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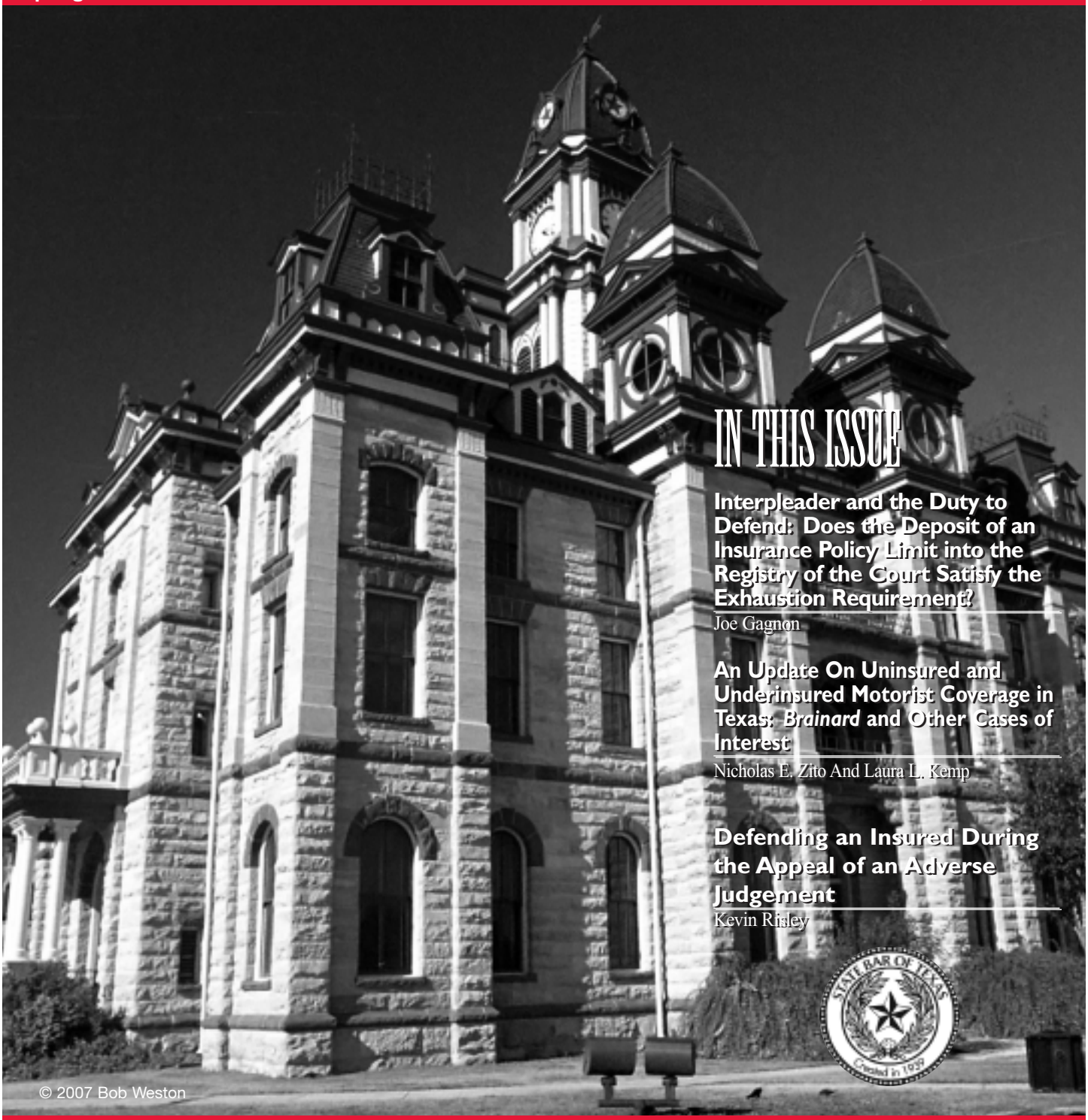

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Official publication of the Insurance Law Section of the State Bar of Texas

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Journal of Texas Insurance Law

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

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

Cover: Caldwell Countty Courthouse. This beautiful Courthouse was built in 1894 and is located in Lockhart, Texas. It is an example of Second Empire Architecture. The Muldoon Blue Sandstone is from Fayette County. Photo by Bob Weston.

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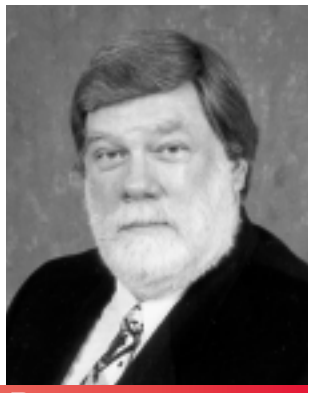

Comments FROM THE CHAIR

BY RUSSELL H. McMAINS
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The Section membership continues to grow and the Section is evolving to meet the challenges of this continuing growth.

To facilitate the spread of information on Texas developments in insurance law, the structure of the Section's publication has been formally changed to incorporate the assistance of three associate editors to work under the leadership of Chris Martin as editor-in-chief. The three associate editors of the Journal are Ernest Martin, Pat Wielinski and Kim Steele. Kim has been working with Chris for some time and her efforts will now be formally recognized. It is hoped that diversity of viewpoints will be enhanced by these changes.

Also to better inform and encourage participation by the membership, our annual business meeting was held this year at the Spring CLE meeting on Advanced Insurance Law in Dallas, Texas on March 29, 2007. In June, there will be a reception at the State Bar Annual Meeting that will be held jointly with the Construction Law Section and another CLE program presented by the Section at the Bar Convention. New proposed insurance council members will be elected at the annual business meeting in March, but officers will continue to be elected by the Council at the State Bar Annual Meeting in June and announced at the CLE program there.

There are, as yet, no new earth-shattering decisions from the Texas Supreme Court despite several such potential cases having pended for a considerable time. These include *Franks Casing Crew*, *Lamar Homes* and the *Captive Counsel* case. Rest assured that the Section will immediately respond with a telephone seminar or webcast when any significant case is decided.

Russell H. McMains
Chair, Insurance Law Section

JOE GAGNON
RAMSEY & MURRAY, P.C.

Interpleader and the Duty to Defend: Does the Deposit of an Insurance Policy Limit into the Registry of the Court Satisfy the Exhaustion Requirement?

No Texas case has held whether an insurance company's filing of an interpleader and deposit of its policy limit into the registry of the court fully satisfies and extinguishes its duty to defend. Prior Texas cases that address related issues suggest such an action would conclude the duty to defend, while public policy arguments and decisions from other states suggest such a rule should at least be limited if not prohibited altogether. Such a ruling, once made, will significantly impact the relationship between insurers and insureds, as well as between primary and excess carriers.

PRIMARY CARRIERS HAVE A DUTY TO DEFEND UNTIL THE APPLICABLE POLICY LIMIT HAS BEEN EXHAUSTED

Insurance policies in Texas, such as the standard Personal Auto Policy, typically include language that "[the insurer's] duty to settle or defend ends when [its] limit of liability for this coverage has been exhausted." At least one Texas case has found this policy language to be "precise, plain and clear." *Am. States Ins. Co. of Tex. v. Arnold*, 930 S.W.2d 196, 201 (Tex. App.—Dallas 1996, writ denied). The *Arnold* court held that the only reasonable interpretation of this policy language is that the insurer will defend or settle any claim, but the defense obligation will terminate if and when the insurer's policy limit is exhausted. *Id.*

Where an insured has both primary and excess coverage, the excess carrier is not obligated to participate in the defense until the primary policy limit is exhausted. *Keck, Mahin & Cate v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 20 S.W.3d 692, 700; *Tex. Employers Ins. Ass'n v. Underwriting Members of Lloyds*, 836 F. Supp. 398, 404 (S.D. Tex. 1993). Accordingly, an excess insurer's duty to defend is not typically invoked merely because a claim has been asserted against the insured in excess of its primary limit.[1] *Keck*, 20 S.W.3d at 701. Likewise, the excess carrier is not required to supervise or participate in the primary carrier's defense until the primary limit is exhausted. *Id.* at 701.

ACTUAL PAYMENT TO A CLAIMANT PURSUANT TO A SETTLEMENT SATISFIES THE EXHAUSTION REQUIREMENT

In *Arnold*, an insurer paid its limit to a claimant on behalf of the insured-owner of the motor vehicle. Upon settling, the claimant asserted a new claim against the insured-permissive user. The court held that the insurer had no duty to defend the insured-permissive user because the policy limit had already been exhausted. *Arnold*, 930 S.W.2d at 202–03.

Another Texas case involving identical policy language held that an insurer had no duty to defend the insured against the claims of an injured party where the insurer had exhausted its policy limit in settlement of the claims of two other claimants. *Mid-Century Ins. Co. of Texas v. Childs*, 15 S.W.3d 187 (Tex. App.—Texarkana 2000, no pet.). Because the policy limit was exhausted and the settlement with the other two parties was reasonable, the duty to defend had been extinguished. *Id.* at 189.

A VALID TENDER OF THE POLICY LIMIT ALSO SATISFIES THE EXHAUSTION REQUIREMENT

An insurer has not "exhausted" its policy limit by simply offering it to a claimant. *Tex. Employers*, 836 F. Supp. at 409. Rather, there must, at a minimum, be a ten-

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der of the policy limit. Under Texas law, a valid "tender" is an unconditional offer by a debtor to pay a sum of money not less than the amount due on the obligation. *Id.* (citing *Baucum v. Great Am. Ins. Co. of N.Y.*, 370 S.W.2d 863, 866 (Tex. 1963)). A valid and legal tender must be accompanied by the actual production of the funds and offer to pay the debt involved. *Id.* (citing *Baucum*, 370 S.W.2d at 866). A tender of payment must include everything to which the claimant is entitled; any lesser sum is ineffectual. *Id.* The party making the tender must relinquish possession of the funds for a sufficient time and under such circumstances as to enable the person to whom it is tendered, without special effort on his or her part, to acquire its possession. *Id.* (citing *Baucum*, 370 S.W.2d at 866). A mere declaration of tender, unaccompanied by actual payment of settlement or judgment or production of the policy proceeds cannot, in and of itself, constitute a valid tender of the policy limit. *Id.* at 410 (citing *Baucum*, 370 S.W.2d at 866).

Baucum involved an insurer that provided a check to the district clerk with instructions to provide the check to a judgment creditor only upon execution of a release.[2] *Baucum*, 370 S.W.2d at 865–66. The Texas Supreme Court disagreed that this constituted a valid tender for purposes of ending the accumulation of post-judgment interest. *Id.* at 866. First, the check was delivered to the district clerk as an agent of the insurer rather than in his official capacity. *Id.* Further, the check was not to be presented to the judgment creditor until a proper release had been executed, and at any time before that the clerk was obligated to return the check and release to the insured's attorney upon request. *Id.* The *Baucum* court noted that entire control of the policy proceeds would have been relinquished by either paying the amount directly to the judgment creditor *or depositing the money in the registry of the court*. *Id.*

INSURER INCENTIVES TO FILE AN INTERPLEADER

Depending upon the circumstances, an insurer may have several reasons to file an interpleader. For example, an automobile liability insurer may interplead its policy limit where: a) there are multiple claimants with damages that would clearly exceed the policy limit; b) liability is clear; and c) the claimants cannot agree upon a distribution of the policy proceeds. Rather than make piecemeal settlements under *Texas Farmers Insurance Co. v. Soriano*, 881 S.W.2d 312 (Tex. 1994), and risk future litigation over the reasonableness of the settlements, the insurer may prefer to file the interpleader and let the claimants litigate their entitlement to recover.

In a situation where excess coverage exists, a primary carrier facing a catastrophic loss with clear liability and insufficient policy proceeds will want to pay its policy limit and allow the excess carrier to assume the defense of the insured. In some instances, however, there may be reasons why this cannot occur. For example, there may be coverage questions under one or more of the policies, or there may be multiple insureds where the plaintiffs cannot accept the primary limit and provide even a partial release without jeopardizing their right to pursue the excess policy proceeds.[3]

An interpleader action represents an attempt by an insurer to limit its costs in the defense of a claim or lawsuit. The open issue, however, is whether such an action satisfies the exhaustion requirement so that the insurer can withdraw the insured's defense altogether.

WHY AN INTERPLEADER CONSTITUTES A VALID TENDER OF THE POLICY LIMIT AND, THEREFORE, SATISFIES THE EXHAUSTION REQUIREMENT

The Texas Supreme Court's ruling in *Baucum*, and its later treatment in the context of the duty to defend by the United States District Court for the Southern District of Texas in *Texas Employers*, strongly supports the notion that the duty to defend is extinguished when an insurance carrier deposits its limit into the registry of the court. The two factors in *Baucum* most critical to establishing a valid tender are the unconditional nature of the offer and the total relinquishment of possession of the policy proceeds. *Baucum*, 370 S.W.2d at 866. The filing of an interpleader satisfies both requirements.

An essential element of an interpleader is that the money at issue must be unconditionally deposited into the registry of the court. *Union Gas Corp. v Gisler*, 129 S.W.3d 145, 152 (Tex. App.—Corpus Christi 2003, no pet.) (citing *Olmos v. Pecan Grove Mun. Util. Dist.*, 857 S.W.2d 734, 741 (Tex. App.—Houston [14th Dist.] 1993, no writ)). Once the funds are deposited into the registry of the court, they are subject to the control and orders of the court. *Tri-State Pipe & Equip., Inc. v. S. County Mut. Ins. Co.*, 8 S.W.3d 394, 403 (Tex. App.—Texarkana 1999, no pet.). By unconditionally relinquishing control of the policy proceeds, the insurer has made a valid tender. As noted by *Texas Employers*, a valid tender goes beyond the mere offer of policy limits and, therefore, satisfies the exhaustion requirement. *Tex. Employers*, 836 F. Supp. at 409.

The filing of an interpleader also satisfies the remaining *Baucum* requirements. By placing the policy proceeds into the registry of the court, the funds are actually produced, as opposed to simply being offered. *See Baucum*, 370 S.W.2d at 866. Additionally, by depositing the entire available policy limit into the registry of the court, the insurer is paying the entire amount it is obligated to pay. *See id.*

In the context of transferring the duty to defend from a primary carrier to an excess carrier, Justice Hecht's concurrence in *Keck* supports the argument that an interpleader is an acceptable method of exhausting a primary limit. Justice Hecht argued that an excess carrier should be required to participate in the defense of its insured where it becomes clear that the potential judgment against the insured may be substantially greater than the amount of the underlying limit. *Keck*, 20 S.W.3d at 705. In a case where excess coverage exists but the plaintiffs cannot or will not accept the primary limit prior to either a complete settlement or a jury verdict, permitting the primary carrier to file an interpleader and transfer the duty to defend to the excess carrier would comport with Justice Hecht's logic in *Keck*: when it is clear that the excess carrier's policy proceeds are at stake, the excess carrier should be participating in and paying for the defense of its insured.

WHY AN INTERPLEADER DOES NOT CONSTITUTE A VALID TENDER OF THE POLICY LIMIT AND, THEREFORE, FAILS TO SATISFY THE EXHAUSTION REQUIREMENT

The *Baucum* factors do not weigh entirely in favor of terminating the duty to defend where an insurer deposits its policy limit into the registry of the court. Most notably, if the claimants are required to engage in lengthy and costly litigation to establish their right to recover the policy proceeds, then the interpleader cannot be said to enable the claimants to obtain possession of the policy proceeds without special effort. *See Baucum*, 370 S.W.2d at 866. Moreover, to the extent the insured's involvement is required in the interpleader action, he or she will still need representation.

Beyond *Baucum*, several factors suggest that an insurer's duty is not, or at least should not be, terminated where an insurer deposits its policy limit into the registry of the court pursuant to an interpleader action. First, allowing the insurer to file an interpleader, deposit its limit into the registry of the court, and then withdraw its defense would effectively promote a cut-and-run strategy in cases involving either catastrophic losses or minimum limits policies. This is problematic if the litigation continues after the interpleader is filed. Under such a framework, the insured would be left without an insurer-provided defense, something he or she bargained for when procuring the insurance policy. Where there is no excess policy, the insured would be required to pay for his or her defense. Where there is an excess policy but coverage is denied, the insured again would be left without counsel. This runs counter to the well-established principle that the duty to defend is greater than the duty to indemnify. *See, e.g.*, *E & L Chipping Co. v. Hanover Ins. Co.*, 962 S.W.2d 272, 274 (Tex. App.—Beaumont 1998, no pet.). Moreover, establishing such a rule would place the insurer's economic self interest over its fiduciary obligations to the insured.

Second, if the policy term "exhausted" is defined to mean "actually paid to the claimants," the interpleader option is not a viable method of concluding the duty to defend. Because there has been no settlement and no determination of fault, the interpleader action represents a unilateral payment. Under such a definition of "exhausted," until the entitlement to the proceeds has been determined and the proceeds paid out of the registry to the claimants, there has been no true exhaustion of the policy limit.

Third, the logic supporting equitable subrogation may be applied to this situation as well. The Texas Supreme Court has recognized that in the absence of equitable subrogation, primary carriers would have less incentive to settle cases within their policy limits. *Am. Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480, 483 (Tex. 1992). As such, a primary carrier's wrongful refusal to settle would likely result in increased premiums imposed by excess carriers. *Id.* In the interpleader context, primary carriers would have the opposite incentive: rather than refuse to settle, the interpleader option would encourage a primary carrier to deposit its limit into the registry of the court and withdraw its defense. Despite the opposite incentive, however, the result would be the same: higher premiums for excess insurance coverage since excess carriers would be called upon to defend cases before the primary limit was truly exhausted.

Finally, the courts of most states that have considered this issue have ruled that filing an interpleader or depositing settlement funds into the registry of the court does not satisfy the duty to defend. *See, e.g.*, *Samply v. Integrity Ins. Co.*, 476 So. 2d 79 (Ala. 1985) (Alabama); *Emcasco Ins. Co. v. Davis*, 753 F. Supp. 1458 (W.D. Ark. 1990) (applying Arkansas law); *Jenkins v. Ins. Co. of N. Am.*, 220 Cal. App. 3d 1481 (4th Dist. 1990) (California); *Continental Ins. Co. v. Burr*, 706 A.2d 499 (Del. 1998) (Delaware); *Aetna Ins. Co. v. Borrell-Bigby Elec. Co.*, 541 So. 2d 139 (Fla. Dist. Ct. App. 2d Dist. 1989) (Florida); *Anderson v. U.S. Fid. & Guar. Co.*, 339 S.E.2d 660 (Ga.

1986) (Georgia); *Douglas v. Allied Am. Ins.*, 727 N.E.2d 376 (5th Dist. 2000) (Illinois); *Exch. Mut. Ins. Co. v. Geiser*, 498 N.Y.S.2d 291 (Sup. Ct. 1986) (New York); *Nationwide Mut. Ins. Co. v. Simmonds*, 434 S.E.2d 277 (S.C. 1993) (South Carolina); *Stanley v. Cobb*, 624 F. Supp. 536 (E.D. Tenn. 1986) (applying Tennessee law); *Farmers Ins. Co. of Wash. v. Romas*, 947 P.2d 754 (Div. 3 1997) (Washington).

At least three cases from other states hold that the tender of policy proceeds into the registry of the court does satisfy the duty to defend, although they may all be found to involve critical distinguishing fact situations. *Farmers Ins. Co. v. Pers. Representative of Mitchell*, 755 F. Supp. 255 (W.D. Ark. 1989) (applying Arkansas law) (involving unique policy language); *Viking Ins. Co. of Wis. v. Hill*, 787 P.2d 1385 (Div. 3 1990) (Washington) (involving insured consent); *Gross v. Lloyds of London Ins. Co.*, 358 N.W.2d 266 (1984) (Wisconsin) (involving unique policy language and court imposing prior notice requirement).

CONCLUSION

While *Baucum* and *Texas Employers* weigh heavily in favor of permitting an insurer to terminate its duty to defend by filing an interpleader and depositing its policy limit into the registry of the court, the issue is by no means settled. Compelling arguments to the contrary may lead a future court to hold that an interpleader either does not terminate the duty to defend or that it is only terminated under certain circumstances. Accordingly, any insurer wishing to test this issue should file the interpleader and continue to defend the insured while seeking a declaratory judgment on the duty to defend. This will bring certainty to the issue while preventing potential liability from either a bad faith suit by the insured or an equitable subrogation suit by an excess carrier.

[1] However, Justice Hecht's concurrence in *Keck* suggests that the Texas Supreme Court may revisit whether an excess carrier never has a duty to defend prior to the exhaustion of the primary limit. *Keck,* 20 S.W.3d at 705. Justice Hecht referred to various insurance-related treatises which argue that excess carriers may have a duty to participate in the defense and share in the cost of defense once it becomes clear that the potential judgment against the insured may be substantially greater than the amount of the primary policy limit. *Id*.

[2] The issue in *Baucum* was whether the insurer's actions satisfied the policy language that it was responsible for post-judgment interest until it had "paid or tendered or deposited in court" the amount owed to the claimant.

[3] An example of this would be an accident involving an employee whose personal auto policy provides primary coverage and an employer whose business auto policy provides excess coverage. If there is a dispute over whether the employee was in the course and scope of his employment at the time of the accident, the plaintiffs may not be able to accept the primary limit until the course and scope issue is resolved.

NICHOLAS E. ZITO AND LAURA L. KEMP

An Update On Uninsured and Underinsured Motorist Coverage in Texas: *Brainard* and Other Cases of Interest

The Texas underinsured/uninsured motorist statute[1] has been in effect now for more than three decades. We continue to see, however, several cases each year which interpret the coverage available under Texas auto policies and the statute. In the past two years we have seen several notable opinions, the most important of which are from three cases all decided by the Texas Supreme Court on the same day. Those cases, of course, are *Brainard*,[2] *Nickerson*[3] and *Norris*[4]. The Court finally addressed two important questions involving UIM coverage: claims for attorney fees under Chapter 38 of the Civil Practices and Remedies Code and claims for *Cavnar*[5]-type prejudgment interest.

We have also seen interesting opinions regarding former Article 21.55 of the Insurance Code, a new "hit and run" case, a case precluding coverage for bystander claims, and a recent case out of the Houston 14th Court of Appeals involving offsets allowed for liability payments against UIM coverage under the same policy.

THE CURRENT STATE OF THE LAW ON PREJUDGMENT INTERESTS AND ATTORNEY FEE CLAIMS

The Texas Supreme Court has now written another chapter on claims for attorney fees and prejudgment interest in UIM suits. As a general rule, prejudgment interest will be allowed, but attorney fees will not.

The *Brainard* trio of cases reached the Texas Supreme Court because of a conflict among the various Courts of Appeals on the issue of whether or not prejudgment interest (*Cavnar*-type interest) and attorney fees could be awarded on a UIM claim. It is interesting that *Norris* was an unpublished Court of Appeals opinion. It was the dissenting opinion in *Norris* that most closely mirrored the opinions announced by the Supreme Court on how to assess prejudgment interest in a case involving a claim for UIM benefits.

BACKGROUND OF *BRAINARD*

Brainard was the subject of three appellate court decisions. Edward H. Brainard, II sustained fatal injuries on July 1, 1999, when he was involved in a head-on collision with a vehicle owned and operated by Premier Well Service, Inc. Trinity Universal Insurance Company was the auto insurance carrier that issued a policy to the family business, Brainard Cattle Company. Trinity made a PIP payment of $5,000 on July 3, 1999. Suit was initially brought by the Brainard family[6] (hereinafter referred to collectively as "Brainard") against Premier and its employee. Through discovery, they learned that Premier's policy limit was $1 million. After settling with Premier for $1 million, Brainard made a written claim to Trinity for the $1 million UIM policy limits on April 18, 2000. Trinity responded with an offer of $50,000. On October 30, 2000, Brainard amended the petition to join Trinity as a defendant. Claims were asserted for contractual UIM benefits and various alleged Insurance Code violations, including a claim under 21.55 of the Texas Insurance Code, also known as the Prompt Payment of Claims Statute. A common law claim alleging a breach of the covenant of good faith and fair dealing was brought as well.

Trinity then filed a Motion for Severance and

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Abatement, which the trial court partially granted. The good faith/unfair settlement practices and article 21.21 claims were severed, but the request to sever the article 21.55 claim was denied. A mandamus action was brought by Trinity and the Amarillo Court of Appeals conditionally granted the Petition for Writ of Mandamus.[7] The trial court ultimately severed the article 21.55 claim, as well.

The contract claim was subsequently tried, resulting in a jury verdict of actual damages of $1,010,000. The jury also awarded attorney fees to Brainard in the amount of $100,000. The trial court entered a judgment that Brainard recover from Trinity $5,000 in actual damages and $100,000 in attorney fees, but denied Brainard's request for prejudgment interest. The sole issue raised by Trinity on appeal challenged the trial court's award of attorney fees. Brainard raised one cross-point dealing with the court's failure to award prejudgment interest on the $1,010,000 in damages prior to offsetting settlement ($1,000,000) and PIP benefit payments ($5,000).

BACKGROUND IN *NICKERSON*

Nickerson involved a 1992 auto accident. Theresa Nickerson filed suit against the other driver in 1994 and, at some unknown point before October 1996, she accepted the third-party tortfeasor's policy limits of $25,000 and accepted $10,000 in PIP benefits under her own policy. She then sued her insurer, State Farm, on November 7, 1994 to recover underinsured motorist benefits. The case went to trial and resulted in a jury verdict of $225,000 in actual damages and $46,500 in attorney fees. After the verdict, but before the judgment was signed, State Farm tendered to Nickerson a check for damages, less the liability and PIP offsets of $35,000, but included postjudgment interest for a total amount of $191,294.52. State Farm excluded attorney fees from its check. The final judgment entered, however, included actual damages and prejudgment interest of $181,849.32 from the date suit was filed (November 7, 1994) for a total judgment of $371,849.32. The actual damages plus prejudgment interest less the offsets exceeded the policy limits of $300.000. Therefore, judgment was awarded for the UIM limits, and State Farm was also ordered to pay Nickerson's attorney fees and any postjudgment interest.

While initially appealing the award of prejudgment interest and the award of attorney fees, State Farm later withdrew the issue of prejudgment interest based upon the Supreme Court's denial of petition in *Menix v. Allstate Indem. Co*.[8] Therefore, the only issue remaining for the Appellate Court to decide was the award of $46,500 in attorney fees. Both sides treated the fees as being sought and awarded pursuant to Section 38.001 of the Texas Civil Practices and Remedies Code. In a footnote, it was stated that a claim for attorney fees under article 21.55 of the Insurance Code appeared not to have been asserted.[9]

Where there is no contractual duty to pay, there can be no "just amount owed."

BACKGROUND IN *NORRIS*

The third case in the UIM trilogy is *Norris*. *Norris* was initially decided by the Waco Court of Appeals in April of 2004.[10] Norris was in an accident on December 8, 1997. The underinsured motorist, Johnston, had policy limits of $50,000. Norris settled his claim against Johnston for $40,000 and then sued State Farm to collect under the UIM provisions of his policy. Norris' case proceeded to trial and the jury found that his damages were $51,200 and attorney fees were awarded. State Farm had previously paid $5,000 in personal injury protection benefits. State Farm also received credit for Johnston's $50,000 policy limits – the amount recoverable. Therefore, the total credits amounted to $55,000. The trial court found that the credits exceeded the amount of the damage verdict and, therefore, entered a Take Nothing Judgment in favor of State Farm. Norris appealed claiming he was entitled to prejudgment interest on $51,200 before applying the credits, as well as his attorney fees. The Waco Court of Appeals agreed on both counts.

THE SUPREME COURT'S HOLDINGS

The opinions in *Brainard*, *Nickerson*, and *Norris* were all authored by Chief Justice Jefferson. In each case, Chief Justice Jefferson found that attorney fees were not recoverable from the UIM insurer under Chapter 38 of the Civil Practices and Remedies Code. The circumstances under which an insured may recover attorney fees under Chapter 38 were described and the UIM policies were held to cover prejudgment interest on the damages attributable to the underinsured motorist. The Court also held that credits were to be applied using the "declining principle" formula which was derived from the Court's earlier opinion in *Battaglia v. Alexander*,[11] a case involving healthcare liability claims.

ATTORNEY FEES

In *Brainard,* the Court reiterated that attorney fees were only recoverable where authorized by statute or by contract. Attorney fees were only sought under Chapter 38 because no other "statutory scheme" applied. The Court noted that in order for Brainard to recover attorney fees, three things must be shown: they were represented by counsel; they presented a claim to Trinity; and Trinity failed to pay the "just amount owed" within 30 days of presentment. It was Brainard's position that their suit was like any other breach of contact suit and, therefore, the presentment occurred in February of 2000 when they made a demand for the UIM policy limits. Trinity argued that UIM policies are different because the carrier's duty to pay does not arise until the underinsured motorist's liability and the insured's damages are legally determined. The Court stated that under article 5.06-1(5) of the Insurance Code, the UIM insurer is only obligated to pay damages which the insured is "legally entitled to recover" from the underinsured motorist. Therefore, the UIM carrier was under no contractual duty to pay benefits until the insured obtained a judgment establishing the liability and the underinsured status of the other motorist, which required a determination of the amount of damages. Therefore, the filing of suit or demand for UIM benefits is insufficient to trigger a contractual duty to pay on the part of the insurer. In other words, where there is no contractual duty to pay there can be no "just amount owed." The Court, therefore, found that when UIM benefits are involved, the claim is not presented until there is a judgment entered by the trial court that establishes both fault and the underinsured status of the other motorist, which necessarily requires a determination of the amount of the insured's damages.

The Court stated that the insured was not required to obtain a judgment against the tortfeasor, but instead could settle with the tortfeasor. The Court held, however, that neither a settlement nor an admission of liability from the tortfeasor would establish UIM coverage.[12] Under the insuring agreement, Trinity had no obligation to pay UIM benefits before the negligence and underinsured status of the tortfeasor (Premier) was established. Therefore, a contact claim was not actually presented until the trial court had rendered its judgment,[13] and Brainard was not entitled to recover attorney fees under Chapter 38.

COMMENT ON CLAIMS FOR ATTORNEY FEES

There are instances, however, when a presentment can be deemed to have occurred without an actual trial of a UIM case. For example, should the carrier consent to the suit against the underinsured motorist, any default judgment or jury verdict obtained against the underinsured motorist would be binding upon the carrier, thereby triggering the 30-day time period set forth in Chapter 38 for payment of claims after presentment.

A case may arise in which the liability of the underinsured motorist may be so clear that it may be established by a summary judgment motion brought in the action against the UIM carrier. This, of course, would not result in establishing damages unless there was a stipulation as to the amount of damages or the damages exceeded a certain threshold limit. Also, situations could arise where the economic damages are so clearly established that the underinsured status of the other motorist could be deemed to have been found. This, of course, would be a rare circumstance where a court would be willing to make such a finding as a matter of law (*i.e.*, on a summary judgment basis). Absent exceptional circumstances, it appears that *Brainard* would foreclose a recovery of attorney fees from a UIM carrier under Chapter 38, as long as any judgment is paid within 30 days of entry.

RECOVERY OF PREJUDGMENT INTEREST

The Supreme Court's opinions in *Brainard* and *Norris* make it clear that prejudgment interest is now recoverable in a case involving a claim for UIM benefits. The issue of prejudgment interest first reached the Texas Supreme Court in another context in *Henson v. Southern Farm Bureau Casualty Ins. Co.*[14] *Henson* was a case where the insured's damages were in excess of $133,000, but the policy limits were $25,000 under a Texas Farm Bureau UIM policy and $20,000 under a Southern Farm Bureau UIM policy, for a total of $45,000. The question before the Court was not whether prejudgment interest could be added to the award against the tort defendant, but instead whether prejudgment interest could be awarded on the contract claim, *i.e.,* on top of the UIM policy limits. The specific question posed to the court was "whether an insurer, obligated to pay uninsured/underinsured benefits, owed on top of those benefits prejudgment interest to be computed either from 180 days after demand for those benefits has been made, or from the day a suit is filed for those benefits."[15] The Supreme Court held that prejudgment interest does not begin running on this type of a claim until the date that liability of the uninsured/underinsured motorist is established (*i.e.,* the date of judgment). The rationale was that the carrier would owe prejudgment interest on top of the policy benefits only if they had wrongfully withheld those benefits.

Since the carrier's contractual obligation to pay does not arise until the judgment was rendered, a claim for prejudgment interest on the policy benefits was properly denied. This type of claim could only earn prejudgment interest if the insurer wrongfully withheld benefits after a judgment was obtained establishing the necessary elements of a UIM claim.

The Court, in dictum, gave a hint of what it would do if it had been faced with a claim for "tort" or *Cavnar*-type interest. The Court stated that:

> there is no doubt that if *Henson* were recovering directly from *Contreras*, the judgment would include prejudgment interest. And the insurers do not dispute that had the trial court awarded prejudgment interest against the tort defendants, the insurers would be obligated to pay the entire judgment including that portion awarded for prejudgment interest, to the extent of policy limits.[16]

Brainard and *Norris*, therefore, presented a different prejudgment issue to the Supreme Court. The issue was whether prejudgment interest could be added to the tort award so as to obligate the carrier to be responsible for that amount up to the respective policy limits. The second question raised in both *Brainard* and *Norris* involved the issue of how and when credits to an award should be applied. *Brainard* sets forth rules on when prejudgment interest accrues and how settlement credits and/or advanced payments are to be credited. *Brainard* also incorporates statutory requirements for tolling the accrual of prejudgment interest once a written settlement offer has been made.

In addition to addressing the issue of prejudgment interest, *Norris* addressed a point that earlier cases had not. It had previously been held that the UIM carrier was entitled to a credit for the amount recovered or recoverable (which ever sum was greater) from the alleged underinsured tortfeasor.[17] *Norris* dealt with how the trial court should handle a claim for prejudgment interest when the insured accepts a settlement amount from the alleged underinsured tortfeasor which is less than the tortfeasor's policy limits.

BRAINARD'S HOLDING ON PREJUDGMENT INTEREST

Brainard claimed that prejudgment interest should be calculated on the entire $1,010,000 jury award before applying credits. Therefore, it was argued that the plaintiff should recover $263,430 in prejudgment interest. Trinity, however, argued that Brainard should not continue to earn interest on $1,010,000 in damages since they had already recovered $1,005,000 in compensation. The Supreme Court agreed with Trinity. The Court looked for guidance in its earlier opinion in *Battaglia v. Alexander*[18] where the Court held it was error to calculate prejudgment interest on total damages before deducting payments that plaintiff had received from other settling parties. Prejudgment interest was only to be awarded for loss of use of money as damages. Where there was a settlement or other payment, there could be no loss of use of money and, therefore, to allow an award of interest would be a windfall to a party and would result in a penalty to a defendant. Therefore, in *Battaglia*, the Court held that settlements must be credited according to the date they are received.[19] The Court adopted the "declining principal" formula as the method to be used in calculating prejudgment interest in UIM cases. Therefore, credits should be applied first to accrued interest and then to principal. In instances where payments were made (*e.g.*, PIP) prior to prejudgment interest accruing, the credit would be applied to principal only.

The relevant dates in *Brainard* are as follows:

(a) July 1, 1999, date of accident;

(b) July 31, 1999, Brainard receives $5,000 PIP payment;

(c) January 19, 2000, prejudgment interest period begins when Brainard files suit;

(d) December 7, 2000, Brainard receives $1,000,000 settlement; and

(e) March 9, 2001, Trinity offers Brainard $50,000.

Pursuant to statute, prejudgment interest begins on the 180th day after the defendant receives written notice of the claim or the date suit is filed, whichever occurs first. Since suit was filed on January 19, 2000 (180 days had not yet elapsed from the date of the accident), prejudgment interest began to accrue on the date of suit.

In addition, where there is a settlement offer, prejudgment interest cannot accrue on the judgment where the damages do not exceed the amount of the settlement offer where the offer is left open. *See* Section 304.105(a)

of the Finance Code which states that: "[I]f judgment for a claimant is equal to or less than the amount of a settlement offer of the defendant, prejudgment interest does not accrue on the amount of the judgment during the period that the offer may be accepted."

Because the $5,000 PIP payment was made prior to the date that prejudgment interest would begin to accrue, it reduced the principal before prejudgment interest was assessed. In the interim, from the date that suit was filed up to the date of the $1,000.000 settlement, prejudgment interest accrued on $1,005,000. Then the $1,000,000 credit would be applied first to accrued prejudgment interest and then to the remaining principal. Interest would then continue to run on the remaining principal up to March 9, 2001, which was the date of Trinity's $50,000 offer.

Since Trinity had made a settlement offer, which was kept open and which exceeded the net jury award, no prejudgment interest accrued on the remaining principal due Brainard.

NORRIS' HOLDING ON PREJUDGMENT INTERESTS

Norris brought a claim against State Farm as a result of injuries he sustained in a December 8, 1997 accident. He first sued the underinsured motorist Johnston on March 29, 1999 and settled with Johnston for $40,000 (a sum $10,000 less than Johnston's $50,000 limit). State Farm paid Norris $5,000 in PIP benefits, but did not make an offer on Norris' UM claim. The jury in the trial of the UIM case found past damages of $51,200. Since there was nothing in the record to show the dates of settlements and/or PIP payments, the Supreme Court remanded the case to the trial court to establish the payment dates so that prejudgment interest could be properly calculated.

In addition, although Norris settled with Johnson for $40,000, State Farm was entitled to a full $50,000 credit, the amount of Johnson's policy limits as of the date that Johnson remitted the settlement amount. Although Norris only received $40,000, the Court held that Norris had forfeited the difference between the settlement amount and Johnson's policy limits. Norris had not lost the use of $10,000 and had released any entitlement to it. Therefore, he waived and/or forfeited his right to receive prejudgment interest on the settlement gap. Prejudgment interest could only be awarded then on the amount of the settlement ($40,000) up to the date of payment, plus whatever amount was in excess of Johnston's policy limits ($1,200).

Norris gives us a refined statement by the Court: (1) the written notice that counts is the written notice received by the underinsured motorist carrier[20] and not the notice received by the underinsured motorist; and (2) settlement with the underinsured motorist for an amount less than their policy limit results in a forfeiture of a right to claim prejudgment interest on the "gap" between the settlement amount and the actual policy limits available.

From *Brainard* and *Norris* (as well as other opinions) we now have the following rules to apply in regards to prejudgment interest on UIM claims.

Rule 1: You apply settlements to past damages first, then to future damages.

Rule 2: By statute, no prejudgment interest is allowed on future tort damages.

Rule 3: Prejudgment interest begins to accrue 180 days after written notice to the UIM carrier of the accident/claim or the date that suit is filed,[21] whichever occurs first.

Rule 4: Payments, such as PIP payments, that were made prior to prejudgment interest accruing are applied directly against principal.

Rule 5: In order to properly credit a settlement, it should be applied:

(a) first to accrued prejudgment interest as of the date the settlement was made;

(b) then to the principal (past damages) thereby reducing or perhaps eliminating prejudgment interest from that point forward.

Rule 6: The insured forfeits any right to claim prejudgment interest on any settlement gap (where the insured settles for an amount less than the underinsured motorist's policy limits).

Rule 7: Settlement offers which are in writing result in a suspension of prejudgment interest up to the amount of the settlement offer and the suspension is effective from the date of the written offer.

QUESTIONS RAISED BY THESE DECISIONS

Question 1: Who has the burden to prove when payment was made?

The Supreme Court did not address this issue, although it was addressed by the Court of Appeals in *Norris*. In *Norris,* the dissenting opinion written by Judge Gray suggests that the burden of proof should be on the party seeking to recover prejudgment interest. Until this issue is resolved, counsel representing the UIM carrier should be prepared to prove up the amount and date of each payment in order to receive a proper credit and/or offset.

Question 2: Can creative drafting of settlement documents circumvent a carrier's right to assert a claim for a credit?

Note that in *Battaglia*, the case that the Supreme Court relied heavily upon in adopting the declining principal formula, it was implied that the insured is not precluded from allocating the amount of a settlement to future damages as opposed to past damages, so long as the allocation is spelled out in the underlying settlement documents.

Question 3: Are 21.55 claims precluded in UIM cases?

Unfortunately, the issues that the court addressed in *Brainard, Nickerson* and *Norris* did not involve article 21.55 of the Insurance Code.[22] The Court's ruling on attorney fees dealt with what were presumed to be Chapter 38 attorney fees claims. Article 21.55 allows for attorney fees and an 18 percent interest penalty for instances where the carrier has failed to comply with the prompt payment of claims provision.

The Texas Supreme Court addressed article 21.55 in *Allstate Insurance Co. v. Bonner.*[23] In *Bonner,* Allstate had failed to timely acknowledge receipt of the claim. Bonner did not prevail on his suit seeking UIM benefits, as the jury award was less than the PIP payment made by Allstate. In order for Bonner to recover under the penalty provisions of article 21.55, he was required to establish: (1) a claim under a policy; (2) *the insurer was liable for the claim*; and (3) the insurer failed to follow one or more sections of article 21.55. Since Bonner could not establish Allstate's liability on the policy, he was precluded from recovering under article 21.55.

The court distinguished the situation in *Bonner* from that in *Dunn v. Southern Farm Bureau Case. Ins. Co.*[24] where Southern Farm Bureau was found liable on the contract claim. The insurer in *Dunn* was subject to the statutory penalties "as a consequence for delaying acknowledgement and payment of a claim for which it was liable."[25]

Brainard causes somewhat of a conflict with the Prompt Payment of Claims Statute. This is because a UIM claim is somewhat unique as liability on the policy (contract) is not established until the liability of the underinsured motorist is determined and damages are found by the jury which establishes the underinsured status of the third-party tortfeasor. Section 542.056 requires that the carrier give notice of acceptance or rejection of a claim within certain statutory deadlines. If the claim is accepted, the carrier must pay the claim not later than the fifth business day after the date notice is made. Another section involving delay of payment of a claim provides:

> …if an insurer, after receiving all items, statements, and forms reasonably requested and required under Section 542.055, delays payment of the claim for a period exceeding the period specified by other applicable statutes or, if other statutes do not specify a period, for more than 60 days, the insurer shall pay damages and other items as provided by Section 542.060.

If the insurer delays payment of the claim, it is required to pay the 18 percent interest penalty and attorney fees set forth in Section 542.060.[26] The Insurance Code does not provide any exception for UIM claims. There is no other statute which specifies a time period for payment as the UM/UIM statute is silent on this point. In order to circumvent the application of the prompt payment statute, it must be implied by *Brainard* that there is no obligation to pay until liability and the underinsured status of the third party motorist is established. Hence, the inherent conflict between the caselaw and the plain meaning of the statute.

There are three decisions by lower courts that we can look to for guidance on this issue. In *Mid-Century Ins. Co. of Texas v. Daniel*,[27] the Amarillo Court of Appeals, on rehearing following the *Brainard* opinion, held that "Mid-Century's payment of [UIM benefits] within two days of the judgment against the third party precludes the award of attorney fees under article 21.55, §§ 4 and 6 or §38.002(s) of the Texas Civil Practice & Remedies Code." That Court also found the assessment of interest under article 21.55 would be triggered by the jury verdict

determining the insured's damages recoverable from the third party, and Mid-Century's payment within two days of that determination precluded interest penalties under article 21.55.

In *Delagarza v. State Farm Mutual Automobile Ins. Co.*,[28] the Dallas Court of Appeals held in an uninsured motorist case that State Farm had complied with the provisions of article 21.55. The record showed that State Farm had timely acknowledged the receipt of Delagarza's claim within 15 days and requested supporting documentation, including medical bills and requested a signed medical authorization. State Farm later received a letter enclosing Delagarza's medical bills and records, but no authorization was included. The letter demanded that State Farm tender payment of $25,000 in return for a release. State Farm had timely responded that it was unable to accept Delagarza's offer, but made a counter offer of $10,000 which it would agree to pay upon receipt of notice that Delagarza accepted the offer. State Farm had also learned that Delagarza had pre-existing degenerative back problems. Therefore, State Farm requested all prior records. Rather than forwarding the records, Delagarza filed suit. Within three weeks of the suit being filed, State Farm forwarded Delagarza a check for $10,000. After conducting discovery, State Farm sent a second check to Delagarza for $15,000 representing the balance of the benefits available under the policy. This left only the 21.55 claim remaining.

...it could be argued that the Prompt Payment of Claims Statute is not triggered if the carrier otherwise complies with all of the statutory deadlines...

The Court found that Section 4 of article 21.55 allowed an insurer to notify its insured that it was accepting only part of a claim and also allowed payment of part of the claim to be conditioned on the performance of an act by the insured, *i.e.,* such as signing a release or agreeing to settle for a lesser amount. *Delagarza,* therefore, stands for the proposition that Section 21.55 of the Insurance Code was not intended to eliminate an insurer's right to dispute all or part of an insured's claim. Instead, the purpose of 21.55 was to "merely establish deadlines by which the insurance company had to act."

Wellisch v. United Services Automobile Assoc.[29] relied upon the holding in *Henson* in finding that an insurer "has the right to withhold payment of UIM benefits until the insured's legal entitlement is established."[30] The San Antonio Court of Appeals interpreted article 21.55 as not precluding a carrier from disputing or denying a claim, but only required that they do so promptly. "Nothing in article 21.55 precludes an insurer from awaiting a judicial determination of an insured's 'legal entitlement' to UIM benefits. It merely requires that the insurer notify the insured of its reasons for delaying the acceptance or rejection of a claim."[31]

Even in *Dunn,* which was discussed in *Bonner,* we find language in support of this point:

> Article 21.55 does not require an insurer to pay every claim within a certain time. It simply requires steps to be taken within a specified time frame….Nothing in the statute suggests that the insurance company could not dispute and deny the claim. Indeed the statute is premised on the presumption that carriers have the right to dispute claims. It merely requires that they do so promptly.[32]

Taking these cases into consideration, it could be argued that the Prompt Payment of Claims Statute is not triggered if the carrier otherwise complies with all of the statutory deadlines by acknowledging receipt of the claim and timely advising the insured if they have accepted or rejected the claim. Reasons must be specified for any delay in payment. The claim must then be paid on a timely basis after judgment. The question then is: when must payment be made? Must it be paid within five business days of the entry of the judgment? Can the carrier delay payment by stating that it will make payment if the insured obtains a judgment establishing liability and underinsured status? Can the insurer rely upon the statement by the Court in *Brainard* that payment must be made within 30 days of entry of judgment? Unfortunately, the answers to these questions have not been given to us by the Court. In *Brainard,* the 21.55 claim had been severed out. In *Norris* and *Nickerson,* it does not appear that a claim under 21.55 was raised as a point on appeal.

Question 4: Are bad faith claims now eliminated for UIM cases?

In ascertaining whether or not there has been a breach of the covenant of good faith and fair dealing, the Texas Supreme Court has held that:

> An insurer has a duty to deal fairly and in good faith with its insured in the processing and payment of claims. A breach of the duty of good faith and fair dealing is established when: (1) there is an absence of a reasonable basis for denying or delaying payment of benefits on other policy and, (2) the carrier knew or should have known that there was not a reasonable basis for denying the claim or delaying payment of the claim. The first element of this test required an objective determination of whether a reasonable insurer under similar circumstances would have delayed or denied the claimant's benefits. This assures that a carrier will not be subject to liability for an erroneous denial of a claim, as long as a reasonable basis for the denial of the claim exists.[33]

More recently, the Supreme Court held that the statutory standards and common law bad faith standard regarding the breach of the duty of good faith and fair dealing are the same. *See Mid-Century Ins. Co. v. Boyte*.[34]

Therefore, exposure may exist in regards to common law bad faith or statutory Insurance Code[35] claims where liability is found on the contract. In order to be successful on such a claim, however, it must be shown that the insurer delayed payment of a claim after its liability became reasonably clear. The current requirement that the liability of the underinsured motorist be established and that the third party's underinsured status be determined as well will certainly strengthen the insurer's position that there was a bona fide coverage dispute. Bona fide coverage disputes, standing alone, do not demonstrate bad faith.[36] Based upon the holding in *Brainard,* there generally can be no breach of contract if the insurer timely pays the claim after the entry of a judgment establishing liability on the part of the underinsured motorist and assessing damages.[37]

Question 5: Has the Court tacitly agreed that punitive damages are not covered by a UIM policy?

In *Brainard*, Trinity had argued that a UIM carrier was only obligated to pay those damages which the insured was legally entitled to recover "because of bodily injury or property damage." Trinity had also suggested the Brainard's interpretation of the UIM endorsement would result in all damages assessed against the underinsured motorist being covered. Trinity then pointed out that several courts of appeals have held that UIM insurance does not cover punitive damages. In *Brainard,* the Supreme Court chose to comment on that analysis. One of the cases discussed in the *Brainard* opinion was *State Farm Mutual Automobile Ins. Co. v. Schaffer*.[38] In *Schaffer,* the Court had conducted an analysis of the legislative intent behind article 5.06-1(5) of the Insurance Code. In *Schaffer,* it was concluded that the legislative intent was to "protect conscientious motorists from financial loss caused by negligent financially irresponsible motorists."[39]

In *Brainard*, the court stated that UIM insurance is compensatory in nature. Prejudgment interest was held to be additional compensatory damages for the insured's bodily injury and, therefore, would be covered under UIM insurance. Because of the lengthy discussion of *Schaffer* and the characterization of prejudgment interest as additional compensatory damages, it appears that the Supreme Court is, in fact, tacitly telling us that punitive damages will not be covered under a UIM policy.

OTHER RECENT CASES OF INTEREST: ARE BYSTANDER/MENTAL ANGUISH CLAIMS COVERED?

We learned in *Trinity Universal Ins. Co. v. Cowan*,[40] that a claim for mental anguish was not a "bodily injury" and, therefore, would not be a covered claim under a liability policy. Since the language in the standard auto policy provides coverage for "bodily injury," a bystander bringing a UIM claim seeking recovery of mental anguish damages alone would not be covered. *See Southern Farm Bureau Casualty Ins. Co. v. Franklin*.[41] Also see earlier opinions cited in *Miller v. Windsor Ins. Co.*[42] which held that claims for mental anguish and loss of consortium by one not involved in the accident, standing alone, are not bodily injuries and, therefore, are not covered losses.

HIT AND RUN CASES

Elchehimi v. Nationwide Ins. Co.[43] involved an appeal of a summary judgment granted to Nationwide on a UIM claim. On appeal, Elchehimi had argued that the facts surrounding the collision were sufficient to meet the "actual physical contact" requirements of the UIM

Statute.[44] In *Elchehimi*, the insured vehicle was struck by an axle with attached wheels which broke away from a tractor trailer traveling in the opposite direction on a divided highway. The Waco court recognized that the San Antonio Court of Appeals had previously held that the "actual physical contact" requirement was not met when a component of a semi-trailer had detached immediately before striking an insured vehicle. *See Smith v. Nationwide Mutual Ins. Co.*[45] The Waco court sought to distinguish the San Antonio court's opinion by stating that the court had not given "adequate weight to the distinction between cargo which has fallen from an unidentified vehicle and an integral part of an unidentified vehicle which strikes an insured's vehicle in an unbroken chain of events."[46] We, therefore, have two divergent opinions on whether or not the actual physical contact requirement will have been met. Under *Elchehimi*, two requirements will need to be met: (1) a showing that the collision and resulting damages were caused by an integral part coming off an unidentified vehicle; and (2) a temporal proximity requirement; *i.e.,* there can be no intervening force to break the chain of causation.

As pointed out by the dissent in *Elchehimi*, a "host of questions" is now left by this opinion. If the reasoning in *Elchehimi* is adopted, courts will be faced with questions such as "What portion of a vehicle will be sufficient to constitute an 'integral part' of a vehicle so as to satisfy the actual physical contact test?" The *Elchehimi* case appears to be suspect, as a separated component from a vehicle cannot meet the definition of "vehicle." In a "hit and run" situation, our UM statute requires actual physical contact with a motor vehicle, not a component which is no longer part of that vehicle.

UNDERINSURED CLAIMS MADE AFTER PAYMENT OF LIABILITY LIMITS

In *Jankowiak v. Allstate Property & Case. Ins. Co.*[47] an insured was allowed to seek UM benefits after collecting the liability limits under the same policy. The Jankowiaks alleged in their suit that both drivers were at fault, and Allstate did not dispute this point in their summary judgment. After conducting a search of the legislative history of the UIM statute, the Houston 14th Court of Appeals determined that the statute was silent on combining coverages. This suggested that the insuring agreement should be analyzed to determine the issue. Both the liability and UM portions of the Allstate policy contained the following language:

> The limit of liability shown in the Declarations for 'each person' for bodily injury liability is our maximum limit of liability for all damages for bodily injury sustained by any one person in any one motor vehicle accident… This is the most we will pay regardless of the number of … claims made...or vehicles involved in the accident.

Allstate claimed that it had satisfied both its liability and UM bodily injury obligations when it tendered its $25,000 limit. The court disagreed with Allstate because the "maximum limit of liability" language was repeated throughout the policy for each coverage. The court stated that a more reasonable interpretation of the offset language in the policy was that its purpose was to prevent a double recovery. Therefore, the amount of damages recoverable was reduced by the payments that were made, but the policy limits available under the UM coverage were not reduced by the payment made under the liability portion of the same policy.

The court also found the earlier opinion in *Hanson v. Republic Insurance Company*[48] was unpersuasive. *Hanson,* of course, involved a reverse situation, where UIM benefits were paid first and the carrier claimed that no liability payment could be due under the liability portion of the policy. The Houston 1st Court of Appeals agreed with Republic.

The typical Texas auto policy contains the following statement in the UM portion of the policy: "any payment under this coverage to or for a covered person will reduce any amount that person is entitled to recover for the same damages under the liability coverage of this policy." Following the logic in *Jankowiak*, if a UM payment is made to a passenger in a case where both drivers are at fault, and then a liability claim is subsequently made by the same claimant against the insured driver, the amount recoverable under the liability portion of the policy (the total damages) will be reduced by the amount of payment under the UIM coverage. *Hanson* states that this may not occur.

We already know that by law and by statute, under the UIM portion of an auto policy, the amount of actual damages is reduced by liability payments.[49] Once again, the deduction is taken from damages and not from the limits. *Jankowiak* takes this one step further, by holding that the source of the liability payment is not relevant, even when it is made under the same policy from which UIM benefits are being sought.

The holding in *Jankowiak* will not apply to a situation where the insured driver is solely at fault. By definition, an underinsured vehicle does not include a vehicle

owned by or furnished for the regular use of the insured. Therefore, where the liability policy limits are insufficient to cover passengers' claims against the insured driver, there is no recourse under the UIM portion of the same policy. If *Jankowiak* is followed, an insured will still be precluded from recovering UIM benefits for the damages which are attributable to the negligence of the operator of the insured's vehicle, except in circumstances where the third party tortfeasor's negligence exceeds 50 percent.[50]

CONCLUSION

Although the Texas Supreme Court resolved what had been some rather pressing questions as to UIM coverage, it is clear that many questions regarding this coverage remain unanswered. The recent decisions in *Brainard*, *Nickerson* and *Norris* did not involve article 21.55 of the Insurance Code[51] or "bad faith" claims. The holding in *Elchehimi*, if followed by other courts, will lead to further appellate court activity until the conflict raised by that decision is resolved. *Jankowiak* has already resulted in many claims, which carriers thought had been resolved, being reopened due to the assertion of UIM claims after liability limits have been paid. It is hoped that the author's analysis of these questions will give some guidance to practitioners in this area of insurance law.

... it is clear that many questions regarding this coverage remain unanswered.

[1] Article 5.06-1 TEX. INS. CODE (Vernon Supp. 2006).

[2] *Brainard v. Trinity Universal Ins. Co.* 50 Tex. Sup. Ct. J. 271 (Tex. December 22, 2006).

[3] *State Farm Mut. Auto. Ins. Co. v. Nickerson*, 50 Tex. Sup. Ct. J. 268, (Tex. December 22, 2006).

[4] *State Farm Mutual Automobile Ins. Co. v. Norris*, 50 Tex. Sup. Ct. J. 269, (Tex. December 22, 2006).

[5] *Cavnar v. Quality Control Parking, Inc.*, 696 S.W.2d 549 (Tex. 1985). *Cavnar* has now been superseded in part by statute. *See* Tex. Fin. Code §304.102 "a judgment in a wrongful death, personal injury, or property damage case earns prejudgment interest."

[6] Brainard's widow and five children were parties to the wrongful death suit.

[7] *See In re Trinity Universal Ins. Co.*, 64 S.W.3d 463 (Tex..App.-Amarillo 2001, orig. proceeding).

[8] 83 S.W.3d 877 (Tex. App.-Eastland 2002, pet. denied).

[9] *State Farm Mut. Auto. Ins. Co. v. Nickerson*, 130 S.W.3d 487, 489 n.2 (Tex. App.-Texarkana 2004), *rev'd*, 50 Tex. Sup. Ct. J. 268, 2006 WL 3754824 (Tex. December 22, 2006).

[10] *Norris v. State Farm Mut. Auto. Ins. Co.*, 2004 WL 811722 (Tex. App.-Waco 2004)(not designated for publication), *rev'd*, 50 Tex. Sup. Ct. J. 269, 2006 WL 3751580 (Tex. December 22, 2006).

[11] 177 S.W.3d 893 (Tex. 2005).

[12] The standard auto policy contains a provision which stands for the same proposition, absent express consent to the suit, any judgment obtained against the tortfeasor is not binding upon the carrier when it is not joined as a party to the suit.

[13] *See* fn. 3 in *Norris*. State Farm avoided liability for payment of attorney fees because a take nothing judgment had been entered against Norris and, hence, there had been no presentment of the "just amount owed" on the day of judgment.

[14] 17 S.W.3d 652 (Tex. 2000).

[15] *Id.* at 652.

[16] *Id.* at 653.

[17] *See Leal v. Northwest Nat. County Mut. Ins. Co.*, 846 S.W.2d 576 (Tex. App.-Austin 1993, no writ) and *Olivas v. State Farm Mut. Auto. Ins. Co.*, 850 S.W.2d 564 (Tex. App.-El Paso 1993, writ denied).

[18] 177 S.W.3d 893 (Tex. 2005.)

[19] *Id.* at 907-08.

[20] Since written notice of the accident was required in order for prejudgment interest to begin to accrue, the Court found that the earliest date in the record showing written notice of the accident was when State Farm had received a narrative from a physician.

[21] In *Brainard* this was held to be the date suit was brought against the underinsured motorist on January 19, 2000. Trinity was not joined as a party until an amended petition was filed on October 30, 2000. The record does not tell us when Trinity first received written notice of the accident. It is presumed that a different trigger date could apply if the insured were to bring a "new" suit against the insurer instead of bringing the carrier into the underlying action against the underinsured tortfeasor.

[22] Former article 21.55 is now codified under Section 542.051, *et. seq.* of the Insurance Code.

[23] 51 S.W.3d 289 (Tex. 2001).

[24] 991 S.W.2d 467 (Tex. App.-Tyler 1999, pet. denied).

[25] *See Bonner*, 51 S.W.3d at 292.

[26] *See Higginbotham v. State Farm Mut. Auto. Ins. Co.,* 103 F.3d 456, 461 (5th Cir. 1997), where it was held that: "A wrongful rejection of a claim may be considered a delay in payment for purposes of (applying Texas slaw) the sixty-day rule and statutory damages. More specifically, if an insurer fails to pay a claim, it runs the risk of incurring this 18 percent statutory fee and reasonable attorney fees. In sum, State Farm took a risk when it chose to reject Higginbotham's claim. State Farm lost when it was found liable for breach of contract. Therefore, it must pay this 18 percent per annum interest and reasonable attorney fees".

[27] 2007 WL 414330 (Tex. App.-Amarillo February 7, 2007, no pet. h.).

[28] 181 S.W.3d 755 (Tex. App.-Dallas 2005, pet. denied).

[29] 75 S.W.3d 53 (Tex. App.-San Antonio 2002, pet. denied).

[30] *Id*. at 57.

[31] *See State Farm Life Ins. Co. v. Martinez*, 174 S.W.3d 772 (Tex.-App.-Waco 2005).

[32] 991 S.W.2d 467, 474.

[33] *See Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 340 (Tex. 1995).

[34] 80 S.W.3d 546, 549 (Tex. 2002).

[35] For instance, article 21.21 of the Insurance Code prohibits an insurer from, among other acts, failing to affirm or deny coverage of a policyholder's claim within a reasonable time; failing to timely investigate a claim; and failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim with respect to which an insurer's liability has become reasonably clear.

[36] *See Provident Amer. Ins. Co. v. Castaneda,* 988 S.W.2d 189,193 (Tex. 1998).

[37] In *Stoker* the court stated that, generally, there could be no bad faith claim when an insurer has promptly denied a claim which is not covered. *See Stoker* at 341. That opinion does not tell us what will occur if the carrier was wrong in denying the claim, but still not in breach of the contract because a judgment had not been entered at the time of the initial denial of the claim.

[38] 888 S.W.2d 146 (Tex. App.-Houston [1st Dist.] 1994, writ denied).

[39] *Id*. at 148-49. Also citing from the Supreme Court's earlier opinion in the *Stracener* case.

[40] 945 S.W.2d 819 (Tex. 1997).

[41] 2006 WL 1373359 (Tex. App.-Amarillo May 19, 2006, no pet. h.).

[42] 923 S.W.2d 91 (Tex. App.-Ft Worth 1996, writ denied).

[43] 183 S.W.3d 833 (Tex. App.-Waco 2005, pet. filed).

[44] Article 5.06-1(2)(d) states that in order to recover, "actual physical contact must have occurred between the motor vehicle owned or operated by such unknown person."

[45] 2003 WL 21391534 (Tex. App.-San Antonio 2003, pet. denied)(not designated for publication).

[46] *Elchehimi*, 183 S.W.3d at 835.

[47] 201 S.W.3d 200 (Tex. App.-Houston [14th Dist.] 2006, no pet. h.).

[48] 5 S.W.3d 324 (Tex. Civ. App.-Houston [1st Dist.] 1999, pet. denied).

[49] *See Mid-Century Ins. Co. of Tx. v. Kidd,* 997 S.W.2d 265 (Tex. 1999) and *Stracener v. United Servs. Auto. Ass'n.,* 880 S.W.2d 378 (Tex. 1989).

[50] Under Chapter 33 of the Civil Practices & Remedies Code, a finding of 51% or more will result in joint and several liability being imposed so that the third party tortfeasor will have been found liable for up to 100% of the insured's damages.

[51] *See* Section 542.051, *et. seq*. of the Insurance Code. There have been some minor changes in the wording of the new statute, including language which makes it clear that the 18% penalty is interest.

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DEFENDING AN INSURED DURING THE APPEAL OF AN ADVERSE JUDGMENT

Despite the drama of television and the movies, the return of a jury verdict in a civil case has no immediate consequences by itself. In Texas, the verdict is only the jury's answers to the factual questions it was asked to answer. It is then up to the judge to take the verdict, apply the law to the facts as found by the jury, and craft a judgment. In many ways, a judgment is a new beginning. For an insurer, however, the entry of a judgment is probably not the end of the duty to defend an insured that exists under most general liability policies.

Once a judgment is entered, the judgment debtor and its insurer will have a fairly short time to decide whether to appeal an adverse verdict and whether to try to prevent execution on the judgment debtor's assets during the appeal. Those decisions may have to be made within 50 days after the judge signs the judgment, although the deadlines can be extended slightly by filing a motion for new trial or certain other motions that will extend the appellate timetables.

The existence of a judgment against an insured presents new risks to both the insured and its insurer. For an insurer who has been defending an insured from the inception of the case through trial, the entry of judgment is a particularly good time to step back for a second and reevaluate the claim that has ripened into a judgment. Rather than the subjective opinions of the client and the professional advice of defense counsel, the litigation world is framed by the fact findings of a jury and the legal rulings of a trial judge. Some (but not all) of the uncertainty that surrounded the claim has now been stripped away. The jury has decided who to believe and not believe, the judge has decided which legal defenses, if any, have validity, and there is now a concrete value of the damages which the claimant may recover.

The entry of judgment may also be a good time to reevaluate (or perhaps make) a coverage determination on the duty to indemnify. Keep in mind, however, that the defense counsel who knows the most about the case may be ethically prohibited from giving any advice or opinion that could be adverse to the insured he represents. Leave the coverage issues with coverage counsel and do not involve defense counsel in that process.

The entry of judgment is also a crucial time to get good appellate counsel involved in the case, for at least two reasons. First, even the best defense counsel who has worked up a case and has lived through the stress and drama of a trial will have a hard time being completely objective about the merits of a case. For a judgment of any size, a fresh pair of eyes will be very helpful in deciding how to handle the claim from this point forward. Second, appellate law is a very special area. The appellate rules of procedure are completely different than the trial court rules. Many of the presumptions and burdens of proof that governed the trial have now shifted or disappeared entirely. While the knowledge that trial counsel has gained throughout the case is important, the ability to look at the case as an appellate court will is equally vital. A good appellate lawyer provides that for whoever is controlling the appeal of a judgment.

Unless an insured is a large business entity or an especially litigious individual, there is a good chance that the insured knows even less about the appellate process and what it means than the insurer does. Because the appellate world is unknown territory to most insureds, it is especially important to keep an insured informed about what is going on, when the next event in the process will or may happen, and whether any crucial stages in the process are approaching. Because there has now been an adverse judgment, the insurer's actions may be subject to even greater scrutiny then they were before, especially when there is a potential that some or all of the judgment may eventually be the financial responsibility of the insured. An insurer who fails to maintain full and complete communication with its insured risks making a bad situation worse.

This article will focus on the two key questions facing an insurer who has a duty to defend an insured against whom a judgment has been entered. First, does a liability insurer have an obligation, as part of its duty to defend, to appeal an adverse judgment against its insured?

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Second, does a liability insurer have a duty to provide a supersedeas bond or other means of preventing the judgment creditor from trying to execute on the insured's assets during appeal? While there is not much Texas authority on these questions, the majority view across the United States is that (1) an insurer has a duty to appeal an adverse judgment against its insured if there is a reasonable basis for an appeal, and (2) an insurer may have no contractual duty to provide a supersedeas bond for an appeal, the insurer may have to pay the premiums on such a bond, and the insurer may run a risk of bad faith liability if it chooses not to supersede at least that part of the judgment that is covered under the policy issued to the insured.

I. DOES A LIABILITY INSURER HAVE A DUTY TO APPEAL AN ADVERSE JUDGMENT AGAINST AN INSURED?

A. A Duty to Appeal Exists in Some Situations

Waffle House, Inc. v. Travelers Indemnity Co., 114 S.W.3d 601 (Tex. App. – Fort Worth 2003, pet. denied), involved a coverage dispute arising out of a suit by a disgruntled former employee against a restaurant chain. The plaintiff claimed that Waffle House had defamed her and interfered with her business relationships by telling a competing restaurant chain that she had been fired for poor performance, was vindictive, and was trying to entice other employees to leave Waffle House. Waffle House was insured under a primary liability policy by Travelers and an excess umbrella policy issued by Federal. Travelers provided a defense to Waffle House subject to a reservation of rights.

After a bench trial, the federal judge hearing the underlying suit issued an opinion of more than two hundred pages, excoriating Waffle House for its "severe and pervasive sexual harassment" of the plaintiff. The judge awarded a substantial amount of damages for defamation. Based on the court's findings, both Travelers and Federal denied coverage for the claim and refused to pay for a lawyer to represent the insured on its appeal of the judgment. Waffle House then filed a breach of contract action against its insurers. The trial court granted summary judgment for the insurers, agreeing that various exclusions in the policies precluded coverage, and Waffle House appealed.

The court of appeals saw things differently. First, the court held that none of the policy exclusions applied. (The main holding was that the employment-related practices exclusion did not apply because the defamatory statements were made after the plaintiff's employment had terminated in an effort to prevent the competitor from hiring other Waffle House employees, and therefore the damages did not "arise out of" the plaintiff's employment. This holding has been criticized by another Texas court). The court also held that because the defamation allegations in the petition in the underlying case did not refer to the plaintiff's employment, Travelers had a duty to defend Waffle House in the case. Travelers then argued that once the case was tried and an adverse judgment was entered, the duty to defend terminated. The court of appeals quickly rejected this argument:

> Travelers' insurance policy provides that Traveler's duty to defend ends when the applicable policy limits are exhausted by qualifying payments. The policy fails to mention any other situation under which Travelers' duty to defend would end. We hold that Travelers' duty to defend Waffle House continues through the appellate process until the applicable limits of the policy are exhausted according to the terms of the policy.

Waffle House, 114 S.W.3d at 611 (footnote omitted). The court also held that if Traveler's policy became exhausted during the appeal and its duty to defend ended, Federal, the excess carrier, would have a duty to assume the duty to defend until its policy was exhausted. *Id*. at 615.

B. How Broad is the Duty to Defend on Appeal?

The holding in *Waffle House* is consistent with the law in most jurisdictions that an appeal from an adverse judgment is simply the continuation of the defense of a claim against an insured, and therefore the duty to defend extends to appeal until the coverage is exhausted. That does not mean, however, that every adverse judgment has to be appealed by the defendant's insurer.

The majority of states that have considered the issue have held that an insurer has a duty to appeal an adverse judgment against its insured only when there is a reasonable basis for the appeal.[1] A few states impose a broader duty to appeal an adverse judgment.[2] In those jurisdictions that have adopted the "reasonable basis" standard, an insurer who is defending an insured against whom an adverse judgment has been entered faces two important questions. First, what constitutes a "reasonable basis" for an appeal? Second, who makes the decision on whether it is reasonable to appeal a specific judgment?

The first inquiry – whether there is a "reasonable basis" to appeal a case – is not easily answered. The reasonableness of an appeal depends on a variety of facts, such as the precise evidence that was admitted at trial or

whether the issue to be challenged involves a factual finding by the jury (which is usually given great deference by the courts of appeals), a legal ruling by the judge (which gets less respect), or an issue on which the judge had discretion in how to act (which is very difficult to reverse). It may also depend on whether the point in dispute is the subject of fairly settled law in the state or is an issue which the courts of that state have never considered before.

It may be reasonable to appeal an adverse judgment even when the chance of reversing the decision is less than 50%. The fact that an appeal may eventually prove unsuccessful does not mean that the decision to appeal was unreasonable. The standard of "reasonableness" therefore probably means something less than a fifty-fifty chance of success on appeal. On the other hand, when an appeal proves successful, it will be awfully hard to convince anyone that a reasonable basis for the appeal did not exist. Good luck to the insurer who tries to convince a judge or jury that there was no reasonable basis for an appeal of a judgment after the insured appeals the case itself and prevails. *See Heshion Motors, Inc. v. Western Int'l Hotels,* 600 S.W.2d 527 (Mo. Ct. App. 1980) (insurer breached its duty to defend by not financing an appeal by the insured that is successful); *Kaste v. Hartford Accident & Indem. Co.*, 5 A.D.2d 203, 170 N.Y.S.2d 614, 616 (1050) (same).

...the relationship between the insurer and the insured retains the same basic structure it did in the trial court...

As to who makes the decision to appeal, the first responsibility falls on the insurer who has been providing the defense through trial. If the defense counsel that was chosen and paid for by the insurer to represent the insured recommends that an appeal is reasonable and should be taken, it will be difficult for the insurer to disagree. Keep in mind, however, that defense counsel owes a duty to protect the interests of the insured, so a good defense counsel who is doing his or her job will be speaking from the standpoint of the insured, not the insurer. If the insured or its attorneys recommend or demand that an appeal be taken, and the insurer has some doubt about relying on the advice of defense counsel, then it may be appropriate for the insurer to retain separate counsel to advise it on whether there is a reasonable basis for an appeal.

In making a decision on whether to pursue an appeal, there are two additional things to remember. First, several courts that have examined the duty to defend on appeal have invoked vague references to the duty of good faith and fair dealing to protect the insured's interests. Therefore, when there is a close call, the safer course of action will usually be for the insurer to prosecute the appeal on behalf of its insured, subject to a reservation of rights (and a right of reimbursement if it is available).

Second, the time between the date a judgment is signed and the date an appeal must be taken is usually fairly short. This means that the insurer will have to make the decision to appeal fairly quickly. It also means that if an insurer decides that it will not pay for a lawyer to appeal the judgment against its insured, the insurer needs to tell that to the insured far enough in advance of the deadline to appeal that the insured can retain its own counsel and make a decision on whether to appeal before any appellate deadlines pass.

C. Who Controls the Appeal?

Because the duty to defend on appeal is a continuation of the duty to defend at the trial level, the relationship between the insurer and its insured on who controls the appeal remains the same as it was. If the policy language which creates the duty to defend gives the insurer full control of the defense, the insurer has the same degree of control on appeal. If the policy language requires the consent of the insured for any settlement, the insured still has that right on appeal. In other words, while there may be different rules and risks on appeal, the relationship between the insurer and the insured retains the same basic structure it did in the trial court, governed by the insurance policy and any common law duties imposed on the insurer.

An important corollary to this is that in those jurisdictions where an insured has a duty to defend the entire case if any allegation creates a duty to defend, the insurer probably has a duty to pay the attorney who is appealing the case for the entire appeal, even if only some of the issues on appeal relate to covered claims.

D. What if the Judgment Exceeds the Policy Limits or the Findings of the Jury Establish that there is no Duty to Indemnify?

What if the judgment entered by the trial court exceeds the limits of the applicable policy and the only reasonable issue on appeal will perhaps reduce the por-

tion of the judgment the insured (or excess carrier) must pay without impacting the portion of the judgment that is up to policy limits? What about the situation in which the jury has made factual findings that establish a policy exclusion so that there is no duty to indemnify the insured? Does the insurer really have to pay for an appeal in those circumstances where there is no possible benefit to the insurer?

At least one respected commentator thinks the answer is yes. If the determination of whether there is a reasonable basis to appeal is examined from the standpoint of the insured, then an insurer should finance an appeal either (a) if there are reasonable grounds to believe that a judgment in excess of the policy limits might be reversed or materially reduced, or (b) if there are reasonable grounds to believe that a judgment entered one or more noncovered claims might be reversed or reduced. Windt, Allen, Insurance Claims and Disputes: Representation of Insurance Companies and Insureds, § 4.17 (3rd ed.).

When a judgment exceeds the policy limits, some courts have held that the insurer can avoid paying for the insured's appeal by tendering policy limits, while other courts have held that the duty to defend is separate from the duty to indemnify and that paying limits in partial satisfaction of a judgment does not do away with the obligation to pay for the appeal. *See generally*, ABA Tort and Insurance Practice Section, Law and Practice of Insurance Coverage Litigation, v. 1, § 4.26.

While this may seem somewhat unfair – especially having to pay for an appeal after a jury's fact findings mean that an insurer has no duty to indemnify and the main purpose of the appeal is to reverse that finding and bring the claim back into coverage – the rationale lies in the difference between the duty to defend and the duty to appeal. Many jurisdictions recognize that the duty to defend is broader than the duty to defend and that there may be a defense obligation when there is eventually no indemnity obligation. The purpose of the duty to defend is to protect the interests of the insured, and that may include a duty to pay a lawyer to act on behalf of the insured even when it is not in the insurer's best interest.

E. What if the Covered Claims Were Resolved Before Trial?

Another situation that may seem surprising involves a claim where summary judgment was granted on all covered claims, the duty to defend therefore terminates, and the insured continues to defend the case with its own counsel. What if the insured loses at trial and decides it wants to appeal on several grounds, including the summary judgment that was granted on the covered claims? If there is a reasonable basis for the appeal of the summary judgment ruling, then the duty to defend may revive like Lazarus from the grave, and the insurer may find itself paying for an appeal in a case where it thought that the duty to defend had ended many months ago.

F. The Duty to Defend on Appeal and Bad Faith

Some widely-recognized commentators have suggested that there is a strong connection between the duty to defend on appeal and the duty of good faith imposed on an insurer:

> Although this language ["to defend any suit against the insured"] does not explicitly require the insurer to appeal an adverse judgment, when the insurer assumes the defense, it is illogical to suppose the word "defense" relates only to the trial of the action and does not embrace an appeal. More broadly then the policy language on the duty to defend, the insurer owes the insured a duty to act in good faith to protect the insured's interests and, frequently, the only way to accomplish this goal is to appeal a trial court's adverse decision

Holmes' Appleman On Insurance 2d, vol. 22, § 136.22[A]. Another recognized name puts it even more succinctly:

> The test of an insurer's obligation to appeal a case on behalf of the insured is one of good faith and fair dealing on behalf of the insurer, balancing rights of both the insurer and the insured.

Segalla, Couch On Insurance 3d, §200:48.

While not all jurisdictions equate defense on appeal with good faith and fair dealing, most courts will look with great suspicion on an insurer who provides a defense to its insured through trial of the case and then refuses to pay for the insured's appeal from an adverse judgment. Because most states interpret an obligation to defend any suit against the insured to include an appeal of a judgment against the insured, pulling the defense from an insured on appeal, even when the result of a successful appeal is to reinstate coverage on a claim that a jury found was not covered, may well lead to a breach of contract suit and a bad faith claim.

On the old television show *Baretta,* suspects usually

proclaimed their innocence while they were being handcuffed and taken away. Robert Blake's response to their protestations was, "You may beat the rap, but you can't beat the ride." That's also true in the coverage world: an insurer may have no duty to indemnify, but if a duty to defend exists, the insurer will probably have to ride with its insured all the way, even through an appeal. Not only will an insurer often be unable to beat the appellate ride, the insurer will often have to pay for it. It is probably best to sit back, enjoy the ride, and try to find ways to make the journey as short as possible.

II. DOES A LIABILITY INSURER HAVE A DUTY TO SUPERSEDE A JUDGMENT AGAINST AN INSURED DURING AN APPEAL?

As discussed above, once a judgment is entered against an insured, it is only a matter of time before the sheriff may be knocking on the insured's door, looking for property to take and sell at auction for pennies on the dollar in a futile attempt to satisfy a judgment on appeal. If an insurer has decided that it has a duty to defend its insured on appeal, and that there is a reasonable basis for appealing an adverse judgment, what obligations does the insurer have to make sure your insured's property remains the insured's property while the appeal is being resolved?

A. What Can Be Done to Stop the Judgment Debtor's Property From Being Seized?

Texas law provides four ways to stop the execution of judgment during an appeal. It is important to realize that filing a notice of appeal is not one of those ways. Filing an appeal, by itself, does nothing to stop execution on the judgment. Instead, the judgment debtor can stop execution only by doing one of the following:

1) filing a written agreement between the parties with the court;

2) filing a good and sufficient bond;

3) making a deposit in lieu of a bond; or

4) providing alternative security ordered by the court.

See Tex. R. App. P. 24.1(a). While each method has some advantages, the bond, which is commonly called a supersedeas bond in Texas, is by far the most common way to stop execution on a judgment.

The simplest way to supersede the judgment is to make a deposit in lieu of bond. The rules allow a deposit of cash, cashier's check or certain negotiable obligations of the United States government, banks, or savings and loan associations. *See* Tex. R. Civ. P. 24.1(c)(1). The deposit will usually be placed on an interest-bearing account, but for a judgment of any size, few defendants or insurers want to tie up a large cash asset for the year or two it typically takes to get through an appeal. Not surprisingly, deposits of cash or negotiable instruments are rarely used.

An agreement with the judgment creditor can be the least expensive way of superseding a judgment and can be an effective tool for a debtor who has few non-exempt assets, but it can be very difficult to get a judgment creditor to agree on something other than a bond when its lawyer knows that an insurer is standing behind the judgment. The judgment creditor can insist on a supersedeas bond as a condition not to execute, so the insurer will probably have to promise the plaintiff something he would not otherwise be able to get in order to avoid the need for a bond.

The Texas rules allow for alternative security, but does not indicate what alternative is acceptable other than whatever is "approved by the court." Given the recent changes in the amount of the supersedeas bond that must be posted (and are discussed below), it is not likely that a court will order alternate security unless the judgment creditor is willing to accept it.

B. What Does it Take to Post a Supersedeas Bond?

A supersedeas bond is a promise by the judgment debtor and a third-party surety to pay the judgment amount to the judgment creditor if an appeal is not pursued or if the appeal proves unsuccessful. There are three main issues involved in obtaining a supersedeas bond:

1) What are the conditions of the bond?

2) Who can be the surety on the bond?

3) How large does the bond have to be?

1. Conditions of the Bond

Texas Rule of Appellate Procedure 24.1(d) establishes the conditions of the bond. When the judgment awards money damages, the bond must provide that the judgment debtor and the surety will be liable for all damages

and costs that may be awarded against the judgment debtor, up to the amount of the bond, if (1) the judgment debtor does not perfect an appeal or the appeal is dismissed or (2) the debtor does not pay the judgment once it becomes final. This means that, as long as the appeal is going on, a supersedeas bond cannot be enforced. Once the appeal is no longer going forward, either because it was not pursued by the judgment debtor or all appeals have run out, the judgment debtor and the surety are obligated to pay the judgment.

2. Parties to the Bond

As to who may be a surety, the rules only provide that the bond must be payable to the judgment creditor, signed by the judgment debtor, and "signed by a sufficient surety or sureties as obligor." Tex. R. App. P. 24.1(b)(1). A judgment debtor cannot be its own surety, because the whole idea of the bond is to provide a source of satisfaction of the judgment other than the debtor. In large counties, the clerk's office usually maintains a list of insurance companies it is willing to accept as a surety. If the surety a judgment debtor wants to use is not on the list, or in a smaller county that does not maintain a list, it is usually best to try to get the judgment creditor to agree on the sufficiency of the proposed surety (which should be no problem with a reputable insurer serving as surety) or, failing that, get a quick ruling from the judge on the sufficiency of the surety.[3]

If a judgment against a party is covered by insurance, however, it will be very difficult to show substantial economic harm in posting the bond.

3. Amount of the Bond

The major issue in posting a supersedeas bond is determining the amount of the bond. At one time, Texas law required the bond be in the full amount of the judgment plus interest that would accrue during the appeal. Although quite a few defendants complained about that requirement, it was not until the decision in *Texaco v. Pennzoil*, where Texaco was going to be required to post a bond of more than $12 billion (it eventually reached an agreement with Pennzoil in lieu of a bond) that Texas changed its rule. The first change to the rule authorized the court to accept a bond in a lesser amount of the judgment debtor showed that it would suffer "irreparable hardship" if it was required to post the full amount.

In 2003, the Texas Legislature adopted a new statute that limited the amount of a supersedeas bond to the lesser of (1) 50% of the judgment debtor's net worth) or (2) $25,000,000. In other words, despite the size of the judgment, the largest amount that can ever be required of a supersedeas bond is $25 million. The Texas Supreme Court has amended the supersedeas bond rule to enforce this change. *See* Tex. Civ. Prac. & Rem. Code § 52.006(b); Tex. R. App. P. 24.2(a). The statute and rule also allow a bond in even a smaller amount if the judgment debtor can show "substantial economic harm" if it has to post a bond in the amount required by the statute and rule. There is no clear definition of what "substantial economic harm" is, but it probably means something less onerous than the old "irreparable hardship" standard. The most likely showing of "substantial economic harm" is in the situation of a company that needs its cash assets to meet current expenses and keep operating, and there may be others. If a judgment against a party is covered by insurance, however, it will be very difficult to show substantial economic harm in posting the bond.

How does the court determine a defendant's net worth in order to determine the maximum amount of the bond? It is probably not surprising that most plaintiffs do not want to accept the defendant's version of its net worth if that version results in a reduced supersedeas bond. Texas Rule of Appellate Procedure 24.2(c) establishes a three-step process to determine net worth. First, if the judgment debtor wants to claim that it is entitled to a reduced bond that is limited to 50% of its net worth, the debtor must file an affidavit that states the net worth "and states complete, detailed information concerning the debtor's assets and liabilities from which net worth can be ascertained." The affidavit constitutes prima facie evidence of the debtor's net worth. If the judgment creditor is not willing to accept that proof, it can file a contest to the affidavit and is allowed to conduct "reasonable discovery concerning the judgment debtor's net worth. Third, once discovery is completed, the court must hold a hearing at which the judgment debtor has the burden of proving net worth. The court must issue an order that "states the debtor's net worth and states with particularity the factual basis for that determination."

What is the judgment debtor has insurance that will

pay for the judgment if it is not reversed on appeal? From an accounting standpoint, the right of indemnity or reimbursement from an insurer is not an asset and therefore is typically not included in net worth determinations. From a practical standpoint, if the debtor is fully insured for the judgment, it seems unfair to reduce the bond if the eventual liability will rest with the insurer rather than the insured. But what if the issue of coverage has not been determined?

During the 2003 legislative session, there were discussions about defining net worth and how to calculate it, and there were statements by at least one legislator that a defendant's insurance should be included in any definition of net worth. In the end, neither the Legislature nor the Texas Supreme Court adopted a definition of net worth, so there is no clear answer to the question of how insurance coverage affects the amount of the supersedeas bond. There will no doubt be plenty of fights about this in the near future.

When net worth is not an issue, and the judgment debtor will be required to post a bond in the full amount required by the appellate rules, it is impossible to make an exact calculation of what that amount will be. The rule states that the amount of the judgment "must equal the sum of compensatory damages awarded in the judgment, interest for the estimated duration of the appeal, and costs awarded in the judgment. The amount of compensatory damages can be easily determined from the judgment (and does not include punitive damages) as is the amount of costs. The interest element, however, has two variables. First, the postjudgment interest rate in Texas now floats between 5% and 10%, based upon a rate published by the State of Texas (it is currently around 7.5%). A judgment will usually recite a specific interest rate, but what is the judgment allows interest "at the maximum rate allowed by law: and the state-determined rate goes from 7.5% to 8%? Does the bond amount need to be changed? There is no clear authority on this issue.

The one absolute unknown, however, is how long the appeal will last. There are fourteen intermediate courts of appeals in Texas, based on geography, and some courts move much more slowly than others. The length it takes to resolve an appeal depends on several other factors, such as the complexity of the case, how quickly the appellate record can be put together and filed, whether or not the court allows oral argument on appeal, and whether the case is eventually appealed to the Texas Supreme Court. An appeal that might take a few months on one court of appeals may take a couple of years in a different appellate court.

Because of the uncertainty about the length of the appeal, it is usually a wise idea to try to get an agreement with the plaintiff or its attorneys about the amount of the bond. Not too long ago, many courts were willing to assume that one year's interest on the judgment amount would be sufficient, but most courts now expect the appellate process to move more slowly. Most reasonable plaintiff's counsel will be willing to accept eighteen months to two years as a reasonable estimate of the time for appeal. This means that the bond typically needs to be in the amount of the compensatory damages plus an additional 12 to 15% to cover interest during appeal.

The court clerk is given the initial responsibility in determining whether a bond complies with all the statutory requirements will be accepted. If you can obtain the agreement of the judgment creditor on the surety and amount of a bond, the court clerk will almost always accept the bond you offer. If the clerk will not accept your bond, or if the bond is accepted and the judgment creditor is unhappy about the amount or surety, there are procedures for the trial court to determine the adequacy of the bond. There are also procedures for appellate court review of a trial court determination of the bond and for changing the amount of the bond if appropriate (for example, if the appeal drags on longer than expected).

C. Who is Responsible for Posting a Supersedeas Bond?

When an insured has had an adverse judgment entered against it, and its insurer has decided to appeal the judgment, which of them is responsible for securing and posting a supersedeas bond? In addition to the logistics of the paperwork, there are at least two economic issues involved: who pays for the premium on the bond, and who provides any collateral that may be required by the surety?

Most liability policies require the insurer to pay the premium on a supersedeas bond (which is probably called an "appeal bond" in the policy). Many courts have read this to mean that the insurer has to pay the entire premium on the bond, even when the amount of the judgment exceeds the policy limits. *See Burford Eqpt. Co. v. Centennial Ins. Co.,* 857 F. Supp. 1499, 1504-05 (M.D. Ala. 1994); *Continental Cas. Co. v Kinsey,* 513 N.W.2d 66 (N.D. 1994). In any policy that requires the insurer to pay the premium on an appeal bond, the insurer will most likely have to pay the premium on the full amount of the bond.

Whether the insurer also has to provide the bond itself, however, or to provide collateral required by a surety, is another matter. Generally, the obligation to pay premiums on a bond does not require that the insurer apply for or furnish a bond. *Cathay Mortuary v. United Pac. Ins.*

Co., 582 F. Supp. 650 (N.D. Cal. 1984). The duty to pay the bond premium is only that, and therefore the duty to pay the premium "would be triggered only if the insured is able to qualify for and procure a bond on its own." Windt, INSURANCE CLAIMS AND DISPUTES § 4.17 (3d ed.).

When part or all of the judgment against an insured is a covered loss, however, the insurer may be subjecting itself to the risk of bad faith liability if it does not assist the insured in obtaining a bond for at least the covered portion of a loss. Because the liability for the covered portion of the judgment is ultimately the insurer's financial responsibility, an insured that is appealing a covered judgment and opens his door and finds the constable looking for property to seize because no supersedeas bond has been posted will not be very happy. If coverage for the claim has been confirmed, there is no reason the insured's assets should be taken to satisfy the judgment.

If coverage for the claim has been confirmed, there is no reason the insured's assets should be taken to satisfy the judgment.

For example, in *Reserve Ins. Co. v. McPeak,* the insurer issued an automobile policy with a $10,000 occurrence limit. The insured was sued following an auto accident, the insurer provided the defense, and a judgment for $15,000 was entered against the insured and another driver jointly and severally. The plaintiff told the insurer that it was willing to accept half the judgment amount in satisfaction of the insured's liability (which was within the $10,000 limit), but the insured appealed and did not post an appeal bond. The plaintiff had a writ of execution issued against the insured, who paid the judgment to avoid losing her property. When she sought recovery of the payment, the insurer claimed that it was a voluntary payment made without the insurer's consent. The court held that the insurer was obligated to reimburse the insured because "it was the duty of the insurer to insulate the insured from an execution of the judgment," the insurer was guilty of bad faith because it breached its duty under the auto policy. 181 So.2d at 664. (The court also noted that payment of the judgment by the insured in the face of a writ of execution could not be considered a voluntary payment).

What if the amount of the judgment is greater than the policy limits and the judgment creditor has not agreed to accept an amount within policy limits? What duty might the insurer have in connection with obtaining a supersedeas bond? The courts are split. In *Seessel v. New Amsterdam Cas. Co.,* 204 S.W. 428, 429 (Tenn. 1918), the court held that an insurer that has full control of the defense has the duty to post a supersedeas bond for the full amount of the judgment, even if exceeds policy limits, because the law "does not release a party to the contract from liability already incurred, because, in order to remove that liability, it becomes necessary to incur the risk of greater liability." On the other hand, in *Kennelly v. London Guarantee & Accid. Co.,* 184 A.D.1, 171 N.Y.S. 423 (1918), the court held that the insurer had an obligation to provide an appeal bond only for its share of the liability under a judgment that exceeded the policy limits. Although there is not much authority, more recent cases tend to follow the rule that an insurer only has to post an appeal bond for an amount in excess of policy limits. *See Continental Cas. Co. v. Kinsey,* 513 N.W.2d 66 (N.D. 1994); *Bowen v. Government Employees Ins. Co.,* 451 So.2d 1196, 1197-98 (La. App. 1984).

The situation becomes even more unclear when there is a dispute about coverage that has not been resolved by the time that it becomes necessary to file a supersedeas bond. While many jurisdictions are happy to entertain quick declaratory judgment actions on the duty to defend, the duty to indemnify cannot always be determined until after the underlying suit against the insured is resolved. If an insurer wrongfully refuses to indemnify its insured on a claim, and the insured is unable to post a supersedeas bond during an appeal, the insurer may find itself responsible for any loss the insured suffers if its property is seized in execution of a judgment. To the extent there is a good faith obligation on the insured in connection with the duty to indemnify, that same duty will probably extend to arranging for a bond for at least the portion of a judgment that eventually is found to be covered under a policy.

What about the situation where an insured is found to have intentionally committed a loss and the applicable policy excludes intentional conduct? As mentioned earlier, the insurer may have a duty to pay for lawyers to appeal the judgment to protect the insured's interests. Is there also a duty to provide a supersedeas bond in that situation? There may be, depending on whether the eventu-

al liability determination against the insured, but it is hard to imagine an insurer being in bad faith in not providing a bond when the judgment is based on conduct of the insured that is not covered under the policy.

There is very limited authority on many of the issues relating to posting bonds to prevent execution against the insured's property pending an appeal of an adverse judgment. In jurisdictions which allow an insurer to be reimbursed by its insured if the insurer makes a payment on behalf of the insured relating to a claim that eventually is found not to be covered, the wiser course of action may be to provide a supersedeas bond to the insured when there is any doubt about the obligation to do so, and relay on the reimbursement right if the insurer's coverage position is later vindicated. In other states, it may be possible to reach an agreement with the insured that would create a contractual right of reimbursement where one does not exist at common law. In some situations, it may be prudent to provide a bond even when there is no right of reimbursement (or where the right is meaningless because of the insured's financial condition, at least up to the amount of the policy limits).

Uncertainty in the extent of the insurer's obligation to post a supersedeas bond creates risk. That risk may be accelerated because most plaintiffs are not willing to forego execution on a judgment if they do not have to, so the decisions on whether a bond has to be posted and, if so, how much, usually have to be made pretty quickly. If a judgment is entered against an insured, the insurer must be prepared to face these issues quickly, because the insurer will seldom have the luxury of a long time to contemplate what to do.

III. CONCLUSION

An insurer's duty to defend its insured does not necessarily end because the insured has suffered an adverse judgment. Once a judgment is entered, the insurer may face new obligations, including paying at attorney to pursue an appeal on behalf of the insured (maybe even including claims that are not covered under the policy), paying the premiums on a supersedeas bond, and perhaps providing collateral for the bond (at least up to the amount of the judgment that is covered under the policy). The decision on whether to appeal, and how to protect an insured during the appeal, have to be made quickly, so an insurer must view the entry of an adverse judgment against its insured as a new beginning rather than the end of its obligations.

[1] *See, e.g., Jenkins v. Insurance Co. of North America,* 220 Cal. App. 3d 1481, 272 Cal. Rptr. 7 (1990); *Aetna Ins. Co. v. Borrell-Bigby Elec. Co.,* 541 So.2d 139 (Fla. Dist. Ct. App. 1989); *Illinois Founders Ins. Co. v. Guidish,* 618 N.E.2d 436 (Ill. App. 1993); *Reichert v. Continental Ins. Co.,* 290 So.2d 730 (La. App. 1974); *Fidelity Gen. Ins. Co. v. Aetna Ins. Co.,* 27 A.D.2d 932, 278 N.Y.S.2d 787 1967).

[2] *Koppie v. Allied Mutual Ins. Co.,* 210 N.W.2d 844, 847 (Iowa 1973) (insurer has duty to appeal if there is "any ground for appeal"); *Palmer v. Pacific Indem. Co.,* 74 Mich. App. 259, 254 N.W.2d 52, 55 (1977) (insurer has an absolute duty to prosecute an appeal from any judgment adverse to the interests of the insured).

[3] A judgment debtor cannot serve as its own surety. *Elliott v. Lester,* 126 S.W.2d 756, 759 (Tex. Civ. App. – Dallas 1939, no writ). According to the San Antonio Court of Appeals, a wholly-owned subsidiary of a judgment debtor cannot serve as a surety for its corporate parent. *TransAmerican Natural Gas Corp. v. Finkelstein,* 905 S.W.2d 412, 414 (Tex. App. – San Antonio 1995, no writ).

Comments FROM THE EDITOR

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

Initially I want to thank two Section members for answering the call for help in editing articles. Terry M. Carroll, Jr., a partner in the Victoria law firm of Walker, Keeling & Carroll, L.L.P. and Pamella Hopper, Senior Counsel with the Austin office of Nickens, Keeton, Lawless, Farrell & Flack, L.L.P., both provided significant editing and proofreading assistance with the articles in this issue of *The Journal.* On behalf of the Section, thank you for your great work that made this issue of the *JTIL* possible.

I also want to recognize and thank our new Assistant Editor, Kim Steele, Special Counsel to Sedgwick, Detert, Moran & Arnold, L.L.P. in Dallas. She was instrumental in helping me edit and finalize this issue of *The Journal.*

If you have an article you would like to publish for the benefit of the Section, we still have some openings in our remaining issues for 2007. Call or e-mail me with your ideas if you are interested.

Finally, I want to thank the members of our Section and the Council for the opportunity to serve as the Editor-in-Chief of *The Journal of Texas Insurance Law*. It is a labor of love and I appreciate the opportunity to be of service to all of our members. As always, if anyone has ideas on how to make this publication better, please let me know.

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