong with respect to their

coverage determination). If the insurer is to be given the right to review coverage in a later reimbursement suit, then the policyholder should reasonably have the right to have independent counsel analyze the underlying lawsuit.

Insurers have never had a duty to settle claims outside coverage. *Garcia*, 876 S.W.2d at 848-49. The practical problem is that plaintiffs' lawyers have learned to make timed demands in liability cases in order to force coverage decisions knowing that the policyholders and the underlying plaintiffs can seek damages from the insurer for failing to timely pay a covered claim. See *Rocor Int., Inc. v. National Union Fire Ins. Co.*, 77 S.W.3d 253 (Tex. 2002) (holding that the policyholder is entitled to seek damages from its insurer under the Texas Insurance Code when the insurer failed to timely pay a covered claim).

What the insurers are really objecting to is the pressure of having to make a coverage decision in limited time with the risk of additional liability from making an incorrect coverage decision. Ironically, *Frank's Casing*, rather than removing this pressure from the equation, actually seems to put this pressure on the policyholder.

The policyholder, probably without the benefit of coverage counsel, institutional experience, or employees trained in coverage, will need to make a coverage decision. The policyholder must weigh its coverage position against the insurer's reservation to decide whether or not to make a settlement demand or expressly agree that the case should be settled. And, of course, the policyholder is making this decision under the same time constraints imposed on the insurer.

Of course, if the policyholder is forced to use panel counsel, the policyholder is making the coverage determination and evaluating potential damages based on the SAME legal and factual analysis relied upon by the insurer. Of course, the litigation guidelines imposed on panel counsel and/or the institutional relationship between the insurer and panel counsel mean that such information and analysis has been tailored to the insurer's most efficient use of such information.

Why the *Frank's Casing* Reimbursement Rule Likely Entitles the Policyholder to Independent Counsel

Insurers will argue that *Frank's Casing* does nothing more than even the playing field. They will say that policyholders

could use *Rocor* and the threat of later coverage suits as leverage to force an insurer into paying claims outside coverage. However, the real net effect has been to tilt the playing field in the insurers' favor whenever coverage rights are reserved.

1. *Frank's Casing* Prohibits an Insurer from Compelling its Policyholder to Accept a Defense from Panel Counsel that is Obligated to Report on Facts to the Insurer

Insurers commonly reserve coverage rights where insufficient facts are available to determine coverage when the suit is tendered. The insurer watches the case develop to both determine coverage and to evaluate the policyholder's potential liability. Watching the case develop is, of course, an integral part of the insurer's right to control the policyholder's defense. How can the insurer evaluate the potential liability without knowing the liability and damage facts? Conversely, since the

policyholder now has a duty to determine coverage and evaluate liability (since he can be sued on essentially liquidated damages for an incorrect decision), how can the insurer condition a defense on the policyholder's use of the same counsel that provides the insurer with the information that it may use to later dispute coverage? After *Davalos*, it seems clear that it cannot.

Why is it unfair for the insurer and the policyholder to rely on the same counsel for case analysis? The answer is clear – because both the insurer and the policyholder have the same duty to determine coverage and evaluate liability. Of course, it is true that the facts are what the facts are. But it is also true that counsel's

assessment of the facts and the applicable law can color a party's determination of the potential coverage dispute. For example, assume that a policyholder is sued for both negligent and intentional torts. As discovery unfolds, the insurer will rely on panel counsel's determination of witness credibility and venue to "gamble" on whether or not a jury will find that some or all of the damages resulted from intentional (and, therefore, non-covered) acts. How panel counsel reports "the facts" will undoubtedly color this decision.

Since both the insurer and the policyholder have duties to determine coverage and evaluate liability, the insurer's reservation coupled with the *Frank's Casing* rule granting the insurer a quasi-contractual right to reimbursement seems to create an irreconcilable conflict of interest with the policyholder. The most efficient method of resolving this conflict is to grant the policyholder the right to independent counsel.

The policyholder, probably without the benefit of coverage counsel, institutional experience, or employees trained in coverage, will need to make a coverage decision.

2. *Frank's Casing* Will Adversely Impact Liability Settlements

Frank's Casing accepts the reasoning adopted in certain California decisions that preserving an insurer's reimbursement rights encourages liability settlements. *Frank's Casing*, 2005 WL 1252321 at *4. However, given the potential risks to the policyholder from demanding that its insurer settle a case after the insurer reserves coverage rights, it seems that the opposite may well be true.

Policyholders that are faced with judgments in excess of their policy limits may elect to assign their bad faith claims against their insurer to the plaintiff in consideration of a covenant to delay execution. In fact, in those cases where the policyholder is essentially judgment proof, this is often the most attractive option for the plaintiff since the insurer is almost always the deep pocket. While the insurer retains its coverage defenses, there is, especially if the judgment is large enough, a good chance that it will be defending against a well-funded and very aggressive adversary. The plaintiff and his attorney want their money and recognize that the only way to get it is to win the coverage suit.

However, if the insurer settles the case but retains the right to seek reimbursement from its policyholder, then it may have removed much of the risk of defending against such an aggressive adversary. The plaintiff is no longer interested, and certainly lacks standing, to pursue any claim against the insurer. The insurer may now become the aggressor, especially if the policyholder is unable to afford to litigate the coverage aspects of the reimbursement suit.

It is, of course, possible for a policyholder to be asset-rich but cash-poor. Consider the individual policyholder that has put all of his retirement funds into a Rockport home. He intends to retire at year's end, sell his current homestead, and move into this second home living on the proceeds from the sale of his first home. While he has assets upon which a judgment creditor could execute, he does not have the funds to pay a lawyer to litigate a coverage suit.

The practical effect of this may well be policyholders' hesitance to demand settlement or agree to settlement in the face of reserved coverage rights. After all, a policyholder can have some leverage to avoid the impact of an adverse judgment by negotiating an assignment with the plaintiff after judgment.

But, the policyholder has no leverage and no ability to avoid additional litigation, not to mention potential liability to the insurer, if the liability case settles. Unfortunately for the policyholder, he may now owe Stowers-type duties back to the insurer. A policyholder that refuses to allow an insurer to settle out of fear of defending a reimbursement suit could find himself a third-party defendant in any later Stowers suit. This is more fully discussed later in this paper.

3. *Frank's Casing* Creates Conflicts in Drafting Liability Settlement Releases.

Another very real problem is created by *Frank's Casing* if and when a settlement can actually be achieved in the face of disputed coverage. Assuming that there are both some covered and some potentially non-covered causes of action at issue (an assumption that will almost always be true given the standard for the duty to defend), how will any settlement be allocated in any release? The policyholder will likely bear the burden of providing some basis to allocate between covered and non-covered causes of action in any later reimbursement action. See *Lyons v. Millers Cas. Ins. Co.*, 866 S.W.2d 597, 601 (Tex. 1993). Therefore, it is in the policyholder's best interest to have the release reflect that most, if not all, of the settlement is expressly allocated to indisputably covered claims. The insurer, by contrast, wants just the opposite.

Who will draft the release? Does panel counsel have an obligation to demand that any release allocate the majority of damages to covered claims? This is clearly a duty owed to the policyholder client. Once again this problem is most efficiently resolved by providing the policyholder with independent counsel whenever rights are reserved.

Before *Frank's Casing* the insurer was the party with the burden of timely determining coverage and evaluating liability. This is no clearly longer the case given the insurer's right to seek reimbursement and the Stowers duties imposed on the policyholder when coverage rights are reserved.

Frank's Casing May Defeat or Weaken Some Defenses to Subsequent Stowers and Bad Faith Suits

An insurer does not incur a duty to pay non-covered claims upon receipt of a Stowers demand. See *St. Paul Fire & Marine Ins. Co. v. Convalescent Servs., Inc.*, 193 F.3d 340, 343

Policyholders that are faced with judgments in excess of their policy limits may elect to assign their bad faith claims against their insurer to the plaintiff...

(5th Cir. 1999). Moreover, an insurer does not risk “creating” coverage through waiver or estoppel. *Minnesota Mut. Life Ins. Co. v. Morse*, 487 S.W.2d 317, 320 (Tex. 1972). An insurer that is comfortable with its coverage position can certainly refuse to pay a Stowers demand and later defend on the basis that liability was not reasonably clear (assuming, of course, that it has timely reserved coverage rights). However, *Frank’s Casing* appears to make the insurer’s defense almost exclusively dependent on the coverage element. The insurer’s ability to contend that a reasonable insurer would not have accepted the demand is minimized given the insurer’s right to reimbursement.

Before *Frank’s Casing*, an insurer defending against a subsequent bad faith or Stowers action could and would defend, in part, on the ground that liability was not reasonably clear. One way to do this was to assert that there was no reasonable basis for concluding that an excess judgment against the policyholder was likely. Another way was to assert that a reasonable insurer would conclude that the settlement demand exceeded the reasonable evaluation of its policyholder’s liability. But *Frank’s Casing* will likely make this defense more difficult, if not impossible, to use. Since the insurer can seek reimbursement from its policyholder and since the policyholder admits that the settlement demand is reasonable by demanding that its carrier accept it, what possible reasonable basis can the insurer have for not paying the demand?

Insurers can probably not defend on the ground that their insured is judgment proof since *Frank’s Casing* states:

[t]he reasonableness of a settlement offer is not judged by whether the insured has no assets or substantial assets, or whether the limits of insurance coverage greatly exceed the potential damages for which the insured may be liable. It is an objective assessment of the insured’s potential liability.

Frank’s Casing 2005 WL 1252321at *3.

In fact, *Frank’s Casing* can reasonably be read to hold that plaintiffs are entitled to a “deep pocket” in liability cases as long as they can establish the policyholder’s liability.

Reimbursement rights encourage insurers to settle cases even when coverage is in doubt. When an insurer settles a claim for which coverage is in doubt, the risk that the insured lacks the resources to fund a settlement is shifted to the insurer and is lifted from the injured plaintiff who sued the insured. The coverage dispute between an insured and its insurer can be resolved after the

injured plaintiff is compensated. Thus, an injured plaintiff’s risk that the defendant has no coverage and may be financially unable to fully compensate the plaintiff is lessened.

Id. at *4.

While insurers may have won the right to seek reimbursement (or at least force a contribution toward settlement) from their policyholders, it seems that *Frank’s Casing* actually imposes an almost strict liability component into Stowers. Insurers failing to pay a Stowers demand or to pay a claim following a demand from their policyholder should be especially careful to ensure that they have properly determined that no coverage exists. Failing to do so may mean that the insurer will be found to have acted unreasonably if coverage is found during later litigation since the ability to argue that a reasonable insurer would not have accepted the demand has been minimized.

The Hecht Concurrence Does Not Alleviate the Conflict Between the Insurer and the Policyholder. In Fact, It Seems to Impose Stowers-Type Duties on the Policyholder.

Justice Hecht’s concurrence seems, at first glance, to limit some of *Frank’s Casing*’s less pleasant effects on policyholders. He wrote:

Perhaps it is necessary to stress, again, that no one suggests that an insurer may unilaterally settle a claim for an unreasonable amount, or in circumstances that actually (rather than hypothetically) prejudice the insured, and then force reimbursement from the insured. Neither the present case nor *Matagorda County* involved such a situation. The Court has never been cited to a case involving such a situation. In the off-chance that such a situation could arise, statutory prohibitions against unfair practices by insurers offer full relief: actual damages, additional damages, and attorney fees.

Id. at *9 (Hecht, J., concurring).

Justice Hecht then adds:

An insured should not be allowed to unreasonably withhold consent to settlement to force the insurer to pay a claim and abandon coverage issues at the risk of incurring stiff statutory liabilities. An insurer’s right to recoup from its insured the amount paid to settle a claim depends on two

things: the reasonableness of the settlement and coverage. That is the essence of today's decision.

Id.

However, it is difficult to imagine a situation where the insurer asserting reimbursement rights will ever be found to have acted improperly to the policyholder's detriment. Reserving coverage rights is expressly permitted by the Texas Insurance Code. See TEX. INS. CODE § 541.060(a)(4)(B). It is well-established that an insurer is not guilty of bad faith simply because it was wrong regarding coverage. *Transportation Ins. Co. v. Moriel*, 879 S.W.2d 10, 17-18 (Tex. 1994) (an insurer is not guilty of bad faith when it is merely incorrect regarding the factual basis for a denial or about an insurance policy's proper construction). Therefore, an insurer that reasonably reserves rights may properly seek reimbursement from its policyholder without fear of violating any duty to its policyholder. See *Universe Life Ins. Co. v. Giles*, 950 S.W.2d 48, 55 (Tex. 1997) (adopting the Texas Insurance Code standard of failing to attempt in good faith to settle a claim where the insurer's liability is reasonably clear as the standard for breach of the duty of good faith and fair dealing).

As long as the insurer has the requisite basis for reserving coverage rights, it will likely be able to rightfully pursue reimbursement from its policyholder without fear of the statutory prohibitions referenced in Justice Hecht's concurrence.

However, the policyholder may now have some liability to the insurer in those cases where it refuses to agree to a settlement. Under both the majority opinion imposing the duty to determine coverage on the policyholder and Justice Hecht's concurrence condemning a policyholder's refusal to accept a reasonable settlement, it seems reasonable to conclude that a policyholder that fails to agree to a settlement and therefore later subjects the insurer to a Stowers suit may be liable to the insurer under some extension of Stowers.

In fact, the Hecht concurrence actually seems to bolster the policyholder's right to independent counsel by highlighting the conflict between the insurer and policyholder. They both have the same duties to determine coverage and evaluate liability. They both are probably subject to potential (and very possibly strict) Stowers liability for failure to do so. And they both are at risk for funding any settlement in an underlying liability case after rights have been reserved.

Reserving Rights and Accepting Qualified Defenses after *Frank's Casing*

Clearly the decision to reserve rights has become much more important after *Frank's Casing*. While the insurer always has had an obligation to ensure that there was a reasonable basis for reserving rights, there was little practical harm in prophylactically reserving rights in cases where coverage disputes could be expected in the future. After *Frank's Casing*, however, insurers must weigh the need to preserve coverage defenses against the risk that they may lose control of the policyholder's defense. Insurers also must carefully consider Stowers demands sent by their policyholders since the right to reimbursement will likely foreclose the ability to later argue that a reasonable insurer would not have accepted such a demand.

Policyholders also should consider whether they still are willing to accept qualified defenses after *Frank's Casing* and *Davalos*. An insured that accepts a qualified defense probably has waived its right to assert that the insurer's panel counsel impermissibly (albeit probably ethically) provided information or analysis to the insurer that could have given the insurer an advantage in determining coverage.

Of course, policyholders should never agree to an insurer's offer to settle a claim or demand that an insurer settle a claim in the face of reserved rights without first carefully considering the coverage dispute and the potential damages. In fact, given the potential Stowers-type duties that the policyholder may owe the insurer when rights are reserved, it seems that the policyholder has an affirmative duty to carefully consider both coverage and liability whenever a demand is received in a liability case.

Whether reservations in future cases can be resolved without contemporaneous declaratory judgment actions or the policyholder's agreement to contribute to a settlement in consideration of the insurer's releasing its reimbursement rights remains to be seen. However, additional litigation regarding the duty to defend and Stowers is almost certainly inevitable. Insurers, policyholders, and practitioners should carefully consider how radically *Frank's Casing* has changed the landscape and tread carefully until the new map has been written.

The Insured's Duty to Cooperate

INTRODUCTION

In the event of a potentially covered loss, claim or lawsuit, the insured is required to cooperate with its insurer in the investigation and resolution of the claim. This “duty to cooperate” is specifically set forth in the vast majority of policies as one of several duties or conditions in the event of a loss, claim or lawsuit.¹ It is an implied condition precedent to coverage, however, even if it is not expressly set forth in the policy. See, e.g., *First Bank of Turley v. Fidelity & Deposit Ins. Co. of Maryland*, 928 P.2d 298 (Okla. 1996)(the duty to cooperate is both contractual and implied as a matter of law.)

Purpose of the cooperation clause. From the insurance company’s standpoint, the cooperation clause serves to assist the insurance company to (i) obtain information concerning a loss while the information is still fresh; (ii) determine its obligations to indemnify the loss and/or defend its insured; (iii) protect itself from fraudulent claims; and (iv) pursue a subrogation claim against a responsible third-party, if applicable. Where a third-party claimant is involved, the cooperation clause also serves to prevent collusion between the policyholder and the claimant. In both the first-party and the third-party context, other, more specific clauses may address some or all of these concerns as well. COUCH ON INSURANCE §199:4, (THIRD ED. 2000).

The insured’s failure to cooperate with the insurer may result in a complete loss of coverage. Of course, in the third-party context, such a forfeiture of coverage may mean that a meritorious claimant will go without a recovery. For this reason and more, courts are rather reluctant to allow insurers to invoke a breach of the duty to cooperate as a complete defense to coverage unless the insurer can show that it was prejudiced by the insured’s failure to cooperate.

Scope of the insured’s duties. The scope of the insured’s duty to cooperate varies greatly depending on the type of policy and the type of loss. In the first-party insurance context, the insurance company, following a loss, must rely on the insured to provide it with sufficient details to evaluate the

claim. Even when an adjuster or surveyor will be assigned to evaluate the claim, there will still be a certain store of critical information that only the policyholder can provide. In the third-party context, the insured’s cooperation may have a significant bearing on the overall liability question. In the usual third-party case, however, the insured’s degree of cooperation will not have much impact on the issue of damages.

The insured’s duty to cooperate can be approached from two perspectives. On the one hand, it may be viewed as a general and overarching duty in the event of a loss, claim or lawsuit. Seen this way, it parallels the insurer’s duty to act in good faith and deal fairly with the insured following a loss. This article will from time to time refer to such a broad, overarching duty to cooperate as the “general” duty to cooperate. From another perspective, the duty to cooperate may be seen as a “fall-back” or residual duty, one that may be invoked by the insurance company as a defense to coverage when other, more specifically enumerated defenses (such as the duty to give prompt notice) do not apply, yet the insured has not been completely forthcoming following a loss. This article will use the term “residual” duty to cooperate when discussing this fall-back aspect of the duty.

Scope of the article. This article will discuss both the general and the residual duty to cooperate from a Texas standpoint. It is intended as a practical guide to the insurance law practitioner rather than as an academically grounded article. Indeed, the article is not “all inclusive” in the sense that it discusses each and every reported Texas case in which an insurer has alleged a breach of the insured’s duty to cooperate, or every topic engendered by such allegations. Rather, the article attempts to give the “flavor” of some of the key cooperation cases, all of which tend to be quite fact intensive. The cases – and as noted below, cooperation cases are not as numerous as one might expect – are thus presented in some factual depth. The intent is to give the reader a taste for the body of facts that will lead courts to conclude that an insured has or has not breached the duty to cooperate, or (more often) that the insurer has or has not shown that it was prejudiced by acts or omissions that clearly amounted to a breach. The astute reader will

probably walk away from this article at least somewhat surprised by the extent to which the insured can fail to cooperate with its insurer and still defeat the insurer's motion for summary judgment based on the breach.

This article discusses the duty to cooperate in both the first-party and third-party contexts. Given the author's much greater experience with third-party liability insurance policies, however, the article is undoubtedly deficient with respect to the first-party insured's duty to cooperate. This shortcoming should be attributed to the author only. Of course, any comments, observations or opinions expressed are those of the author alone, and not necessarily (or at all) those of his firm, his clients or the Journal's editors.

In any discussion of third-party lawsuits, the reader should assume that the discussion concerns a policy in which the insurance company has the obligation to assume the insured's defense in the event of a covered or potentially covered claim or lawsuit. Allegations of non-cooperation by an excess liability insurer with no duty to defend may raise different or additional questions, but such questions are outside the scope of this article.² For the interested reader, some guidance can be found in *Laster v. Am. Nat'l Fire Ins. Co.*, 775 F.Supp. 985 (N.D. Tex. 1991), *aff'd* 979 F.2d 676 (5th Cir. 1992)(table decision), *Warren v. Am. Nat'l Fire Ins. Co.*, 826 S.W.2d 185 (Tex. App. – Ft. Worth 1992, writ denied) and *Vang v. Delta Lloyds Ins. Co.*, 2001 WL 722279 (Tex. App. – Dallas 2001, no pet.)[not designated for publication]. The *Laster* and *Warren* decisions spring from the same operative facts; the federal court opinion gives a more thorough factual review.

An observation. It is not the purpose of this article to address the friction that often exists between the insured and its liability insurer when coverage is denied. It is widely acknowledged, in the third-party context at least, that once the insurer has denied coverage, it may no longer rely on the insured's compliance with *any* of the conditions of the policy (though it may still assert that the policy does not cover the occurrence). *Enserch Corp. v. Shand Morahan & Co., Inc.*, 952 F.2d 1485, 1496, fn. 17 (5th Cir. 1992); *Gulf Ins. Co. v. Parker*, 498 S.W.2d 676, 679 (Tex. 1973).³

Other articles have explored these outright-denial-of-coverage issues in great detail, and no attempt to duplicate these materials will be made. The author does wish to note, however, that where the insurer has not completely disclaimed coverage, yet has reserved its rights on one or more issues, the insured's subsequent actions can give rise to what, in the author's opinion, are often misplaced assertions that the insured is violating the duty to cooperate. Another, perhaps better, way to say this is that many insurance practitioners, and especially those who either work directly for insurers or represent insurers to the

exclusion of policyholders, view the insured's duty of cooperation as being much broader than it really is.

For example, where the insured has some degree of control over its own defense or otherwise takes a great interest in the lawsuit, the insured may question the insurance company's choice of defense counsel, request constant updates and reports from counsel, push to have a lawyer of its own choosing appointed as defense counsel, ask the insurer to compensate the insured's lawyer at her regular hourly rate instead of the insurance company's regular hourly rate for "approved" lawyers, object to the use of "litigation guidelines" by defense counsel, demand that counsel be as diligent in defending non-covered claims as she is in defending covered claims, or otherwise "interfere" with the insurance company's handling of the defense of the case.

Faced with such a "rebellious" insured, some adjusters and coverage attorneys will argue that the insured's continued resistance to what the insurance company considers the proper administration of the claim amounts to a breach of the duty to cooperate. (For a discussion of such allegations in a typically contentious factual situation, *see Quorum Health Res., L.L.C. v. Maverick County Hosp. Dist.*, 308 F.3d 451, 468-472 (5th Cir. 2002), a case which, for better or for worse, does not entirely resolve the cooperation issue, since the Fifth Circuit reviewed the facts in the context of a granted motion for summary judgment in favor of the insurer, largely predicated on an unrelated topic (the express negligence doctrine).)

In the author's opinion, friction between the insured and the insurer over the proper conduct of the shared defense of a third-party lawsuit may well lead to justifiable disputes over which party should pay which part of which attorney's legal fees. Other disputes may arise as well. However, it should only rarely be suggested in such a situation that the insured has breached the cooperation clause. While the cooperation clause surely precludes an insured from sabotaging the insurance company's interests, the clause does *not* require the insured to subjugate its own best interests, fairly advanced, to the best interests of the insurance company. Rather, the cooperation clause should be seen as requiring the insured to put forth an honest effort to defeat or minimize the claims, insured or not, advanced by the "common enemy" – the third-party plaintiff.

A note on the scarcity of case law. The number of cases discussing the duty to cooperate (as either a general or a residual duty) is not overwhelming. Where possible, the courts attempt to discuss violations of more specific duties. For example, and as third-party practitioners are well aware, there are a plethora of cases dealing with the insured's duty to give prompt notice of a lawsuit and forward suit papers. Yet cases discussing the situation where an insured gives prompt

notice of a claim or lawsuit, but then refuses to further cooperate, are much fewer in number.

If reported cases discussing the insured's general or residual duty to cooperate in the third-party context are rather scarce, cases discussing the duty in the first-party context are scarcer still. This is probably due in part to the fact that first-party claims are often smaller in size (or at least more actuarially predictable) than third-party claims. Also, the interaction between the claimant and the insurance company is – or should be – less confrontational in the first-party context; the claimant is, after all, the customer as well, and insurance companies that are heavily invested in the first-party market are “reputation sensitive.” First-party insurers as a group may be more likely to compromise a disputed claim and less likely to invoke a potential defense to coverage than are liability insurers.

Two more factors may account for the relative dearth of first-party cooperation cases. First of all, the insured, following a first-party loss, has every incentive to cooperate with the insurance company. If she takes an “I’ve got better things to do” attitude, she will not be reimbursed for her loss. Second, the information that the insurance company will need from its insured following a first-party loss is usually quite predictable. The policy will typically provide that the insured, following a loss, must comply with certain well-defined duties such as providing adequate notice, filing a proof of loss, mitigating damages, submitting to an examination under oath or an independent medical examination, etc. *See, e.g., Lidawi v. Progressive County Mut. Ins. Co.*, 125 S.W.3d 725 (Tex.App. – Houston [14th Dist.] 2003, no pet.)(discussing the duty to cooperate in a general sense but focusing on the requirement to submit to an examination under oath on request); *see generally* COUCH, §199:1.

In the third-party liability context, on the other hand, the scope and extent of the cooperation that may be required from the insured following a potentially covered claim or the filing of a lawsuit is more difficult to predict due to the presence of an important extra factor in the insurance equation – to wit, the third-party claimant. The third-party claim situation is also much more likely to involve attorneys, with all attendant difficulties. Accordingly, while the modern liability policy provides that the insured must comply with specific duties such as giving timely notice of the occurrence, forwarding suit papers if the claim matures into a lawsuit, obtaining the

attendance of witnesses at trial, assisting with settlement negotiations and refraining from making voluntary payments, to a certain extent the general, overarching duty to cooperate is less predictable and somewhat more amorphous than is the case in the first-party context. *See generally id.* With this lack of specificity – and with the higher dollar amounts often at stake in the third-party context – comes a greater willingness to go to court over alleged breaches of the cooperation clause.

EXAMPLES OF BREACHES OF THE COOPERATION CLAUSE.

As alluded to earlier, most breaches of the “general” duty to cooperate are also breaches of a more specific duty, and are best discussed as such. Texas cases involving a breach of the “residual duty” to cooperate often involve fairly clear violations of the duty to cooperate, however defined; the real question presented is whether and to what degree the insurer can show that it has been prejudiced by the insured’s obviously deficient conduct.

The separation of cases into this section and the next (dealing with the insurance company’s need to show that it was prejudiced by a breach of the duty to cooperate) is fairly arbitrary; the two questions invariably go hand in hand. However, the following three cases – all over 40 years old – demonstrate how far an insured may stray from a proper course of conduct, yet still be entitled to coverage.

It should be noted at the outset of this section that what constitutes a breach of the cooperation clause is usually a question of fact. Under certain egregious circumstances, however, a court may hold that the insured breached the cooperation clause as a matter of law. *Frazier v. Glens Falls* (discussed immediately below), 278 S.W.2d at 391.

Frazier v. Glens Falls. In *Frazier v. Glens Falls Ind. Co.*, 278 S.W.2d 388, 391 (Tex.Civ.App. – Ft. Worth 1955, writ ref’d n.r.e.), the Court examined a situation in which the insured, rather than showing no interest in a third-party claim, showed too much interest in the claim. In reversing the trial court’s entry of summary judgment in favor of the insurer and remanding for trial, the Court outlined an approach to the duty to cooperate which suggests that an insured may go so far as to openly cooperate with the claimant and root for the claimant to recover, so long as the insured does not deceive the insurer, engage in outright fraud or otherwise cross the line into collusive behavior.

*First-party insurers
as a group may
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For better or for worse, many of the salient “cooperation” facts of *Frazier* are not set forth by the Court in an entirely straight-forward fashion. (The author guesses why this is so later on in this discussion.) It is clear that O.S. Frazier was seriously injured, and Mrs. Frazier was killed, while riding as passengers in a car driven by George W. New. New was Glens Falls’ insured and, of greater import to the case, the son-in-law of Mr. and the late Mrs. Frazier.

(On these facts, the modern reader must recall that in 1955, Frazier and the estate of his late wife would normally be prohibited from recovering from New by virtue of the Texas Guest Statute. The Guest Statute, Tex.Rev.Civ.Stat. Ann. art. 6701b, prohibited a cause of action against a driver by a non-paying passenger if the passenger was related to the driver within two degrees of consanguinity or affinity. An exception allowed such a passenger to recover *if* the driver intentionally or recklessly caused the accident. Thirty years after *Frazier* was decided, the Texas Supreme Court held that the Guest Statute was unconstitutional under the Texas equal protection clause. *Whitworth v. Bynum*, 699 S.W.2d 194 (Tex.1985).)

While New was in the hospital, he gave a statement to the Glens Falls adjuster, but later refused to sign the adjuster’s transcription of the statement. At some point, New gave another statement to an attorney who was representing not only New, but also his father-in-law, Frazier. This statement was passed along to the insurer; New’s wife (Frazier’s daughter) also gave a statement through the lawyer. While the Court does not come right out and say it, it appears that New’s statement to his and Frazier’s attorney, which related that New was driving recklessly at the time of the fatal accident, contradicted the closer-in-time statement given to the adjuster. At any rate, the attorney eventually wrote to Glens Falls, on behalf of both of his clients, demanding that the insurer settle Frazier’s claim.

Remanding to the trial court, the court of appeals noted that at the summary judgment stage, New’s refusal to sign the adjuster’s statement would be presumed to have been for valid reasons, since the insurer had presented no compelling evidence to the contrary. 278 S.W.2d at 391-92. And, while noting that the attorney might have ethical difficulties representing both New and Frazier, the court appeared disinclined to throw out Frazier’s claim based solely on the attorney’s bad judgment. *Id.* at 392.

As to the gist of the insurer’s defense, the Court offered the following observations on the duty to cooperate:

Besides the affirmative duty on the part of New to make a full, frank and fair disclosure of the facts, he owed certain negative duties to the Company.

He was obliged to refrain from any fraudulent or collusive act which might operate as a means of prejudice to the Company in the conduct of the defense against, or settlement of, the claim Frazier made against him. Cooperation with Frazier would not constitute a breach of the cooperation clause of the policy so long as fraud played no part therein.

New desired that Frazier collect the greatest possible amount from the Company. This state of mind constituted no breach of contract. New could cooperate with Frazier and the Company at one and the same time. Cooperation with the one would not necessarily foreclose cooperation with the other. The making of statements to Frazier by New was proper if they were true statements. Even had they been false, no breach would be involved absent some prejudice to the company. New’s demands upon the Company to settle Frazier’s claims were proper demands if made in good faith. This is true even though it were conclusive that because thereof the Company’s interests were actually prejudiced. Fraud or collusion must be a factor, and prejudice must result.

278 S.W.2d at 392.

The Court’s observations, made in the course of remanding the case to the trial court, would probably come as a surprise to many insurance law practitioners. The Court seems to be saying that an insured may assist the claimant in the pursuit of his lawsuit, so long as there is no fraud; *i.e.* so long as no falsehoods are concocted. (The Court’s statement that the insured can demand in good faith that its insurer settle the case, even if that demand is prejudicial to the insurer, is less noteworthy. Indeed, following the explosion of “*Stowers* demand” cases in the last quarter century, it would probably seem unusual to the modern insurance law practitioner to suggest that when an insured demands that a third-party claim be settled, he is somehow violating the duty to cooperate.)

A comment on Frazier. Reading *Frazier v. Glens Falls* and its broad but almost tongue-in-cheek pronouncement on what will *not* be considered a breach of the duty to cooperate, one gets the impression that something more is going on than is readily apparent. It may be – this is purely conjecture on the author’s part – that the Court was sending a strong statement to the insurance company to take steps to prove at the full trial that New and Frazier, assisted by their joint attorney, had concocted a version of the accident that deviated from the truth so as to avoid the effect of the Guest Statute.

While *Frazier v. Glens Falls* is still instructive – no later case has challenged its formulation of the scope of the insured’s duty to cooperate – the case probably would not come up today. Ignoring for a moment the impact of the Guest Statute, few modern and knowledgeable attorneys would represent both the insured and the claimant in the same accident, and the insurance company would go to greater lengths to show how its insured’s actions prejudiced it before moving for summary judgment.

Griffin v. Fidelity and Casualty. In *Griffin v. Fid. & Cas. Co. of New York*, 273 F.2d 45 (5th Cir. 1960), the insured driver, Arthur White, made the mistake of allowing his 14 year old nephew, Arthur Felder, to drive his (White’s) pickup truck. (Note: The facts are more fully outlined in the district court opinion, *Fid. & Cas. Co. v. Griffin*, 178 F.Supp. 678 (S.D. Tex. 1959).) Felder promptly struck two minors on a motor scooter, rendering them unconscious. While the victims remained unconscious, White appeared on the scene and later told the authorities that he (White) had been driving the pickup truck. White promptly notified Fidelity & Casualty of the accident, again asserting that he, and not his young nephew, was the driver.

Several months later, a lawsuit was filed, which named White as the driver and sole defendant. White timely forwarded the suit papers to his insurer, without noting the discrepancy between the facts alleged and the true facts. Fidelity & Casualty appointed defense counsel and began its investigation of the case. A few months later, just before his deposition was to take place, White confided to his counsel that it was Felder who had actually been the driver. The deposition went ahead as scheduled and White testified truthfully that his nephew, and not he, had been driving at the time of the accident.

Fidelity & Casualty filed a declaratory judgment action, alleging that White had violated both the duty to give timely notice (by giving a falsified version of the notice) and had failed to cooperate by waiting almost seven months from the time of the accident (and roughly three months from the time of the filing of the lawsuit) to give the true version of events.⁴

The district court entered judgment for Fidelity & Casualty. In its opinion, the falsified notice was no notice at all. The district court also noted the rule (in effect at the time) that the insurance company was not required to show any prejudice in order to invoke failure of timely notice as a defense to coverage. As for the breach of the cooperation clause, the Court stated that it was unclear whether the insurer, having shown an obvious breach, needed to demonstrate that it was prejudiced by the breach. If a showing of prejudice was required, however, the district court found that because it had been delayed by at least seven months from

ascertaining the true facts of the accident, the insurer had in fact been prejudiced.

The Fifth Circuit reversed and remanded. As to White’s provision of notice, the court held that the notice was timely, in that it identified the date of the accident, the vehicles involved, and the injuries sustained; moreover, White had promptly forwarded the suit papers to the insurer when the lawsuit was filed. That was sufficient to provide the insurer with timely notice notwithstanding the falsification of the driver’s identity.

With respect to the duty to cooperate, the court of appeals stated “under the overwhelming weight of authority, including that of the courts in Texas, it is the law that is essential to proof of breach of the cooperation clause, that actual, not merely suppositious or theoretical prejudice to the insurer therefrom be shown, and no such showing is made.” 273 F.2d at 48. The court cited, *inter alia*, to *Frazier v. Glens Falls*. There is no subsequent history for *Griffin*, and it is unclear whether the insurer would be able to show prejudice on remand. It is also unclear whether Fidelity & Casualty might have had a defense to coverage based on White’s improvident loan of his truck to young Felder, but if it did, it likely would not have pursued the failure to cooperate angle.

U. S. Cas. Co. v. Schlein. *United States Cas. Co. v. Schlein*, 338 F.2d 169 (5th Cir. 1964) grew out of an accident which occurred in Beaumont, Texas involving a car owned and driven by Schlein, U.S. Casualty’s insured, and another vehicle. At his deposition, Schlein testified that he had been playing cards at his club the day of the accident but had not had anything to drink, that he was traveling alone at the time of the accident, and that he was proceeding in an easterly direction on 16th Street when the claimants’ car ran a stop sign and stuck his vehicle. At their depositions, both claimants testified that the insured was proceeding west on 16th Street when, without prior warning, he made a complete U turn in an intersection and struck the claimants’ car. The claimants further testified that the insured had a passenger in the backseat of his car (a convertible). The claimants apparently did not suggest that Schlein had been drinking. *Id.* at 170.

A few days after Schlein testified, an attorney in the office of defense counsel received a call from Schlein’s personal attorney. The personal attorney related that Schlein had lied at his deposition. Specifically, Schlein had been drinking on the day of the accident, had in fact made a U turn in the intersection, and did in fact have his maid in the back seat of his convertible at the time of the accident. Defense counsel wrote to the insurance company and, without coming right out and saying that his client had perjured himself, related that Schlein was most likely completely

wrong about how the accident occurred. *Id.* at 170-72.

The insurance company ordered defense counsel to withdraw from the case, based on a breach of the cooperation clause. Thereafter Schlein, assisted by his personal attorney, consummated a settlement for the accident in the amount of \$10,000 (well within the policy limits). It was formally stipulated that the settlement was fair, reasonable and prudent. Schlein then sued the insurer, seeking the amount of the settlement, together with his attorney's fees. *Id.* at 172.

While both the district court and the court of appeals readily concluded that Schlein had in fact breached the cooperation clause, both courts held that the insurer had failed to show how it might have been prejudiced. Speaking to the breach itself, the court of appeals stated:

We can accept the proposition that the law generally, and presumably does so in Texas, regards purposeful falsification of material information by the insured to be a breach of the cooperation clause. . . . Truthfulness as an element of cooperation has been variously described. "Truthfulness seems to be the keystone of the cooperation arch." [Citation omitted.] "The [insurance] company is entitled . . . to an honest statement by the insured of the pertinent circumstances surrounding the accident, as he remembers them. Lacking that, the company is deprived of the opportunity to negotiate a settlement, or to defend upon the solid ground of fact. Nothing is more dangerous than a client who deliberately falsifies the facts." [Citation omitted.]

338 F.2d at 173. The Court further noted that caution must be taken so that misstatements based on faulty observation or mistaken recollection are not interpreted as purposeful, conscious breaches of the duty to cooperate. *Id.*

Despite the egregious behavior by its insured, the court of appeals upheld the district court's holding in favor of Schlein, because U.S. Casualty had not shown how it might have been prejudiced by Schlein's breach of the duty to cooperate. As the court noted, the insurer seemed content to rely on the general proposition that since Schlein had given false testimony in a formal pretrial deposition, his credibility would be subject to serious attack if the case were tried. There was, however, no indication that the case would in fact be tried. Given the true facts, the insurance company would undoubtedly have endeavored to settle the case, and as all agreed, Schlein himself, with the assistance of his personal attorney, had attained a fair, reasonable and prudent settlement. *Id.* at 174. "There is thus no indication whatsoever that [Schlein's breaches] put the insurer

in a predicament of being unable to work out that disposition of the case which its own intrinsic merits – then sufficiently known – reasonably dictated." *Id.* at 175.

Summary. The insured would seem to have a great deal of leeway in violating the cooperation clause before the third-party primary liability insurer may disclaim coverage. While the insured's acts or omissions may amount to a breach of the duty to cooperate as a matter of law, *Frazier v. Glens Falls*, the gravamen of the insurance company's case will almost never be the egregiousness of the insured's breach but rather whether the insurer was prejudiced thereby.

THE DEGREE OF PREJUDICE THE INSURER MUST SHOW.³

All liability policies impose certain duties upon the insured in the event of a potentially covered loss, claim or lawsuit. For many years, a debate raged over whether these duties served as absolute conditions precedent to coverage, the violation of which automatically destroyed coverage, or whether the insurer was required to show that it was prejudiced in order to disclaim coverage. As late as 1993, Texas courts took a scatter-shot approach to enforcement of these conditions, imposing a "prejudice" requirement as to some duties, but not others. In the "late notice" arena, for example, whether the insurer was required to show prejudice could depend on what type of policy was breached, or even what coverage part within the policy was breached.⁶

Since the Texas Supreme Court decided *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691 (Tex. 1994)(a "no settlement without consent" case, discussed further below), however, some courts and commentators have expressed the opinion that an insurer must now *always* show that it was prejudiced in order to raise a breach of *any* condition precedent as a defense to coverage. As might be expected, the burden is on the insurer to demonstrate how it was prejudiced by its insured's alleged breach of a condition. *Id.* at 692.

Compared to the confusion surrounding the duty to give prompt notice, there has never been much confusion on the basic question of whether an insurer must show prejudice in order to disclaim coverage based on a breach of the duty to cooperate. It has long been held that an insurer must show at least some prejudice to raise such a breach as a defense to coverage. *See, e.g.*, discussions of *Frazier*, *Griffin* and *Schlein supra*. For better or for worse, however, cases purporting to follow *Hernandez* may have introduced some confusion as to exactly what *degree* of prejudice – some, a good deal, a great deal – the insurer must show to deny coverage based on a failure to cooperate.

What *degree* of prejudice must the insurer show to escape liability on the policy due to the insured's lack of cooperation? Ignoring for a moment *Hernandez* and its (possibly incorrect) progeny, the answer appears to be "actual prejudice" – some prejudice, perhaps a material adverse change in position, but not necessarily a great deal of prejudice.

McGuire v. Commercial Union. In *McGuire v. Commercial Union Ins. Co. of New York*, 431 S.W.2d 347 (Tex. 1968), the supreme court used the term "actual prejudice" in describing the degree of prejudice the insurer must show in order to be discharged from its obligations following a breach of the cooperation clause. In this case, a two car collision led to the death of Commercial Union's insured, Charles Pryor. The driver of the other car, Billy Patton McGuire, was seriously injured. Pryor's widow, Karen, filed a wrongful death action against McGuire and his employer. McGuire filed a counterclaim against Pryor's estate, alleging that Pryor's negligence had led to McGuire's serious injuries. *Id.* at 349.

The insurance carrier for McGuire and his employer was willing to pay \$10,000 on behalf of McGuire and the employer in settlement of Pryor's wrongful death claim. Without any input from Commercial Union, it was determined that McGuire's insurer would pay \$10,000 to Pryor's widow, the counterclaim would be severed from the original lawsuit, and McGuire's personal injury lawsuit against the Pryor estate would continue. *Id.* at 349-50. The settlement entered into between the McGuires and Karen Pryor stated that:

... this compromise and settlement and the judgment entered in pursuance hereof shall in no way affect or prejudice such counter-claim or any other cause of action which may be asserted by any person by reason of the injuries sustained by Billy Pat McGuire in said collision, all such claims and causes of action being expressly protected and reserved.

It is further understood and agreed that this compromise settlement agreement, the fact of the settlement and the judgment entered in pursuance hereof shall never be used or admissible in evidence against any of the parties released hereby.

Commercial Union, Pryor's insurer, filed an answer to the McGuire counterclaim but reserved the right to refuse to further defend the suit or pay any judgment in favor of the McGuires. Commercial Union then filed its declaratory judgment action, and argued that Mrs. Pryor, by having entered into the agreed judgment in the wrongful death suit without the knowledge or consent of Commercial Union, released any claims she might have had under the policy. *Id.* at 350.

Because the wrongful death settlement could not be used in evidence against its insured in the subsequent personal injury lawsuit, the court ruled that Commercial Union had not been prejudiced and could not thereby interpose Pryor's settlement, admittedly entered into without the knowledge or consent of Commercial Union, as a defense. The court stated:

We recognize the rule that, because of the provisions of an insurance policy granting the insurer the right to defend suits and requiring the assured to cooperate with the company, the assured cannot make any agreement which would operate to impose liability upon his insurer or would deprive the insurer of the use of a valid defense. [Citations omitted.] However, this principle will not operate to discharge the insurer's obligations under the policy unless the insurance company is actually prejudiced or deprived of a valid defense by the actions of the insured. . . . [T]his is not the case here. Commercial Union has every defense that would be available to it had the wrongful death

action not been compromised or settled[.]

Id. at 352 (emphasis added).

Two later cases. The "degree of prejudice" question was more squarely addressed in two later cases, *Members Ins. Co. v. Branscum*, 803 S.W.2d 462 (Tex.App. – Dallas 1991, no writ) and *In Re Texas Eastern Transm. Corp. PCB Contamination Ins. Cov. Litig.*, 15 F.3d 1249 (3rd Cir. 1994), cert. denied 513 U.S. 915 (1994). Both cases are essentially late notice cases, however; although the courts address the duty to cooperate, either case could have been decided by reference to the duty to provide prompt notice without discussing cooperation.

In *Branscum*, an auto policy case, the court stated in dictum that the insurer would be required to show "actual" preju-

dice, but not “substantial” prejudice, to defeat the claim on the facts at hand. 803 S.W.2d at 467. In *In Re Texas Eastern*, one of many reported decisions arising out of a massive dispute between alleged CERCLA polluters and their insurers, the Philadelphia-based Third Circuit Court of Appeals made its *Erie* guess that under Texas law, prejudice results to the carrier when there is a “material change in the carrier’s bargaining position.” 15 F.3d at 1255. The insurers were prejudiced, the court concluded, by the alleged polluters’ late notice and lack of cooperation because, even though no final judgment had been entered against any of the alleged polluters, the insurers had lost out on the opportunity to engage in several rounds of preliminary negotiations between the government and the insureds.

Hernandez v. Gulf Group Lloyds. With this background in mind, the question may be raised whether *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691 (Tex. 1994) and its progeny have “raised the bar” for an insurer asserting a cooperation defense. *Hernandez* dealt with a “no settlement without consent” clause. The Court held that an auto insurer could not deny uninsured/underinsured motorist coverage when the family of a girl killed in an auto accident settled with the at-fault driver for his full policy limits without the consent of their own insurer. The family had clearly violated the “no settlement without consent” clause, but the driver had no other assets and the insurer could not show how it was prejudiced.

Stressing that insurance policies are contracts, and subject to the same rules applicable to contracts generally, the court stated:

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

* * *

... [T]here may be instances when an insured’s settlement without the insurer’s consent prevents the insurer from receiving the anticipated benefit from the insurance contract; specifically, the settlement may extinguish a valuable subrogation right. In other instances, however, the insurer may not be deprived of the contract’s expected benefit, because any extinguished subrogation right has no value. In the latter situation – where the insurer is not prejudiced by the settlement – the insured’s breach is not material.

875 S.W.2d at 692-93. In other words, the supreme court said, the insured’s **breach** of the condition precedent is **not material** unless the insurer is **actually prejudiced**.

Since *Hernandez* was decided, several courts and commentators have expressed the opinion that, given the supreme court’s contract-based analysis, its “material breach/actual prejudice” holding extends not just to the “settlement-without-consent” clause but to all conditions precedent to coverage. See, e.g., *Hanson Prod. Co. v. Americas Ins. Co.*, 108 F.3d 627, 630-01 (5th Cir. 1997)(late notice case).

In *Quorum Health Res., L.L.C. v. Maverick County Hosp. Dist.*, 308 F.3d 451, 468 (5th Cir. 2002)(discussed very briefly above as involving a dispute between the insurer and the insured over the proper conduct of the defense of a third-party lawsuit), the court determined that *Hernandez* furnished the degree of prejudice rule for breach of the duty to cooperate. The court also relied on other cases pre-dating *Hernandez*, including *State Farm Fire & Cas. Co. v. S.S.*, 858 S.W.2d 374, 385 (Tex. 1993), a late notice case which, like *Hernandez*, applied an “actual prejudice” standard. Unfortunately, in rather briefly articulating the *Hernandez* standard, the Fifth Circuit may have inadvertently changed the rule. Rather than stating the Texas rule as “the breach is not material unless the insurer is actually prejudiced,” the *Quorum Health Resources* Court stated:

...To breach its duty to cooperate, an insured’s conduct must **materially prejudice** the insurer’s ability to defense (sic) the lawsuit on the insured’s behalf... *Hernandez*, 875 S.W.2d at 692-93...

308 F.3d at 468 (emphasis added).

By flipping the modifier “material” from the nature of the insured’s breach to the degree of the insurer’s prejudice, the Fifth Circuit in *Quorum Health Resources* may have unwittingly imposed a greater obligation on a Texas insurer seeking to disavow coverage for a breach of the duty to cooperate than is required by the Texas Supreme Court. It is unclear whether the court’s mistaken recitation of the prejudice standard affected its eventual decision, because the court found that fact issues precluded the entry of summary judgment and remanded to the district court.

“Curing” the insured’s breach of the duty to cooperate.

Of course, when an insurance company successfully raises the breach of a condition as a defense to coverage, the real loser can be a meritorious third-party plaintiff. The fact that an innocent party may be denied a remedy accounts for much of the rationale behind requiring the insurer to show at least some prejudice occasioned by the breach. The courts also unanimously agree that forfeitures of insurance coverage are disfavored, and “[t]here is no reason to require a forfeiture of coverage merely upon a technicality.” *Bay Electric Supply, Inc. v. Travelers Lloyds Ins. Co.*, 61 F.Supp.2d 611, 620 (S.D. Tex. 1999).

In the 30 years or so since Texas first embraced the rule that (at least some) insurers must show prejudice in order to invoke late notice as a defense to coverage, the courts have struggled with the question of whether and to what extent a claimant may “cure” the insured’s failure to give timely notice by giving what might be called “substitute notice.” The rule that has evolved is that if the insurance company has received adequate and timely notice from the claimant, the insurer cannot claim that it was prejudiced as a result of the insured’s failure to give the necessary notice.

For cases discussing the claimant’s ability to “cure” the insured’s failure to give notice, *see, e.g., Ohio Cas. Group v. Risinger*, 960 S.W.2d 708 (Tex.App. – Tyler 1997, writ denied); *Allstate Ins. Co. v. Pare*, 688 S.W. 2d 680 (Tex. App. – Beaumont 1985, writ ref’d n.r.e.); *see also Struna v. Concord*, discussed below. For an example of how *not* to attempt to perform an “end run” on the insurance company following insufficient notice, *see Harwell v. State Farm Mut. Auto Ins. Co.*, 896 S.W.2d 170, 174 (Tex. 1995)(after insured driver died in auto accident, passenger’s attorney *had his own secretary appointed temporary administrator of estate*; secretary offered no defense, then sent suit papers to insurer the day after the deadline to perfect appeal); *see also Rodriguez v. Texas Farmers Ins. Co.*, 903 S.W.2d 499 (Tex.App. – Amarillo 1995, writ denied), a case of clear collusion between the insured and the claimant.⁷

An insured – and especially an unsophisticated insured – may be willing enough to alert his insurer to the fact that he has been in an accident and has been sued, yet be unwilling to cooperate in the defense of the lawsuit once an answer is filed on his behalf and discovery begins. If that failure involves not just a lack of diligence in answering discovery, reluctance to appear for depositions, etc. and extends to failing to attend trial, it is universally acknowledged that such a failure is a serious breach of the duty to cooperate. It is also quite likely to prejudice the insurer. As two different courts stated the matter:

Simple logic and common sense would indicate the difficulty one would have in imagining the case in which a defendant’s failure to appear for trial would *not* be prejudicial to his defense. . . . The defendant’s absence leaves him open to unrebuttable innuendos and characterizations by the plaintiff. . . .

Fireman’s Ins. Co. of Newark v. Cadillac Ins. Co., 679 S.W.2d 821, 823 (Ark.App. 1984).

Every person familiar with the trial of cases by jury knows that the case of an individual defendant is seriously, if not hopelessly, prejudiced by

his absence from the trial. . . . His failure to be present in defense of the claim can have an intangible effect upon the jury both as to the question of liability and the amount of the verdict, the net effect of which is difficult to measure.

H.Y. Akers & Sons, Inc. v. St. Louis Fire & Marine Ins. Co., 172 S.E.2d 355, 359 (Ga.App. 1969) (internal citations omitted).

In a few states, where an insured fails to appear for trial, the courts will hold that the insurance company is prejudiced *per se*. The majority rule, however, is that the insurer is not prejudiced *per se*, even by the insured’s absence from the trial. The courts are split, however, on questions such as the lengths to which the insurance company must go to attempt to secure its insured’s presence at the trial, which party has the burden to prove what the result would have been if the insured had, in fact, attended trial, etc. *See generally* COUCH, § 199.54.

Struna v. Concord Ins. Services. Can the hapless third-party claimant in Texas somehow “cure” the insured’s failure to cooperate in his defense, even to the point of failing to appear for trial? The answer appears to be a qualified “probably.” One case offering guidance on the question is *Struna v. Concord Ins. Services, Inc.*, 11 S.W.3d 355 (Tex.App. – Houston [1st Dist.], 2000, no pet.). This case, however, like so many cases discussing the duty to cooperate, deals as much or more with the duty to give prompt notice. The case also came to the court of appeals following a grant of summary judgment in favor of the insurer, so the court’s reversal of the grant does not say as much as an appeal following full trial would have said. Still, *Struna* at least suggests that the claimant *may* be able to assert a case for liability that allows the court to award policy proceeds notwithstanding the insured’s complete lack of cooperation with the defense.

Struna was the driver of a car struck by Guillory. Guillory was ticketed for running a red light. Concord was the insurance agent for Home State County Mutual, which insured Guillory. Guillory never reported the accident to Concord or to Home State and, when Struna later filed suit, Guillory never initiated any contact regarding the lawsuit. Attempts by Concord to reach Guillory met with no success. Struna and later her attorney, however, were quite diligent in keeping Concord and Home State informed of the accident and the lawsuit Struna eventually filed.

Struna gave immediate notice of the accident to Concord, and within a few weeks, Home State paid Struna some \$2,400 for property damage to her car and rental charges. Shortly before the statute of limitations ran, Struna sued Guillory, alleging personal injuries. Thereafter, the trial court author-

ized substitute service, substitute service was effected, and the trial court granted Struna's motion for default judgment and set a damages hearing. The trial court eventually entered a \$250,000 default judgment in favor of Struna. 11 S.W.3d at 356.

At all times during the pendency of the lawsuit, Struna's attorney kept Concord's claims manager informed of the lawsuit's progress. He contacted Concord's claims manager prior to and after filing the suit, two weeks before obtaining the default judgment, and again after obtaining the default judgment (but well in advance of the hearing on damages). He also forwarded pertinent papers to Concord, including medical records in anticipation of the damages hearing.

Following the entry of the default judgment, Struna filed suit against Concord and Home State seeking \$20,000 (the policy limits) and attorney's fees. Concord and Home State jointly moved for summary judgment, arguing that they could not be held liable because, *inter alia*, (1) the insured had failed to provide notice of the lawsuit; and (2) the insured had failed to cooperate in the investigation. *Id.* at 357. The trial court granted the insurer's motion for summary judgment without specifying the grounds upon which it relied. *Id.* at 358.

On appeal, the court rather easily determined that Concord and Home State had failed to meet their burden of showing prejudice by the lack of notice. There was uncontroverted evidence of their actual notice of both the accident and the lawsuit. *Id.* at 359-60.

With respect to the matter of cooperation, the court of appeals did not go so far as to say that the insurer had not been prejudiced. However, it reversed summary judgment in favor of the insurers and remanded the case to the trial court, finding that a material fact existed as to whether the insurer was in fact prejudiced. Stating that it would be the insurers' burden to prove prejudice caused by the breach of the duty, the court summarized the evidence in a way that would certainly suggest that the insurers would *not* be able to show the requisite prejudice:

Here, the police report shows that, in addition to Struna, there were two independent witnesses to the accident. The insured, Guillory, received a ticket for running the red light. The record does not show what information the insurers acquired from any independent investigation. The insurers may have determined from their investigation that their insured, Guillory, was the responsible party, a reasonable explanation for their decision to pay Struna, less than two months after the accident,

\$1,962.70 for property damage to Struna's car, and \$439.78 for rental car costs.

Id. at 360.

A comment on *Struna*. *Struna* shows that under the proper conditions, the third party claimant will be able to overcome the insured's lack of cooperation and assert her claim as a third-party beneficiary of the insurance policy. The *Struna* court also stated that, on remand, the burden would be on the insurer to show how it was prejudiced by its insured's failure to cooperate. This certainly suggests that in a future "no show for trial" case – one involving a full evidentiary trial, and not just a default trial – Texas will side with those states that hold that it is up to the insurer to show how the case would have been decided if its insured had, in fact, attended the trial.

At the same time, however, it must be recalled that the facts of *Struna* were "easy." The liability clearly seemed to rest with the insured, and the attorney for the third-party claimant was at all times aboveboard with the insurance company and gave the insurer every opportunity to provide what defense it could muster for its wayward insured. *Struna* may well state the rule that, where the liability facts are overwhelmingly against the insured, the fact that he or she does not take an active part in defending the case is of little consequence. Where the liability facts are closer, however, and the insured completely fails to cooperate, going so far as refusing to attend a full evidentiary trial, *Struna* does not seem persuasive enough on the question of whether (and on whose burden) the insurer will be required to pay a resulting judgment entered against the insured.

REMEDIES AVAILABLE TO THE INSURANCE COMPANY.

Ordinarily, the insurer's remedy for a material breach of the cooperation clause should be a denial of coverage for the particular claim. Can the insurer ask for additional remedies?

It is possible, though not likely, that an insured might dramatically fail to cooperate with its insurer with respect to one particular claim, yet offer complete cooperation in the defense of another claim. (The situation would probably arise for reasons that have much more to do with business or family relationships than insurance coverage.) The insurer faced with this unusual fact situation might have reason to deny coverage for the first claim, yet still be required to provide a thorough defense and, if need be, indemnity on the second claim. Such a claim-by-claim approach seems consistent with the implied duty to cooperate and the terms of the policy itself. The cooperation clause spells out specific and practical obligations of the insured in the event of a claim, loss or law-

suit, not overarching “life or death of the policy” duties.

In some cases, however, it is at least conceivable that rescission may be the appropriate remedy for breach of the duty of cooperation. Practitioners interested in such an approach may wish to consult *Costley v. State Farm Fire & Cas. Co.*, 894 S.W.2d 380 (Tex.App. – Amarillo 1994, writ denied). In that complicated case, involving a suit by a daughter-in-law against her father-in-law, with a third-party claim against the son/husband, the court ruled that rescission might indeed be an appropriate remedy.

A sword as well as a shield? Clearly the breach of the duty to cooperate can be used by the insurance company as a “shield” – as a defense to coverage. However, it apparently cannot be used as a “sword” to recover moneys the insurer would not have paid but for the insured’s breach of the duty. In *Philadelphia Ind. Ins. Co. v. Stebbins Five Companies, Ltd.*, 2002 WL 31875596 (N.D. Tex. 2002), the insurance company, after paying some \$200,000 to settle a lawsuit, sued its insured to recover that amount, alleging that as a result of the insured’s conduct, the originally assigned counsel was forced to withdraw from several lawsuits, and the insurer incurred excess costs in obtaining new counsel to defend the insureds. 2002 WL 31875596 at *5.

The insurer characterized the insured’s obligation to cooperate as a “promise” rather than a condition precedent, and one whose breach can in fact give rise to a cause of action. The insurer further contended that its action for breach of contract was analogous to an action to recover premium payments, and ample case law supported such a cause of action. The insureds, on the other hand, argued that the cooperation clause is a condition precedent to insurer coverage, but its breach cannot give an insurer an affirmative cause of action against the insured. *Id.* at *5-6.

Neither the parties nor the court could find any case law supporting a cause of action in favor of the insurance company for breach of the duty to cooperate. With the only applicable case law treating the cooperation clause as a condition precedent which served to relieve an insurer of liability, the court concluded that its breach could not create an affirmative cause of action.

CONCLUSION.

Insurance policies almost universally require the insured to cooperate with the insurance company following a loss, claim or lawsuit. Cooperation clauses benefit the insurer by obligating the insured to help the insurer avoid liability if possible or reduce damages where liability is found. “Lack of cooperation” is a broad term; it may include fraud or collusion,

but may also mean merely a refusal of the insured to do the things required by the policy. It is agreed by courts in Texas and around the nation that minor violations of the duty to cooperate, resulting in little or no prejudice to the insurer, should not result in a forfeiture of coverage. However, where the violation is material, and actually prejudices the insurer, forfeiture of coverage may result.

1. For example, the 1986 CGL occurrence-based ISO form provides as follows:

Duties in the Event of Occurrence, Claim or Suit.

* * * * *

You and any other involved insured must:

- (1) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with the claim or “suit”;
- (2) Authorize us to obtain records and other information;
- (3) Cooperate with us in the investigation, settlement or defense of the claim or “suit”; and
- (4) Assist us, upon our request, in the enforcement of any right against any person or organization which may be liable to the insured because of injury or damage to which the insurance may also apply.

Form CG 00 01 11 85, § IV(2)(c)(1)-(4).

The 1973 ISO CGL form provided as follows:

Insured’s Duties in the Event of Occurrence, Claim, or Suit.

* * * * *

The insured shall cooperate with the company and, upon the company’s request assist in making settlements, in the conduct of suits and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the insured because of injury or damage with respect to which insurance is afforded under this policy; and the insured shall attend hearing and trials and assist in securing and giving evidence and obtaining the attendance of witnesses. The insured shall not, except at his own expense, voluntarily make any payment, assume any obligation or incur any expense other than for first aid to others at the time of accident.

1973 ISO Comprehensive General Liability Policy Jacket.

The auto policy cooperation clause at issue in *Griffin v. Fid. & Cas. Co. of New York*, 273 F.2d 45 (5th Cir. 1960) read as follows:

Assistance and Cooperation of the Insured. . . . The insured shall cooperate with the company and, upon the company’s request, attend hearings and trial and assist in making settlements, securing and giving evidence, obtaining the attendance of witnesses and in the conduct of suits. The insured shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for such immediate medical and surgical relief to others as shall be imperative at the time of the accident.

273 F.3d at 46, fn 1.

2. The author is currently embroiled in a case which raises the issue of the insured's duty to cooperate with an excess insurer which has no duty to defend. It is at least possible that different rules may apply to such an insurer, as compared to a primary carrier with a duty to defend. Given the pendency of the case, the author does not wish to discuss his views on the scope of the insured's duty to cooperate with an excess insurer one way or the other.

3. *But see Burney v. Odyssey Re (London) Ltd.*, 2005 WL 81722 (N.D. Tex. Jan. 14, 2005)[not released for publication] (where insurer initially offered only qualified defense, then waived reservations and offered full defense, insured's failure to accept and cooperate with attorney appointed by insurer allowed insurer to avoid coverage). Somewhat outside of the scope of this article is the question of whether the duty to cooperate extends to providing the insurance company with information that might tend to defeat coverage. *See, e.g., Lafarge Corp. v. Hartford Cas. Ins. Co.*, 61 F.3d 389, 397 (5th Cir. 1995)(indicating that it probably does not).

4. The modern reader will note with interest that White's appointed defense counsel filed the declaratory judgment action on behalf of the insurance company. Obviously this case arose many years before *Employers Cas. Co. v. Tilley*, 496 S.W.2d 552 (Tex. 1973)(insured's defense counsel cannot assist the insurer in developing a defense to coverage). Neither the district court nor the court of appeals found anything unusual in White's insurer-appointed defense attorney also representing the insurance company in its declaratory judgment action against White.

5. The reader is asked to recall that in the third-party context, the author is limiting his observations on prejudice to the case of a primary insurer with a duty to defend. *See* fn. 2 above.

6. As is discussed below in the text, most courts believe that, pursuant to *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691 (Tex. 1994), an insurer must now show prejudice in order to successfully assert a breach of any condition. Until July 1, 2005, however, a debate raged over whether different rules might apply to different policies and different coverage parts where the duty to provide prompt notice is concerned. In *Hanson Prod. Co. v. Americas Ins. Co.*, 108 F.3d 627, 630-01 (5th Cir. 1997), the court held, seemingly without qualification, that *Hernandez* applied to the late notice defense. Later courts, however, did not always agree.

In *Gemmy Indus. Corp. v. Alliance Gen. Ins. Co.*, 190 F.Supp.2d 915 (N.D. Tex. 1998), *aff'd* (without opinion) 200 F.3d 816 (5th Cir. 1999), the court held that *Hanson* was distinguishable because it (*Hanson*) dealt with Coverage A of a CGL policy (bodily injury/property damage), while *Gemmy* was concerned with Coverage B (personal injury/advertising injury). Coverage A and Coverage B are distinguishable in the late notice context because Coverage A has long been governed by a Texas Department of Insurance regulation requiring an insurer to show prejudice before invoking a late notice defense, while Coverage B has not. Among other cases, both *Hanson* and *Members Ins. Co. v. Branscum*, 803 S.W. 2d 462, 467 (Tex. App. – Dallas 1991, no writ) give a history of the TDI regulation, which dates back to the early 1970s.

On July 15, 2005, the Fifth Circuit decided *Ridglea Estate Condominium Ass'n v. Lexington Ins. Co.*, — F.3d —, and rejected the piecemeal approach once and for all. The court held that *all* occurrence-based insurers must show that they were prejudiced in order to invoke a late notice defense. The court stated that its earlier decision in *Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co.*, 174 F.3d 653, 658-59 (5th Cir. 1999) had settled the question; an occurrence based-insurer must show prejudice to invoke the late notice defense; a claims-made insurer need not. The Court had no comment as to why *Gemmy* had been affirmed in the same year *Matador* was decided.

7. Claimants faced with this situation are wise to give not only prompt notice of the accident but prompt notice of the filing of the lawsuit as well. Merely notifying the insurance company that an accident has occurred will not be sufficient; notice of an accident is not notice of a lawsuit, and the insurer, having been alerted to an accident involving its insured, is not required to engage in sentry duty at the courthouse to discover whether the accident has in fact led to a lawsuit. *Branscum, supra*. Indeed, a mere "heads up" phone call to the adjuster or written notice of an intention to file a lawsuit will be inadequate. The claimant should make sure that the insurance company receives specific details of the lawsuit and a courtesy copy of the date-stamped petition after it has been filed, and should continue to notify the insurer when key events take place (service is returned, default judgment is requested, etc.). The conduct of the plaintiff's attorney in *Struna* (discussed below in the text) gives a good road map for the type of notification to the insurer that will overcome the insured's lack of notice.

2005 Legislative Update on Insurance

I. INTRODUCTION

The Texas Legislature has now completed its regularly scheduled 2005 Legislative Session, though the legislators have been called back for a special session dealing with school finance. During the regular session, the legislature passed several new statutes dealing with insurance, particularly including an overhaul of workers compensation and asbestos/silica reform, though also dealing with issues such as the receivership of insurers, insurance fraud and many other areas of property and casualty insurance.

This paper identifies and provides an overview of these new statutes dealing with property and casualty insurance. And, while this article is primarily a preview of these new laws, it will be months, and in some cases, years, before caselaw interpreting these statutes appear and the impact of this legislation is fully felt.

II. ANALYSIS OF NEW STATUTES REGARDING WORKERS COMPENSATION:

H.B. 7: Relating to continuation of the Worker's Compensation Commission:

This is the Worker's Compensation Reform bill and sunset legislation for the Texas Worker's Compensation Commission. The following is a summary of the bill:

- **Texas Workers' Compensation Commission is abolished** effective September 1, 2005.
- H.B. 7 creates an "agency within an agency" – a stand-alone **Division of Workers' Compensation within the Texas Department of Insurance ("TDI")**. The governor will appoint, with the advice and consent of the senate, a Commissioner for the division to serve a two year term, beginning September 1, 2005. The Division will exercise all authority in its purview, allowing for "advice and comment" by the Insurance Commissioner on rulemaking issues. The Division's Commissioner will be named by October 1, 2005, and transition of TWCC's functions to the Division will be complete by February 28, 2006.

- The newly created **Office of Injured Employee Counsel** (the "Public Counsel") is administratively attached to the TDI but independent of TDI and the workers' compensation division. The Public Counsel will be a governor-appointed lawyer with rule-making authority who will operate the agency which will include and supervise the ombudsman program. The Public Counsel will not represent individual workers, but will speak on behalf of a substantial number of workers within the system.

- Texas Department of Insurance will administer and draft rules for Health Care **Networks** (similar to Insurance Code Chapter 1305 networks). Networks will be certified by the Division. Carriers can establish or contract with networks to provide workers' compensation medical benefits. Workers injured before the Act or creation of the network must still treat within the network if their employer chooses to participate in a network. The bill contains "transition" provisions for such claims. Carriers are liable for out of network care for employees who live outside the service area.

• Network details:

- Employees who are in an **HMO** plan can treat with their **PCP** from that plan and the PCP will be considered "in-network."
- Employees with a "chronic, life-threatening injury or **chronic pain** related to a compensable injury" can apply to the network to use a nonprimary care specialist in the network as their treating doctor.
- "**Hold harmless**" clause included for claimants billed for violating provider selection rules.
- Network doctors cannot serve as Designated Doctor in-network claimant.
- 30 mile urban/60 mile rural **access standard** for treating doctors; 75 mile for specialists; networks can make arrangements with providers outside of area to obtain specialists not available in area.
- **Networks must include** "sufficient numbers and types of health care providers to ensure choice, access and quality of care" to employees; networks can designate specialties of providers who serve as treating doctors.
- **Termination of contracts** is covered by contract, not statute.
- Networks must have a **Quality Improvement Program**, including a Medical Director.

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- Carriers pay for **IRO** of in-network service; SOAH is eliminated from review process; challenge of an IRO decision is internal at network, then through judicial review process.
- The Division's research group will produce a **report card** comparing networks and in versus out of network care.

- **Medical Care details:**

- The Commission and networks must select "evidence-based, scientifically valid, and outcome focused" **treatment guidelines** and return to work guidelines. Treatment cannot be denied solely because it is not addressed in the guideline used.
- The Commissioner may also adopt **disability management** for appropriate out-of-network claims requiring a treatment plan. Parties would work together with the Division to agree on a treatment plan; appeal to an IRO.
- **Fee guidelines** follow current statute and only apply to out-of-network services; Division can adopt "one or more" conversion factors and payment can be made under/over the fee guidelines by contract in or out-of-network.
- **Prompt pay** rules apply to all network claims on a 45 day initial deadline; carrier can pay 85% and conduct audit within 160 days; violations are Class C/\$1000 max penalty; carriers can ask for refunds when appropriate.
- Carriers must notify in-network providers of any denial of **compensability** and can't deny services prior to notification; carrier can recover costs from any responsible party if care is later determined to be noncompensable (applies to in or out-of-network care); carrier's liability is limited to \$7000 if compensability is contested successfully; carriers can request medical exam by treating doctor to "define the compensability" of an injury; treating doctor would describe the compensable injury and carrier could require preauthorization for treatment of any other conditions; disputes are considered "extent of injury."
- Division will adopt rules listing services requiring **preauthorization** (which must include PT and OT services) for out-of-network care; care that is preauthorized cannot be retrospectively denied.
- The **Approved Doctor List** is abolished by September 1, 2007; out of network employees can use any willing provider but must name a treating doctor; requirements for IR training and testing and financial disclosure among treating physicians are maintained; doctors previously removed from the ADL cannot return after its elimination;
- Division must adopt a closed formulary; **pharmacies** are exempt from inclusion in networks.
- SOAH eliminated from **dispute resolution process** starting September 1, 2005; IROs are available for in and out-of-network medical necessity disputes; in-network disputes go to internal resolution first; IRO's are appealed to district court but binding on carrier during appeal on preauthorization disputes; IROs must contain specific elements, consider the adopted treatment guidelines, and must state a basis for ruling counter to them;

- Division must adopt rules regarding **peer review** doctors including Texas licensure requirement;
- Division must adopt **e-billing** rules by January 1, 2006; Division can adopt **e-payment** rules for carriers after December 1, 2008;

- **Average Weekly Wage** increased to 88% of TWC's AWW effective October 1, 2006; Division Commissioner can raise AWW to 100%; **retroactive period** shortened from 4 weeks to 2; strengthens "good faith effort" definition for SIBs claimants looking for work and requires Division to adopt rules setting compliance standards;

- Requires carriers to **pay injured worker's attorney fees** in case where worker prevails and carrier loses in District Court;

- Parties are limited to two **BRCs** prior to a CCH; clarifies BRCs meditative role and requires BRCs only after demonstration of effort by parties to resolve issues;

- **Appeals Panel** retained but limited to one three-member panel; Appeals panel will maintain a precedent manual and will only rule when reversing or remanding;

- **Designated Doctor** opinions can be used when requested by either party to resolve a dispute on any indemnity-related issue (including extent of injury, disability, and ability to return to work) requiring medical expertise; DD opinion has presumptive weight but can be overcome by a preponderance of the evidence; Division will determine DD credentials by rule; carrier must pay based on DD's opinion during appeal; DD can communicate with any treating provider; **REM** only available for out-of-network disputes on medical necessity;

- Adjudication of an injury as non-compensable does not waive exclusive remedy protection for employer;

- Classes of **administrative penalties** are eliminated; Division has authority similar to TDI's; specific schedule of penalties not required; oversight and compliance functions will be performance based; Division will designate high or low performers every 2 years minimum; allows for a fraud unit; requires reporting of fraud; prohibits misuse of Division name and/or logo;

- Division must produce info on benefits of **return to work**, target IBs claimants with return to work assistance, and require carriers to determine when to assign skilled case management on lost time claims; Division and DARS must work closely with workers in need of vocational rehab and report on results; establishes pilot program for small businesses who pay accommodations for injured workers to return to work;

- **Political subdivisions** must determine that use of networks is not available or practical before opting out; subdivisions

may use a group health benefit pool to provide medical care to workers; pool must have access to IRO and report stats;

- **HMOs and PPOs** can become certified as workers comp networks;
- Employee who tests **positive for drugs** on the job must overcome a rebuttable presumption that he was intoxicated and injury is not compensable;
- Non-subscribers cannot use **post-injury waivers** unless it is knowing and voluntary, signed at least 10 days after injury, and after worker has seen a non-emergency provider;
- **Premiums** cannot be excessive or inadequate; TDI must report on impact of H.B. 7 reforms on workers comp insurance market and premiums; TDI must hold a workers' comp **rate hearing** by December 1, 2008, and take action if rates are found to be excessive at that time; carriers must file underwriting guidelines with TDI;
- Carriers must designate a single point of contact for an injured employee;
- Division, TDI and OIEC will undergo Sunset review in 2009.

Timeline

09-01-2005 Effective date of Act; TWCC abolished; Medical Advisory Committee abolished; Division and OIEC established; termination of new cases with SOAH; AWW increases to \$540.00

10-01-2005 Deadline for Governor to appoint Commissioner of Division and Public Counsel; TDI to provide space and facilities to support OIEC; transition to begin

12-01-2005 Deadline for health care network rules; Deadline for TDI and Division to rule on transfer of programs to TDI

01-01-2006 Deadline for E-billing rules; TDI will accept 1305 network applications; Pilot program will take effect

02-01-2006 Deadline for Division must implement new RME and DD rules

02-28-2006 Deadline for completion of TWCC transfer to TDI

03-01-2006 Deadline to complete transfer of ombudsman program to OIEC; deadline for Public Counsel to adopt initial rules and rules relating to the transfer of programs to OIEC

03-31-2006 Deadline for Division to adopt new RME & DD rules

08-01-2006 Deadline for Division and DARS initial report on actions and improvements to vocational rehabilitation services

10-01-2006 SAWW becomes 88% of TWC calculation

10-01-2006 Deadline for Division to report on the implementation of the DD oversight.

12-01-2006 Deadline for TDI Commissioner to submit the initial report regarding network costs and quality of medical care

02-01-2007 Public Counsel and Division Commissioner term expires

09-01-2007 ADL expires (if not sooner)

01-01-2008 Division can draft rules for e-payment of medical bills

10-01-2008 Deadline for Division Commissioner to report on the Return to Work Pilot Program

12-01-2008 Deadline for initial report of research and evaluation group; deadline for TDI Commissioner to issue first report regarding workers comp rate hearing

09-01-2009 Small Employer Pilot Program ends TDI; TDI, Division, OIEC undergo sunset review

III. OTHER NEW INSURANCE LEGISLATION

H.B. 160: Relating to motor vehicles equipped with recording devices.

A manufacturer of a new motor vehicle must disclose if the vehicle is equipped with a recording device. Information recorded or transmitted may not be retrieved other than by court order, consent of the owner, for the purpose of improving motor vehicle safety if the identity of the owner or driver is not disclosed, or for facilitating emergency medical response in the event of an accident.

This bill is effective September 1, 2005.

H.B. 251: Relating to release of certain information regarding a workers' compensation claims.

This bill adds insurance carriers to the list of entities who can receive information about a workers' comp claim. It

applies to certified self-insureds and various forms of health insurers and applies even if the entity has no sub-claim on file. Carriers can obtain this information by filing a monthly written request with a list of names for which claim information is requested. A carrier must certify that each person is/was an insured. A carrier may also request "full claims data" consisting of an electronic download or tape in an electronic format of all information for all insured on list. A carrier must sign a written agreement to comply with Division's rules governing security applicable to the transfer of claim information and electronic data before submitting first request for information.

TWCC (now the Division) must promptly provide the following information in electronic, un-redacted form if available: full name, SSN, DOB, employer name, DOI, description of type of injury or body part affected including claimant's description of how incurred, treating doctor name, comp carrier's name, address, claim number, and adjuster, TWCC number;

Health insurers can file sub-claims based on information obtained; information received is subject to Labor Code confidentiality requirements;

The Division can charge a fee not to exceed \$.05 per claimant for the information.

Autopsy reports related to workers' comp claims must be released by the 15th business day after the request was received from an authorized person. If no report has been filed yet, the responding office must respond to the request within 10 business days of receipt and notify the requestor that the report has not been filed and when the requestor will receive the report to the best of their knowledge.

This bill is effective June 20, 2005.

H.B. 363: Relating to the declination of certain property and casualty insurance policies.

This bill applies only to declinations for fire, homeowners or farm and ranch owners policies. It prohibits an insurer from considering a "customer inquiry" in deciding whether to issue or decline to issue a policy. "Customer inquiry" is defined to include a call or other communication to an insurer with regard to the terms or coverages under a policy. It includes questions on the process for filing a claim that does not result in an investigation or claim.

This bill is effective September 1, 2005.

H.B. 480: Relating to the towing and storage of certain vehicles.

This bill applies to vehicles towed at the direction of a

law enforcement agency for purposes of examination or evidence and requires the government agency to pay the cost of towing and storage. It further describes when a government agency is not liable for towing and storage to include towing for illegal parking, vehicles involved in an accident, or vehicles recovered after being stolen. A storage facility may not refuse to allow the owner of a vehicle to take a car because a government agency has not paid fees for which it is responsible.

The bill applies only to procedures or storage facility on the seizure of a vehicle on or after the effective date of the act.

The act is effective September 1, 2005.

H.B. 654: Relating to professional liability insurance for volunteer health care providers.

Although insurers are not currently prevented by law from selling professional liability insurance to volunteer health care providers, the coverage needed by these volunteer health care providers is currently not available in sufficient amounts. This bill would clarify language in the Insurance Code that an insurer is authorized to provide professional liability insurance coverage for a volunteer health care provider.

This bill is effective May 27, 2005.

H.B. 655: Relating to certain volunteer health care providers.

Volunteer health care providers, although protected from liability under the Charitable Immunity and Liability Act, still need liability policies to cover defense costs. This bill would require the Joint Underwriting Association to make available medical liability coverage to volunteer health care providers covered under the Charitable Immunities Act. It requires the Texas Medical Liability Insurance Underwriting Association to make available medical liability insurance or appropriate health care liability insurance covering a volunteer health care provider for the legal liability of the person against any loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence in rendering or the failure to render professional service while acting in the course and scope of the person's duties as a volunteer health care provider as described by Chapter 84 (Charitable Immunity and Liability), Civil Practices and Remedies Code.

It also authorizes a self-insurance trust under Art. 21.49-4, Insurance Code, to offer professional liability insurance to volunteer health care providers rendering services in the course and scope of the person's volunteer duties.

This bill is effective May 30, 2005.

H.B. 698: Relating to the disposal of certain business records that contain personal identifying information.

This bill requires a business disposing of business records that contain personal identifying information of a customer to shred, erase or use other means to make personal identifying information unreadable or undecipherable. A business that does not properly dispose of a business record would be liable for a civil penalty up to \$500 for each record. A business would not be liable for the civil penalty if the record was reconstructed in whole or in part through extraordinary means. A business is considered to comply with the requirements of this act if it contracts with a person engaged in the business of disposing records. The disposal requirements do not apply to a financial institution defined by federal law or to a covered entity defined in the privacy law of Chapters 601 or 602 of the Insurance Code, which would include insurance companies and agents.

This bill is effective September 1, 2005.

H.B. 755: Relating to procedures relating to the doctrine of forum non conveniens in a civil cause of action.

This bill is an attempt to give the court more discretion in deciding whether to grant a motion to stay or dismiss a motion under the doctrine of forum non conveniens. It removes the prohibition that a case may not be dismissed on grounds of forum non conveniens if a party opposing the motion alleges and makes a prima facie showing that an act or omission that was a proximate or producing cause of the injury or death occurred in this state. Instead, the bill requires the court to consider the extent to which an injury or death resulted from acts or omissions that occurred in this state. Additionally, this bill removes permissive language, requiring the court to consider the following factors when determining whether to grant a motion to stay or dismiss an action under the doctrine of forum non conveniens: 1) whether an alternate forum exists in which the claim or action may be tried, 2) whether the alternate forum provides an adequate remedy, 3) whether maintenance of the claim or action in the courts of this state would work a substantial injustice to the moving party, 4) whether the alternate forum, as a result of the submission of the parties or otherwise, can exercise jurisdiction over all the defendants properly joined to the plaintiff's claim, 5) whether the balance of private interests of the parties and the public interest of the state predominate in favor of the claim or action being brought in an alternate forum, which shall include the consideration of the extent to which an injury or death resulted from acts or omissions that occurred in this state, and 6) whether the stay or dismissal would not result in unreasonable duplication or proliferation of litigation. The bill also requires the court that grants a motion under the doctrine of forum non conveniens to set forth specific findings of fact and conclusions of law.

This bill is effective September 1, 2005.

H.B. 941: Relating to restrictions on the use of claims history for certain water damage.

This bill amends Article 5.35-4, Insurance Code, to provide for the definition of an "appliance." This article now provides the full definition of an "appliance," and includes hoses directly attached to the device. Article 5.35-4 disallows the use of prior appliance related claims as a basis for determining the rate to be paid for that property or determining whether to issue, renew, or cancel an insurance policy if the prior appliance related claim was properly remediated and was inspected and certified by a person knowledgeable and experienced in remediation of water damage. An insurer can use the prior appliance related claim in determining rates if the insured or property had previously experienced three or more appliance related claims under a homeowner's insurance policy.

This bill is effective September 1, 2005, and applies to policies issued or renewed on or after January 1, 2006.

H.B. 1130: Requiring the adoption of a privacy policy by a person who requires the disclosure of a social security number.

H.B. 1130 adds Section 35.581 to the Business & Commerce Code to make a privacy policy necessary when a person requires disclosure of an individual's social security number to obtain goods or services or enter into a business transaction. The policy must be made available to the individual and the policy must provide for confidentiality and security of the social security number.

This bill does not apply to a person required to maintain a privacy policy under the Gramm-Leach-Bliley Act, the Family Educational Rights and Privacy Act, or the Health Insurance Portability and Accountability Act of 1996, which would include insurers and agents.

A person who violates this law is subject to a penalty not to exceed \$500 per month of violation and subject to a restraining order sought by the Texas Attorney General.

This bill is effective September 1, 2005.

H.B. 1137: Relating to the authority of the DPS to enter into agreements with foreign countries for issuance of driver's licenses.

This bill allows the DPS to enter into agreements with a foreign country where a person over 18 may receive a Class C driver's license. The foreign country and Texas must be parties to a reciprocity agreement on driver's licensing, and the

license laws must be similar to those in Texas as determined by the DPS. A person who is not a citizen must present documentation issued by the US authorizing that person to be in the US before a license may be issued.

This bill is effective June 18, 2005.

H.B. 1572: Relating to the recovery of certain costs and payments relating to losses covered by personal automobile insurance.

The bill applies only to personal automobile subrogation actions. If an insurer brings an action against a responsible third party and the third party is uninsured, the insurer may recover, in addition to payments made by the insurer, attorney fees and court costs.

This bill also provides an insurer that has paid a PIP claim with a right of subrogation and a claim against a person causing the loss if they do not have insurance as required by the financial responsibility laws.

This bill is effective September 1, 2005.

H.B. 1891: Relating to certain insurers subject to the Windstorm Insurance Association.

Under current law, farm mutuals and a county mutual that writes exclusively industrial fire insurance are exempt from TWIA. At the present time, there is only one county mutual in Texas that qualifies as an industrial fire county mutual. Industrial fire insurance includes coverage on dwellings and typically provides wind coverage. This bill provides that an "affiliated" industrial county mutual is subject to TWIA.

This bill is effective September 1, 2005.

H.B. 1893: Relating to authorizing a consumer credit reporting agency to provide certain information if needed to avoid a violation of federal law.

The 1994 Federal Crime Act (18 U.S.C. § 1033) makes it a federal crime for an individual who has been convicted of a criminal felony involving dishonesty or breach of trust to be engaged in the business of insurance. As a result, insurance companies must be certain that none of their officers, directors or agents have been convicted of such activity. Under Texas law, Section 20.05(a)(4), currently prohibits the consumer reporting agency from providing a consumer report that discloses and arrest, indictment or conviction of a crime that is more than 7 years old. This bill amends that provision to allow a consumer reporting agency to furnish to a person a consumer report that contains the information that is more than 7 years old

if it is needed by the person to avoid a violation of federal law.

This act is effective September 1, 2005.

H.B. 2017: Relating to non-substantive revision of the statutes relating to the Department of Insurance.

This bill is the fourth installment of the re-codification of the Insurance Code. This reorganization is an ongoing project of the Texas Legislative Council. The purpose of the law is to recodify the laws but make no substantive changes in the law. The following new statutes are involved in this bill:

1. New Title IV. Regulation of insolvency, including general provisions reserves, investments, delinquent insurers, guaranty associations, requirements of other jurisdictions and reinsurance.
2. New Title X. Property Casualty provisions, including provisions for liability insurance for physician, automobile insurance, fire insurance and allied lines, residential property insurance, coverage for aircraft, self insurance, rate making in general, policy forms in general.
3. New Title XII. Other types of coverage such as credit, involuntary unemployment, mortgage guaranty insurance, surety bonds and related instruments.
4. New Title XIV. Utilization review and independent review organizations.

This act will be effective April 1, 2007.

H.B. 2157: Relating to the receivership of insurers.

This bill adopts the draft NAIC Insurer Receivership Model Act. The purpose of this bill is to clarify the law and promote cooperation in multi-state receiverships. This bill also give the commissioner additional authority to act sooner and take control of a failed insurer. This bill repeals the current statute, Article 21.28, Insurance Code, relating to the liquidation, rehabilitation, reorganization of insurers.

The bill also amends the Property Casualty Guaranty Act in a number of respects. First, it makes it clear that transactions involving captive insurers or policies (other than workers' compensation) in which deductible or self-insurer retention is substantially equal to the amount of liability are not covered by the guaranty act.

It also makes it clear that a covered claim shall not include any amount that is directly or indirectly due any reinsurer, insurer or self-insurer, etc.

The bill clarifies that the Guaranty Association may bring an action against a TPA attorney or a representative of an insurer that has a receiver to obtain custody and control of information related to the insurer that it is necessary for the association to carry out its duties. The association is entitled to an award of attorney's fees to obtain information.

The bill clarifies the venue either by or against the Guaranty Association must be in Travis County.

The bill clarifies that the net worth exclusion from coverage under the act for large employers or large groups with a net worth of more \$50 million. Workers' compensation claims would be handled by the Guaranty Fund and would recover workers' compensation claims paid from a corporation with a net worth of \$50 million. The Guaranty Fund would not handle any claims other than workers' compensation for such large employers. The association is given authority to establish procedures for requesting and obtaining financial information from an insured or a claimant on a confidential basis for the purpose of applying the net worth provisions in the law. The bill also clarifies that an insured or claimant bears the burden of proof concerning its net worth at the relevant time.

The act is effective September 1, 2005.

H.B. 2388: Relating to insurance fraud reporting requirements.

This bill amends Section 701.051 of the Insurance Code to require a person who determines or reasonably suspects that insurance fraud has been or is about to be committed to submit a report to TDI within 30 days of the determination or suspicion of fraud. The report must be submitted to the TDI's Fraud Unit in the format prescribed by National Association of Insurance Commissioners (NAIC) or TDI. A report to TDI constitutes notice to other appropriate authorized governmental agencies. A person may comply with this law but authorizing an organization which investigates and prosecutes insurance fraud on their behalf to report suspected fraud to TDI, but retains liability for the organization's failure to report. Insurance fraud or suspicion of fraud may be reported to the TDI anonymously by an individual.

The bill also eliminates the requirement that an insurer conducting an investigation of insurance fraud complete the investigation in order to request an investigation by TDI or law enforcement. An insurer conducting an investigation of suspected insurance fraud is required to report the findings on conclusion of the investigation.

Section 701.052(f), Insurance Code, is repealed. This section required insurers to exercise "reasonable care" when reporting fraud.

The effective date is September 1, 2005.

H.B. 2437: Relating to nonstandard personal automobile insurers.

Under S.B. 14 as enacted in 2003, certain insurers, as determined by rule, which had served high-risk, nonstandard business, were allowed to have lesser filing requirements for rate filings under Art. 5.13-2, Insurance Code. This bill provides that an insurer is subject to the lesser filing requirements if the insurer and its affiliates meets the following requirements: (1). issued policies only below 101% of the minimum financial responsibility limits and (2). The insurer and all affiliates had a market share of less than 3.5% of the personal automobile insurance market.

This bill is effective June 18, 2005.

H.B. 2565: Relating to prohibiting rebates regarding certain insurance coverage.

Article 5.20, Insurance Code, prohibits rebates in the sale of motor vehicle insurance. This bill requires county mutuals and farm mutuals to be subject to the anti-rebating laws. This bill also changes references in sections that were recodified to make Lloyds, reciprocals, county mutuals and farm mutuals subject to certain recodified provisions of the Insurance Code.

Finally, this bill amends Chapter 2502, Insurance Code, to provide that certain promotion and advertising activities by title agents and title insurers is not a rebate.

This bill is effective September 1, 2005.

H.B. 2613: Relating to the adoption of the Interstate Insurance Product Regulation.

This bill adopts the NAIC Model Law concerning an interstate insurance product regulation compact. The compact is a model representing an agreement among member states to create and implement a streamline system of insurance product regulation through the employment of national uniform product standards. The compact creates a multi-state commission to receive, review and make decisions on product filings according to national uniform standards thereby reducing the number of variations of the same product the company must product. This bill is intended to provide a more efficient review and approval process for four specific product lines: life insurance, annuities, disability income and long-term care insurance. A management committee of 14 members is to oversee the day-to-day activities of the compact. H.B. 2613 permits Texas to serve as a member of the management committee and permits Texas to participate in other states to create and refine uniform product standards. This will be done through the rulemaking process.

Once 26 states, or states representing 40% of the premium volume for designated products have adopted the compact, then Texas would have a right to participate in other states. The commissioner of insurance is given broad authority, not only in the establishment of uniform standards for life insurance and other products, but also in the receipt and review of product filings and in evaluating whether adopted product standards have been adhered to in particular compact states.

This bill is effective September 1, 2005.

H.B. 2614: Relating to the applicability of certain insurance laws to Lloyds and Reciproals

This bill subjects Lloyds and reciprocals to requests for information from the TDI under Section 38.001, Insurance Code.

It also amends Section 551.004 to provide that a transfer of a policyholder between admitted companies with the same insurance group is not considered a refusal to renew. This section also applies for purposes of obtaining written declinations under the PIP and UM statutes in Articles 5.06-1 and 5.06-3, Insurance Code.

This bill is effective September 1, 2005.

H.B. 2678: Relating to underwriting and ratemaking for professional liability insurance physicians and health care providers.

This bill contains three amendments to Article 5.15-1 dealing with professional liability insurance for physicians.

First, H.B. 2678 prohibits an insurer selling healthcare professional liability insurance from considering whether, or to the extent to which, a physician or healthcare provider provides services to Medicaid or CHIP recipients when making a decision regarding denial or cancellation of coverage or in rating.

Second, the bill amends the rate standards for determining whether rates are excessive. Under current law, in order to deem a rate for professional liability insurance for physicians and health care providers excessive, the Texas Department of Insurance (TDI) must prove that the rate is unreasonable for the insurance coverage provided and that a reasonable degree of competition does not exist. This bill deletes the requirement for competition in determining whether rates are excessive.

Third, the bill adds new Section 13 to Article 5.15-1, restricting underwriting for certain lawsuits and requiring refunds. H.B. 2678 prohibits an insurer from using a lawsuit filed against a physician or health care provider to set premiums or eliminate a claims free discount if the lawsuit was dismissed by the claimant or non-suited and no payment was

made to the claimant. The bill requires either a refund or reinstatement of a claims free discount. This section does not prohibit an insurer from using aggregate historical loss and expense experience in setting rates, however, an insurer may not assign a physician a particular classification based on lawsuits that have been dismissed.

The bill is effective September 1, 2005.

H.B. 2761: Relating to the amount of homeowners insurance required in connection with certain financing arrangements.

The 78th Legislature, Regular Session, 2003 enacted H.B. 1338, which prohibited a lender from requiring an amount of insurance greater than the replacement value of the dwelling. This prohibition is currently being recodified into the Insurance Code, Section 549.0551. However, Section 549.056(a) and (d) of the Insurance Code provides that a lender may require evidence that insurance has been obtained in an amount sufficient to cover the amount of the debt or loan. This creates a potential conflict between these two sections. This bill would clarify this conflict by allowing lenders to require evidence of insurance in an amount necessary to cover the debt or loan, except where the requirement would be a condition of financing a mortgage or any other financing arrangement for residential property. This statute re-enforces the Legislature's original intent that the lender not require insurance in an amount greater than the replacement value of the dwelling.

This bill is effective May 17, 2005.

H.B. 2870: Relating to the regulation of rates and forms used to write guaranty bonds.

Under current law, Article 5.13, Insurance Code, states that Subchapter B, Chapter 5 applies to the writing of fidelity, surety and guaranty bonds. When Article 5.13-2 was amended regarding the regulation of rates and forms for bonds, guaranty bonds were omitted.

H.B. 2870 adds guaranty bonds to the lines of insurance subject to Article 5.13-2, Insurance Code.

The effective date is September 1, 2005.

H.B. 2872: Relating to the applicability of certain insurance laws to multi-peril insurance policies.

This bill repeals Article 5.81, Insurance Code, which provided the commissioner of insurance with the authority to regulate multi-peril policies of insurance under any of the subchapters of Chapter 5, Insurance Code. It would amend Article 5.13-2, Insurance Code, to include multi-peril insurance

as a line of insurance subject to regulation under that article.

This bill is effective September 1, 2005.

H.B. 2941: Relating to the compensation of insurance agents.

This bill arose out of the Spitzer investigation of broker compensation in New York. The bill is largely the NCOIL Model Law.

This bill requires written or electronic acknowledgement, before a purchase of an insurance product, that an agent is to receive compensation both from the customer and from an insurer or third party, unless the compensation from the customer is for reimbursement of expenses under Section 4005.003, Insurance Code, an inspection fee under Section 550.001, Insurance Code, or an application fee.

The disclosure must include a description of the method and factors used to compute the compensation the agent will receive from the insurer or other third party for placement of the policy.

The new law applies to almost all types of agents, whether property and casualty, or life, health and accident, but it does not apply to adjusters, third party administrators, reinsurance intermediaries, risk managers, or agents holding specialty licenses. The provisions of this new law also do not apply to (1) an agent that acts only as an intermediary between an insurer and the customer's agent, including an MGA; (2) a reinsurance intermediary or surplus lines agent placing surplus lines insurance or reinsurance; or (3) an agent whose sole compensation for placing or servicing of an insurance product is derived from remuneration paid by the insurer.

This bill does not abolish contingency payments nor does it specifically require disclosure of the exact amount of the compensation. The TDI will likely issue regulations dealing with what it believes should be disclosed.

This bill is effective September 1, 2005.

H.B. 2965: Relating to insurance premium finance agreements.

H.B. 2965 amends Chapter 651, Insurance Code, which regulates licensing and transactions involving premium finance agreements. This bill clarifies several items and puts limitations and restrictions on agents and premium finance companies.

An express exception has been added in Subchapter B, Section 651.051, which requires licenses in order to do business as premium finance company. H.B. 2965 provides that

Subchapter B does not apply to a person or entity who purchases or acquires a premium finance agreement from a premium finance company if the premium finance company: (1) retains the right to service the agreement and to collect payments due under the agreement, and (2) remains responsible for servicing the agreement in compliance with the statute.

H.B. 2965 places limitations or inducements on sharing of profits and fees. It is made to apply to servicers of premium finance companies. No person described in the law may directly or indirectly pay, allow, give or offer to pay, allow or give in any manner to an insurance agent or employee of an agent any consideration, compensation or inducement for soliciting, accepting an application for, or delivering or administering premium finance agreements and they may not pay, allow or offer an agent or an employee of an agent to share the profits or any portion of the profits is determined, in whole or in part, by the amount of premium dollars financed or premium finance agreements placed. A premium finance company may not pay or allow to any insurance agent or employee any portion of fees, including late fees, which are related to the premium finance agreement.

An insurance agent or employee may receive an article of merchandise having a value of \$10 or less on which there is an advertisement of the premium finance company.

One exception to these limitations is that an insurance agent may be the sole owner or sole shareholder of an insurance premium finance company and receive profits and fees of that company if an agent discloses in writing the agent's interests in the finance company to an insured placed by the agent with that premium finance company.

Another exception to the limitations on the sharing of fees and profits is that the restrictions above do not apply to a person or entity related to financing of premiums for commercial lines of insurance if: (i) the agent discloses in writing the source of any compensation to be received by the agent from the insured entering into an agreement; (ii) if the amount of compensation received by the agent exceeds 2% of the premium financed, the agent must provide in writing to the insured the amount of compensation to be received by the agent as a percentage of the premium financed and the amount of compensation is based only on the amount of premiums financed and is not paid as an advance on future premium finance agreements or not paid as a form of bonus to an agent for placing of future business with the premium finance company.

This bill is effective June 17, 2005.

H.B. 3048: Relating to insurance coverage for certain structures located over water.

This bill requires TWIA and the FAIR Plan to provide coverage to a structure located wholly or partially over water including the corporeal movable property contained therein.

The bill also permits farm mutuals and county mutuals to include coverage for buildings or other structures built over water.

This bill is effective September 1, 2005.

H.B. 3300: Relating to certain coverages under an automobile insurance policy.

This bill amends Section 551.106, Insurance Code, to allow an insurer to reinstate a personal auto policy that has been cancelled for nonpayment of premium. Reinstatement is permitted if the premium is paid not later than 60 days after the date of cancellation. Coverage lapses when cancelled and is not effective again until the premium is received by the insurer.

The bill also amends the PIP and UM statutes, Articles 5.06-1 and 5.06-3, Insurance Code, to provide that coverage previously rejected does not need to be provided in a reinstated policy unless such coverage is requested by the insured in writing.

This bill is effective June 18, 2005.

H.B. 3376: Relating to criminal offenses involving theft and fraud.

This bill amends the offenses of money laundering and insurance fraud to streamline the investigation and prosecution of those offenses.

Punishments for those offenses are standardized to make them consistent with the rest of the Penal Code's value ladder (this lowers the penalties compared to current law), and adds them to Engaging in Organized Criminal Activity (which returns the offense level to current law, but only if 3 or more defendants commit the offense together). Aggregation of amounts is allowed so they can be handled in a single prosecution.

The statute of limitations is increased for felony insurance fraud to match the federal period.

Effective date is September 1, 2005.

S.B. 14: Relating to disapproval by the commissioner of insurance of certain property and casualty insurance rates.

Refunds with Interest

In 2003, the Texas Legislature added art. 5.144 to allow

the Commissioner to order refunds for excessive or unfairly discriminatory premiums for personal auto and residential property insurance. Among other things, this year's S.B. 14 allows the Commissioner to also order a refund of premiums plus interest. Interest for any refund ordered is the lesser of 18% or the sum of 6% and the prime rate for the calendar year in which the order is issued. Interest is calculated beginning from the date the notice is provided to the insurer from the TDI that the insurer is allegedly charging an excessive or unfairly discriminatory rate.

An insurer may not claim a premium tax credit unless it is in compliance with the refund provisions of this article.

Rating Territories

In 2003, S.B. 14 enacted new art. 5.171 that prohibited the use of rating territories that sub-divided a county unless the rate for any subdivisions within the county were not greater than 15% higher than the rate in other subdivisions. An exception allows the Commissioner by rule to allow greater rate differences for residential property or personal automobile.

This year's S.B. 14 applies the statute to an insurer writing residential property or personal auto. The Commissioner still has the authority by rule to approve greater differences. This year's version seems to restrict the restrictions on rating territories to only residential property and personal automobile insurance.

Market Conduct Surveillance

S.B. 14 adds new Chapter 751 dealing with the regulation of insurer market conduct surveillance and is based on the NCOIL Model Law. This chapter describes how TDI must perform its market conduct oversight. Market conduct examinations must be focused on general business practices rather than on individual consumer complaints or infrequent or unintentional random errors that do not cause significant consumer harm. The bill also encourages the TDI to consider other actions such as correspondence with the insurer, interviews, and interrogatories before proceeding with a targeted examination, and also to perform desk examinations rather than on-site examinations. The TDI is given authority to contract with outside personnel to perform activities, including examinations and market conduct surveillance. Coordination with other states is required and qualified immunity is provided for providing information in the course of an examination in good faith and without fraudulent intent or intent to deceive.

The examination reports and the information provided in connection with the examination are confidential. The Commissioner may disclose the contents of a final market conduct examination report to another insurance department or federal agency if the department or agency agrees in writing to

maintain the information as confidential. The Commissioner must disclose to the insurer the fact that the examination has been released to another department or agency within five (5) days after the release of the information.

The Commissioner is required to collect and report market data to the NAIC and also to coordinate the department's market analysis and examinations with other states through the NAIC.

The Commissioner is required, at least annually, to provide information to insureds and agents regarding new laws, rules, enforcement actions and other information relevant to ensure compliance with market conduct requirements.

The Commissioner is given the responsibility for conducting market conduct examinations on domestic insurers. The Commissioner does have the authority to delegate responsibility for market conduct examination to the insurance commissioner of another state and the Texas Commissioner is required to accept a report prepared by an insurance commissioner to whom the responsibility has been delegated. Insurers that are members of a holding company system may be subject to an examination in Texas, but the examination of insurers that are not Texas domestics requires the consent of the insurance commissioners of the states in which the affiliates are organized.

The bill authorizes the Commissioner to impose sanctions for violations detected through a market conduct examination and oversight. However, the bill requires the Commissioner to consider whether an insurer is a member and complies with the standards of a best practice organization, as well as the extent to which the insurer maintains an internal self-assessment compliance program.

The bill sets forth guidelines for conducting an examination and requires the department to prepare a work plan that includes a statement of the reasons for the examination, the scope of the examination, an estimate of the time for the examination, and a budget for the examination if the cost is to be billed to the insurer. A target examination is to be conducted in accordance with the Market Conduct Uniform Examination Procedures and the Market Conduct Examiners Handbook adopted by the National Association of Insurance Commissioners. The Commissioner is required to give insurers notice not later than sixty (60) days before the scheduled date of an examination. Pre-examination conferences are to be held not later than thirty (30) days before the scheduled date of an examination. A final examination report must include an insurer's response to the report. The Commissioner may not conduct a market conduct examination more frequently than once every three (3) years.

An insurer may not be compelled to disclose a self-audit document or waive any statutory or common law privilege.

This law becomes effective September 1, 2005.

Residential Property: Claims Free Discounts & Surcharges

S.B. 14 amends art. 5.43, Insurance Code that was enacted in 2003. This statute permits an insurer to offer discounts for a residential policyholder that has been claim free for at least three years. This year, S.B. 14 amended art. 5.43 to provide that a claim does not include a claim that results from a loss caused by natural causes, that is filed but is not paid or payable under the policy, or that an insurer is prohibited from using under art. 5.35-4. Article 5.35-4 deals with certain water damage and appliance-related claims that have been remediated. Article 5.43 has been amended to include a tier classification or discount program that has premium consequences based in whole or in part on claims experience.

Changes in the discount must also comply with Section 551.107, which was also amended. This section deals with non-renewal and cancellations of personal auto, homeowners and farm and ranch owner's policies. This section currently permits an insurer to surcharge a policy if an insured has filed two or more claims in the preceding year. A claim under Section 551.107 does not include a loss caused by natural causes or a claim that is filed but is not paid or payable under the policy.

S.B. 14 now excludes water damage from an appliance claim that has been remediated under art. 5.35-4. Section 551.107 has also been amended to now allow a premium surcharge if an insured has filed one more claims in the preceding three (3) years. The requirement for the language of the notice to an insured that he may be non-renewed for further claims has been amended to require disclosure of those items that cannot be considered.

Finally, the phrase "premium surcharge" has been redefined to mean an additional amount that is added to the base rate. The term does not include the reduction of or elimination of a discount previously received by an insured or the reassignment from one rated tier to another or a re-rating of insureds or re-underwriting of an insured using multiple affiliates.

This bill is effective September 1, 2005.

S.B. 265: Relating to certain continuing education requirements for insurance agents.

Chapter 4004, Insurance Code, relates to continuing education requirements for agents. An individual holding a general lines license must complete 15 hours of continuing education annually, at least 50% of which must be completed in a classroom setting or classroom equivalent setting approved by the TDI. Limited lines holders must complete 5 hours of CE

annually. License holders must also complete 2 hours of continuing education in ethics during each license renewal period.

S.B. 265 authorizes the Commissioner, by rule, to grant not more than four hours of continuing education credit to an agent who is an active member of a state or national insurance association. The rule would specify the types of associations and establish reasonable requirements for active participation in the association. Continuing education credit under this new law would not be available where classroom hours or ethics are required. Agents would be required to file a sworn affirmation on the number of education hours claimed. The agent has must also certify that the agent has either reviewed education materials provided by the association or attended educational presentations sponsored by the association.

This bill is effective September 1, 2005.

S.B. 742: Relating to disqualification for eligibility for WC benefits for certain professional athletes.

Senate Bill No. 742 adds the Central Hockey League to the workers' compensation insurance coverage provisions defining "professional athlete" in Section 406.095, Labor Code, which would prevent the city of San Angelo from being held liable for uninsured hockey players in that league. Current law includes two other professional hockey leagues but omits the Central Hockey League.

This bill is effective September 1, 2005.

S.B. 781: Relating to the Business of Unauthorized Insurance.

This bill amends Chapter 101, Insurance Code, by changing the required culpable mental state for commission of an offense of conducting the business of unauthorized insurance to reckless, knowing or intentional from knowing or intentional.

This bill is effective June 17, 2005.

S.B. 1283: Relating to the application of certain laws to certain insurance holding company systems.

Under Section 823.015(a) of the Holding Company Act, Chapter 823, Insurance Code, the holding company act did not

apply to an insurer group if each affiliate was owned by not more than five security holders each of whom was an individual. S.B. 1283 repealed that provision so that all domestic insurers would be subject to the Holding Company Act.

This bill is effective September 1, 2005.

S.B. 1591: Relating to accountant practice requirements for certain audits of insurer financial reports.

S.B. 1591 gives the Texas Department of Insurance (TDI) greater ability to rely on certified public accountant (CPA) audits of insurers by amending the Insurance Code to require CPAs to consider the procedures illustrated in the National Association of Insurance Commissioners Examiner's Handbook while performing insurer audits.

S.B. 1591 amends Section 12(c), Article 1.15A, Insurance Code, to prohibit the commissioner from accepting an audited financial report prepared in whole or in part by an individual or firm who the commissioner finds has directly or indirectly entered into an agreement of indemnity or release of liability regarding an audit of an insurer.

This bill is effective September 1, 2005.

S.B. 1592: Relating to special deposits required of certain insurers.

The Texas Department of Insurance (TDI) believes that the current law regarding voluntary deposits under Article 1.10, Section 17, of the Insurance Code should be clarified to specify that the commissioner may require and hold special deposits to address case specific instances of an insurer's potentially hazardous financial condition.

This bill adds new Article 1.33 which gives the Commissioner broad authority to require special deposits. A deposit under this section is in addition to any other deposit required by law.

This bill is effective September 1, 2005.

Comments

FROM THE EDITOR

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

I have been told repeatedly over the past two years by lawyers and Bar leaders that the *Journal of Texas Insurance Law* is the best publication from any Section of the State Bar of Texas. I am not objective enough to make any such evaluation nor am I the type of person that would make any such claim, but the compliments are very nice to receive. We strive to provide insightful articles that can be used by the members of our Section to help them better understand the rapidly changing perimeters of Texas Insurance Law. Our publication, however, is only as good as the articles we receive. If you have an interest in publishing anything, please call or e-mail me. We have several openings in our upcoming editions and would love to give you an opportunity to publish.

I also want to use this opportunity to welcome the newest Chair of our Section, Veronica Czuchna. Veronica has been one of the hardest working members of the Section since its inception. Veronica made very significant strides in cleaning up and reconciling the Section's balance sheet when she took over the treasurer's position several years ago. She sacrificed countless hours to get a complete handle on the financial situation of the Section and she helped establish a framework through which we have been able to maintain the progress that she brought to the Section. I know from personal experience that she is a very talented insurance lawyer and we are very fortunate to have her at the helm of our Section for the next year. In addition to an exceptional mind, an amazing work ethic, and a tireless commitment to the Section, Veronica is one of the nicest people you will ever meet. If you have an interest in becoming more involved in the Section, or if there is anything you would like to see done to improve the Section, please let Veronica know. Her contact information is on the front inside cover page.

Christopher W. Martin,
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