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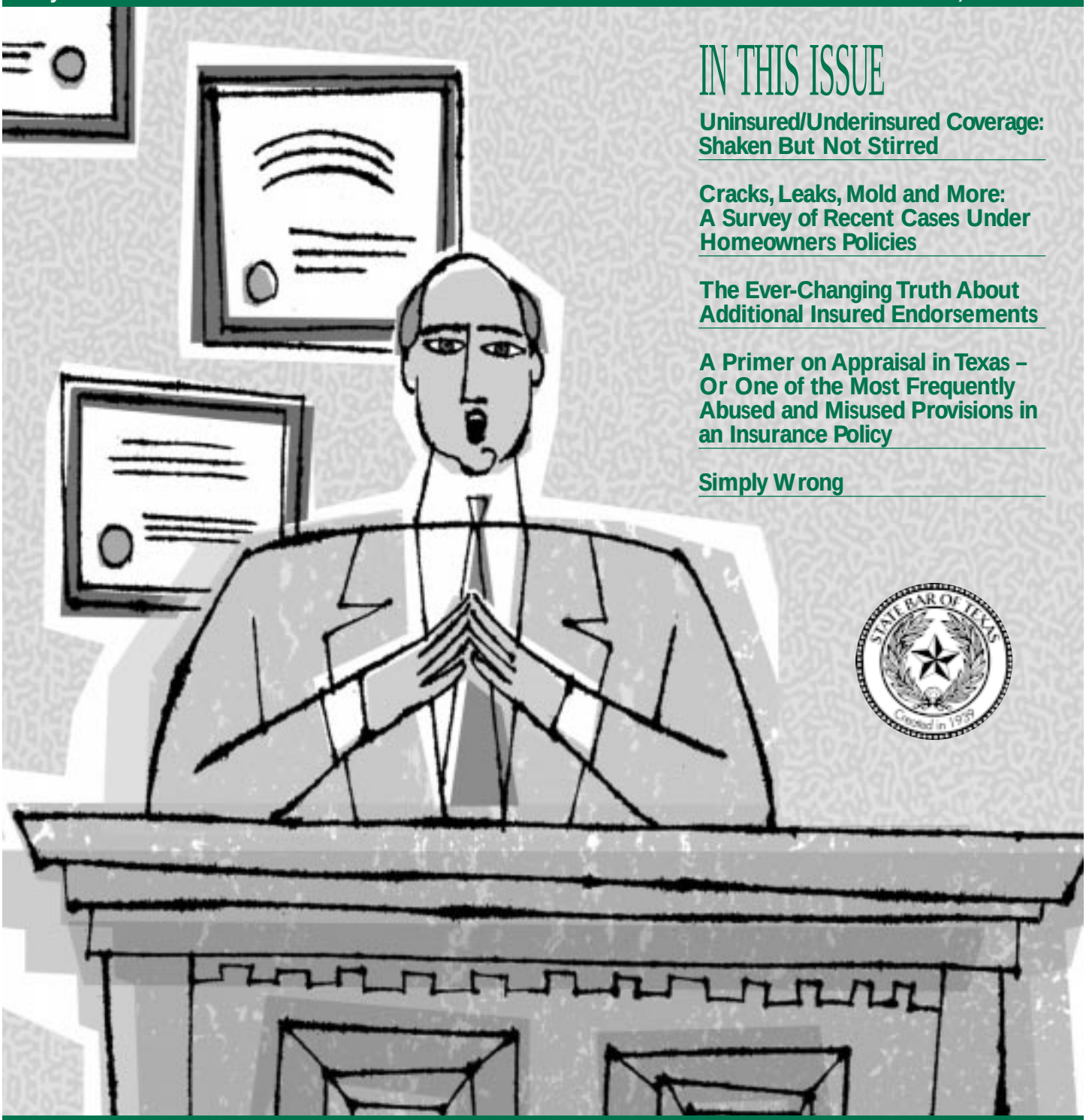

IN THIS ISSUE

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

Journal of Texas Insurance Law

EDITOR-IN-CHIEF
Christopher W. Martin
Martin, Disiere, Jefferson & Wisdom, L.L.P.
808 Travis, Suite 1800
Houston, Texas 77002

PUBLICATION DESIGN
Bob Peretti
Peretti Design
713-502-6153

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

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

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Comments FROM THE CHAIRMAN

BY JAMES CORNELL
Haynes & Boone, L.L.P.

In 1995, Ernest Martin and I set out on a mission that we were not certain we could ever achieve: creating the Insurance Law Section for the State Bar. For over two years, Ernest and I met with numerous Bar leaders, Section leaders, and Bar Board members, gathered hundreds of signatures on petitions, established a network of interested attorneys across the State, filled out forms and wrote By Laws and Mission Statements. After countless hours of grass-roots work by many attorneys across the State, the Section was approved by the State Bar in 1998. We started out with about 350 members. Six years later, we have close to 1500 members, and we are still growing.

This year, I have tried to focus my term on the basics. Over the past year, I have spoken with many leaders in other sections and I have come to believe that attorneys join sections for three primary reasons: to network with other attorneys with similar interests; to receive the official publication or Journal; and, to enjoy the benefits of the specialized CLE. These are the services that I have focused on this year. Judging from the positive responses that I have received from scores of members, we have been successful.

We have accomplished goals this year never before achieved by this Section. We have published three Journals, have co-sponsored two successful CLE programs, have launched an ambitious telephonic CLE program, and have planned a two day CLE program in June as well as a CLE program in connection with our annual meeting at the State Bar. We have also dramatically increased our membership. We have continued to send out our weekly case law update "Hot Off The Press" delivering the latest case law right to your computers. We have strengthened our relationship with the State Bar and are seeking new opportunities to coordinate new activities with the Bar. All of this could not have been achieved without the help of members of our Council. I am very pleased that I will leave the Section at the end of my term in good shape for the future.

Publishing a Journal takes more time and coordination than you can ever imagine. Before you can finish one issue, you are already working on the next. It is an endless process. Each step has multiple deadlines requiring the coordination of numerous people, from authors to proof-readers to publishers to shippers and mailers. A setback at any step delays the entire process, rippling throughout each remaining step. I know this because I have tried to assist our Editor-in-Chief, Chris Martin, this year with some of the innumerable tasks and deadlines. For one final time, I would like to thank Chris Martin for his never-ending contributions to this Journal and the Section. I doubt if we would have a Journal without Chris' unfaltering efforts.

Finally, I would like to thank all of the authors who have contributed to the Journal this year. Their contributions have made this Journal the best in the State Bar. And, last but not least, I would like to thank Olga Georgette Otero, Rabecca Cross and Trevor Hall for their assistance in proofing and editing this Journal. Their contributions have provided great assistance in this very complex and time-consuming undertaking.

James L. Cornell
Chair – Insurance Law Section

BY JANET COLANERI

COLANERI & MASSAD, ARLINGTON, TEXAS

Uninsured/Underinsured Coverage: Shaken But Not Stirred

I. UNINSURED/UNDERINSURED MOTORIST COVERAGE-AN OVERVIEW OF THE BASIC ELEMENTS OF COVERAGE

The relationship of insurer to its insured is that of contracting parties, and their respective duties are established by the terms of the policy.[1] However, unlike most relationships where the terms of the contract are freely negotiable between the parties, the business of insurance is a highly regulated industry in Texas. That regulation has extended to create the basic terms of the "standard" Texas personal automobile policy– "standard" because the Texas Legislature spells out the minimum coverage recognized by law and requires the use of a prescribed form, approved by the Texas Board of Insurance.[2] The purpose of this article is to provide an overview of Uninsured/Underinsured Motorist protection (UM/UIM coverage) in light of its statutory basis, and explore some of the current trends and important caselaw defining the basic scope of coverage. This article does not address all of the policy's exclusions or limitations that may apply.

II. STATUTORY BASIS

As part of the Legislature's attempts to safeguard motorists operating on Texas roads, the "Texas Motor Vehicle Responsibility Act" requires every operator of a motor vehicle in the state to demonstrate proof of "financial responsibility" for damages the person may become liable to pay because of an automobile accident.[3] To further this requirement, all auto liability policies issued for delivery in Texas must comply with the Act and provide certain minimum coverage. First and foremost, the policy must cover the insured's liability for bodily injury or property damage arising out of the ownership, maintenance or use of the auto, and offer policy limits in amounts that meet or exceed the Act's minimum requirements.[4] The Legislature currently requires auto liability coverage in the following amounts:

> (1) $20,000 for bodily injury to or death of a person in a single auto accident;
> (2) $40,000 for bodily injury or death of two or more persons in a single auto accident, subject to the amounts for each person stated above; and
> (3) $15,000 for damage to or destruction of property of others in one auto accident.

But not all motorists carry sufficient liability insurance to cover the damages incurred in an auto accident for which they may be responsible. To protect the driving public and their passengers from financially irresponsible, negligent motorists, article 5.06–1 of the Texas Insurance Code requires all auto liability policies issued in compliance with the Texas Motor Vehicle Responsibility Act to provide UM/UIM coverage.[6]

UM/UIM coverage is often viewed as a corollary to liability coverage and supplies the injured party with financial protection against injury that should have otherwise been satisfied by the negligent motorist. Because UM/UIM protection is required as a matter of public policy, limitations on coverage that undermine this policy are invalid.[7] UM/UIM coverage must be offered and issued in amounts that are at least equal to the minimum coverage required for liability insurance under the Texas Motor Vehicle Responsibility Act.[8] The insured may request additional coverage, but not for amounts that are greater than the insured's own liability limits.[9]

Janet Colaneri, the senior partner of Colaneri & Massad, has practiced exclusively in the field of insurance defense since her graduation from the University of Arkansas Law School in 1984. Ms. Colaneri is Board Certified by the Texas Board of Legal Specialization in Personal Injury Trial Law and Civil Trial Law. She is an "AV" rated attorney. Ms. Colaneri co-authored the treatise: Texas Standard Automobile Insurance Policy Annoted. The third edition has been released and is now available for purchase through The Texas Lawyer.

Under article 5.06–1, UM/UIM coverage consists of coverage for payment to the insured of all sums that he is legally entitled to recover as damages from the owner or operator of an underinsured motor vehicle because of bodily injury or property damage.[10] This requirement is written into the standard policy's insuring agreement for UM/UIM Coverage, which recites in relevant part:

> ***PART C – UNINSURED/ UNDERINSURED MOTORISTS COVERAGE INSURING AGREEMENT***
> *We will pay damages which a covered person is legally entitled to recover from the owner or operator of an uninsured motor vehicle because of bodily injury sustained by a covered person, or property damage, caused by an accident.*

The insurer's obligation to pay damages is reduced by the amount recovered or recoverable from the insurer of the underinsured motor vehicle.[11]

A. Rejection of UM/UIM Coverage

Unlike the minimum coverage requirements for auto liability insurance, article 5.06–1 of the Insurance Code allows an insured to reject UM/UIM coverage.[12] If UM/UIM coverage is properly rejected, the insurer is not required to provide coverage in later renewals or supplements unless the insured requests coverage in writing.[13] But, absent a valid rejection, UM/UIM coverage is included in the policy as a matter of law, regardless of the parties' intent at the time the policy was issued.[14] If coverage is deemed because there was no valid rejection by a named insured, then UM/UIM coverage exists in an amount that is at least equivalent to the statutory minimum for auto liability insurance.[15]

UM/UIM coverage may only be rejected in writing by an insured who is "named in the policy." For example, in Old *American County Mutual Fire Insurance Co. v. Sanchez*, the Austin Court of Appeals recently held that a wife's rejection of UM coverage for her husband was ineffective, even though she was named in the policy application for her husband's policy, because she was not explicitly named as an insured in the policy declarations.[16]

The Insurance Code does not require any specific language to effectively reject UM/UIM coverage.[17] But, a rejection of UM/UIM coverage must be express and clear, otherwise, it is ineffective. For example, in *Unigard v. Schaefer*, the Texas Supreme Court held that a written endorsement that excluded all coverage while a specific driver was operating the vehicle was ineffective as a rejection of UM coverage, because it failed to specifically state that the insured was rejecting UM coverage.[18] By contrast, in *Sims v. Standard Fire Ins. Co.*, the Houston Court of Appeals held that a similar endorsement effectively rejected UM coverage when the excluded driver was operating the vehicle, where the rejection stated: "You further agree that this endorsement will also serve as a rejection of Uninsured/Underinsured Motorists Coverage and Personal Injury Protection Coverage."[19]

B. Covered Person

Although article 5.06–1 mandates UM/UIM coverage to protect the owner or operator of a motor vehicle for damages caused by an uninsured or underinsured motorist, the statute does not otherwise define the class of persons who must be included within the scope of coverage. Nevertheless, under the UM/UIM coverage, the standard policy broadly defines the term "covered person" to include:

> *1. You [the named insured] or any **family member**;*
> *2. Any other person **occupying** your covered auto;*
> *3. Any person for damages that person is entitled to recover because of bodily injury to which this coverage applies sustained by a person described [above]*

In the majority of cases, this definition is broad enough to provide coverage for the named insured and his or her family members for damages they may receive while occupying any auto, as well as all occupants of the insured's covered auto. The definition also includes statutory and common law beneficiaries who are entitled to recover for injuries the named insured or a covered occupant might sustain. But within this broad definition, the question of "who" is *covered person* can and does arise.

1. Family Member. The policy defines the term "family member" to include "a person who is a resident of your household and related to you by blood, marriage or adoption." Most of the cases considering this definition turn on the issue of whether the person claiming coverage is a "resident" of the named insured's household. In these cases, courts have recognized that a person can have more than one residence or be insured as a household member, even if they are not presently living within the home, especially when the person is a minor.[20] The test commonly applied by the courts is whether the absence of a party is intended to be temporary or permanent and considers such factors as the person's relationship to the household, the nature of the stay, and the intent of the parties to live as a family unit.[21]

But whether the named insured is a corporation or other business entity, the definition of "family member" generally has no application in broadening the scope of coverage. For

example, considering the plain meaning of the term "family member," in *Grain Dealers Mutual Insurance Co. v. McKee*, the Texas Supreme Court held that a corporation insured under business automobile insurance policy cannot have a "family" as that term was commonly understood.[22]

2. Occupants. With regard to persons who seek UM/UIM and do not qualify as "family members" of the named insured, the standard policy covers any person "occupying your covered auto." The standard policy defines "occupying" broadly to mean "in, upon, getting in, on, out or off." Mere contact with the vehicle does not appear to be sufficient to constitute "occupying" a vehicle as defined in the policy. For example, in one summary judgment case, the term "occupying" did not include touching a vehicle while the person was working on it from below.[23] In contrast however, in where the claimant was resting his entire weight on fender while working under raised hood, the court found this evidence to be sufficient to raise a question of fact that was appropriate for a jury to consider.[24]

3. Excluded Drivers. Aside from the definition of "covered person," personal auto liability policies are increasingly issued with a "named driver exclusion," which is written into the policy by a separate endorsement. The endorsement excludes all coverage under the policy when the named person is operating the vehicle. The standard 515A endorsement approved by the Texas Department of Insurance provides:

> You agree that none of the coverages afforded by this policy shall apply while [NAMED DRIVER] is operating your covered auto or any other motor vehicle. You further agree that this endorsement will serve as a rejection of Uninsured/ Underinsured Motorists Coverage and Personal Injury Protection Coverage while your covered auto or any other motor vehicle is operated by the excluded driver.

In the context of liability coverage, the "named driver exclusion" has been upheld on public policy grounds because it serves the useful purpose of suspending coverage when a specific person, considered or known to be an unsafe or unlicensed driver, is operating the covered vehicle.[25] Following this rationale, the policy's named insured is encouraged to limit the unsafe driver's access to the vehicle in exchange for a reduction in premiums.

In the context of liability coverage, the "named driver exclusion" has been upheld on public policy grounds…

But the validity of the named driver exclusion has not been directly addressed by lower courts with regard to UM/UIM coverage. In fact, this issue has been specifically reserved by at least one lower court.[26] Nevertheless, the policy reasons supporting the validity of the named driver exclusion with regard to liability insurance appears to be equally applicable to UM/UIM coverage, so long as the policy also contains the named insured's written rejection of UM coverage for the excluded driver. Although the Texas Supreme Court has had the opportunity to consider the validity of the named driver exclusion directly, it has not yet done so.[27]

C. Legally Entitled to Recover.

A common misconception is that the UM/UIM provisions of the standard policy create unconditional coverage for injuries the insured receives as the result of acts by an uninsured or underinsured motorist. To the contrary, the insurer is only obligated to pay what the insured is *"legally entitled to recover"* from the uninsured or underinsured motorist.[28] This requirement has been construed as a "condition precedent" to the insurer's obligation to pay UM/UIM benefits.[29] That is, until the insured establishes that he is "legally entitled to recover" from an uninsured or underinsured motorist, the insurer has no obligation to pay UM/UIM benefits.[30]

The phrase "legally entitled to recover" is not defined in the policy or by statute, but because this language triggers the insurer's obligation to pay UM/UIM coverage, it has been the subject of numerous published opinions and is the most pressing unresolved issue affecting UM/UIM coverage before the courts today.

The Texas Supreme Court has interpreted the phrase "legally entitled to recover" to mean, "the insured must be able to show fault on the part of the uninsured [or underinsured] motorist and the extent of the resulting damage."[31] Although the Court has not altered this definition, recent caselaw suggests that it is moving towards a narrow interpretation that would require the insured to obtain a judgment or agreement, establishing the motorist's liability for damages before UM/UIM coverage is triggered.

In *Henson v. State Farm Bureau Cas. Ins. Co.*, the Texas Supreme Court attempted to clarify when the insurer's obligation to pay UM/UIM benefits arises, not by addressing the question directly, but indirectly – by explaining when the

obligation does not arise.[32] In that case, the insured, Henson, sued both the motorist and State Farm Bureau, Henson's UM/UIM insurer. Prior to trial, and with State Farm Bureau's consent, Henson then settled his claims against the motorist for the motorist's liability policy limits, but without any admission of liability. After a judgment was entered by the trial court establishing the motorist's liability and damages in excess of her liability limits, State Farm Bureau tendered the UM/UIM policy limits to Henson. But Henson refused the tender, demanding pre-judgment interest on top of UM/UIM policy limits.

In holding that Henson was not entitled to pre-judgment interest on top of UM/UIM benefits, the Court observed that an insurer owes pre-judgment interest on top of policy limits only if it withholds those policy limits in breach of the insurance contract. The Court explained that an insurer's duty to pay UM/UIM benefits is not triggered by filing a claim with the insurer or by filing suit against the motorist, but by establishing that the insured is "legally entitled to recover" from the motorist. The Court then noted that Henson did not establish that he was legally entitled to recover from the motorist at any time prior to entry of the judgment. Accordingly, the Court held that State Farm Bureau did not breach its contract because it promptly paid the policy limits following the judgment.

Henson suggests that in the absence of a settlement or agreement containing an admission of liability by the motorist, the insurer's obligation to pay UM/UIM benefits does not arise until a judgment establishing the motorist's liability and the amount of damages is entered that exceeds the motorist's liability insurance limits. To establish a motorist's liability for damages, the insured can sue the motorist, bring a direct action against its insurer, or join both in the same lawsuit.[33] But, absent an agreement, an insurer's failure to pay UM/UIM benefits prior to entry of a judgment will not support a claim for breach of contract because the claim is not yet mature.[34] However, the Court's subsequent opinion in *Allstate v. Bonner* makes this aspect of *Henson* somewhat unclear.

In *Allstate v. Bonner*, the Court revisited the issue of when an insurer's obligation to pay UM/UIM benefits arose.[35] In that case, Bonner, the insured, brought suit against Allstate to recover UM/UIM benefits and penalties for failing to timely acknowledge the insured's claim under the Prompt Payment of Claims Act.[36] Prior to suit, Bonner submitted a notice of her claim for personal injury protection ("PIP") benefits, along with a chiropractic bill for $1,802.00. Allstate acknowledged the claim and paid Bonner $1,802.00 under her PIP coverage. Bonner then submitted notice of her claim for uninsured motorist benefits, which Allstate received but failed to acknowledge within 15 days as required by the article 21.55 of the Texas Insurance Code. When Allstate declined to pay additional benefits, Bonner filed suit directly against Allstate and obtained a verdict establishing that the uninsured motorist was negligent in causing the accident. The jury found that Bonner was entitled to recover $1,000.00 for chiropractic care, but nothing for pain and suffering. The jury also awarded Bonner $7,500.00 in statutory attorneys fees against Allstate under article 21.55. But because the policy contained a non-duplication of benefits provision, allowing Allstate to offset the PIP payments it previously made against the damages found by the jury, the trial court entered a take-nothing judgment against Bonner.

The Texas Supreme Court upheld the take-nothing judgment. The Court observed that a "claim," which triggers the insurer's duties under article 21.55, was defined as one "that must be paid" by the insurer directly to the insured. Citing *Henson*, the Court recognized that that to recover UM benefits under the policy, Bonner had to satisfy all applicable policy provisions. Here, because the non-duplication of benefits provision allowed Allstate to offset the PIP benefits Allstate previously paid, the Court noted that Bonner had the burden of proving she was entitled to recover more in damages than she had already received. But Bonner only proved damages that she was entitled to recover less than what Allstate had already paid. Therefore, her claim for UM benefits was not a claim "that must be paid," and Allstate had no obligation to acknowledge the claim within 15 days as required by article 21.55.

The problematic aspect of the *Bonner* opinion is that it can be read to imply that had Bonner proved more in damages at trial than Allstate's available offset, then Allstate would have been subject to all of the penalties imposed under article 21.55 because Bonner's UM claim was one "that must be paid" when Allstate first received notice. But this interpretation conflicts with the Court's observation in *Henson* that neither the filing of a claim or the filing of suit triggers the insurer's obligation to pay. It appears that lower courts have tacitly rejected this interpretation of *Bonner*.

For example, in *Menix v. Allstate Indemnity Co.*, the most recent post-Henson UM/UIM case published to date, the Eastland Court of Appeals observed:

> Although it did not use the term "condition precedent," the Texas Supreme Court in *Bonner* made it clear that the condition precedent had not been satisfied… The *Bonner* court indicated however, that attorneys' fees might have been awarded under Article 21.55 had Bonner established that her damages entitled her to UIM benefits… The *Bonner* court thus indicated that a claim can be presented to an insurer even though the condition precedent for UIM benefits has not been satisfied.[37]

Considering this statement, it appears the Eastland Court of Appeals harmonized *Henson* and *Bonner* by concluding not that the insurer's obligation to pay arose prior to judgment, but rather, under *Bonner*, a claim that was not yet mature could be presented for purposes of invoking the insurer's obligations under article 21.55. Consistent with *Henson*, the court went on to hold that attorneys' fees were not recoverable under section 38.001 of the Texas Civil Practices and Remedies Code in a suit to establish UM/UIM coverage. The court reasoned that there was no failure by the insurer to pay the "just amount owed" within 30 days of presentment of a "valid claim," because the insurer's obligation to pay UM/UIM benefits did not arise until judgment was entered.[38]

In another recent case, *Wellisch v. United Services Automobile Association*, the San Antonio Court of Appeals considered *Henson*, as well as several earlier opinions from lower courts that construed the term "legally entitled to recover" as a condition precedent. The Wellisch court observed:

> The above cases make clear that an insurer is not obligated to pay UIM benefits until the insured becomes legally entitled to those benefits. This will generally require a settlement with the tortfeasor or a judicial determination following trial on the issue of the tortfeasor's liability. Thus, an insurer has the right to withhold payment of UIM benefits until the insured's legal entitlement is established.[39]

The court then went on to hold:

> Here, USAA's liability did not arise on the date of the accident in which Jessica was fatally injured. USAA's liability arose on the date the trial court entered final judgment following a determination that Salinas' negligence caused the accident and a jury returned a verdict favorable to the Wellisches in the amount of $6 million. Because USAA paid the Wellisch's UIM claim on the same day the trial court entered judgment, USAA did not violate Article 21.55's prompt payment provisions.[40]

Interpreting the phrase "legally entitled to recover" as a condition precedent, as the court in *Wellisch* did, some insurer's have argued that when the insured is barred by some defense from obtaining a judgment against the motorist directly, then a direct action against the insurer is barred as well. The argument is grounded on the premise that the motorist's complete defense to liability destroys the insured's predicate for satisfying the condition precedent to coverage.

For example, in *Essman v. General Accident Ins. Co.*, the insured's breach of contract claim failed against her UM/UIM insurer, where she settled a prior suit brought against her by the motorist.[41] The court explained, "[T]he compromise and settlement of the first lawsuit destroyed Essman's predicate for recovery of UM benefits under her policy because she cannot establish fault on the part of the alleged tortfeasor."[42]

This reasoning was very similar to that followed a year earlier by the Houston First District Court of Appeals in *Valentine v. Safeco Lloyds Ins. Co*., where the court held that, as a matter of first impression, an employee could not collect UM coverage from her own insurer for injuries caused by her employer's negligence after she received worker's compensation payments.[43] Looking to both the language of the policy, and article 5.06–1 of the Texas Insurance Code, the court explained that the insured was required to prove she was "legally entitled to recover" damages from her employer. But because she was barred by the Worker's Compensation Act from litigating her employer's negligence, she could not satisfy this prerequisite to UM/UIM coverage.

Similarly, in *United States Fidelity & Guar. Ins. Co*., the Dallas Court of appeals held that the insured's dismissal of her claims against the motorist with prejudice destroyed the insured's predicate for recovery under both the provisions of article 5.06–1 and the UM/UIM coverage of the policy, because the dismissal removed any legal entitlement that the insured had against the motorist.[44] This reasoning was subsequently followed in *Walton v. Prudential Property & Casualty*, a recent unpublished post-*Henson* opinion, where the plaintiff erroneously dismissed the uninsured motorist in an amended pleading in the same action against the insurer, and the insured was barred by limitations from joining the motorist back into the suit.[45]

The reasoning followed by these courts has logical appeal. If the purpose of UM/UIM coverage is to protect the insured from a negligent motorist's lack of financial responsibility, then it makes little sense to hold the insurer liable for damages that, by law, the motorist would not be required to pay – regardless of negligence. Moreover, article 5.06–1, and the standard policy itself, protect the insurer's right to subrogation against the motorist to recover payments the insurer makes under UM/UIM coverage to its insured.[46] If the insured's suit is barred against the motorist, then the insurer's right to recover payments would be nullified given the derivative nature of a subrogation claim.[47] But in *Franco v. Allstate Ins. Co*., a pre-*Henson* case, the Texas Supreme Court rejected the argument that in defending an action on the contract the UM/UIM insurer could interpose the motorist's procedural defense of limitations that would be available in a tort action.[48] The decision in *Franco* turned on the nature of a suit to establish UM/UIM

coverage as sounding in contract, not tort, and did not consider whether the phrase "legally entitled to recover" created a strict condition precedent to coverage. Considering *Henson*, it appears that *Franco* was wrongly decided or is limited to its holding that suits to establish UM/UIM coverage are governed by a four year statute of limitations.

Defining the point at which the insured is "legally entitled to recover" has importance beyond the contractual issue of UM/UIM coverage. Suits to establish the motorist's liability are often coupled with extra-contractual claims against the insurer for failing to timely pay, or denying the claim in bad faith.[49]

The traditional response to extra-contractual claims that are tied to an insurer's failure to pay UM/UIM benefits has been to sever and abate the extra-contractual claims pending a determination of the motorist's liability for damages.[50] In fact, the Texas Supreme Court has suggested in dicta that severance may be "necessary" when an insurer has made settlement offers.[51]

But, based on *Henson*, it appears that severance may be required for extra-contractual claims simply because they inject issues of insurance handling into the underlying suit to establish coverage. For example, in *In re Trinity Universal Ins. Co.*, a post-*Henson* case, the trial court's failure to sever the insured's claims for statutory interest under article 21.55 could only be remedied by mandamus, because resolution of the 21.55 claim would have injected issues of insurance claim handling into the insured's suit to establish coverage. In holding that the insured's 21.55 claims were distinct causes of action from the contractual UM/UIM claim, the court observed:

> [T]he provisions of the UIM endorsement condition payment of benefits upon a determination of liability of the UIM motorist and damages… It is clear that a UIM claim does not mature until the claimant establishes that the negligence of the UIM motorist (1) caused the accident and amount of damages, [and] (2) the motorist was in fact underinsured.[53]

Arguably, under *Henson*, extra-contractual causes of action should fail when they are predicated on the insurer's failure to pay prior to entry of a judgment for the same reason a breach of contract claim does – the claim is not yet mature. In *Republic Ins. Co. v. Stoker*, the Texas Supreme Court held that there can be no claim for bad faith where the insurer has promptly denied a claim that is not in fact covered.[54] But, recent opinions among lower courts have not resolved this issue.

For example, in an unreported case, the Fourteenth District Court of Appeals recently recognized the general rule articulated in *Stoker* and upheld the trial court's dismissal of the plaintiffs' severed extra-contractual claims, after the jury returned a verdict awarding the insured less than the amount offered by the insurer to settle their UM/UIM claims.[55] The court reasoned that the extra-contractual causes were mooted because the insurer did not breach its contract. But applying *Henson* literally, the extra-contractual claims should have failed on the grounds that the insured's UM/UIM claim was not yet mature when presented.

Defining the point at which the insured is "legally entitled to recover" has importance…

In *Lias v. State Farm*, a recent published opinion, the Dallas Court of Appeals held that the plaintiff's non-suit of his causes of action for breach of contract on a UM/UIM claim did not preclude his causes of action for bad faith.[56] The Court observed that while both breach of contract and bad faith claims involve underlying questions of coverage, a cause of action for bad faith sounds in tort, and coverage can be established in the tort action. Accordingly, the breach of contract claim was not a necessary predicate for bringing a cause of action for bad faith. But, again, applying *Henson* literally, the extra-contractual claims should have failed because the insured's UM/UIM claim was not mature prior to a judgment establishing the motorist's liability for damages.

Although recent caselaw suggests that courts are moving towards a stricter interpretation of the phrase "legally entitled to recover," resolution of this issue will require further clarification from the Legislature or Texas Supreme Court. Significantly, a petition for discretionary review has been filed in the *Menix* case and may present the Texas Supreme Court with yet a third opportunity to directly address the issue and confirm or reject the proposition that, in the absence of an agreement, to the insurer's obligation to pay UM/UIM coverage is not mature until a judgment establishes the motorist's liability for damages.

D. Bodily Injury, Property Damage, and Punitive Damages.

The standard UM/UIM insuring agreement requires the

insurer to pay damages for bodily injury and property damage. Although the policy defines the term "property damage" it does not define "bodily injury."

1. Bodily Injury. In *McGovern v. Williams* the Texas Supreme Court explained that "bodily injury" contemplates a requirement for physical harm to the person claiming the injury. Accordingly, consistent with the majority of other states, the Court held that derivative claims, such as loss of consortium, arising only as a consequence of injuries to another person do not constitute bodily injury.[57] Similarly, in *Trinity Universal Ins. Co. v. Cowan*, a case involving a claim under a homeowner's policy, the Texas Supreme Court held that damages for "mental anguish" were not recoverable as a separate "bodily injury," absent a physical manifestation of harm, because the commonly understood meaning of the term "bodily" implies a physical, and not purely mental, emotional, or spiritual harm.[58] As construed by the courts, the term "bodily injury" has not been applied to limit the injured party's ability to recover UM/UIM coverage within the policy limits for injury to a single person. Rather, the courts have applied the term to limit the ability of spouses, bystanders, and other persons who have derivative claims from expanding the policy limits to those available "per occurrence."

2. Property damage. The standard policy defines property damage as injury to, destruction of, or loss of use of:

> 1. Your covered auto, not including a temporary substitute auto.
> 2. Any property owned by [a covered person] while contained in your covered auto.
> 3. Any property owned by you or any family member while contained in any auto not owned, but being operated, by you or any family member.

Because of the policy's unambiguous language, cases considering UM/UIM coverage for property damage are limited. Of interest though, recent caselaw may increase the number of claims for UM/UIM coverage for the diminished value of property caused by auto accident.

In *American Manufacturers Mut. Ins. Co. v. Schaefer*, the Texas Supreme Court held that that the collision coverage of a personal automobile policy does not require the insurer to pay the diminished value of a fully and adequately repaired vehicle, because of the coverage limitation providing that the insurer is only required to pay the lesser of the vehicle's actual cash value or the value for replacement or repair of the property.[59] *Schaefer* resolved a growing dispute among numerous lower courts as to whether the diminished value of a repaired vehicle was recoverable under the standard policy's collision coverage.[60]

Significantly, however, article 5.06–1 of the Texas Insurance Code permits the insured to elect between collision and UM/UIM coverage for property damage to the insured vehicle. If the insured has both collision coverage, which is not required by statute, and UM/UIM coverage under the policy, the insured may recover under either policy coverage.[61] In the event that neither is sufficient to cover all damage resulting from a single occurrence, the insured may recover under both coverages.[62] When recovering under both, the insured must elect between which coverage is primary, and which is secondary.[63] The primary coverage must first be exhausted before any recovery can be made under the secondary coverage. In no event is the insured permitted to recover more than the actual damages he suffered.[64]

In no event is the insured permitted to recover more than the actual damages he suffered.

Unlike collision coverage, where the insurer's liability is limited to the lesser of the vehicle's actual cash value or the value of replacement or repair, under UM/UIM coverage the insurer is required to pay for property damage the insured is "legally entitled to recover" from the uninsured motorist. Generally, diminished value is recoverable as an element of damages from a negligent motorist. Because the *Schaefer* opinion turned on an interpretation of language that was specific to collision coverage under the policy, it may not be the last word on whether diminished value is recoverable under UM/UIM coverage.

3. Punitive Damages. Despite conflicting opinions among lower courts, the Texas Supreme Court has never squarely addressed the question of whether punitive damages are covered under the standard policy's UM/UIM provisions.[65] While some courts have held that punitive damages are covered as damages for "bodily injury" or "property damage,"[66] in more recent cases, lower courts have rejected this notion on public policy grounds, reasoning that the purpose of awarding punitive damages is to punish the wrongdoer and deter future wrongdoing, not to compensate the insured.[67] For example, in reversing its own prior case law, the Houston Fourteenth District Court of Appeals observed:

> [T]he policy considerations which permit an insurer to obligate itself for punitive damages are different than those where uninsured motorists coverage is at issue. As noted by the Austin Court of Appeals in Safeway Steel, [a]s long as insurance companies are willing, for a price, to provide protection against liability for punitive damages to corporations they deem good risks . . . we see no reason why these contracts should not be enforced. With uninsured motorist coverage, there has been no opportunity for the insurer to bargain 'for a price;' coverage is mandated by law with a stated purpose of relieving innocent motorists of actual losses.[68]

E. Accident.

The vast majority of UM/UIM claims involve collisions between two or more vehicles. However, the standard policy's UM/UIM coverage does not cover all damage or injuries involving an automobile, but only those injuries resulting from an "accident" that "arises out of" the "ownership, maintenance, or use" of an uninsured or underinsured motor vehicle.

In *Farmers Texas County Mut. Ins. Co. v. Griffin*, the Texas Supreme Court explained that an automobile accident generally refers to situations where one or more vehicles are involved with another vehicle, object, or person.[69] However, in *Mid-Century Ins. v. Lindsey*, the Court later clarified that a collision is not required for UM/UIM coverage to apply.[70]

The Court in *Lindsey* explained that for an injury to "arise out of" the use of a vehicle, there must be some causal connection between the injury and use of the vehicle *as a vehicle*. It is not enough that the vehicle is the place where the injury occurred. For example, *Lindsey* involved an incident in which a child caused a shotgun to discharge while entering a vehicle. The Court determined that a causal connection was established under the facts of the case, because the shotgun discharged while the child was attempting to enter the vehicle and came into contact with the shotgun only as the result of his attempt to enter the vehicle. In contrast, the Court distinguished the facts in *LeLeaux v. Hamshire-Fannett I.S.D.* where it previously observed:

> The bus in this case was not in operation; it was parked, empty, with the motor off. The driver was not aboard; there were no students aboard. The bus was not doing or performing a practical work; it was not being put or brought into action or service; it was not being employed or applied to a given purpose. The bus was nothing more than the place where Monica happened to injure herself.[71]

The Court in *Lindsey* also explained that an injury is "accidental" if the injury could not be anticipated by the insured, or would not ordinarily follow from the action or occurrence which caused the injury, and the actor did not intend to produce the result or cannot be charged with the design of producing it.[72] The injury in *Lindsey* was accidental because the insured's contact with the shotgun was inadvertent and unintentional. Here, the facts were distinguishable from the intentional drive-by shooting it considered in Griffin.[73]

F. Uninsured/Underinsured Motorist.

In simple terms, a person is an uninsured or underinsured motorist in Texas when:

> 1. his insurer becomes insolvent or denies coverage;
> 2. he is a hit-and-run driver;
> 3. the damages he is legally responsible to pay exceed his available liability coverage, or
> 4. he has no insurance.[74]

But, as defined by the standard policy, an "uninsured motor vehicle" is *a land motor vehicle or trailer of any type:*

> *1. To which no liability bond or policy applies at the time of the accident,*
> *2. Which is a hit and run vehicle whose operator or owner cannot be identified and which hits:*
> *a. you or any family member;*
> *b. a vehicle which you or any family member are occupying; or*
> *c. your covered auto.*
> *3. To which a liability policy applies at the time of the accident but the bonding or insuring company:*
> *a. Denies coverage; or*
> *b. is or becomes insolvent.*
> *4. Which is an underinsured motor vehicle.*[75]

If a dispute arises between the insurer and the insured as to whether a vehicle is actually uninsured, the burden of proof is on the insurer.

1. Insurer Insolvency. Companies that write insurance policies in Texas are heavily regulated, and the Legislature has provided numerous safeguards to protect the public against insurer insolvency.[77] In connection with this statutory safeguards, article 5.06–1 of the Texas Insurance Code requires the definition of "uninsured motorist" to include a vehicle for which the liability carrier is or becomes insolvent.[78] As an adjunct to this requirement, the Texas Property and Casualty Insurance Act provides further protection for the public against failure of licensed insurance companies as a result of insolvency. The Act creates a Guaranty Association for the purpose of

paying unpaid claims, including those of third-party liability claimants that arise out of and are within the insured's coverage, but not in excess of the insured's applicable policy limits.[79] Covered claims are limited to $300,000 in value.[80]

But, while the Act does provide the insured with a source for recovering damages that would be assessed against an uninsured motorist, the Act does not alter a solvent insurer's obligation to pay UM/UIM coverage, and, in fact, requires the insured to first exhaust UM/UIM coverage that may be available under his or her own policy. In this regard, the Act provides:

> A person who has a claim against an insurer under any provision in an insurance policy other than a policy of an impaired insurer that is also a covered claim shall exhaust first the person's rights under the policy, including any claim for indemnity or medical benefits under any worker's compensation, health, disability, uninsured motorist, personal injury protection, medical payments, liability, or other policy…[81]

2. Hit-and-Run Drivers. The UM/UIM provisions of the standard policy include coverage for damages caused by a hit and run driver who cannot be identified. However, to recover damages caused by a hit-and-run driver, actual contact must occur between the insured vehicle and the "hit and run" vehicle.[82] The "actual contact" requirement is imposed by article 5.06–1 of the Texas Insurance Code, and courts have construed the standard's policy language as no less restrictive than the statutory requirement, because it reduces the potential for fraudulent claims that would arise without this limitation.[83]

But, some courts have recognized the limited exception of "indirect physical contact," where an unidentified driver hits another vehicle that then contacts the insured vehicle.[84] This limited exception does not apply, however, if the intervening object is something other than a vehicle, such as road debris.[85] For example, in *Texas Farmers v. Deville*, the insured driver was killed when a water pump fell from the back of an unknown vehicle and crashed through the insured's windshield.[86] The court of appeals reluctantly held that when an accident involves an unknown vehicle, the insured may not obtain UM/UIM coverage under the definition for a vehicle to which no liability insurance applies, but must satisfy the "actual physical contact" requirement for hit-and-run vehicles.

3. Underinsured Vehicle. The standard policy defines an underinsured vehicle as *one to which a liability bond or policy applies at the time of the accident but its limits of liability either:*

> *1) is not enough to pay the full amount the covered person is legally entitled to recover as damages; or*
>
> *2) has been reduced by payment of claims to an amount which is not enough to pay the full amount the covered person is legally entitled to recover as damages.*

In *Strancener v. United Services Auto. Ass'n*, the Texas Supreme Court held that under article 5.06–1 of the Texas Insurance Code, a negligent motorist is underinsured whenever the available proceeds of his liability insurance are insufficient to compensate the injured party's actual damages.[87] This holding resolved certain ambiguities in the statutory language that had led many lower courts to hold that a motorist was not underinsured if his liability limits were equal to or exceeded the injured party's UM/UIM coverage limits.[88] In those instances in which the negligent motorist is covered by two or more liability policies, the limits of those policies may be aggregated or "stacked" to determine whether the motorist is underinsured.

The injured party is not required to exhaust the negligent motorist's liability limits before making a UM/UIM claim. But, article 5.06–1 and the policy allow the UM/UIM carrier to offset amounts that are "recovered or recoverable from the insurer of the underinsured motor vehicle."[89] Consequently, if the insured settles with the negligent motorist, the UM/UIM carrier is allowed to offset not just the amount paid by the negligent motorist's insurer, but the full amount of the policy limits available to pay the injured party's claim against the motorist.[90] If the injured party is legally entitled to recover less than the liability limits available to pay the motorist's claim, then the motorist is not "underinsured."

Significantly, in those instances in which the UM/UIM carrier settles the insured's claim for benefits, and the insured subsequently obtains a judgment against the negligent motorist, the motorist is not entitled to an offset or credit against the judgment for the amount of the UM/UIM benefits paid. For example, in *Bartley v. Guillot*, the injured party settled with her UM/UIM carrier for $20,000 in benefits and then proceeded against the negligent motorist. The motorist sought an offset of the $20,000 against the judgment, which the trial court refused. In affirming the judgment, the court of appeals held that the UM/UIM carrier was not a "settling party" for purposes of determining comparative responsibility. Therefore, the motorist was not entitled to receive any credit for the UM/UIM carrier's payment to its insured.[91] But, the insured's recovery against the motorist does not result in a windfall. If an insurer makes a payment to any person for UM/UIM coverage, the policy entitles the insurer to recover up to the amount of the payment from the proceeds of any judgment or settlement with the person.[92]

1. *See Henson v. State Farm Bureau Cas. Ins. Co.*, 17 S.W.3d 652, 653 (Tex. 2000).

2. *See* TEX. INS. CODE ANN. art. 5.06 (1)-(3) (West Supp. 2004).

3. *See* TEX. TRANSP. CODE ANN.§ 601.53 (West 1999); *see id*.§ 601.002(3) (defining "financial responsibility").

4. *See id*.§ 601.071-601.077.

5. *See id*.§ 601.072 (a)(1)-(3).

6. Because UM/UIM coverage is only required to be included in an "auto liability policy" an umbrella indemnity insurance policy that provides excess coverage for liability arising out of an auto accident is not required to include UM/UIM coverage under TEX. INS. CODE ANN. art. 5.06–1 (West Supp. 2004). *See Sidelnik v. American States Ins. Co*., 914 S.W.2d 689 (Tex. App.—Austin 1996, writ denied).

7. *See Fontanez v. Texas Farm Bureau Ins. Co*., 840 S.W.2d 647, 649 (Tex. App.—Tyler 1992, no writ).

8. *See* TEX. INS. CODE ANN. art. 5.06-1 (3)-(4)(a) (West Supp. 2004).

9. *See id.*

10. *See id*. art. 5.06–1 (5).

11. *See id*. art. 5.06–1 (1).

12. *See id*.

13. *See* TEX. INS. CODE ANN. art. 5.06–1(1); *Poteet v. State and County Mut. Fire Ins. Co*., 7 S.W.3d 679, 681 (Tex. App.—Eastland 1999, no writ).

14. *See Howard v. INA County Mut. Ins. Co.*, 933 S.W.2d 212, 218 (Tex. App.—Dallas 1996, writ denied).

15. *See Allstate Ins. Co. v. Hunt*, 469 S.W.2d 151, 155 (Tex. 1971).

16. *See Old American County Mut. Fire Ins. Co. v. Sanchez*, 03-01-00150-CV, 2002 WL 1377870 (Tex. App.—Austin 2002, no pet.).

17. *See Ortiz v. State Farm Mut. Auto. Ins. Co*., 955 S.W.2d 353, 357 (Tex. App.—San Antonio 1997, pet. denied).

18. *See Unigard Sec. Ins. Co. v. Schaefer*, 572 S.W.2d 303, 308 (Tex. 1978).

19. *See Sims v. Standard Fire Ins. Co*., 781 S.W.2d 328, 330 (Tex. App.—Houston [1st Dist.], 1989, writ denied).

20. *See, e.g. Hartford Cas. Ins. Co. v. Phillips*, 575 S.W.2d 62 (Tex. Civ. App.—Texarkana 1978, no writ) (holding that a child of divorced parents can be a member of both his parents' households); *State Farm Mut. Auto. Ins. Co. v. Nguyen*, 920 S.W.2d 409 (Tex. App.—Houston [1st Dist.] 1996, no writ.) (holding six-day-old baby who spent entire life in hospital was resident of insured's household for insurance purposes under family member exclusion in auto liability policy); *Southern Farm Bureau Cas. Ins. Co. v. Kimball*, 552 S.W.2d 207 (Tex. Civ. App.—Waco 1977, writ ref'd n.r.e.) (holding wife who was temporarily separated from husband was resident of same household).

21. *See Easter v. Providence Lloyds Ins. Co.*, 17 S.W.3d 788, 790 (Tex. App.—Austin 2000, pet. denied) (homeowner's policy).

22. *See Grain Dealers Mut. Ins. Co. v. McKee*, 943 S.W.2d 455 (Tex. 1997); *see also Webster v. U.S. Fire Ins. Co*., 882 S.W.2d 569 (Tex. App.—Houston [1st Dist.] 1994, writ denied).

23. *See supra* note 16.

24. *See, e.g., Hart v. Traders and Gen. Ins. Co*., 487 S.W.2d 415, 418 (Tex. Civ. App.—Fort Worth 1972, writ ref'd n.r.e.).

25. *See Zamora v. Dairyland County Mut. Ins. Co*., 930 S.W.2d 739, 741 (Tex. App.—Corpus Christi, writ denied); *Wright v. Rodney D. Young Ins. Agency*, 905 S.W.2d 293, 296 (Tex. App.—Fort Worth 1995, no writ).

26. *See Zamora v. Dairyland County Mut. Ins. Co*., 930 S.W.2d 739, 740 n. 1 (Tex. App.—Corpus Christi 1996, writ denied).

27. *See supra* note 18.

28. *See Franco v. Allstate Ins. Co*., 505 S.W.2d 789, 792 (Tex. 1974); *Reliance Ins. Co. v. Falknor*, 492 S.W.2d 721, 723 (Tex. Civ. App.—Houston [1st Dist.] 1973, writ ref'd n.r.e.).

29. *See Keith Langston*, 53 Baylor L. Rev. 229 *Is Your UIM Policy in Texas "Worth Less": Henson v. State Farm Bureau Mut. Ins. Co*. (Winter 2001) (Note).

30. *Sprague v. State Farm Mut. Auto. Ins. Co.*, 880 S.W.2d 415, 416 (Tex. App.—Houston [14th Dist.] 1993, writ denied).

31. *See Franco v. Allstate Ins. Co*., 505 S.W.2d 789, 792 (Tex. 1974).

32. *See Henson v. State Farm Bureau Cas. Ins. Co.*, 17 S.W.3d 652, (Tex. 2000).

33. *See State Farm Mut. Auto. Ins. Co. v. Matlock*, 462 S.W.2d 277, 278-79 (Tex. 1970). In *State Farm*, the Texas Supreme Court rejected the argument that the insured was required to obtain a judgment directly against the motorist, explaining, "[N]either Article 5.06–1, Insurance Code, V.A.T.S., nor the policy provisions of the insurance contract… required the Matlocks to obtain a judgment against an uninsured motorist prior to seeking judgment against the insurer." See id. at 278.

34. This is in contrast to an insurer's obligation to its insured for auto liability coverage, which, under the Texas Motor Vehicle Responsibility Act becomes absolute at the time bodily injury, death, or damage occurs. *See* TEX. TRANSP. CODE § 601.073 (c). The liability coverage may not require the insured to satisfy a judgment for bodily injury, death, or property damage as a condition precedent under the policy to the right or duty of the insurance company to make payments for liability coverage. *See* TEX. TRANSP. CODE § 601.073 (d). With regard to a third-party claim against the insured's liability policy, the Texas Supreme Court has previously interpreted the promise to pay damages "for which any person becomes legally responsible because of an auto accident" as a strict condition precedent. *See State Farm County Mut. Ins. Co. v. Ollis*, 768 S.W.2d 722, 723 (Tex. 1989). Accordingly, Texas courts have uniformly declined to impose any duty on an insurer towards a third-party until the insured's liability is established by judgment or agreement.

35. *See Allstate Ins. Co. v. Bonner*, 51 S.W.3d 289 (Tex. 2001).

36. *See* TEX. INS. CODE ANN. art. 21.55, § 6 (West Supp. 2004).

37. *Menix v. Allstate Indem. Co*., 83 S.W.3d 877 (Tex. App.—Eastland 2002, pet. filed).

38. The purpose of awarding attorney's fees under Chapter 38 of the Texas Civil Practices & Remedies Code is to punish a party for failing to pay a just debt when it is owed. *See Huff v. Fidelity Union Life Ins. Co.*, 158 Tex. 433, 312 S.W.2d 493, 501 (Tex. 1958); *Wheelways Ins. Co. v. Hodges*, 872 S.W.2d 776, 783 n.8 (Tex. App.—Texarkana 1994, no writ). But, to recover attorneys fees under Chapter 38 , the party must first prove:

(1) recovery of a valid claim in a suit on a written or oral contract;
(2) representation by an attorney;
(3) presentment of the claim to the opposing party; and
(4) failure of the opposing party to tender payment of the just amount owed within 30 days of presentment.

See TEX. CIV. PRAC. & REM. CODE ANN. § 38.002 (West 1997) (emphasis added).

39. *Wellisch v. United Serv. Auto. Ass'n*, 75 S.W.3d 53, 57 (Tex. App.—San Antonio 2002, pet. denied).

40. *Id*.

41. *See Essman v. Gen. Accident Ins. Co*., 961 S.W.2d 572, 574 (Tex. App.—San Antonio 1997, no writ).

42. *See id*. at 573

43. *See Valentine v. Safeco Lloyds Ins. Co*., 928 S.W.2d 639, 644 (Tex. App.—Houston [1st Dist.] 1996, writ denied).

44. *See United States Fid. & Guar. Ins. Co*., 723 S.W.2d 209, 210 (Tex. App.—Dallas 1986, no writ).

45. *See Walton v. Prudential Property & Cas. Co*., No. 05-98-01134-CV, 2001 WL 1013569 (Tex. App.—Dallas 2001, no pet.).

46. If an insurer makes a payment to any person under this coverage, the insurer is entitled to recover up to the amount of the payment from the proceeds of any judgment or settlement with the person. *See* TEX. INS. CODE ANN. art. 5.06–1 (6). The policy excludes coverage when the insured settles a claim against the third-party tortfeasor without the UM/UIM carrier's written consent. The written consent requirement is valid and enforceable. *See U.S. Fire Ins. Co. v. Millard*, 847 S.W.2d 668 (Tex. App.—Houston [1st Dist.] 1993, orig. proceeding). Texas courts have upheld such provisions as a means of protecting the carrier's subrogation rights. *See Ford v. State Farm Mut. Auto. Ins. Co*., 550 S.W.2d 663 (Tex. 1977); *Dairyland County Mut. Ins. Co. v. Roman*, 498 S.W.2d 154 (Tex. 1973). But, in *Hernandez v. Gulf Group Lloyds*, the Texas Supreme Court held that the insured's failure to obtain the insurer's consent before settling with the tortfeasor was not a material breach of the policy's "settlement without consent" exclusion, and thus did not relieve the insurer of liability for underinsured motorist benefits, absent a showing that the insurer was prejudiced by the insured's conduct. *See Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691 (Tex. 1994).

47. *See supra* note 42.

48. *See Franco v. Allstate Ins. Co.*, 505 S.W.2d 789, 792 (Tex. 1974).

49. Although not limited in origin or scope, "extra-contractual" claims are generally recognized as common law and statutory tort causes of action relating to the insurer's payment or handling of an insurance claim. Most extra-contractual causes of action appearing in pleadings relate to a breach of the common law duty of "good faith and fair dealing," (also recognized as a cause of action for "bad faith"), violation of Texas Insurance Code articles 21.21 (Unfair Competition and Unfair Practices), 21.21-2 (Unfair Claim Settlement Practices), and 21.55 (Prompt Payment of Claims), and violation of Texas Business and Commerce Code, section 17.46 (the Texas Deceptive Trade Practices Act).

50. *See, e.g.*, *State Farm Mut. Auto. Ins. Co. v. Wilborn*, 835 S.W.2d 260 (Tex. App.—Houston [14th Dist.] 1993, orig. proceeding); *U.S. Fire Ins. Co. v. Millard*, 847 S.W.2d 668 (Tex. App.—Houston [1st Dist.] 1993, orig. proceeding).

51. *See Liberty National Fire Ins. Co. v. Akin*, 927 S.W.2d 627, (Tex. 1996).

52. *In re Trinity Univ. Ins. Co*., 64 S.W.3d 463 (Tex. App.—Amarillo 2001, orig. proceeding).

53. *Id.* at 468.

54. *See Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 341 (Tex. 1995); *Transportation Ins. Co. v. Moriel*, 879 S.W.2d 10, 17 (Tex. 1994). When extra-contractual causes of action do nothing more than recharacterize the plaintiff's bad faith claim, a defense to bad-faith serves to defeat the extra-contractual causes of action. *See Lane v. State Farm Mut. Auto. Ins. Co*., 992 S.W.2d 545, 554 (Tex. App.—Texarkana 1999, pet. denied).

55. *See Laas v. State Farm Mut. Auto. Ins. Co*., No. 14-99-00194-CV, 2001 WL 1479228 (Tex. App.—Houston [14th Dist.] 2001, no pet.).

56. *See Lias v. State Farm Mut. Auto. Ins. Co*., 45 S.W.3d 330 (Tex. App.—Dallas 2002, no pet.).

57. *See McGovern v. Williams*, 741 S.W.2d 373, 374 (Tex. 1987); see also *Miller v. Windsor Ins. Co*., 923 S.W.2d 91, 97 (Tex. App.—Fort Worth 1996, pet. denied); *Girard v. Texas Farmers Ins. Co*., 00-01520-CV (Tex. App.—Fort Worth 2001, unreported).

58. *See Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819, 824 (Tex. 1997); *see also State Farm Lloyds v. Borum*, 53 S.W.3d 877, 884-85 (Tex. App.—Dallas 2001, no pet.) (homeowner's policy).

59. *See American Mfr. Mut. Ins. Co. v. Schaefer*, No. 02-0295, 2003 WL 22417186 (Tex. 2003).

60. Prior to the Texas Supreme Court's opinion in *Schaefer*, the Dallas, Austin, Beaumont, and Corpus Christi courts each held that the word "repair" or "replace" means the restoration of the automobile to substantially the same condition as immediately prior to the collision. Accordingly, by electing to repair or replace a vehicle, the insurer was required not only to repair and replace any physical damage but also to restore the vehicle to substantially the same value as that of the vehicle prior to the loss. In each of these cases, the courts focused on a plain interpretation of the policy language.

In contrast, the Houston Fourteenth Court of Appeals held that where the insurer has fully, completely, and adequately repaired or replaced the vehicle with other of like kind and quality, reduction in market value due to factors not subject to repair or replacement cannot be deemed a component part of the cost of repair or replacement. Accordingly, a car could be "fully, completely, and adequately" repaired as long as all of the damage that could be

repaired was repaired. The opinions of the Fourteenth Court of Appeals were based on the Texas Insurance Commissioner's interpretation of the collision coverage. In Bulletin B-0027-00, April 6, 2000, the Commissioner took the position that an insurer is not obligated to pay a first party claimant for diminished value when the automobile is completely repaired to its pre-damaged condition, noting that the language of the policy makes no reference to payment for diminished value.

61. *See* TEX. INS. CODE ANN. art. 5.06-1 (4)(b).

62. *See id*.

63. *See id.*

64. *See id*.

65. *See Government Employees Ins. Co. v. Lichte*, 792 S.W.2d 546 (Tex. App.—El Paso 1990), writ denied per curium, 825 S.W.2d 239 (Tex. 1991).

66. *See, e.g., Home Indem. Co. v. Tyler*, 522 S.W.2d 594, 597 (Tex. Civ. App.—Houston [14th Dist.] 1975, writ ref'd n.r.e.).

67. *See Vanderlinden v. United States Auto, Ass'n Prop. Cas*., 885 S.W.2d 239, 241-42 (Tex. App.—Texarkana 1994, writ denied); State Farm Mut. Auto. Ins. Co. v. Shaffer, 888 S.W.2d 146 149 (Tex. App.—Houston [1st Dist.] 1994, writ denied).

68. *See Milligan v. State Farm Mut. Auto. Ins. Co*., 940 S.W.2d 228, 232 (Tex. App.—Houston [14th Dist.] 1997, writ denied).

69. *See Farmers Texas County Mut. Ins. Co. v. Griffin*, 955 S.W.2d 81, 83 (Tex. 1997).

70. *See Mid-Century Ins. Co. of Texas v. Lindsey*, 997 S.W.2d 153, 156 (Tex. 1999).

71. *LeLeaux v. Hamshire-Fannett Indep. Sch. Dist*., 835 S.W.2d 49, 51 (Tex. 1992).

72. *See supra* note 69.

73. This is in contrast to the intentional drive-by shooting considered by the Court in *Farmers Texas County Mut. Ins. Co. v. Griffin*, 955 S.W.2d 81 (Tex. 1997).

74. *See* TEX. INS. CODE ANN. art. 5.06–1(2)(a)-(c); *Milton v. Preferred Risk Ins. Co*., 511 S.W.2d 83, 85 (Tex. Civ. App.—Houston [14th dist.] 1974, writ ref'd n.r.e.).

75. Under the policy, the term "uninsured motor vehicle" does not include *any vehicle or equipment:*

> *1. Owned by or furnished or available for the regular use of [the named insured] or any family member.*
>
> *2. Owned or operated by a self-insurer under any applicable motor vehicle law.*
>
> *3. Owned by any governmental body unless:*
> *a. the operator of the vehicle is uninsured; and*
> *b. there is no statute imposing liability for damages on the governmental body for an amount less that the liability for this coverage.*
>
> *4. Operated on rails or crawler treads.*
>
> *5. Designed mainly for use off public roads.*
>
> *6. While located for use as a residence or premises.*

76. *See* TEX. INS. CODE ANN, art. 5.06–1 (7) (West Supp. 2004).

77. *See, e.g., id*. art. 21.28-C; Tex. Transp. Code Ann. ß 643.105 (West 1999).

78. *See* TEX. INS. CODE ANN. art. 5.06–1(2)(a) (West Supp. 2004).

79. *See id*. art. 21.28-C §§ 2(1), 3, 5(8).

80. *See id*. art. 21.28-C § 5(8).

81. *See id*. art. 21.28-C § 12.

82. *See Republic Ins. Co. v. Stoker*, 903 S.W.2d 338 (Tex. 1998).

83. *See* TEX. INS. CODE ANN. art. 5.06–1(2)(d); *Mayer v. State Farm Mut. Auto. Ins. Co*., 870 S.W.2d 623, 625 (Tex. App.—Houston [14th Dist.] 1994, no writ).

84. *See, e.g., Latham v. Mountain States Mut. Cas. Co*., 482 S.W.2d 655, 657 (Tex. Civ. App.—Houston [1st Dist.] 1972, writ ref'd n.r.e.).

85. *See Republic Ins. Co. v. Stoker*, 867 S.W.2d 74 (Tex. App.—El Paso 1993), *reversed on other grounds*, 903 S.W.2d 338 (Tex. 1995); *Williams v. Allstate Ins. Co*., 849 S.W.2d 859, 861 (Tex. App.—Beaumont 1993, no writ).

86. *See Texas Farmers Ins. Co. v. Deville*, 988 S.W.2d 331, 334 (Tex. App.—Houston [1st Dist. 1999, no writ).

87. *See Strancener v. United Serv. Auto. Ass'n*, 777 S.W.2d 378 (Tex. 1989).

88. Article 5.06–1 of the Texas Insurance Code defines an "underinsured motor vehicle" as:

> [A]n insured motor vehicle on which there is valid and collectible liability insurance coverage with limits of liability for the owner or operator which were originally lower than, or have been reduced by payment of claims arising from the same accident to, an amount less than the liability stated in the underinsured coverage of the insured's policy.

TEX. INS. CODE ANN. art. 5.06–1(2)(b).

89. *See* TEX. INS. CODE art. 5.06–1(2)(b), (5); *see supra* note 86.

90. *See Olivas v. State Farm Mut. Auto. Ins. Co*., 850 S.W.2d 564 (Tex. App.—El Paso 1993, writ denied); *Leal v. Northwestern Nat'l County Mut. Ins. Co*., 846 S.W.2d 576 (Tex. App.—Austin, 1993, no writ).

91. *See Bartley v. Guillot*, 990 S.W.2d 481 (Tex. App.—Houston [14th Dist.] 1999, writ denied).

92. *See* TEX. INS. CODE ANN. art. 5.06–1 (6).

BY BETH D. BRADLEY

THOMPSON, COE, COUSINS & IRONS, L.L.P., DALLAS, TEXAS

Cracks, Leaks, Mold and More:

A Survey of Recent Cases Under Homeowners Policies

The past few years have seen a surge in coverage disputes under homeowner's policies. The mold explosion, and the coverage questions engendered by mold claims, account for a lot of the cases. The promulgation of mold endorsements and the influx of non-standard forms may reduce coverage for mold, but will likely ensure litigation over new issues.[2] There have also been developments in other areas, including the use of expert testimony in foundation claims, the meaning of "like kind and quality," and the rights of the innocent insured in arson cases. Courts have also addressed issues under the liability coverage, including the meaning of "occurrence" and what constitutes a business pursuit. This paper seeks to identify the trends, major developments, and highlights in recent homeowners' cases.[3]

I. Property Coverage

Trigger

Trigger of coverage is uncertain under Texas law, and no less so in homeowner's claims. While courts have typically utilized a manifestation trigger, at least for property damage claims, the growth patterns of mold and the problems associated with its discovery presented an unforeseen twist. When, after all, does mold "manifest"?

In *Martinez v. Allstate Texas Lloyd's*, No. M-02-091 (S.D. Tex., Oct. 7, 2002), the court implicitly followed a manifestation trigger, where the insureds had discovered "mildew" before policy inception, but were unaware of its implications. The homeowners experienced leaks before inception of their coverage with Allstate. In addition, the homeowners acknowledged that black spots, which they perceived to be mildew, had appeared in their house prior to inception of their coverage with Allstate, and prior to the time any claim was reported. *Id.* at 3-4. Over time, the Martinezes had made efforts to repair the leaks, and to clean the "mildew." *Id.* at 4. In their third year of coverage with Allstate, the Martinezes made their first claim under the policy. Allstate moved for summary judgment under the fortuity doctrine, claiming that there was known loss or loss in progress at the time of the commencement of the coverage with Allstate. In the alternative, Allstate contended there was late notice. *Id.* at 1. The court did not reach the late notice argument, but agreed with Allstate that the fortuity doctrine precluded coverage. The court noted that it was not determinative that the insureds may not have realized the scope of the problem, or that the "mildew" was actually black mold. *Id.* at 5. The court also noted, however, that there was no evidence that there had been any new water loss or ensuing mold which began within the policy period. *Id.*

Late Notice

The mold "crisis" led to changes in policies, away from the Texas Homeowners Form B (HO-B), and toward more restricted coverage for water damage. Late notice came to the fore in the frenzy to assert mold claims while coverage still existed. Many leaks and mildew spots were "re-evaluated" and became insurance claims. In *Flores v. Allstate Texas Lloyd's Co.*, 278 F.Supp.2d 810 (S.D. Tex. 2003), the court distinguished between the initial leak and subsequent mold damage, and concluded that failure to notify an insurer of the leak did not preclude coverage for a later manifestation of mold. In *Flores*, the evidence showed that the leaks, for which

Beth D. Bradley[1] is a partner with the Dallas office of Thompson, Coe, Cousins & Irons. She specializes in insurance coverage disputes and insurance lawsuits involving extra-contractual allegations. She speaks regularly at insurance CLE seminars and is a member of the Council of the Insurance Law Section of the State Bar of Texas.

the mold damage arose, occurred months to years prior to the claim. The claim, however, was only for the mold, not the original leak. Using a manifestation theory, the court found there was no duty to notify until the mold became "apparent" – when it was discovered by remediators, or was "capable of being easily perceived, recognized, and understood." The court also noted that, in most cases, late notice could be an issue of fact. The court then turned its attention to the various leaks and subsequent mold, finding fact issues – even as to leaks 3-4 years earlier, but finding late notice where the insureds were aware of mold on the ceiling 6 months prior to notice of the claim.

The same court addressed the timeliness of notice again in *Salinas v. Allstate Texas Lloyd's Co.*, 278 F.Supp.2d 820 (S.D. Tex. 2003). In *Salinas*, the facts showed that the air conditioning system would leak as a result of the coils freezing every few years. Following the leaks, the areas affected "looked black and smelled moldy." *Id*. at 824. Although the HVAC system was repaired, insufficient measures were taken to dry the wet areas or eliminate the mold. Based on evidence that the insured was aware of mold growth years before providing notice, there could be no coverage for the damage resulting from the air conditioning leaks. *Id*. Similarly, the court found that the insured had actual knowledge of water damage and mold growth from a leak in the master bath shower pan at least a year before notifying Allstate of its claim. *Id*. at 825. In regard to alleged mold damage from roof leaks, however, the court found there was insufficient evidence to grant summary judgment. *Id*.

Fortuity and Known Loss

In addition to the trigger issue and late notice defense, mold claims played their part in the resurgence of the "known loss" or "loss in progress" doctrine. Grounded in the axiom that insurance protects against risk, and is based on fortuity, the "known loss" doctrine provides that public policy will not allow an insured to obtain coverage for a loss that has already occurred, or begun, and is known to the insured.[4]

In *Martinez v. Allstate Texas Lloyd's Co.*, No. M-02-091 (S.D. Tex., Oct. 7, 2002), the court applied the "known loss" doctrine to the insured's mold claim. There was evidence the insureds had known of various plumbing leaks, and had seen evidence of mold, at least five years before inception of their policy. The court found it irrelevant that the insureds might have believed their cleaning efforts had cured the problem, and held that "[a] claim for such loss, which began prior to the inception of the policy, is precisely what is proscribed by the fortuity doctrine." *Id*. at 4.

Foundation/Leaks

A pool is not a plumbing system. At least that was the court's conclusion in *Kolenic v. Travelers Lloyd's of Texas Ins. Co.*, No. 03-02-00366, 2003 Tex. App. LEXIS 1081, 2003 WL 247117 (Austin Feb. 6, 2003, no pet. h.). The insureds suffered damage to their foundation and swimming pool caused by leaks from the pool. They asserted a claim under their homeowners policy (HO-B), which was denied as loss caused by settling and cracking. The insureds contended that the exclusion repeal provision applied because the swimming pool was part of the plumbing system, relying on *Balandran v. Safeco Ins. Co. of America*, 972 S.W.2d 738 (Tex. 1998). The court rejected this contention. The court noted, however, that there was no allegation that the accidental discharge arose from the plumbing system for the pool itself.

A sprinkler system may be part of the plumbing system, but it still has to cause the damage. In *Norstrud v. Trinity Univ. Ins. Co.*, 97 S.W.3d 749 (Tex. App.—Fort Worth 2003, no pet. h.). The homeowners asserted a claim for foundation damage, which was denied. The homeowners brought suit, alleging that the damage was caused by leakage from the sprinkler system. The jury rejected this argument, agreeing with Trinity that the sprinkler system, while leaking, could not have caused the foundation damage. *Id*. at 751. Instead, Trinity adduced expert testimony that the foundation damage resulted from the use of improper piers when the home was designed and built. *Id*. at 753-54. The court of appeals affirmed. The court also affirmed the trial court's rejection of the homeowners' challenge to Trinity's expert testimony. The court found that the expert engineer based his conclusion on several different factors, and while some factors may have been suspect, the others were sufficient to support his opinion. *Id*. at 754.

In *Hill v. State Farm Lloyds*, 79 Fed. Appx. 644, 2003 WL 22469757, 2003 U.S. App. LEXIS 22385 (5th Cir., Oct. 30, 2003), the court found that there was no contradiction in a verdict finding both that the plumbing leaks did not cause foundation damage to the home, and that State Farm nevertheless owed coverage for the cost of tearing out portions of the home to access the leaks in the plumbing system. The court found that the mere existence of leaks did not imply that the leaks caused the foundation damage.

Expert Testimony: Establishing Causation and Allocation

In 2002, an analysis of expert testimony and foundation cases led to the conclusion that a "wild ass guess" was not necessarily unreliable, where the overall substance of the testimo-

ny was reliable. See *State Farm Fire & Cas. Co. v. Rodriguez*, 88 S.W.3d 313 (Tex. App.—San Antonio 2002, pet. denied).[5] Insureds and insurers continue to take up the challenge, contesting the reliability of one another's expert witnesses under the *Daubert/Robinson* standards. Acknowledging the requirement that an insured allocate covered and non-covered damages, courts also debated whether there must be evidence to support a percentage, or whether the jury can choose from the range of expert opinion.[6]

In *Coury v. Allstate Texas Lloyd's*, 2003 U.S. Dist. LEXIS 16766 (S.D. Tex. 2003), the court rejected an argument that the language in an assignment to an outside engineering expert demonstrated a lack of reliability. In *Coury*, the plaintiff discovered water damage and mold within six weeks of her purchase of a home. Apparently, the former owners had made an insurance claim for damage caused when the washing machine flooded the house, but had withdrawn the claim before a coverage determination was made. *Id*. at *2. After the new claim, Allstate investigated and retained Rimkus to determine the original cause of the mold and the date of onset. Rimkus found visible mold and mildew and evidence of prior leaks, and concluded that the conditions had been present before the policy's inception. *Id*. at *6. The insured sued, asserting both contractual and extra-contractual claims. In part, the insured claimed that the Rimkus report was not reliable and there was evidence of bad faith. The court disagreed. The court also noted that the suggestion that the job assignment, which requested that Rimkus "try to found out what the original cause of mold is, and when that happened to determine if it's covered under their policy or not. If that can't be determined, I need to know what to do to remediate their home," did not demonstrate a lack of reliability. *Id*. at *16-18. The report itself indicated that the expert conducted testing and examined the property before reaching his conclusion, and there was no suggestion that his methodologies were inappropriate. *Id*. at *16.

Insureds and insurers continue to take up the challenge, contesting the reliability of one another's expert witnesses under the Daubert/Robinson standards.

Reliability was also at issue in *United Services Auto. Ass'n v. Pigott*, 2003 Tex. App. Lexis 10806, 2003 WL 23093726 (Tex. App.—San Antonio, Dec. 31, 2003, no pet. h.). When the insured purchased her house, she installed a French drain to remedy an existing drainage problem. More than ten years later, the insured had 13 piers installed to level the house. After the leveling, the gravel in the French drain was commingled with dirt and clay. *Id*. at *1-2. Two years later, in 1996, the plumbing system was replaced. At the same time, an engineer concluded that the leaks in the plumbing system were not the cause of further foundation movement, which was causing the walls to crack. *Id*. at *2-3. USAA agreed, however, to pay for replacement of the plumbing system, which was not covered, as well as for access costs. *Id*. at *3. In 1998, the insured reported additional foundation movement. USAA contacted the same engineering group to re-investigate. No plumbing leaks were found, and the engineers again concluded that foundation movement was not the result of plumbing leaks. *Id*. In January of 1999, the insured again contacted USAA because of a possible leak. A leak was indeed identified in an incoming water line, but further testing revealed no additional leaks. A new engineering firm was consulted, and also concluded that the leak that was identified did not cause any foundation movement. *Id*. at *4. As they had done in 1998, USAA and the experts recommended that the insured contact her foundation contractor regarding the movement in the piers, and a possible warranty claim. Instead, the insured contacted an attorney. The insured retained an expert who then concluded that the leaks had caused foundation movement. USAA sent the report to the previous two engineers, who both disagreed with the conclusions. *Id*.

In a subsequent lawsuit, a jury found that 40% of the damage was caused by plumbing leaks, and awarded damages accordingly. *Id*. On appeal, USAA contended that Bradley, the insured's expert, was not qualified because he was an industrial engineer, and not a civil or geotechnical engineer. The court rejected this argument, based on Bradley's other qualifications and experience. *Id*. at *6. USAA also contended that the testimony was not reliable. The court first concluded that the underlying test data was admissible, as Bradley relied on the same data collected by the insurance company's experts. *Id*. at *10. The court then reviewed the rest of Bradley's conclusions, and determined that his testimony was grounded in the application of his engineering training data regarding elevations and soil samples, and was more than his objective or unsupported speculation. *Id*. at *14. The court also found that the 40% allocation awarded by the jury was within the range of expert testimony, from the zero percent asserted by the experts for the insurer, to the 99 and 44/100ths percent, to which Bradley attested. *Id*. at *18.

The reliability of expert testimony was again at issue in *Allstate Texas Lloyds v. Mason*, 2003 WL 22805319 (Tex. App.—Fort Worth, Nov. 26, 2003, no pet.). The suit involved contractual and extracontractual claims arising from foundation damage. The house was one of three in a row, constructed by the same builder, which all suffered foundation settlement. The other two owners sued the builder, but the previous owner of the Masons' house did not. *Id*. at *1. Because the "fill" was not properly compacted, the foundation settled and the southeast corner of the house rested 5 to 7 inches below other parts of the house, causing cracks in the interior and exterior walls. Before the Masons purchased the house, the previous owners retained an engineer to conduct an inspection. The engineer discovered many symptoms of foundation movement, and concluded that sub-surface water had caused the foundation upheaval. Accordingly, the engineer recommended that a French drain be installed. After it was installed, he re-inspected, and concluded that the drain was working, and the foundation appeared stable. *Id*. at *1-2. The Masons purchased the home, aware that there had been some repairs made, and the French drain had been installed, but believing the house was otherwise in excellent condition. *Id*. at *2. Several years after purchase, cracks in the walls and ceilings began to appear. Ultimately, the Masons asserted a claim under their policy, contending that the damage was the result of plumbing leaks. *Id*. Allstate paid access costs, but did not pay for the actual cost of repairing the broken pipes. Allstate also retained an engineer to inspect the house, to determine whether the foundation damage was caused by a leak. The engineer inspected the house, and also reviewed the prior reports. Based on this investigation, he concluded that the sub-surface drainage caused soil expansion, which was alone sufficient to damage the house. He also concluded that the resulting foundation movement in turn broke the pipe. Because the foundation damage did not result from a plumbing leak, Allstate denied the claim. *Id*. at *3.

Upon trial, the jury found against Allstate on both the contractual and extracontractual claims, and awarded repair costs based on an earlier appraisal award, as well as bad faith damages and $3.5 million in exemplary damages. *Id*. On appeal, the court affirmed the finding of breach of contract and damages under Tex. Ins. Code art. 21.55, but reversed the awards for extracontractual and exemplary damages. *Id*. at *14.

One of the points raised by Allstate was the admissibility of testimony from the Masons' engineering expert, who opined that all damage was the result of a plumbing leak under the bathroom. Allstate contended the testimony was unreliable because the expert did not rule out other plausible causes, including the pre-existing foundation problems. *Id*. at *4.

During the Daubert hearing, the expert had conceded that he did not investigate why the bathroom pipes broke, or whether the break could be the result of soil movement. The court nevertheless found that the trial court had not abused its discretion in determining the evidence was reliable. *Id*. at *5. The court noted the testimony from the expert that he had excluded the pre-existing foundation problems as a cause of damage. Moreover, although Allstate never specifically asked, the evidence also showed that the expert had excluded the possibility that sub-surface drainage caused the soil to move, resulting in the foundation problems. The court also found that many of Allstate's theories were based on hypothetical situations, and not demonstrated to be plausible causes of foundation damage. *Id*.

An expert can be right for some of the wrong reasons: even some unreliable bases will not render the entire opinion inadmissible, if other bases are reliable. See Norstrud v. Trinity Univ. Ins. Co., 97 S.W.3d 749 (Tex. App.-Fort Worth 2003, no pet.) (where expert engineer based conclusion on several factors, even though some factors were suspect, the others were sufficient to support the expert's opinion).

Discovery of Expert Reports

A court may allow discovery of all reports by the insurer's expert, relating to similar claims, to see if the insurer has breached its duty of good faith and fair dealing by a pretextual investigation. This is the essence of the court's holding in *Hussey v. State Farm Lloyd's Ins. Co*., 216 F.R.D. 591 (E.D. Tex. 2003). *Hussey* involved claims for damage to the home's foundation, floors, walls and ceilings allegedly caused by a plumbing leak. State Farm investigated and discovered a plumbing leak, but then retained an expert who investigated and opined that the leak did not cause the damage to the foundation or other related damage. Plaintiff sought to subpoena from the expert all engineering reports prepared for State Farm for the past five years on residential foundation claims where damage was alleged to be caused by a plumbing leak. *Id*. at 593. State Farm contended that the reports were not discoverable, and that discovery would be unduly burdensome. *Id*. The court took guidance from *State Farm Lloyd's v. Nicolau*, 951 S.W.2d 444 (1997) in which the Texas Supreme Court upheld a finding that State Farm had breached its duty of good faith and fair dealing by relying on an expert's report, when the report was not objectively prepared or was unreasonable. *Id*. at 593-94. The evidence in Nicolau indicated that the majority of the engineer's work came from insurance companies, and that the engineering firm had advocated the view that plumbing leaks were unlikely to cause foundation damage, and that State Farm was aware of this view before retaining the expert. The

court also found that a deposition alone would not be sufficient, and that State Farm had not demonstrated that the discovery would cause undue burden or expense. *Id*. 595-96.

Mold: The Ensuing Loss Debate

Courts in Texas have struggled with "ensuing loss" provisions, and are divided in their interpretation. The HO-B covers "ensuing loss caused by . . . water damage . . . if the loss would otherwise be covered under this policy." At issue is whether the water damage that causes this "ensuing loss" must result from an otherwise excluded peril, or if the otherwise excluded damage must merely "ensue" from water damage.[7]

In *Fiess v. State Farm Lloyds*, 2003 U.S. Dist. LEXIS 10962, 2003 WL 21659408 (S.D. Tex., June 4, 2003), the court granted State Farm summary judgment, based in part on its conclusion that the "ensuing loss" exception did not restore coverage for mold, which was otherwise excluded under the policy. *Id*. at *6-7. The Fiesses' home sustained damage from Tropical Storm Allison. The plaintiffs' expert, who had inspected the home, identified six areas of water intrusion: flood waters, roof leaks, plumbing leaks, HVAC leaks, exterior door leaks, and window leaks. The flood damage was separately insured, and not covered under the HO-B. The expert initially opined that 25% of the mold was "non-Allison related," but later changed his testimony to 70%. *Id*. at *2. State Farm maintained the mold damage was not covered, but made a partial payment for remediation in areas with pre-flood leaks. The Fiesses sued, asserting contractual and extracontractual claims, and contending the mold damage was covered as an ensuing loss. The court disagreed. The court reasoned instead that the exclusions explicitly applied to mold, regardless of cause. *Id*. at *6. The ensuing loss provision did not restore coverage, because the provision refers to "water damage which is the result, rather than the cause, of one of the types of damage enumerated in exclusion f, in this case, mold." *Id*. at *8. Because the mold did not cause the water damage, but was caused by it, it was excluded, despite the ensuing loss provision. The court also noted that the insured's interpretations would nearly destroy the exclusion and would expand, rather than narrow, coverage.[8] *Id*. The court also held, in the alternative, that the insureds had not provided a reasonable basis to distinguish mold from the flood from mold caused by other events, and so were unable to allocated damages, even if mold were covered. *Id*. at *8. The court also found there was a bona fide dispute as to coverage, and that State Farm's partial payment did not constitute waiver, and granted summary judgment on the extracontractual claims. *Id*. at *10.

Another court in the same district, however, has rejected the reasoning in Fiess, and interpreted the ensuing loss provision to allow coverage for mold. *Flores v. Allstate Texas Lloyd's Co*., 278 F.Supp.2d 810 (S. D. Tex. 2003). The court in *Flores* specifically declined to follow Fiess. *Id*. at 814 n.3. Instead, also relying on *Yates*, the court concluded that mold was covered if it ensued form an otherwise covered loss, such as a plumbing or air conditioning leak. *Id*. at 814. In regard to the coverage for personal property (Coverage B), the court also concluded mold was covered, because accidental discharge from a plumbing or air conditioning system was a covered peril, and the exclusion for mold did not apply. *Id*. at 815. *See also Salinas v. Allstate Texas Lloyd's Co*., 278 F.Supp.2d 820 (S. D. Tex. 2003). The court in *Salinas* acknowledged that the "ensuing loss" provision provides coverage for mold that ensues from otherwise covered water damage events, adopting its own reasoning in its prior opinion in *Flores v. Allstate Texas Lloyd's Co*., 278 F.Supp.2d 810 (Tex. 2003). Nevertheless, the court refused to extend the "ensuing loss" argument to include coverage for mold damage resulting from another excluded loss, such as deterioration. *Id*. at 824. The court concluded that neither *Home Ins. Co. v. McLain*, 2000 Tex. App. LEXIS 969 (Tex. App.—Dallas, Feb. 10, 2000) nor *Burditt v. West America Ins. Co*., 86 F.3d 475 (5th Cir. 1996) compelled this result.

A magistrate judge adopted the reasoning of *Flores* and *Salinas* and concluded that mold could constitute and ensuing loss, in *Coury v. Allstate Texas Lloyds*, No. H-02-2238 (S. D. Tex., Jan. 7, 2004). In a prior memorandum and recommendation, adopted by the District Judge, the magistrate granted Allstate summary judgment on its extracontractual claims. Upon consideration of a second motion, addressing only the contractual claims, the magistrate judge recommended denial of summary judgment on the policy language. The magistrate acknowledged the competing arguments and opinion, but reasoned that the cases construing the ensuing loss provision to preclude coverage "…present a remotely plausible reading of the exception" but require "manipulation" of the language. Instead, the magistrate concluded that "[t]he more reasonable and natural reading is that 'collapse of the building…water damage, or breakage of glass' are the losses to which the latter part of the clause refers. If those losses are otherwise covered by the policy, then the ensuing losses (i.e., the losses which follow), even if they would normally be excluded, are also covered." *Id*. at *10.

The *Balandran* Dilemma

Policyholders have urged that the supreme court's ruling in the *Balandran* case also creates coverage for mold. In *Balandran v. Safeco Ins. Co. of America*, 972 S.W.2d 738, 740 (Tex. 1998), the supreme court found that the HO-B form was

ambiguous and that the "repeal provision" of exclusions 1(a) through 1(f) for personal property also applied to coverage for the dwelling. In so doing, the court found coverage for foundation damage that resulted from a plumbing leak. In *Salinas v. Allstate Texas Lloyd's Co*., 278 F.Supp.2d 820 (S.D. Tex. 2003), the court rejected an argument that the same analysis created coverage for mold. The court reasoned that, unlike the exclusion at issue in *Balandran*, which related to foundation damage, the exclusion relating to mold included no express restriction to dwelling coverage, and that mold could affect personal property as well as real property. *Id*. at 823.

The *Ballard* Case

Allison v. Fire Ins. Exchange ("the *Ballard* case"), 98 S.W.3d 227 (Tex. App.—Austin 2002), the long-awaited opinion in the Dripping Springs mold case, laid the ground rules for bad faith disputes arising from mold claims.

On appeal from the bad faith case, arising from a series of claims for leaks, water damage, and resulting mold, the court affirmed the exclusion of expert testimony, attempting to demonstrate causation between the mold and alleged bodily injury. *Id*. at 240. The court also affirmed the bad faith findings, finding violations of 21.55 and DTPA, finding "some evidence" to support the jury's findings, but reversed the findings of unconscionability, fraud, and "knowing" breach of a duty of good faith and fair dealing. *Id*. at 250-52. The underlying claim began as a single water damage claim, but ultimately evolved into multiple claims for various leaks, and claims of mold contamination in the entire house. In reviewing the evidence of bad faith, the court focused on the adjuster's lack of authority or experience in handling claims of this magnitude, and various incidents in the long period of claim handling. Specifically, the court noted that the adjuster had authority for only $20,000, although she knew immediately that the estimates for repair were in excess of $100,000. *Id*. at 249. When the adjuster sought the 45-day extension under 21.55, she stated that the additional time was needed to complete the claim investigation, when in fact she simply needed additional time to obtain authority. *Id*. The court also noted a possible misrepresentation in stating that a "complete plumbing test" had been performed; what the plumbers traditionally refer to as a "complete" test actually tests only underground systems, and not any pipes above the floor. *Id*. at 251. In addition, there was a question about whether there was a delay in removing flooring because of the insurer's conduct, and whether there was some evidence of a pattern of failure to promptly pay. *Id*. at 249-50. The court also found, however, that there was no evidence of a "knowing" violation, or of unconscionable or fraudulent conduct. *Id*. at 252. And, in reviewing the 21.55 claim, the court reasoned that some of the delays were attributable to the insured, and that the 18% penalty should not accrue for these periods. *Id*. at 264. This case settled while pending at the Texas Supreme Court and this opinion was subsequently withdrawn.

The court also held the trial court had erred in awarding the Gordons additional living expenses.

Additional Living Expense (ALE)

Many homeowners policies include a separate provision and sub-limit for additional living expense, necessitated by a covered loss. The provision in the HO-B form provides up to 20% of The Dwelling limit (Coverage A) for "any necessary and reasonable increase in living expense you incur so that your household can maintain its normal standard of living." *Beacon Nat'l Ins. Co. v. Glaze*, 114 S.W.3d 1 (Tex. App.—Tyler 2003, pet. denied) involved a dispute over proof and payment of ALE. The insurer contended that the insureds had not fulfilled a condition precedent, as they had not provided receipts showing their actual expense. The court disagreed, finding that the policy allowed more than one method of proof, and that the examination under oath, in which the insureds estimated the cost of additional living expenses, could suffice. *Id*. at 5.

The court also found, however, that the insureds were not entitled to recover attorney's fees. Relying on cases involving UM/UIM coverage, the court found that the insurer had a right under the contract to have liability and the extent of damages determined before it was obligated to pay under the policy, and until a duty to pay had been established, there was no "just amount owed" as required by TEX. CIV. PRAC. & REM. CODE § 38.002(3) (Vernon 1997). *Id*. at 6.

On the other hand, mere estimates are not sufficient. *USAA v. Gordon*, 103 S.W.3d 436 (Tex. App.—San Antonio 2002, no pet.). In a case involving alleged foundation damage resulting from plumbing leaks, the insureds prevailed on their contract and DTPA claims at trial. On appeal, the court affirmed the contract claim, but concluded that the insureds

had failed to prove any damages apart from those related to denial of the claim, and were therefore not entitled to recover extracontractual damages. The court also held the trial court had erred in awarding the Gordons additional living expenses. The Gordons had estimated their potential costs of additional living expenses. The court concluded, however, that the policy language clearly required that the expenses be incurred before the insureds were entitled to recover them from the insurer.

Like Kind and Quality

The Austin Court of Appeals reviewed the policy requirement that the cost to repair or replace be based on materials of "like kind and quality" in *Beacon Nat'l Ins. Co. v. Montemayor*, 86 S.W.3d 260 (Tex. App.-Austin 2002, no pet.). Beacon brought a declaratory action seeking a determination of the propriety of its treatment for insured's claims for roof repairs. At issue was the number of roofs that needed to be replaced. Where there are multiple layers, there may be no "nailable surface." Beacon maintained that only one layer of roofing should be removed and replaced with like kind and quality, as the damage to any further layers was the result of wear and tear, and not a covered peril. Beacon asserted that TDI initially approved Beacon's interpretation, but later reversed its position in a letter to Beacon, indicating there were situations in which there would be coverage for the cost to remove multiple layers of roofs to obtain a suitable nailing surface.[9] Beacon's declaratory action was rejected, largely on procedural grounds. The court found that the lawsuit lacked necessary parties, that TDI's advisory letter did not rise to the status of the rule, and that Beacon had failed to exhaust its administrative relief. Accordingly, any action was premature.

The Austin Court of Appeals reviewed the policy requirement that the cost to repair or replace be based on materials of "like kind and quality."

Appraisal

In one of the lesser issues in the *Ballard* opinion, the court reviewed the insurer's invocation of the appraisal provision. *Allison v. Fire Ins. Exchange*, 98 S.W.3d 227 (Tex. App.—Austin 2002, pet. filed). The insureds attacked the appraisal on a number of bases. The jury found that the appraisal award was rendered as a result of fraud, accident or mistake. Ballard attacked the qualifications of the appraiser, the timing of the award, the basis of the bids used, the validity of the bids, and typographical errors in the appraisal award. On appeal, the court rejected the argument that the appraiser's previous work with Farmers, and with insurance companies, supported a finding of a lack of independence. The court noted that the appraiser was instructed to determine costs on his own, and not from figures that FIE provided, and FIE did not instruct him on how to estimate costs, or restrict the assistance he could receive from outside experts. Further, the court found there was no evidence that the appraiser lacked competence, as he was a registered professional engineer with experience in structural engineering. His inexperience with mold remediation was not significant, and no different than Ballard's own expert, as he retained additional experts to assist him with the remediation estimate. Accordingly, the court found that the appraisal decision was binding and enforceable, and reversed the award to Ballard for her reasonable and necessary cost of appraisal. The court also found, however, that because Ballard's claims were for extracontractual damages, her damages were not limited to the amount of the appraisal decision.

The impartiality of the appraiser was also at issue in *Gardner v. State Farm Lloyds*, 76 S.W.3d 140 (Tex. App.—Houston [1st Dist.] 2002, no pet.). Following alleged damage to a roof from a hail storm, State Farm and its insureds disputed the amount of the claim, and the insureds invoked the appraisal provision of their homeowners policy. State Farm's appraiser inspected the roof, but did not find hail damage exceeding the deductible. The insureds' appraiser disagreed, but the umpire agreed with State Farm's appraiser, and the two of them signed an appraisal determination that awarded no money. The insureds sued for breach of contract and extracontractual damages. State Farm moved for and obtained summary judgment, arguing there had been a valid appraisal determination. On appeal, the insureds contended that the appraisal award was not binding because State Farm's appraiser was not independent. The insureds relied on evidence of a pre-existing relationship between State Farm and Haag Engineering, the appraiser's employer. The court noted, however, that there was no evidence of improper influence or control, and no evidence that the appraiser was an employee of State Farm or had a financial interest in the claim. The court found that the prior business relation-

ship was not evidence of impartiality, and that the appraisal award properly barred any further suit by the insureds.

Motor Vehicle Exclusion

The insured's race cars were deemed to be for recreational purposes, and therefore within an exception to the exclusion for motor vehicles, in *Farmers Ins. Exch. v. Neal*, 2003 WL 22438960 (Tex. App.—Texarkana, Oct. 29, 2003, no pet. h.). The cars were destroyed in a fire. The insurer denied coverage, based on the exclusion, and the insured's failure to report the purchase of the cars. Despite its own reservations as to whether the use of the cars should be considered recreational, the court found in favor of the insured. The court also found there was no evidence that the insured's failure to report the purchase of the cars was an intentional misrepresentation.

Innocent Insured

The doctrine of the innocent insured was re-visited in *McEwin v. Allstate Texas Lloyds*, 118 S.W.3d 811 (Tex. App.—Amarillo 2003, no pet.). A fire occurred at the McEwin's house. The house was insured under an HO-B policy, designating both husband and wife as named insureds. It was discovered that the husband, James, had instigated the fire. His wife, Kathy, was apparently uninvolved and unaware of his plans. The McEwins submitted a proof of loss, that did address the cause of the fire. Allstate made some initial advances and paid off the mortgage, but then denied the claim based on arson and on the "Concealment or Fraud" provision of the policy. The provision purports to void the policy if there is an intentional misrepresentation, before or after the loss. Kathy McEwin sued, asserting she was entitled to benefits as an innocent spouse, relying on *Kulubis v. Texas Farm Bureau Undw'rs Ins. Co*., 706 S.W.2d 953 (Tex. 1986). The court reasoned, however, that the innocent spouse doctrine did not supersede other policy provisions. Because the "Concealment or Fraud" provision voided the policy as to the named insured ("you") and any other insured, if any insured made an intentional misrepresentation, there could be no coverage.[10] The court also found that Article 21.19, TEX. INS. CODE (Vernon 1981) did not apply where the misrepresentation was in the arson and loss report, not the proof of loss. While it remains to be seen, the *McEwin* opinion may give new life to the Concealment or Fraud provision, which many practitioners have ignored, because of the apparent impact of Article 21.19.[11] But cf. Farmers Ins. Exch. v. Neal, 2003 WL 22438960 (Tex. App.-Texarkana, Oct. 29, 2003, no pet. h.) (no evidence insured intentionally concealed purchase of race cars).

II. LIABILITY COVERAGE

Trigger

Courts have applied a manifestation trigger to most claims for injury under homeowners policies, whether for property damage or bodily injury, and whether arising under the property or liability coverage. *See, e.g., Vanguard Undw'rs Ins. Co. v. Forist*, 1999 Tex. App. LEXIS 5265, 2002 WL 31059883 (San Antonio July 14, 1999, pet. denied) (not designated for publication) (applying manifestation trigger to claim for damage from plumbing leaks); *Closner v. State Farm Lloyds*, 64 S.W.3d 51 (Tex. App.—San Antonio 2001, no pet. h.) (same). As discussed in the sections relating to property damage, recent opinions addressing mold claims still appear to utilize a manifestation trigger.[12] In *Allstate Ins. Co. v. Hicks*, 2003 Tex. App. LEXIS 7915, 2003 WL 22096500 (Amarillo Sept. 10, 2003, no pet. h.), the court analyzed the proper trigger for claims of bodily injury and property damage from mold exposure. In regard to the claims for bodily injury, the court noted both the uncertainty in Texas law, and the opinion from the Houston Court of Appeals, in *Pilgrim Enterp., Inc. v. Maryland Cas. Co.*, 24 S.W.3d 488, 495 (Tex. App.—Houston [1st Dist.] 2000, no pet.), applying an "exposure" trigger to both bodily injury and property damage claims caused by exposure to chemicals arising from dry cleaning operations. The trial court also noted the precedent applying a manifestation trigger to homeowners claims in other contexts. Ultimately, the court concluded that determination of the appropriate trigger for bodily injury claims was unnecessary because under either a manifestation or exposure trigger there is no occurrence during the policy period. The court also found that the claims for property damage, which allegedly resulted in loss of use of the home, did not occur during the policy period, as the plaintiffs contended that they did not learn of the mold contamination until several years after they had purchased the house from the insured.

Notice

An insured's discussion of a claim with her agent does not constitute notice, as required by the policy conditions. *Deschenes v. Farmers Ins. Exchange*, 2002 Tex. App. LEXIS 3362, 2002 WL 971911 (Dallas May 13, 2002, pet. denied) (not designated for publication). The underlying claim involved a suit for libel and slander. The insured discussed the incident with her agent, but did not formally submit a claim or request a defense. Ultimately, the insured lost the defamation suit, and assigned her claims to the claimant, who sued the insurer on contractual and extracontractual theories. The court

found there was sufficient evidence that there was no "occurrence" to affirm a summary judgment on indemnity. In regard to the duty to defend, the court found there was sufficient evidence that the insured had failed to provide any written notice to its insurer to sustain summary judgment. In addition, the court rejected the extracontractual claims, finding that this was not a situation in which extracontractual violations had been established, regardless of the lack of a contract claim.

Occurrence: Intentional Conduct as Accident

In *Julian v. Mid-Century Ins. Co.*, 2002 Tex. App. LEXIS 5906, 2002 WL 1870441 (Dallas Aug. 15, 2002, no pet.) (not designated for publication), the court found coverage under a homeowners policy for a parent's liability for the intentional conduct of a child. The underlying lawsuit arose from the murder of the claimant's son. The claimant then sued Farmers' insureds, who sought coverage under their homeowners and auto policies. The insurers brought suit for declaratory relief, in which the claimant intervened. The trial court granted both insurers' summary judgment. An appeal was taken solely by the claimant, and solely in regard to the homeowners policy. The claimant contended the court erred in granting summary judgment because fact issues existed as to whether there was an "occurrence." The court followed the supreme court's opinion in *King v. Dallas Fire Ins. Co.*, 85 S.W.3d 185 (Tex. 2002), in which the court concluded that coverage could exist under a general liability policy for an employer's liability, under theories of *respondeat superior*, for an intentional assault by an employee. Following the supreme court's reasoning, the court held that, although the son's conduct might have been intentional, the alleged negligence of the parents was not so related and interdependent as to fall outside of coverage as a matter of law. Accordingly, the case was remanded for further proceedings.

Texas follows the majority of jurisdictions in holding that misrepresentation in the sale of a house is not an "occurrence."

Misrepresentation Not an Occurrence

Texas follows the majority of jurisdictions in holding that misrepresentation in the sale of a house is not an "occurrence." *Allstate Ins. Co. v. Hicks*, 2003 Tex. App. LEXIS 7915, 2003 WL 22096500, 2003 WL 22096500 (Amarillo Sept. 10, 2003, no pet. h.). Plaintiffs alleged that they suffered bodily injury and damage to their home because of exposure to mold, as a result of defects in the house that were known to the insured, but not disclosed. The trial court granted summary judgment for the insured. On appeal, the court addressed the question of whether there was an "occurrence," concluding, in part, that the claims of misrepresentation and failure to disclose were not accidents, and any damage was not the result of an "occurrence." *Id.*[13]

Tenant's Activities Could Be Occurrence

In *Hallman v. Allstate Ins. Co.*, 114 S.W.3d 656 (Tex. App.—Dallas 2003, pet. filed), the court concluded that negligence claims against the owner of a property, for blasting activities conducted by the tenant, could still constitute an occurrence. In *Hallman*, neighboring property owners sued the insured for damages relating to blasting and mining for limestone. The insured made a claim under her homeowners insurance policy for defense and indemnity. Allstate sought a declaratory judgment asserting that the damages did not arise from an "occurrence" or, in the alternative, were barred by the "business pursuits" exclusion. *Id.* at 660. The trial court entered summary judgment for Allstate, and the insured appealed. On appeal, the court noted that the insured had intentionally leased her property, but that the allegations were that she had negligently allowed the property to be used in a way that was harmful to the plaintiffs. *Id.* at 661. The court found that the alleged damage was not the intended or expected result of leasing the property. *Id.* The court also found that the lease did not constitute a "business pursuit" and reversed the summary judgment, rendering judgment in favor of the insured. *Id.* at 662.

Business Pursuits

Typically, courts find a business pursuit where there is an activity, regularly engaged in, accompanied with a profit motive. *See, e.g., United Services Auto. Ass'n v. Pennington*, 810 S.W.2d 777, 779 (Tex. App.—San Antonio 1991, writ denied). While the common law act construction pre-dates the policy definition, many policies now define business as a "trade, profession or occupation." In *Hallman v. Allstate Ins. Co.*, 114 S.W.3d 656 (Tex. App.—Dallas 2003, pet. filed), the court held that leasing of property was not a business pursuit. Relying heavily on the *Pennington* case, the court concluded that "a trade is the business practiced or work engaged in regularly for gainful employment, livelihood… An occupation is

the principal business of one's life, means of earning a living… The profession is a calling that requires specialized knowledge and training, often in historical, scientific or scholarly principles, that are fundamental to the skills and methods needed." *Id*. at 662. The court found that allegations that the insured entered into one lease agreement regarding mining operations did not establish that the insured regularly engaged in leasing the property as a livelihood and means of earning a living, or that it was her principal business, or that she had specialized knowledge or training in leasing property. Accordingly, there was no basis to conclude that the lease fell within the "business pursuits" exclusion. *Id*. The court also refused to consider deposition testimony that was extrinsic to the factual allegations in the pleadings. *Id*. at 663. While the court's analysis of the business pursuit exclusion appears to comply with preceding law, this refusal to consider extrinsic evidence in the business pursuits exclusion is arguably at odds with other precedent.[14] Moreover, it makes it unlikely that any insurer can prevail on a business pursuits defense, as it is improbable that any plaintiff will specifically allege facts to establish a trade, profession or occupation.

III. PROCEDURE

Severance and Abatement

The prerequisites for severance and abatement were set forth in *Liberty Nat'l Fire Ins. Co. v. Akin*, 927 S.W.2d 627 (Tex. 1996). In part, the court held that severance of the extracontractual claims was appropriate where there had been an offer to settle the contract claim. *Akin* was revisited, and distinguished, where the offer to settle addressed only part of the claim. *In re Republic Lloyds*, 104 S.W.3d 354 (Tex. App.—Houston [14th Dist.] 2003, no pet.). A suit for contractual and extracontractual claims arose from claims under a homeowners policy for damage resulting from water leaks. After the trial court refused to sever the extracontractual claims, the insurer sought mandamus relief. The insurer relied upon a check issued to the insureds for the full amount stated in a Proof of Loss. *Id*. at 356. The insureds argued, however, that the check covered only the undisputed plumbing leak claim, and not the disputed foundation damage claim, and therefore there was no offer to settle the entire claim. *Id*. The court of appeals found that there was not conclusive evidence of an abuse of discretion, as there was not conclusive evidence that the insurer had attempted to settle the entire claim. *Id*. at 359-60. The court also found it significant that the check was issued months before the proof of loss, and there was no evidence that it was tendered in response to the proof of loss. *Id*. A dissenting justice disagreed, arguing that the failure to sever and abate, even if an offer of settlement related to only a portion of the claim, would negate the requirements and reasoning of *Akin*. *Id*. at 360-61 (Yates, J., dissenting)

Statute of Limitations

In a suit involving a claim for foundation damage, the court concluded that a fact issue existed as to whether an oral denial was sufficient to begin the running of the statute of limitations. *Ehrig v. Germania Fire Mut. Ins. Ass'n*, 84 S.W.3d 320 (Tex. App.—Corpus Christi 2002, pet. denied).[15] After the claim was submitted, the adjuster orally informed the insureds that the claim was denied. The claim was subsequently denied in writing on two separate occasions. Germania argued that the initial oral denial was sufficient to start limitations. The insured, on the other hand, contended that no cause of action accrued until the claim was denied in writing on the second occasion. The court concluded that it was not clear whether the initial denial was an "outright denial" sufficient to trigger the commencement of limitations, and thus presented a fact issue. On the other hand, multiple notices, followed by multiple denials, will not extend limitations. *Stewart Title Guar. Co. v. Hadnot*, 101 S.W.3d 642 (Tex. App.—Houston [1st Dist.] 2003, pet. denied).

Reconsidering a claim may extend limitations. *See, e.g., Pena v. State Farm Lloyds*, 980 S.W.2d 949 (Tex. App.—Corpus Christi 1998, no pet.). Where there are multiple claims, however, adjusted separately, the second claim will not extend limitations for the first. *Mangine v. State Farm Lloyd's*, 73 S.W.3d 467 (Tex. App.—Dallas 2002, pet. denied).[16] In *Mangine*, the insureds appealed from a finding that their homeowners claim for hail damage was barred by limitations. When an initial claim was made, State Farm inspected but found no hail damage to the roof. State Farm sent a check for $50 for the cost to repair the bathroom ceiling, minus the deductible. The insureds disputed the finding and asked State Farm to re-examine the roof, along with the Mangines' own inspector. The State Farm adjuster did so, and provided a "Building Estimate" form that stated he found no evidence of hail damage. A year later, the insureds made a claim for hail damage and a leak in the bathroom. State Farm opened a new claim and sent another adjuster to inspect. This time, the adjuster found minor damage to the bathroom, but no evidence of damage to the roof, other than wear and tear. The adjuster sent a letter explaining his findings and the policy's exclusion for wear and tear. He also enclosed his estimate for the cost of repairs, which did not exceed the deductible. The insureds sued alleging contractual and extracontractual claims. State Farm contended that the extracontractual claims, related to the first hail damage claim, were barred by limitations. The insureds contended that the second claim was a "continuation"

of their claim, and was not finally denied more than two years before they brought suit. The court concluded that the alleged hail damage was not an ongoing or continuing problem, and that State Farm had not treated the two claims as related. Instead, the insurer had investigated two separate incidents and reached two separate conclusions. Accordingly, State Farm had not reconsidered or withdrawn its earlier denial, and the first claim was expressly denied more than two years before suit was filed.

A partial payment may not constitute a denial. *Carper v. State Farm Lloyds*, 2002 U.S. Dist. LEXIS 17485 (N. D. Tex., Sept 13, 2002). The court, relying on *Mangine*, reasoned that State Farm's payment for water damage in 1996 did not unambiguously constitute a denial. Accordingly subsequent contractual and bad faith claims for mold damage asserted in 1999, caused by prior water losses, were not barred as a matter of law. *Id*. at *4. But, in *Wetsel v. State Farm Lloyds Ins. Co.*, 2002 U.S. Dist. LEXIS 13117, 2002 WL 1592665 (N. D. Tex., July 18, 2002), the court held that partial payment of a foundation claim, with an explanation that other damages were excluded, was sufficient to constitute a denial and begin limitations running. An offer to consider additional information was "language of courtesy" and did not constitute ongoing negotiations. *Id*. at *6.

1. Any opinions expressed in this article are solely the author's, and do not necessarily reflect the views of her firm or its clients.

2. For an excellent discussion of the forms and endorsements, and their implications, *see* Chris Martin, *The Mold Solution: An Analysis of the Texas Homeowners Policy Endorsements*, THE NEW TORT AND INSURANCE LEGISLATION (Insurance Law Section of the State Bar of Texas and The Texas Institute of Continuing Legal Education, 2003).

3. The author gratefully acknowledges the assistance of Li Chen, an associate at Thompson Coe, with the research for this article.

4. *See, e.g., Burch v. Commonwealth Mut. Ins. Co*., 450 S.W.2d 838, 840-41 (Tex. 1970); *Scottsdale Ins. Co. v. Travis*, 68 S.W.3d 72 (Tex. App.—Dallas 2001, pet. denied).

5. The expert, and engineer, was opining about the percentage of the foundation damage attributable to the covered leak.

6. The first ruling addressed only the extracontractual claims. In a subsequent opinion, the magistrate recommended denial of Allstate's motion for summary judgment on the contractual claim, reasoning that mold could be covered as an ensuing loss.

7. *Compare Lambros v. Standard Fire Ins. Co*., 530 S.W.2d 138, 141 (Tex. Civ. App.—San Antonio 1975, writ ref'd) ("if we give to the language of the exception its ordinary meaning, we must conclude that an ensuing loss caused by water damage is a loss caused by water damage where the water damage itself is the result of a preceding cause…"); *Zeidan v. State Farm Fire & Cas. Co*., 960 S.W.2d 663 (Tex. App.—El Paso 1997, no writ) *and Merrimack Mut. Fire Ins. Co. v. McCaffree*, 486 S.W.2d 616 (Tex. Civ. App.—Dallas 1972, writ ref'd n.r.e.) *with Employers Cas. Co. v. Holm*, 393 S.W.2d 363 (Tex. Civ. App.—Houston [1st Dist.] 1965, no writ) (damage to flooring from shower leaks was an ensuing loss caused by water damage, not subject to exclusion for inherent vice, deterioration or rot); *Allstate Ins. Co. v. Smith*, 450 S.W.2d 957 (Tex. Civ. App.—Waco 1970, no writ) (water damage from defective pipe was within ensuing loss exception).

8. Citing *Aetna Cas. & Sur. Co. v. Yates*, 344 F.3d 939,941 (5th Cir. 1965). The *Fiess* case was appealed to the Fifth Circuit by the insured and oral argument was conducted on May 5, 2004.

9. *Cf. Republic Underwriters Ins. Co. v. Mex-Tex, Inc*., 106 S.W. 3d 174 (Tex. App.—Amarillo 2003, pet. denied). In *Mex-Tex*, the court construed a similar provision in a commercial property policy, and held that "like kind and quality" required only that the roof be comparable, not identical. *Id*. at 181.

10. A similar argument was raised in *Texas Farmers Ins. Co. v. Murphy*, 996 S.W.2d 873 (Tex. 1999). The court, after first noting that many jurisdictions limit the concealment clause to the culpable party, refused to reach the issue, finding it was not properly preserved.

11. Art. 21.19 provides that:
Any provision in any contract or policy of insurance issued or contracted for in the State which provides that the same shall be void or voidable, if any misrepresentations or false statements be made in proofs of loss or of death, as the case may be, shall be of no effect, and shall not constitute any defense to any suit brought upon such contract or policy, unless it be shown upon the trial of such suit that the false statement made in such proofs of loss or death was fraudulently made and misrepresented a fact material to the question of the liability of the insurance company upon the contract of insurance sued on, and that the insurance company was thereby misled and caused to waive or lose some valid defense to the policy.
Tex. Ins. Code art. 21.19 (Vernon 1981)

12. *Supra* at p. 14 and 18.

13. The court cited *Freedman v. Cigna Ins. Co*., 976 S.W.2d 776 (Tex. App.—Houston [1st Dist.] 1998, no pet.) and *State Farm Lloyds v. Kessler*, 932 S.W.2d 732 (Tex. App.-Fort Worth 1996, writ denied).

14. *See, e.g., State Farm Fire & Casualty Co. Wade*, 827 S.W.2d 448, 452 (Tex. App.—Corpus Christi 1992, writ denied) (allowing extrinsic evidence to determine whether a boat was being used for business pursuit).

15. This case was cited with approval in *Provident Life & Accid. Ins. Co. v. Knott*, 47 Tex. Sup. Ct. J. 174, 2003 WL 22999368 (Dec. 19, 2003).

16. This case was cited with approval in *Provident Life & Accid. Ins. Co. v. Knott, supra*.

BY DANA HARBIN

COOPER & SCULLY, P.C., DALLAS, TEXAS

The Ever-Changing Truth About Additional Insured Endorsements

In today's industrial and service-oriented society comprised of complex contractual relationships, it is no wonder that liability policies are often supplemented with additional insured endorsements. Business relationships are often consummated by a risk transfer designed to shift potential legal liabilities that could arise in connection with the performance of a contract. The theory or rationale behind these risk transfers is to place the party who has the most control over the risk with the legal liability for suffering any financial loss, should that party fail to prevent such loss. Most often employed in the construction industry, the parties enter into hold harmless or indemnity agreements whereby one party, the indemnitor, assumes the other party's, the indemnitee's, legal liability, including defense expenses. The indemnity agreement is often coupled with a contractual requirement that the indemnity obligation be insured by the indemnitor. The parties then look to the contractual liability coverage of the commercial general liability policy to respond to the indemnity obligations.

However, the indemnity approach for risk transfer is problematic for several reasons: (1) contractual risk transfer depends upon a legally enforceable indemnity agreement, (2) contractual risk transfer may be in direct violation of public policy and anti-indemnity statutes, (3) contractual risk transfer may depend upon the availability of insurance to cover the indemnity obligation, and (4) though contractual liability coverage may be available to respond to the indemnity obligation, the indemnified party has no direct rights under the insurance policy. To ensure protection in light of the risks involved with indemnity agreements, parties also include insurance provisions in their contracts to require one party to purchase liability insurance that includes coverage for the other party as an additional insured. The result is a collection of standard form and manuscript additional insured endorsements, which have evolved to meet those additional insureds' needs.

This article will focus on additional insured endorsements that are most often litigated in relation to construction contracts. The main focus of the article is to address various issues that arise from the use of additional insured endorsements, including: (1) the different judicial interpretations on the scope of the various standard ISO form additional insured endorsements, (2) the interrelation between the indemnity agreement and the requirement to procure insurance and how that affects additional insured coverage, (3) the effect of a certificate of insurance on the additional insured coverage, (4) a brief discussion of the use of manuscript additional insured endorsements, and (5) how other policy provisions apply to the additional insured.[2] The article will focus primarily upon rulings from Texas courts;. Hhowever, it is necessary to consider trends from other jurisdictions in order to capture the full overview of additional insured endorsements.

I. SCOPE OF VARIOUS ADDITIONAL INSURED ENDORSEMENTS

While it would seem that the contracting parties would have control over the scope of additional insured coverage, the parties are usually unaware of the actual content of the additional insured endorsement and even sometimes the entire liability insurance policy. In fact, most indemnitees expect the same coverage as that provided to the named insured. Therein

Dana Harbin[1] is with the law firm of Cooper & Scully, P.C. in Dallas, where she specializes in insurance coverage disputes involving all types of insurance policies. Dana gratefully acknowledges the editing assistance of Michele Robberson.

lies the potential for litigious controversies and the resulting gambit of judicial interpretations.

Over 30 ISO form endorsements are available to the general liability insurer as a means of securing additional insured status in a variety of business or social contexts. Many of these endorsements are designed for use in relationships outside of a business context, such as club members, church members, social associations, etc. However, the focus of this article is on additional insured endorsements used in the furtherance of business or contractual relationships in the construction industry.

A. CG 2007 – ARCHITECTS, ENGINEERS AND SURVEYORS

Engineers, architects, and surveyors can be added as additional insureds and often seek such status from project owners or general contractors by way of ISO Form CG 2007. However, the insurance available under the CG 2007 form is limited to the general negligence of the architect, engineer, or surveyor and does not insure professional liability. CG 2007 endorsement reads:

> ADDITIONAL INSURED - ENGINEERS, ARCHITECTS, OR SURVEYORS
>
> This endorsement modifies insurance provided under the following:
>
> COMMERCIAL GENERAL LIABILITY COVERAGE PART
>
> A. Section II ñ Who Is An Insured is amended to include as an insured any architect, engineer, or surveyor engaged by you but only with respect to liability arising out of your premises or ongoing operations performed by you or on your behalf.
>
> B. With respect to such architects, engineers, or surveyors described in Paragraph A. above, the following exclusion is added to Paragraph 2., Exclusions of Section I – Coverage A – Bodily Injury and Property Damage Liability and Section I – Coverage B – Personal and Advertising Injury liability:
>
> The insurance does not apply to "bodily injury", "property damage," "personal injury" or "advertising injury" arising out of the rendering of or the failure to render any professional services by or for you, including:
>
> 1. The preparing, approving, or failing to prepare or approve maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; and
>
> 2. Supervisory, inspection, architectural or engineering activities.

Several issues have resulted in litigation involving the CG 2007 form, either in its current state or as previously written. The most common question is whether the additional insured's conduct giving rise to a claim was "professional" in nature. Insurers are likely to deny coverage under the CG 2007 form when the injury is allegedly caused by services that the architect, engineer, or surveyor contracted to perform. However, most demand letters or petitions are not so clear and may include allegations of conduct not included in the work contract. Another significant question is the coverage afforded to the additional insured once the subject project is completed. The following is a survey of cases involving courts' interpretation or likely interpretation of the Architects, Engineers and Surveyors Endorsement.

Interpretation of CG 2007 or Similar Endorsments

One court interpreted the CG 2007 endorsement and held that the professional liability exclusion part of the endorsement precluded coverage. In *Prisco Serena Sturm Architects, Ltd. ("PSSA") v. Liberty Mut. Ins. Co.*,[3] the coverage dispute arose out of PSSA's alleged responsibility for construction defects to the Montessori School of Lake Forest. Under the contract, PSSA had responsibilities for both the design and construction phase of the project, and the school sued PSSA for its failure to guard against defects and deficiencies in Axelrod's (contractor's) performance.

The coverage dispute began when Axelrod purchased the contractually- required CGL policy from Liberty, which included the "Additional Insured-Engineers, Architects, or Surveyors," numbered CG 2007 (01 87). The court recognized that PSSA was an additional insured by way of this endorsement in the contractor's liability policy. After concluding that the complaint alleged an occurrence with allegations of negligent construction and supervision, the court further concluded that the "your product" exclusion did not apply to PSSA because the underlying action alleged damages to Axelrod's product (the building) by PSSA's negligent misrepresentations about Axelrod's work, and there were no allegations that PSSA's drawings, designs, and architectural work caused the damage.

Still, the court found no coverage for the School's lawsuit against PSSA because the endorsement excluded the specific conduct for which PSSA was allegedly liable. Liberty argued

that the Axelrod/School contract did not require Axelrod to provide for PSSA's professional liability coverage for "(1) the preparation or approval of maps, drawings, opinions, reports, surveys, change orders, designs, or specifications, or (2) the giving of or the failure to give directions or instructions by the Architect, his agents or employees, to the extent that such giving or failure to give is the cause of the injury or damage." The court instead relied upon the specific exclusion within the CG 2007 endorsement - "insurance with respect to ... architects ... does not apply to ... 'property damage' ... arising out of the rendering of or the failure to render any professional services by or for you, including: (a) the preparing, approving, or failing to prepare or approve maps, drawings, opinions, reports, surveys, change orders, designs or specifications; and (b) supervisory, inspection, or engineering services." The court first recognized that this exclusion applieds to PSSA as if it were the only insured. It then held that the exclusion applied based upon the specific allegations that PSSA was responsible for the damage because allegedly it had failed to determine the quality of Axelrod's work did not conform to the contract, it had failed to ascertain that Axelrod's work was not proceeding in accordance with the contract, it had not kept the School correctly informed about the quality of Axelrod's work, it had failed to guard against defects and deficiencies in Axelrod's performance, and some of its design documents were faulty, which resulted in damage to the School. The court held that these allegations fell directly within the professional services exclusion in the CG 2007 endorsement.

…the damages asserted in these suits arose out of "engineering services" performed by Southwestern, which were excluded under the policy provisions.

Texas and Other Courts Rule on Similar Language in Professional Services Exclusion – Ambiguous or Unambiguous?

In *Aetna Fire Underwriters Ins. Co. v. Southwestern Engineering Company*,[4] the Beaumont Court of Appeals dealt with a coverage issue between Southwestern, a consulting engineering firm that designed telephone systems, and its insurer on coverage for Southwestern's costs of defense and settlement of three property damage suits filed against it. Aetna denied the defense on the grounds that the damages asserted in these suits arose out of "engineering services" performed by Southwestern, which were excluded under the policy provisions.

Southwestern entered into a contract with Fort Bent Telephone Company to design expansion facilities of Fort Bend in Waller County. Sandidge Construction Company contracted with Fort Bend to construct the facilities designed by Southwestern. On April 3, 1974, while digging a trench to bury telephone cable, Sandidge struck an underground pipeline owned by Phillips Pipeline Company. As a result, three damage suits were filed against Southwestern.

Aetna refused to defend the three damage suits based upon the following exclusionary provision:

> It is agreed that the insurance does not apply to bodily injury or property damage arising out of any professional services performed by or for the named insured, including (1) the preparation or approval of maps, plans, opinions, reports, surveys, designs or specifications and (2) supervisory, inspection or engineering services.[5]

Aetna contended that the location of the underground pipelines under the rights of ways upon which Fort Bend's facilities were to be located was one of the contractual obligations undertaken by Southwestern. The court carefully reviewed the contract between Southwestern and Fort Bend and found no such provision either authorizing or obligating Southwestern to locate any underground pipelines.[6]

Aetna then argued that the location of such pipelines was an activity in the performance of "engineering services" and "the preparation or approval of maps, plans… surveys, designs or specifications," and, as such, any liability arising from the failure to locate same was excluded from coverage under the Architect, Engineer and Surveyors exclusion. In reconciling this issue, the court focused upon the fact that the term "engineering services" was not defined in either Southwestern/Fort Bend's contract and/or Aetna's insurance policy. The court noted the definition of "practice of engineering" or "practice of professional engineering," as defined in the Texas Engineering Practice Act[7] as follows:

> Shall mean any service or creative work,… the performance of which requires engineering education, training and experience in the application of special knowledge of the mathematical, physical, or engineering sciences to such services or creative work.[8]

The court refused to hold as a matter of law that the physical act of digging for and locating underground pipelines

requires engineering education, training and experience in the application of special knowledge of the mathematical, physical or engineering sciences, so as to constitute the practice of professional engineering. In fact, the court held that the term "engineering services," not being defined in the policy, is an ambiguous term. Applying well established law in Texas on the construction of exclusionary clauses, the court construed the Architects, Engineers and Surveyors exclusion in favor of Southwestern.

More recently, the Texarkana Court of Appeals held the architects, engineers and surveyors professional services exclusion unambiguously applied to services provided by both engineering and non-engineering personnel. In *Utica Lloyd's of Texas v. Sitech Engineering Corporation*,[9] a declaratory judgment action resulted from Utica's denial of Sitech's defense based upon the professional services exclusion that excluded:

> 1. The preparing, approving, or failing to prepare or approve maps, drawings, opinions, reports, surveys, change orders, designs or specifications; and
> 2. Supervisory, inspection or engineering services.

In the underlying action, the plaintiffs alleged that Jarred Lindsley died as a result of Sitech's negligent acts by its "engineers and non-engineering personnel." Sitech was allegedly negligent in three respects: (1) failing to make daily inspections of excavations, the adjacent area. and protective systems, especially after every rainstorm or other hazardous condition, (2) in the design and drafting of the system for excavation and for failing to indicate the spoil pile adjacent to the excavation, and (3) misrepresenting its qualifications to prepare the safety requirements, and to design the excavation system, and that it would properly inspect and monitor the excavation.

Sitech contended that these allegations, at least in part, referred to the acts or omissions of nonengineering personnel and, therefore, the claim was not excluded because the exclusion applied to professional services. Of course, Utica disagreed.

The Texarkana Court of Appeals held that the professional services unambiguously excluded the claim and lawsuit against Sitech. The court distinguished *Aetna Fire Underwriters Ins. Co. v. Southwestern Engineering Company*,[10] by concluding that the case does not stand for the proposition that the phrase "engineering services" is always ambiguous. Also, the court noted that the circumstances in Aetna Fire Underwriters were different; the insured was digging a trench, which was conduct that was not specifically defined as an engineering service in the policy. On the other hand, the services allegedly performed by Sitech were explicitly defined in the policy exclusion as professional services.[11]

As for Sitech's argument that the allegations involving non-engineering personnel were non-professional, the court held those allegations were legal conclusions (*i.e.*, theories) that could not be considered when determining the duty to defend.[12]

Other jurisdictions have interpreted this exclusion with similar mixed results. Some courts find the same professional services exclusion ambiguous,[13] while other courts have held the professional services exclusion unambiguous.[14]

B. CG 2010 and CG 2033 – OWNERS, CONTRACTORS AND LESSEES

In the context of insurance coverage procured by contractors/subcontractors seeking to add as additional insureds project owners, lesseess or contractors, the most frequently used standard ISO endorsements to the general liability type policies are CG 2010 and CG 2033. These endorsements can be written to provide additional insured coverage on either a "scheduled" basis, where the additional insured is listed either on the endorsement itself or on the declarations page, or on a "blanket" basis, where the additional insured is determined by whether a written contract requires that such insurance be procured. These forms afford good examples of the various interpretations of the standard ISO terminology and the issues arising out of its usage.

The most recent version of CG 2010 reads:

> ADDITIONAL INSURED – OWNERS, LESSEES OR CONTRACTORS
>
> This endorsement modifies insurance provided under the following:
>
> COMMERCIAL GENERAL LIABILITY COVERAGE PART
>
> SCHEDULE
>
> **Name of Person or Organization:**
>
> (If no entry appears above, information required to complete this endorsement will be shown in the Declarations as applicable to this endorsement.)
>
> **Who Is An Insured (Section II)** is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability arising out of your ongoing operations performed for that insured.

This version of CG 2010 was substantially changed from the prior versions. The 1985 version broadly included coverage for the additional insured's "liability arising out of 'your work'" for the named insured. The 1997 version was narrower, extending coverage to the designated additional insured only for "liability arising out of your ongoing operations." Then, the 2001 version was modified to delineate between the "work" and the "ongoing operations" of the named insured to make more explicit the intention that such additional insured coverage was not to include "completed operations" coverage for occurrences arising after completion of the named insured's work.[15] The narrowed coverage under the 2001 versions of CG 2010 is intended to correspond with another additional insured ISO endorsement form issued in 2001, CG 2037, which specifically affords only completed operations coverage to an additional insured to the extent included in the "products-completed operations hazard" coverage.

The latest version of CG 2033 (7/98) amends the general liability policy coverage to include as an insured "any person or organization for whom you are performing operations when you and such person or organization have agreed in writing in a contract or agreement that such person or organization be added as an additional insured on your policy." The endorsement further limits coverage for the additional insured to "liability arising out of your ongoing operations performed for that insured." The endorsement makes it expressly clear that there is no additional insured coverage for completed operations because the coverage "ends when your operations for that insured are completed."

The minority view is to limit the additional insured's coverage to vicarious liability of the named insured's own negligence.

The Owners, Contractors and Lessees additional insured endorsements have been the center of various judicial decisions. One of the primary issues is the scope of coverage available to the additional insured. Specifically, the question in many cases is whether the endorsements afford coverage for the additional insured only for vicarious liability or whether they insure the additional insured for its own negligence.

Minority View: Additional Insured Coverage Limited to Vicarious Liability for Named Insured's Acts

The minority view is to limit the additional insured's coverage to vicarious liability of the named insured's own negligence. This is certainly the interpretation preferred by the insurance industry because only recently did insurance companies begin to actually charge a worthy premium for additional insured coverage.[16]

Various arguments support this view. Some argue that the additional insured's coverage cannot exceed the named insured's indemnity obligation.[17] Others limit additional insured coverage to the imputed liability of the additional insured because broader interpretation could erode the limits of coverage.[18]

The insurer's efforts to limit coverage available to the additional insureds are premised upon obvious concerns. Once an owner is included as an additional insured on a contractor's general liability policy, the contractor's insurer faces liability to its additional insured for virtually any type of premises liability claim involving the completed project, whether that claim involves the negligence of the named insured or the additional insured owner. This problem appears to have been addressed by the latest version of CG 2010 limiting coverage for the additional insured to "ongoing operations," and the CG 2037 endorsement extending coverage for completed operations. Another concern is that the coverage premium reflects a rating for coverage for vicarious liability only, not the additional insured's own negligence.

Majority View: Additional Insured Coverage Extends to Negligence of Additional Insured

The majority approach to the additional insured endorsement is to give it a liberal construction so that the additional insured is covered for its own negligence if a causal connection exists between the injury and the named insured's work on the subject project.[19] Questions arise about what level of causal connection is necessary to trigger additional insured coverage.[20] However, the majority of jurisdictions that employ this interpretation give it such a liberal construction that the required causal connection is tenuous.[21]

Texas View: Anybody's Guess

Texas decisions demonstrate the ever changing "truth" of the additional insured endorsements by first adopting the interpretation that precludes coverage for an additional insured unless there has been negligence on the part of the named insured, and then later adopting the majority view.

In 1992, the Amarillo Court of Appeals first addressed the issue. In *Granite Construction Company, Inc. v. Bituminous Insurance Company*,[22] Granite was a contractor who contracted with Joe Brown company to haul asphalt materials from its construction site. Pursuant to this contract, Brown agreed to and did carry liability and property damage insurance, which had been issued to Brown by Bituminous in the form of gener-

al and excess liability policies. Granite was named as an additional insured under the general liability insurance policy by way of an endorsement, which read:

> 1. The "Persons Insured" provision is amended to include as an insured the person or organization named below [Granite Construction Company] but only with respect to liability arising out of operations performed for such insured [Granite] by or on behalf of the named insured [Brown].[23]

Brown's employee, Valchar, brought a negligence action against Granite, alleging that Granite negligently loaded his truck with dirt in such a manner that it overturned and injured him. Thereafter, Granite requested Bituminous defend it against Valchar's action. Bituminous refused, stating that the acts of Granite were not covered by Brown's policy and, therefore, Bituminous owed no duty to defend. Granite brought a declaratory judgment action seeking a determination that Bituminous had a duty to defend and a duty to indemnify.

Granite argued that, because Valchar alleged that his claim against Granite stemmed from operations performed pursuant to the Granite/Brown contract, Valchar's claim clearly arose "out of operations performed [namely, hauling] for such insured [Granite] by or on behalf of the named insured [Brown]."[24] Thus, Bituminous was liable under the general liability insurance policy endorsement.

The Court held in favor of Bituminous:

> …Valchar's claim against Granite was for its negligent loading of his truck. Under the Granite/Brown contract, the loading operation was the sole obligation of Granite, and Brown was not responsible for that operation. Measuring the policy coverage provided Granite by the allegations in Valchar's petition, it is at once obvious that Valchar's claim of Granite's liability arose out of the loading operations performed by Granite; it was not a claim "arising out of operations performed for [Granite] by or on behalf of [Brown]," the only operations for which Granite was insured. It follows that the endorsement is susceptible of only one reasonable interpretation: Granite is not afforded coverage for its own loading operations upon which Valchar's suit is predicated. Accordingly, the trial court correctly determined as a matter of law that Bituminous had no duty to defend Granite against Valchar's suit.[25]

The *Granite* court focused specifically on the exact activity that gave rise to Valchar's claim and then reviewed each parties' contractual obligations. Thus, it can be argued that the *Granite* decision is limited solely to the factual scenario presented to the court.

In 1995, the federal district court in the Northern District of Texas dealt directly with this issue, but it failed to provide any guidance. In *Northern Insurance Company of N.Y. v. Austin Commercial, Inc.*,[26] Judge Maloney relied upon *Granite* in holding that if the third party's claims involve direct negligence on the part of the named insured, then the insurance company is obligated to defend those claims on behalf of the additional insureds. This case involved Northern's additional insured endorsement extending coverage for "liability arising out of 'your work'." In this case, the court recognized that the lawsuit against the additional insured did not involve the direct negligence of the named insured. In fact, the named insured was not named as a defendant in the state court actions. There were no allegations that the injuries were caused by the named insured. Instead, the injured parties sought recovery directly from the additional insured on the basis of its own negligence.

The Granite *and* Austin Commercial *decisions raise several questions about the true purpose of the CG 2010 endorsement…*

Austin Commercial claimed contributory negligence against the injured claimant worker in the underlying state court action. However, the federal court held such allegations have no bearing on whether the injury arose out of the named insured's [Process Piping's] liability for its employee's claims against Austin Commercial.

The *Granite* and *Austin Commercial* decisions raise several questions about the true purpose of the CG 2010 endorsement, especially given the common circumstances under which parties seek such coverage. For example, an employee of the named insured is injured while working on the owner's project. The employee recovers under the named insured's worker's compensation policy and is thereafter barred from raising a claim against the named insured. Even if the employee asserts a claim against the named insured, then there is no coverage under a general liability policy due to the employee's bodily injury and worker's compensation exclusions. So, the employee sues the owner for its own negligence. Arguably,

the owner is not entitled to the status of additional insured under the *Granite* and *Austin Commercial* decisions. However, the only equitable defense available to the owner is the benefit of the worker's compensation bar. Thus, one justification for limiting the scope of the CG 2010 endorsement is that the general liability policy is not designed to cover employee injuries, whether the claim is brought against the named insured or the additional insured. Instead, the policy is designed to cover bodily injury and/or property damage suffered by a third party.

In 1999, the Texas courts switched gears and found new truth in the additional insured endorsements. In both *McCarthy Brothers Company v. Continental Lloyds Insurance Company*, and *Admiral Insurance Company v. Trident NGL, Inc*.,[27] the courts concluded that the additional insured endorsements covered the additional insured for claims involving injuries to employees of the named insured. In *McCarthy*, the McCarthy Brothers Company was sued by an employee of a subcontractor, Crouch, for negligence arising out of a duty it owed to him as a business invitee. Crouch's employee was injured as he walked down a slippery incline. Walking down the incline to get tools to perform Crouch's work was an integral part of its work for McCarthy. McCarthy was an additional named insured on a general liability policy issued to Crouch as the named insured. The endorsement insured McCarthy "only with respect to liability arising out of 'your work' for that insured by or for you." The court noted the employee's injury occurred while he was on the construction site for the purpose of carrying out Crouch's work for McCarthy. Thus, the court held, there was a causal connection between the injury and Crouch's performance of its work for McCarthy; accordingly, McCarthy's liability for the injury "arose out of" Crouch's work for McCarthy.[28]

Trident NGL involved a similar "additional insured endorsement" that restricted coverage for the additional insured to liability arising out of the named insured's operations.[29] Trident also involved an injury to an employee of the named insured occurring on the "premises of the additional named insured." In Trident, the court followed the rule of a majority of courts around the country, that it was sufficient that the named insured's employee was injured while present at the scene in connection with performing the named insured's business, even if the cause of injury was the additional insured's negligence.[30]

Recently, in *Highland Park Shopping Village v. Trinity Universal Ins. Co.*,[31] the Dallas Court of Appeals held that an injury to the employee of a contractor, the named insured, as he returned to his car in a Man-Lift occurred while he was on premises to do the work of his employer and arose out of the named insured's work. Thus, the landowners were additional insureds, even though the employee alleged negligence only by the landowners.

The interesting aspect of about *Highland Park* is that the employee was not even actually working at the time he incurred an injury. He had completed his work and used the Man- Lift to get to his car parked outside the garage so that he could leave the premises. These Texas cases demonstrate the court's' willingness to interpret the terms "arising out of" broadly and with little actual causal connection between the named insured's work and the injury or damage.

The most recent decision from a Texas court is *ATOFINA Petrochemicals, Inc. v. Evanston Ins. Co.*[32] ATOFINA sought insurance coverage as an additional insured under a policy issued to Triple S by Evanston. The liability policy included as an additional insured the following:

> 6. A person or organization for whom you have agreed to provide insurance as is afforded by the policy; but that person or organization is an insured only with respect to operations performed by you or on your behalf, or facilities owned or used by you.

The court rejected the argument that the subject injury did not arise out of Triple S' operations because the evidence showed that the death actually occurred while the Triple S employee was performing work for Triple S on the project for ATOFINA.

It appears that Texas courts have swung the pendulum of ever- changing truth about the additional insured endorsements, from coverage limited to vicarious liability of the additional insured to full coverage for the additional insured's own negligence. The issue has not gone before the Texas Supreme Court and it's anybody's guess as to how it will rule, though it is likely the Supreme Court will follow the majority.

"As Required By Written Contract" Requirement

Often, an additional insured will not be identified on the endorsement, but where the endorsement seeks identity of the named insured, the terms "as required by written contract" will be used. CG 2033 is designed to extend coverage to any additional insured where is when a contract between the named insured and the additional insured requires the named insured to purchase additional insured coverage. One Texas court has held that an additional insured endorsement that identifies the additional insured as "required to be made an additional protected person in a written contract" merely clarifies which persons or entities are to be additional insureds under the policy.[33] The provision is not an explicit reference clearly indicating the

parties' intention to include the terms and provisions of the contract between the parties as part of the insurance policy.[34]

A provision in a construction contract will not be interpreted as requiring the procurement of additional insured coverage unless such a requirement is expressly and specifically stated. In addition, contract language that merely requires the purchase of insurance will not be read as also requiring that a contracting party be named as an additional insured.[35] This is the issue addressed recently in the case of *Continental Casualty Company v. Fina Oil & Chemical Company*.[36] There, the additional insured endorsement was premised upon the requirement to procure additional insured insurance under a written contract. Continental argued that Fina was not an additional insured as defined by the additional insured endorsement because no written contract or agreement existed requiring A & B to add Fina as an additional insured. Fina responded that its written bid, dated August 12, 1997, which proposed to "furnish… insurance," became the written contract when it was accepted by Fina. The court held that a bid to "furnish… insurance," with nothing more, cannot be said to embody the material terms of a contract to provide that insurance. The court noted that it may be true, as argued by Fina, that both Fina and A & B understood that Fina would become an additional insured under A & B's policy and that A & B requested the issuance of a certificate of insurance on August 12. However, neither A & B's bid, nor Fina's purchase requisitions or purchase orders, specifically required Fina as an additional insured. Accordingly, the court held that Fina was not an additional insured under A & B's policy on August 14, 1997, the date of the subject injury.[37]

C. MANUSCRIPT ADDITIONAL INSURED ENDORSEMENTS

It is not unusual for insurers to include manuscript additional insured endorsements. Often, the purpose of these endorsements is to make clear the intent not to insure the additional insured for its own negligence. A case in point is *Continental Casualty Company v. Fina Oil & Chemical Company*,[38] where the liability policy included the following manuscript additional insured endorsement:

> IF YOU ARE REQUIRED TO ADD ANOTHER PERSON OR ORGANIZATION AS AN ADDITIONAL INSURED ON THIS POLICY UNDER A WRITTEN CONTRACT OR AGREEMENT CURRENTLY IN EFFECT, OR BECOMING EFFECTIVE DURING THE TERM OF THE POLICY, AND A CERTIFICATE OF INSURANCE HAS BEEN ISSUED, THEN WHO IS AN INSURED (SECTION II) IS AMENDED TO INCLUDE AS AN INSURED THAT PERSON, OR ORGANIZATION (CALLED "ADDITIONAL INSURED")[.]
> *2 THE INSURANCE FOR THAT ADDITIONAL INSURED IS LIMITED AS FOLLOWS:
> 1. THAT PERSON, OR ORGANIZATION, IS ONLY AN ADDITIONAL INSURED FOR ITS LIABIITY ARISING OUT OF PREMISES "YOU" OWN, RENT, LEASE OR OCCUPY OR FOR "YOUR WORK" FOR OR ON BEHALF OF THE ADDITIONAL INSURED; AND
> 2. THE INSURANCE AFFORDED THE ADDITIONAL INSURED UNDER THIS ENDORSEMENT DOES NOT APPLY TO (a) PUNITIVE OR EXEMPLARY DAMAGES IN WHATEVER FORM ASSESSED AGAINST THE ADDITIONAL INSURED AND/OR (b) ANY LIABILITY ARISING OUT OF ANY ACT, ERROR OR OMISSION OF THE ADDITIONAL INSURED, OR ANY OF ITS EMPLOYEES.

In *Continental*, the manuscript endorsement was successful in limiting coverage for the additional insured to the vicarious liability for the named insured's negligence. The court reviewed the petition and found that it did not allege negligence on the part of the named insured, but instead alleged negligence on the part of Fina (*i.e.*, the allegation that Fina was negligent in "demanding that A & B proceed to unload unbanded steel without proper equipment.") Thus, although Fina's liability arose out of the premises occupied by A & B, Fina's liability also arose solely out of the acts, errors, or omissions of Fina or its employees. Therefore, the court held, even if Fina was an additional insured at the time of the accident, coverage under that endorsement did not apply.[39]

II. SEVERABILITY OF INTEREST: ADDITIONAL INSURED'S RIGHTS AND DUTIES

Securing the status of additional insured does not necessarily guarantee coverage. The additional insured is subject to all policy provisions, including exclusions, conditions and definitions.[40] Once an indemnitee secures the status as additional insured, he should have the same rights and duties as that imposed on the named insured. In fact, general liability policies contain a severability of interest provision designed to achieve that very purpose. Nevertheless, despite the inclusion of a severability of interest provision, multiple disputes have arisen regarding the additional insured's rights and duties under its indemnitor's insurance policy. These disputes are inevitable because of the uncertainty of specific policy terms as they relate to an additional insured, as well as the variety of contexts in which an additional insured seeks coverage.

The principle that an additional insured should receive no broader coverage than that provided to the named insured is primarily based upon the inclusion of a severability of interest provision, which often reads:

> **7. Separation of Insureds**
> Except with respect to the Limits of Insurance, and any rights or duties specifically assigned in this Coverage Part to the first Named Insured, this insurance applies:
> a. As if each Named Insured were the only Named Insured; and
> b. Separately to each insured against whom claim is made or "suit" is brought.

The severability of interest clause distinguishes between the named insured and any other insured. This distinction is relevant when applying policy provisions to an insured versus the named insured. For example, some policy exclusions specifically apply only to the "named insured" and not to an additional insured. An insurer should consider this factor when designing and employing the use of manuscript endorsements to secure additional insured coverage. The obvious exception to the severability of interest mechanism is the application of policy limits, that is, only one policy limit is available for all insureds, and each insured does not get a separate policy limit. However, the effect of the severability clause is most apparent in determining the insurer's and additional insured's rights and duties to each other.

The severability of interest clause distinguishes between the named insured and any other insured.

Texas courts recognize that the effect of the severability of interest provision is to apply the policy provision to the insured against whom claim is made or suit is brought, independently of any other insured. In *Admiral Ins. Co. v. Trident NGL, Inc.*,[42] the court considered whether several exclusions applied to Trident as an additional insured. First, the court considered the employee exclusion, which reads:

> This insurance does not apply:
> (k) to bodily injury to any employee of the Insured arising out of and in the course of his employment by the Insured for which the Insured may be held liable as an employer or in any other capacity…[43]

The court held that the exclusion applies to "the insured," not the "named insured" by its very terms. Applying the severability of interest clause, the court held that, because the injured plaintiff was not an employee of Trident, the exclusion did not apply.[44]

Another effect of the severability of interest provision is the availability of cross- liability coverage to each insured. If one insured sues another insured, then the severability of interest provision affords coverage as if a separate insurance policy were issued to each insured.[45] Of course, the general liability policy can be endorsed to prevent such a scenario.

The general liability policy also differentiates between the named insured and an insured by use of the terms "you" and "your." These terms are specifically set out in the policy to refer to the "named insured," and such reference is necessary to determine the applicability of policy provisions, conditions and exclusions to the named insured versus the additional insured.[46] One Texas court ignored the use of the terms "you" and "your" when determining the available limits to the additional insured. In *Phillips Petroleum Company v. St. Paul Fire & Marine Insurance Company*,[47] the parties did not dispute that Phillips was an additional insured, but instead disputed whether the policy limits were eroded by claims expenses incurred on behalf of the named insured, Zachry, such that no limits were available to insure Phillips. The St. Paul policy included the following Contractors Commercial General Liability Deductible:

> Deductibles Apply To Damages And Claims Expenses – Limits Are Reduced By The Deductible Amounts
> This endorsement changes your Contractors Commercial General Liability Protection.
> IMPORTANT NOTE: This endorsement makes you responsible for paying damages and claims expenses within the deductibles that apply.
> ....
> Bodily injury and property damage each event deductible—other than products and completed work. $1,000,000.
> ....
> There are two changes which are explained below.
> 1. The following section is added. This change adds deductibles to be paid by you.
> DEDUCTIBLES
> The deductibles shown in the Deductible Table and the information contained in this section fix the amount of damage and claim expenses that

you'll be responsible fo[r] paying. Only those deductibles for which amounts are shown in the Deductible Table apply.
We will pay all or part of the deductible for you, unless we agree to do otherwise. WHEN WE DO MAKE PAYMENT, YOU AGREE TO REPAY THAT AMOUNT TO US PROMPTLY AFTER WE NOTIFY YOU OF THE PAYMENT.
Also, if we pay claim expenses that's [sic] subject to the applicable deductible, YOU AGREE TO REPAY THAT AMOUNT TO US PROMPTLY AFTER WE NOTIFY YOU OF THE PAYMENT.
Claim expenses includes [sic] the following fees, costs and expenses that result directly from the investigation, defense, or settlement of a specific claim or suit:
* *fees, costs or expenses of attorneys.*
....
Bodily injury and property damage each event deductible—other than products and completed work. You'll be responsible for the amount of damage and claim expenses within this deductible....
....
2. The following is added to the Limits of Coverage section. This section explains how the limits of coverage apply when a deductible applies.
The limits shown in the Coverage Summary, other than the General Total Limit and the Products and Completed Work total limit, *are reduced by the deductible amount that applies.* (emphasis added).

St. Paul argued that this deductible endorsement made the policy a "fronting" policy, but Phillips argued that the deductible provisions only applied to the named insured, Zachry, because the deductible endorsement used the term "you," which is defined by the policy as "Zachry," instead of the term "protected persons," which was the terms used to described the additional insureds.

The court held that, because the policy purchased by Zachry was, in fact, a "fronting" policy and Zachary was obligated to reimburse St. Paul for all claims expenses, including attorney's fees, incurred in defense of the underlying lawsuits, St. Paul owed no further obligation to Phillips once St. Paul expended $1 million in defending Phillips. The court reasoned that applying the construction of the terms of the policy as urged by Phillips would have the effect of rendering the terms of the deductible endorsement meaningless with regard to St. Paul's obligations to Zachry's named insured, Phillips, while simultaneously leaving them valid and enforceable with regard to St. Paul's obligations to its named insured, Zachry.[48] Note that petition for review was filed in this matter on August 18, 2003.

III. INTERRELATION BETWEEN INDEMNITY AGREEMENT AND AGREEMENT TO PROCURE INSURANCE

It is not an unusual argument that the coverage provided by an additional insured endorsement should correspond to the scope of the contractual indemnity agreement between the parties. As the Texas Supreme Court noted in *Urrutia v. Decker*,[49] "Texas law has long provided that a separate contract can be incorporated into an insurance policy by an explicit reference clearly indicating the parties' intention to include that contract as part of their agreement." One of the purposes of the agreement to procure insurance is to secure the right to indemnity.[50] However, unless explicit, the contract terms do not become part of the insurance policy, primarily because the insurer and the insured are the contracting parties to the insurance policy, including the additional insured endorsements. The indemnitee usually has no contractual relationship with the insurer. Thus, it is unlikely that a court would impose upon an insurer an interpretation of an endorsement in line with the scope of an indemnity agreement to which the insurer is not privy, unless explicit provisions tie the indemnity agreement to the agreement to procure insurance.

One of the purposes of the agreement to procure insurance is to secure the right to indemnity.

Texas Courts Interpret Additional Insured Coverage According to Scope of Indemnity Agreement Only When Requirement to Procure Insurance Supports Indemnity Obligation

The Houston Court of Appeals addressed the issue in *Emery Air Freight Corp. v. General Transportation Systems, Inc.*,[51] GTS contracted with Emery to provide local delivery services in Beaumont, Texas and Lake Charles, Louisiana. The contract, the "Cartage Agreement," provided that GTS would add Emery as an additional insured under its liability insurance policies. However, GTS did not comply with this contractual requirement. Subsequently, an employee of GTS was injured and filed suit against Emery. Emery then filed the Houston action against GTS when it discovered it had not been added to GTS' insurance policies.

The central issue in the *Emery* case was whether the Cartage Agreement required GTS to insure Emery against liability arising from Emery's own negligence. However, Emery made arguments that shed light on Texas courts' view of the relationship between indemnity agreements and additional insured endorsements. Emery argued that GTS' contractual requirement to add Emery as an additional insured shifted the risk of Emery's own negligence to GTS' insurer. The specific language upon which Emery relied is found in clauses 7 and 8 of the Cartgage Agreement:

> 7. Contractor shall obtain and maintain at its own expense insurance in such forms and minimum amounts as set forth below naming Emery as an additional insured. Contractor shall furnish Emery certificates from all insurance carriers showing the dates of expiration, limits of liability thereunder and providing that said insurance will not be modified on less than thirty (30) days' prior written notice to Emery.
>
> Minimum Limits of Insurance:
>
> A. Worker's Compensation – Statutory
> B. General Liability Insurance – $1 Million Combined Single Limit
> C. Automobile Liability – $1 Million Combined Single Limit
>
> If Contractor fails to obtain and maintain the insurance coverage set forth above, Emery shall have the right, but not the obligation, to obtain and maintain such insurance at Contractor's cost or, at its option, to terminate this Agreement for cause as provided in Section 9 hereof.
>
> 8. Contractor shall be solely responsible and liable for any and all loss, damage or injury of any kind or nature whatever to all persons, whether employees or otherwise, and to all property, including Emery shipments while in the Contractor's custody and control, arising out of or in any way resulting from the provision of services hereunder, and Contractor agrees to defend, indemnify and hold harmless Emery, its agents, servants, and employees from and against any and all loss and expense, including legal costs, arising out of the provision of the services hereunder, by Contractor.

The Houston Court of Appeals relied on two previous Texas Supreme Court decisions in its analysis. In *Fireman's Fund Ins. Co. v. Commercial Standard Ins. Co.*,[52] the contract at issue had a liability insurance clause that required the contractor to obtain liability insurance to "protect the owner… against all liabilities, claims, or demands for injuries or damages to any person or property growing out of the performance of work under this specification."[53] In the same contract, another clause indemnified the owner from claims arising from performance of the contract, excluding those claims arising out of the owner's negligence. The Supreme Court addressed whether the language of the insurance clause reflected an intention for the contractor to carry insurance covering the owner's negligent acts. The court first noted that the above-quoted language was "insufficient to clearly indicate an intention to protect the contractor-indemnitee against liability for damages caused solely by the latter's own negligence."[54] The court then carefully considered all the other relevant provisions of the contract and held:

> While the meaning of the contract provisions relating to liability insurance are not clear, the most reasonable construction is that they were to assure performance of the indemnification agreement as entered into by the parties. Such provisions are often required to guard against the insolvency of the indemnitor, and they should not be considered as evidence of intent to broaden the contractual indemnity obligation.[55]

The *Emery* court also relied upon *Getty Oil Co. v. Insurance Co. of North America*.[56] In *Getty*, the insurance and indemnity provisions fell within the same contractual clause. The insurance provision required the seller to carry liability insurance to protect the purchaser and the indemnity provision required the seller to indemnify the purchaser from claims "arising out of or incident to the performance or the terms of this order…"[57] The *Getty* court distinguished Fireman's Fund based upon the difference in the two contracts. The indemnity provision in *Getty* contained an internal provision for insurance to support it, while the agreement to procure insurance required the extension of coverage "whether or not required [by the other provisions of the contract]."[58] Based upon this distinction from the *Fireman's Fund* contract, the Supreme Court held the insurance provision did not support the indemnity provision, but was instead a free-standing obligation.[59]

In *Emery*, the Houston Court of Appeals applied a two-step analysis: (1) whether the indemnity clause satisfies the express negligence rule as set out in *Ethyl Corp. v. Daniel Constr. Co.*,[60] and (2) whether the insurance clause supports the indemnity clause or stands alone, representing an independent obligation. In so doing, the court held that the two clauses in the Cartage Agreement resembled those in the Fireman's Fund contract more closely than those in the Getty Oil contract. The court found that the Cartage Agreement did not meet the

express negligence test. The court concluded that neither the indemnity clause nor the insurance clause expressly covered negligence.

The court held that the most reasonable construction of the insurance provisions in the Cartage Agreement "is that they were to ensure performance of the indemnity agreement as entered into by the parties."[61] In effect, the Houston Court of Appeals held that the indemnity clause and insurance clause were interrelated, such that the agreement to procure insurance was determined by the scope (or validity) of the indemnity agreement.

The Beaumont Court of Appeals recently addressed the issue of interrelation between the insurance requirement and the indemnity obligation in *ATOFINA Petrochemicals, Inc. v. Evanston Insurance Company*.[62] Evanston argued that ATOFINA was not entitled to insurance coverage beyond the scope of the indemnification provision. The contract between Triple S and ATOFINA required that (a) Triple S obtain general liability insurance and excess liability insurance, (b) the general liability policy include coverage for Triple S's indemnity obligations, and (c) a certificate be issued listing ATOFINA as additional insured. The court noted that, when Triple S agreed to purchase insurance for ATOFINA, it did not limit that agreement to insuring only the indemnity obligation. The court relied upon *Emery* and *Getty Oil* for the proposition that the insurance requirement is limited to the indemnity liability only when the agreement to provide insurance is provided solely to support the indemnity obligation; but, when the additional insured provision stands separately from the indemnity provision, the scope of the insurance requirement is not limited to the scope of the indemnity clause.[63] The court then noted that the language in the ATOFINA/Triple S contract, requiring that the general liability coverage include coverage for the indemnity obligation, did not apply to the excess policy because the term "including" was a term of enlargement. This meant that insurance for the indemnity obligation was in addition to the other contractually required insurance.[64] On that basis, the court held that the insurance purchasing requirement of the contract was not merely in support of the indemnity provision.

Other Jurisdictions Vary In Considering Indemnity Agreements When Determining Scope of Additional Insured Coverage

Several jurisdictions seem to follow the same trend to analyze whether the insurance requirement is dependent upon the indemnity agreement or whether the requirement to procure insurance is separate and independent.[65] Under one theory, where an indemnity agreement is in violation of state law, the obligation to provide insurance to cover the void contractual obligation may not be enforceable.[66] The argument is that a party cannot circumvent a statutory prohibition against indemnity by simply becoming an additional insured. Where the indemnity agreements are allowed, but possibly invalid contractually, the parties may argue that the insurance requirement is also invalid, or, at least, very limited in scope.[67] Another argument suggests that where the additional insured endorsement is limited to "as required by written contract," and the contract includes an insurance requirement that solely supports the indemnity obligation, then the scope of coverage for the additional insured is limited to the indemnity obligation.[68]

On the other hand, more courts recognize the distinction between the indemnity obligation and the insurance requirement and rule that an invalid and unenforceable indemnity agreement does not necessarily render coverage for an additional insured null and void.[69] These cases generally rely only upon the policy language to determine the scope of coverage afforded to the additional insured.

One way for the insurer to clear this issue is to include language in its policy limiting its liability to the extent that the insured is liable under an indemnity agreement. This is what happened in the case of *Certainteed Corporation v. Employers Insurance of Wausau*.[70] In *Certainteed*, Wausau included an additional insured endorsement in the insurance policies issued to Teichmann. The endorsement:

> Section Two—Who Is An Insured:
>
> 5. Any person or organization other than a joint venture, for which you have agreed by written contract to procure bodily injury or property damage liability insurance, but only for liability arising out of operations performed by you or on your behalf, provided that:
>
> * * *
>
> b. The insurance afforded to any person or organization as an insured under this paragraph 5. shall include only the insurance that is required to be provided by the terms of such agreement to procure insurance, and then only to the extent that such insurance is included within the terms of this policy.[71]

Of course, in the *Certainteed* case, neither party disputed Certainteed's status as additional insured. The parties did disagree, however, on the extent of coverage that the additional insured provision extended to Certainteed. The court resolved this issue by determining what liability Teichmann assumed under the construction contract, requiring an analysis of the scope of the indemnity agreement.

One interesting aspect of the *Certainteed* case is not only the fact that the additional insured endorsement limited coverage to that required by the terms of the agreement between the

parties, but also that the parties had included a section in their construction contract that required Teichmann to secure insurance that would indemnify Certainteed for any liability that Teichmann assumed under that contract. Because the contract between Certainteed and Teichmann required Teichmann to provide Certainteed with insurance coverage that would indemnify Certainteed for its own negligence, except for its sole negligence, the court held Certainteed was entitled to additional insured coverage, except for injuries arising out of Certainteed's sole negligence.[72]

IV. INTERRELATION BETWEEN CERTIFICATES OF INSURANCE AND THE ADDITIONAL INSURED ENDORSEMENT

When a party requires the other party to procure additional insured insurance, the parties often also require that a certificate of insurance be issued by the insured's agent to confirm coverage. Sometimes the certificate will indicate that the policy contains an additional insured endorsement when, in reality, no such endorsement is attached to the policy. In other cases, the certificate may be silent as to the existence of additional insured coverage, without notice to either of the parties to the contract or to the insurance agent. In other situations, the named insured fails to provide the certificate of insurance and the project commences without objection by the additional insured.

Generally, the certificate of insurance plays no part in determining the actual coverage afforded to the additional insured. For example, the certificate of insurance may identify one party as an additional insured, but unless the named insured's policy is endorsed to that effect, it provides no additional insured coverage.[73] Applying Texas law, the federal court followed this majority rule most recently in *TIG Insurance Company v. Sedgwick James of Washington*.[74] In that case, the court held that a certificate, which stated it was issued "as a matter of information only" and does not purport to "amend, extend, or alter" the terms of any insurance policies listed therein, did not provide additional insured coverage where the policy at issue did not include an additional insured endorsement. Relying upon uncontroverted Texas precedent, the court recognized that a certificate of insurance cannot create coverage where none exists.[75] This is the law whether or not the certificate holder chose to review the subject policy to insure that additional insured coverage was endorsed.[76]

V. CONCLUSION

Insurance available to additional insureds by endorsement serves a valid purpose in the realm of risk transfer. These endorsements often satisfy the insured's contractual obligation to provide insurance to an indemnitee. However, a risk transfer by way of additional insured endorsement is not without its limitations or litigious controversies, as seen by the number of cases that have ruled on the interpretation of these endorsements. Furthermore, qualifying as an additional insured may not provide the same rights and obligations as the named insured, depending upon the language and the applicability of a severability of interest clause. Also, the coverage afforded the additional insured may be limited by the scope of the indemnity agreement, if the insurance requirement serves solely to support the indemnity obligation. Still, the additional insured endorsement is an inexpensive and oftentimes effective method of securing protection when multiple parties are involved in a construction project.

1. Dana Harbin is with the law firm of Cooper & Scully, P.C. in Dallas, where she specializes in insurance coverage disputes involving all types of insurance policies. Dana gratefully acknowledges the editing assistance of Michele Robberson.

2. See P. BRUNER and P. O'CONNOR, JR., 2 BRUNER & O'CONNOR ON CONSTRUCTION LAW, §5:219, ¶11.3.3 – No Additional Insured Coverage (Risk Allocation) (May 2003), for discussion of additional issues that may arise from the use of additional insured endorsements.

3. *Prisco Serena Sturm Architects, Ltd v. Liberty Mut. Ins. Co.*, 126 F.3d 886 (7th Cir. 1997).

4. *Aetna Fire Underwriters Ins. Co. v. Southwestern Eng'g Co.*, 626 S.W.2d 99 (Tex. App.—Beaumont 1981, writ ref'd n.r.e.).

5. *Id.* at 101.

6. *Id.*

7. Tex. Rev. Civ. Stat. Ann. art. 3271a, 2(4) (1968).

8. *Id.*

9. *Utica Lloyd's of Texas v. Sitech Eng'g Corp.*, 38 S.W.3d 260 (Tex. App. — Texarkana 2001, no pet).

10. 626 S.W.2d 99 (Tex. App. — Beaumont 1981, writ ref'd n.r.e.).

11. 38 S.W.3d at 264.

12. *Id.*

13. *Camp, Dresser and McKee, Inc. v. Home Ins. Co.*, 568 N.E.2d 631 (Mass. Ct. App. 1991) (term "supervisory" ambiguous because it could be construed narrowly as describing supervision of purely professional activities or broadly as describing management or control of aspects of a project involving both professional and non-professional activities).

14. *See GRE Ins. Group v. Metropolitan Boston Housing Partnership, Inc.*, 61 F.3d 79 (1st Cir. 1995) (Mass. law) (claimant's allegations of injuries caused by inadequate inspections fell outside Engineers Professional Services Exclusion where court held inspections non-professional in nature and considered the further complaints of general negligence unrelated to pro-

fessional services); *Harbor Ins. Co. v. Omni Constr., Inc*., 912 F.2d 1520 (D.C. Cir. 1990) (architect, engineer or surveyor endorsement unambiguously excluded coverage for loss caused by engineering service including related nonprofessional work where design/construction responsibilities performed by a single contractor); *Natural Gas Pipeline Co. of Am. v. Obom Offshores Surveys, Inc*., 889 F.2d 633 (5th Cir. 1989) (failure to perform services under contract constituted failure to perform "professional services" though some services may not be surveying services); *U.S. Fidelity & Guar. Co. v. Armstrong*, 479 S.W.2d 1164 (Ala. 1985) (engineering firm's function as liaison between city and contractor fell outside the purview of "professional services" triggering coverage as additional insured); *U.S. Fidelity & Guar. Co. v. Continental Cas. Co*., 505 N.E.2d 1072 (Ill App. Ct. 1987) (no coverage where architectural firm was in charge of entire construction project and failed to perform certain acts in that capacity); *Fidelity & Cas. Co. of N.Y. v. Envirodyne Engineers, Inc*., 122 Ill. App.3d 301, 461 N.E.2d 471 (Ill. Ct. App. [1st Dist.] 1983) (court reviewed extrinsic evidence to determine to determine whether functions of insured on project fell within professional services exclusion); *Sheppard, Morgau and Schwaab, Inc. v. United States Fidelity & Guar. Co*., 358 N.E.2d 305 (Ill. App. 1976) (architect, engineer or surveyors exclusion unambiguous where defines type or services excluded and thus court refused to refer to Illinois statute defining practice of professional engineering); *Wheeler v. Aetna Cas. & Sur. Co*., 298 N.E.2d 329 (Ill. App. 1973) (for purpose of determining whether architect's public liability insurer was obligated to defend action by workman who alleged in his complaint that architects failed to place and operate hoist properly, court took judicial notice that employees of contractors and subcontractors place and operate hoists and that architects and their employees never do so); *Gregoire v. AFB Constr., Inc*., 478 So.2d 538 (La. Ct. App. [1st Cir.] 1985) (Gregoire's allegations that certified engineer knew of the danger but allowed the project to proceed could be construed to include the breach of the general duty of reasonable care owed by all involved in the project, to report unsafe conditions and thus triggered coverage despite the Architects, Engineers and Surveyors exclusion); *CBM Engineers, Inc. v. Transcontinental Ins. Co*., 460 So.2d 745 La. Ct. App. (3rd Cir. 1984) (allegations that insured failed to make certain that all phases of construction were operating properly could be interpreted liberally to include conduct beyond that specifically enumerated in the professional services exclusion); *MacMillin Co. v. Aetna Cas. & Sur. Co*., 601 A.2d 169 (N.H. 1991) (No coverage for professional services as architect, engineer or surveyor even though insured was not engineering/ architectural firm, contract between insured and owner specifically provided that insured would serve as architect/engineer and insured did not enter into any subcontract for design and engineering services, but provided these services itself).

15. *See Mid-Continent Cas. Co. v. Chevron*, 205 F.3d 222 (5th Cir. 2000), and *Pardee Const. Co. v. Ins. Co. of the West*, 92 Cal. Rptr. 443 (2000), where both courts concluded that "your work" included completed operations coverage, but in dictum concluded that "your ongoing operations" language in the later versions of the endorsement did not. *See also* D. HENDRICK, INSURANCE LAW: UNDERSTANDING THE BASICS REGARDING ëADDITIONAL INSUREDS,' Insurance Law 2003: Understanding the ABC's, Practising Law Institute, p. 619 (2003) (including the terms "ongoing operations" in additional insured endorsements clarified the intention that such additional insured coverage was not to include "completed operations" coverage for occurrences arising after completion of the named insured's work).

16. *See G.E. Tignall & Co., Inc. v. Reliance Nat'l Ins. Co*., 102 F. Supp.2d 300, 306 (D. Md. 2000) (coverage provided to an additional insured under the Reliance policy, namely, for liability arising out of named insured's ongoing operations performed for additional insured, was indistinguishable from provision in parties' contract, so court held policy limited additional insured coverage to liability arising out of the named insured's work and does not cover additional insured for its own negligent acts); *Gates v. James River Corp. of Nev*., 602 S.2d 1119 (La. Ct. App. 1992) (court recognized that owner obtained Additional Insured Endorsement for two reasons: (1) proof of insurance from contractors for their own liability, and (2) an additional layer of insurance for the owner's own coverage in the event of its liability arising from the fault of the named insured).

17. *See e.g., St. Paul Fire and Marine Ins. Co. v. American Dynasty Surplus Lines Ins. Co*., 124 Cal.Rptr.2d 818, 830 (Cal. Ct. App. 2002); *see also G.E. Tignall & Co., Inc. v. Reliance Nat. Ins. Co*., 102 F. Supp.2d 300, 301 (D.Md., 2000).

18. See P. BRUNER and P. O'CONNOR, JR., 2 BRUNER & O'CONNOR ON CONSTRUCTION LAW, § 5:219, ¶11.3.3 – No Additional Insured Coverage (Risk Allocation) (May 2003), for discussion of issues arising from broad interpretation of additional insured endorsements.

19. *See i.e., Marathon Ashland Pipe Line LLC v. Maryland Cas. Co*., 243 F.3d 1232,1234 (10th Cir. 2001); *McIntosh v. Scottsdale Ins. Co*., 992 F.2d 251 (10th Cir. 1993); *Vitton Constr. Co. v. Pacific Ins. Co*., 2 Cal.Rptr.3d 1 (Cal. Ct. App. 2003); *Acceptance Ins. Co. v. Syufy Enters*., 81 Cal.Rptr.2d 557 (1999); *Andrew L. Youngquist, Inc. v. Cincinnati Ins. Co*. 625 N.W.2d 178, 183 (Minn. Ct. App. 2001); *Tishman Constr. Corp. of New York v. American Mfrs. Mut. Ins. Co*., 303 A.2d 323 (N.Y. App. Div. 2003); *Consolidated Edison Co. v. N.Y., Inc. v. Hartford Ins. Co*., 203 A. 2d 83, (N.Y. App. Div. 1994).

20. *See Pro Con Constr., Inc. v. Acadia Ins. Co*., 794 A.2d 108 (N.H. 2002) (general contractor's alleged liability for slip and fall by painting subcontractor's employee walking from work area to coffee truck for a break did not arise out of the subcontractor's ongoing operations performed for the general contractor, and, thus, the general contractor was not an "additional insured" under the subcontractor's commercial general liability policy; no nexus or causal connection existed between the painting operations and the injuries).

21. *See* Note 19.

22. *Granite Constr. Co., Inc. v. Bituminous Ins. Co*., 832 S.W.2d 427 (Tex. App.—Amarillo 1992, no writ).

23. *Id*. at 428.

24. *Id*. at 429.

25. *Id*. at 430.

26. *Northern Ins. Co. v. Austin Commercial, Inc*., 908 F. Supp. 436 (N.D. Tex. 1995).

27. *McCarthy Bros. Co., v. Continental Lloyds Ins. Co*., 7 S.W.3d 725 (Tex.App.—Austin 1999, no pet.); *Admiral Ins. Co. v. Trident NGL, Inc*., 988 S.W.2d 451 (Tex.App.—Houston [1st Dist.] 1999, pet. denied); *see also St. Paul Ins. Co. v. Texas Dept. of Transp*., 999 S.W.2d 881, 886†(Tex.App.—Austin 1999, pet. denied) (additional-insured endorsement provides coverage for damage that "results from" Abrams' work for TxDOT or TxDOT's supervision of that work; to be covered, the claim need only arise out of Abrams' work or TxDOT's supervision).

28. 7 S.W.3d at 730.

29. 988 S.W.2d at 454.

30. *Id*. at 454-55. *See General Agents Ins. Co. v. Arredondo*, 52 S.W.3d 762, 767 (Tex.App.-San Antonio 2001, pet. denied) (for injuries to "arise out of" a contractor's or subcontractor's operations, they need not be caused by an act of the contractor or subcontractor; all that is required is a causal connection); *Admiral Ins. Co. v. Trident NGL, Inc*., 988 S.W.2d 451, 454-55 (Tex. App.—Houston [1st Dist.] 1999, pet. denied) (holding "arising out of" in the context of an "additional insured" *endorsement* does not require that named insured's act caused accident). The Fifth Circuit has recognized that the phrase "arising out of" is "understood to mean 'originating from,' 'having its origin in,' 'growing out of,' or 'flowing from.' "*American States Ins. Co. v. Bailey*, 133 F.3d 363, 370 (5th Cir. 1998) (quoting *Red Ball Motor Freight, Inc. v. Employers Mut. Liab. Ins. Co*., 189 F.2d 374, 378 (5th Cir. 1951)). Thus, "a claim need only bear an 'incidental relationship' to the excluded injury for the policy's exclusion to apply." *Cf. Mid-Century Ins. Co. v. Lindsey*, 997 S.W.2d 153, 156-57 (Tex. 1999) ("For liability to 'arise out of' the use of a motor vehicle, a causal connection or relation must exist between the accident or injury and the use of the motor vehicle.").

31. *Highland Park Shopping Village v. Trinity Universal Ins. Co*., 36 S.W.3d 916, 917-18 (Tex. App.-Dallas 2001, no pet.).

32. *ATOFINA Petrochemicals, Inc. v. Evanston Ins. Co*., 104 S.W.3d 247 (Tex. App. —Beaumont 2003, no pet.).

33. *Phillips Petroleum Co. v. St. Paul Fire & Marine Ins. Co*., 2003 WL 21197132 at *6 (Tex. .App.-Houston [1st Dist.] 2003, pet. filed).

34. *Id*.

35. *Trapani v. 10 Arial Way Assoc*., 301 A. 2d 644, 647 (N.Y. App. Div. 2003).

36. *Continental Cas. Co. v. Fina Oil & Chemical Co*., 2003 WL 21470362 (Tex. App.—Houston [1st Dist.] 2003, no pet.).

37. *Id*. at *4.

38. *Id*. at *1 -2.

39. *Id*. at *4-5.

40. *Wymer v. North Am. Specialty Ins. Co.*, 78 F.3d 752 (1st Cir. 1996); *Oakland Stadium v. Underwriters at Lloyds, London*, 313 P.2d 602 (Cal. 1957).

41. *Commercial Std. Ins. Co. v. American Gen. Ins. Co*., 455 S.W.2d 714 (Tex. 1990); *Walker v. Lumbermen's Mut. Cas. Co.*, 491 S.W.2d 696 (Tex. Civ. App.—Eastland 1973, no writ).

42. *Admiral Ins. Co. v. Trident NGL, Inc*., 988 S.W.2d 451 (Tex. App.—Houston [1st Dist.] 1999, pet. denied).

43. *Id*. at 456.

44. *Id., see also Erdo v.Torcon Const. Co., Inc*., 645 A.2d 806 (N.J. Ct. App. 1994).

45. See D. MALECKI, P. LIGEROS AND J. GIBSON, THE ADDITIONAL INSURED BOOK, p. 139 (4th 2000).

46. *See Texas Farmers Ins. Co. v. Gerdes*, 880 S.W.2d 215 (Tex. App.—Fort Worth 1994, writ denied); *Black v. BLC Ins. Co*., 725 S.W.2d 286 (Tex. App.—Houston [1st Dist.] 1986, writ ref'd n.r.e.); *but see Wymer v. North Am. Specialty Ins. Co*., 78 F.3d 752, 756-57 (1st Cir. 1996) (inclusion of the terms "you" and "your" and "we," "us" and "our" serves to draw distinction between the insurer and the named insured, not between the named insured and the additional insured.).

47. 2003 WL 21197132 (Tex. App.—Houston [1st Dist.] 2003, pet. filed).

48. *Id*. at *6.

49. *Urrutia v. Decker*, 992 S.W.2d 440, 442 (Tex.1999) (citing *Goddard v. East Tex. Fire Ins. Co*., 67 Tex. 69, 1 S.W. 906, 907 (1886)).
50. *See* D. MALECKI , P. LIGEROS AND J. GIBSON, THE ADDITIONAL INSURED BOOK, p. 56 (4th 2000).

51. *Emery Air Freight Corp. v. General Transp. Sys., Inc*., 933 S.W.2d 312 (Tex. App.—Houston [14th Dist.] 1996, no pet.).

52. *Fireman's Fund Ins. Co. v. Commercial Std. Ins. Co*., 490 S.W.2d 818 (Tex. 1972).

53. *Id*. at 821.

54. *Id*. at 822.

55. *Id*. at 823.

56. *Getty Oil Co. v. Insurance Co. of N. Am*., 845 S.W.2d 794 (Tex.).

57. *Id*. at 796-97.

58. *Id*. at 804.

59. *Id*. at 804-06.

60. *Ethyl Corp. v. Daniel Constr. Co*., 725 S.W.2d 705, 708 (Tex. 1987).

61. *Emery*, 933 S.W.2d at 315.

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

63. *Id*. at 250.

64. *Id*.

65. See *Allianz Ins. Co. v. Goldcoast Partners, Inc*., 684 So.2d 336 (Fla. App. 1996) (manufacturer's agreement to provide insurance to franchisees as additional insureds did not require coverage beyond manufacturer's own liability, where manufacturer had no duty to indemnify franchisee for franchisee's own negligence); *Transcontinental Ins. Co. v. National Union Fire Ins. Co. of Pittsburgh*, 662 N.E.2d 500 (Ill. 1996) (agreement to procure insurance to the extent of indemnitor's agreement to assume indemnitee's negligence held void under Illinois Indemnification Act, and, thus, no coverage was available to indemnitee as additional insured); *Shaheed v. Chicago Transit Auth*., 484 N.E.2d 542 (Ill. Ct. App. 1985) (insurance clause and contract required that subcontractor maintain insurance "insuring all subcontractor's indemnity obligations", court rendered insurance provision unenforceable because it sought insurance against an invalid agreement to indemnify); *Posey v. Union Carbide Corp*., 507 F. Supp. 39 (M.D. Tenn. 1980) (agreement to indemnify owner from any claims for bodily injury sustained on premises resulting from construction work along with agreement to procure insurance to the same effect held unenforceable by virtue of invalid indemnity agreement).

66. *See, e.g., Shaheed v. Chicago Transit Authority*, 484 N.E.2d 542 (Ill. App. 1985).

67. *See Allianz Ins. Co. v. Goldcoast Partners, Inc*., 684 So.2d 336 (Fla. App. 1996) (manufacturer's agreement to provide insurance to franchisees as additional insureds did not require coverage beyond manufacturer's own liability where manufacturer had no duty to indemnify franchisee for franchisee's own negligence).

68. *See e.g. St. Paul Fire & Marine Ins. v. Hanover*, 187 F. Supp.2d 584 (E.D. N.C. 2000). See also section C., supra. .

69. *See Shell Oil Co. v. National Union Fire Ins. Co. of Pittsburgh, Pa*., 52 Cal. Rptr.2d 580 (1996) (though Washington statute forbids risk transfers for sole negligence, such law has no bearing upon insurance coverage, including coverage for indemnitee's sole negligence); *Chevron U.S.A., Inc. v. Bragg Crane & Rigging Co*., 225 Cal. App. 740 (1986) (agreement to procure insurance for additional insured's sole negligence held enforceable despite state statute prohibiting risk transfers for sole liability); *Chrysler Corp. v. Merrell & Garaguso, Inc*., 796 A.2d 648 (Del. Ct. App. 2002) (additional insured status remained despite void indemnity agreement); *Container Corp. of America v. Maryland Cas. Co*., 707 So.2d 733 (Fla. 1998) (language of policy naming additional insured is controlling as to scope of coverage, not indemnity agreement); *McAbee Constr. Co. v. Georgia Craft Co*., 343 S.E.2d 513 (Ga. Ct. App. 1986) (court held indemnification provision construed with insurance clause enforceable where parties to a business transaction mutually agreed that insurance would be provided as part of the bargain); *W.E.O' Neill Const. Co. v. General Cas. Co*., 748 N.E.2d 667 (Ill. App. 2001) (though indemnity contract was rendered void, court held additional insured status remained valid, where requirement to procure insurance was not inextricably tied to indemnity agreement); *Bosio v. Branigar Org., Inc*., 506 N.E.2d 996 (Ill. Ct. App. 1987) (court held that construction contract provision requiring public liability insurance for owner's benefit did not violate states' anti-indemnity statute prohibiting broad form hold harmless agreements); *Heat & Power Corp. v. Air Prod. & Chem., Inc*., 578 A.2d 1202 (Md. Ct. App. 1990) (indemnitee as additional insured on indemnitor's liability policy can obtain protection against its own negligence even though Maryland's statute forbids transfer of liability for sole negligence); *Long Island Lighting Co. v. American Employers Ins. Co*., 517 N.Y.S.2d 44 (N.Y. Sup. Ct. 1987) (court ruled that a utility as an additional insured under another entity's liability policy was protected by the policyholder's insurer, even if the indemnity provision were to be void as being against public policy). See also P. BRUNER and P. O'CONNOR, JR., 2 BRUNER & O'CONNOR ON CONSTRUCTION LAW, § 11:63, Slippery Slope of Additional Insured Coverage (May 2003), and D. HENDRICK, INSURANCE LAW: UNDERSTANDING THE BASICS REGARDING "ADDITIONAL INSUREDS," 690 PLI/Lit 591 (2003), for discussion of acquiring an owner's and contractor's protective liability policy (OCP) to insure all parties on a project as named insureds.

70. *Certainteed Corp. v. Employers Ins. of Wausau*, 939 F. Supp. 826 (D. Kan. 1996).

71. *Id*. at 829.

72. *Id*. at 831.

73. *See Mountain Fuel Supply v. Reliance Ins. Co*., 933 F.2d 882, 889 (10th Cir. 1991) (stating majority rule that standard ACORD certificate does not alter terms of policy); *Empire Fire & Marine Ins. Co. v. Bell*, 64 Cal. Rptr. 2d 749 (1997); *Pekin Ins. Co. v. American Country Ins. Co*., 572 N.E.2d 1112 (Ill. Ct. App. 1991) (certificate of insurance that stated general contractor was a named insured where policy expressly excluded coverage if subcontractor was to perform roofing work, afforded no coverage because certificate of insurance was not part of the policy; and therefore no conflict arose between the certificate and the policy language); *Trapani v. 10 Arial Way Associates*, 301 A. 2d 644, 647 (N.Y. App. Div. 2003) (a certificate of insurance which expressly states that it is "a matter of information only and confers no rights upon the certificate holder" is insufficient, by itself, to show that additional insured coverage has been purchased); *but see Niagara Mohawk Power Corp. v. Skibeck Pipeline Co*., 270 A. 2d 867 (2000) (where agent preparing the certificate of insurance, which showed the "additional insured" coverage, was deemed an "agent" of the insurer, additional insured coverage afforded, even though it was omitted through clerical error by the agent from the policy itself).

74. *TIG Ins. Co. v. Sedgwick James*, 184 F. Supp.2d 591 (S.D.Tex. 2001).

75. Id. at 597 (citing *Wann v. Metropolitan Life Ins. Co*., 41 S.W.2d 50, 52 (Tex. Comm'n 1931)(noting that certificate of insurance does "not constitute the complete contract of insurance" and must be construed in connection with underlying insurance policy); *RNA Invest., Inc. v. Employers Ins. of Wausau*, 2000 WL 1708918 (Tex. App.—Dallas 2000) (unpublished opinion) (certificates of insurance in and of themselves do not create insurance coverage); *C & W Well Service, Inc. v. Sebasta*, 1994 WL 95680, at *7 (Tex. App.—Houston [14th Dist.] 1994) (unpublished opinion) (citing *Granite* and noting insurance coverage is that provided by policy, not certificate of insurance); *CIGNA Ins. Co. of Texas v. Jones*, 850 S.W.2d 687 (Tex. App.—Corpus Christi 1993, no writ) (certificate of insurance does not extend the terms of the insurance policies certified therein); *Granite Construction Co., Inc. v. Bituminous Ins. Co*., 832 S.W.2d 427 (Tex. App.—Amarillo 1992, no writ); *Boyd v. Travelers Ins. Co*., 421 S.W.2d 929 (Tex. Civ. App.—Houston [14th Dist.] 1967, writ ref'd n.r.e.).

76. *Id*. at 598.

BY MARK A. TICER

LAW OFFICE OF MARK A. TICER, DALLAS, TEXAS

A Primer on Appraisal in Texas: One of the Most Frequently Abused and Misused Provisions in an Insurance Policy

Appraisal is an option/process frequently found in many insurance policies but most commonly used in the property damage context. The language of most polices states that appraisal is mandatory when properly demanded by the insurer *or* insured. Appraisal when properly employed is binding on the parties as to the amount of loss only. All too frequently though appraisal is improperly invoked, employed, and carried out almost exclusively by insurers and appraisers to the detriment of the insured. Appraisals are frequently carried out without attorneys, usually just between the insurer and the insured.

BACKGROUND

Appraisal is *not* arbitration. In arbitration, all contested issues are submitted to an arbitrator(s) for resolution while in appraisal only the amount of loss is decided by two (2) appraisers and an umpire, if necessary. Arbitration and appraisal are alike in that arbitrators, appraisers, and umpires are to be impartial, independent, and free from bias. Arbitration is formal in nature functioning somewhat like a court while appraisal is an informal process conducted by two (2) appraisers who determine solely the amount of loss. If the two (2) appraisers disagree, then an umpire is chosen by the parties to resolve differences; if the appraisers cannot agree on an umpire then frequently a court is petitioned to appoint one.

The appraisal language in a policy typically reads as follows:

> **Appraisal. If you and *we fail to agree on the actual cash value, amount of loss, or cost of repair or replacement,* either can make a written demand for appraisal. Each will then select a *competent, independent,* appraiser and notify the other of the appraiser's identity within 20 days of receipt of the written demand. The two appraisers will choose an umpire. If they cannot agree upon an umpire within 15 days, you or we may request that the choice be made by a judge of a district court of a judicial district where the loss occurred. The two appraisers will then set the amount of loss, stating separately the actual cash value and loss to each item.**
>
> **If the appraisers fail to agree, they will submit their differences to the umpire. An itemized decision agreed to by any two of these three and filed with us will set the amount of loss. *Such award shall be binding on you and us.***
>
> **Each party will pay its own appraiser and bear the other expenses of the appraisal and umpire equally.** Emphasis added.

MARK A. TICER is the principal in the Law Office of Mark A. Ticer. Mr. Ticer's practice primarily focuses in insurance law, particularly insurance coverage, bad faith insurance practices and claims. He received his B.S. degree with honors, from Oklahoma State University and his J.D. degree from Southern Methodist University. Mr. Ticer is a member of the Dallas Bar Association, The Association of Trial Lawyers of America (ATLA), the Texas Trial Lawyers Association (TTLA) and the Dallas Trial Lawyers Association. He is also the former chairman of the Dallas Subcommittee of the Unauthorized Practice of Law Committee.

Appraisal is employed to determine the amount of loss, nothing more. Ideally, this clause can be invoked by either party when a determination on the amount of loss is all that is at issue. For example, you inherited your grandmother's fine silver including utensils and plates. These items are stolen from your home. You claim the items taken are worth over $10,000. The insurer asserts the value is $1,000. Your homeowners' insurer acknowledges coverage. The use of appraisal in this instance would be appropriate.

Appraisal does not apply in the third party liability context. In other words, a third party making a claim against an insured is not required to engage in the appraisal process with the third party's insurer.

THE LAW REGARDING APPRAISAL IN TEXAS

A. The Basics

Appraisal is not arbitration. *In Re Allstate County Mut. Ins. Co.*, 85 S.W.3d 193, 195 (Tex. 2002); *Scottish Union & Nat'l Ins. Co. v. Clancy*, 71 Tex. 5, 8 S.W. 630, 631 (Tex. 1888). In theory, appraisal is to be used to provide a simple, speedy, inexpensive, and fair method of determining the amount of loss only. *Fire Ass'n of Philadelphia v. Ballard*, 112 S.W.2d 532, 534 (Tex. Civ. App.–Waco 1938, no writ). If a lawsuit is filed and one party demands appraisal, abatement is not required. *In Re Allstate County Mut. Ins. Co.*, at 85 S.W.3d at 193, 195 (Tex. 2002). If appraisal is properly invoked, carried out, and awarded, the amount of loss is binding on the insurer and the insured. *Clancy*, 8 S.W. at 631; *Standard Fire Ins. Co. v. Fraiman*, 514 S.W.2d 343, 344-345 (Tex. Civ. App.-Houston [14th Dist.] 1974, no writ).

Appraisal is employed to determine the amount of loss, nothing more.

Appraisal clauses are inserted for the insurer's benefit and may be waived. *Int'l Service Ins. Co. v. Brodie*, 337 S.W.2d 414, 415 (Tex. Civ. App.-Fort Worth 1960, writ ref'd n.r.e.). The insurer "will not be permitted to use this clause oppressively, or in bad faith." *Id.* at 417, citing *Cont'l Ins. Co. v. Vallandingham & Gentry*, 76 S.W. 22, 24.

B. When Is Appraisal Appropriate?

Absent agreement between the parties, appraisal is only to be used to determine the amount of loss. *Wells v. American States Preferred Ins. Co.*, 919 S.W.2d 679, 684 (Tex. App.-Dallas 1996, writ denied). Appraisers and umpires have no authority or power in an appraisal to determine "questions of causation, coverage, or liability…" *Id.* If there is only one case and one issue that you take away from this article, it should be the *Wells* case and the fact that appraisal cannot be used to determine causation, coverage, or liability.

Appraisal is not appropriate where an insurer claims only partial damage while the insured claims total damage. *Glens Falls Ins. Co. v. Peters*, 386 S.W.2d 529, 532 (Tex. 1965). "Whether a building is an actual total loss… depends upon whether a reasonably prudent owner, uninsured, desiring to rebuild, would have used the remnant for restoring the building." *Id.* at 531. This is more than a question of the amount of loss. Once the issue of total loss is decided, appraisal is proper. *Id.* at 532.

It is this writer's experience that appraisers and insurers frequently misuse appraisal to determine causation and coverage. For example, appraisal is frequently invoked by insurers in roof damage claims. A dispute will arise over whether the roof was damaged by hail (a covered peril) or ordinary wear and tear (not covered). The appraisers and umpires will get on a roof in an appraisal and one appraiser may decide that hail caused the damage resulting in a total loss while the other appraiser will make a finding of no hail damage. The umpire will make his decision with one side or the other. In these circumstances, appraisal is clearly inappropriate because the appraisers and umpire are making a determination concerning causation and ultimately coverage. These determinations have no place in an appraisal.

Insurers wanting a quick resolution on a claim are sometimes guilty of using appraisal to determine causation and coverage. It is not uncommon for an adjuster to make a written demand for appraisal and state that the appraisers and umpire will decide the amount of hail damage and when the loss occurred. These statements invalidate the appraisal process. The appraisers and umpire all too often accommodate this sort of demand. The participants' compliance with these terms in the appraisal does not validate the appraisal award or waive the insured's subsequent objection. *Wells*, 919 S.W.2d at 685.

Some appraisers and/or umpires simply could care less what their duties are; they will make their findings as they see fit. It is this writer's experience that the frequently used appraisers hired by an insurer who are professionals will make all sorts of findings which are contrary to the appraisal process.

In one instance, an appraiser who had *signed* an oath as an appraiser to only determine the amount of loss testified that appraisers have to decide what is hail and what is not hail and that if the memorandum of appraisal had the wrong date of loss, the appraiser should change same.

The dangers of appraisal are apparent.

C. The Demand For Appraisal and Memorandums of Appraisal

The appraisal language requires that a demand for appraisal must be in writing. The language also addresses certain time limits for naming appraisers and umpires, how that it is to be accomplished, who pays, and appointment of an umpire. In addition, insurers sometimes use a memorandum of appraisal for the appraisers and/or umpire to sign. The memorandum often includes the property damaged, the date of loss, the cause of the loss, and sometimes an oath for an appraiser to sign. The policy language though does not mandate any memorandum of appraisal.

While a memorandum of appraisal is not required, its use cannot be underestimated. A proper memorandum specifies the parameters of an appraisal including the appraiser's duty of only affixing the amount of loss. The memorandum avoids waiver issues such as arguments that the parties agreed to allow the appraisers to determine causation, coverage, and/or liability. A memorandum would also include an oath for appraisers and umpires to be disinterested, impartial, and competent. In sum, a properly drafted memorandum eliminates wiggle room and subsequent misunderstandings. It also helps to avoid fraud and misrepresentation.

One would think an insurer would want these protections to eliminate uncertainty. Yet, one insurance defense lawyer has said form memorandums of appraisal may cause undue problems: "As a result, the adjuster is given this sound legal advice concerning such form: 'Throw every one of them in the trash.'" Bowman, R., "An Overview of the Appraisal Clause in Texas," (October 21, 1996), (unpublished paper, on file with author) p. 8. Perhaps the defense lawyer was concerned that the memorandum of appraisal form is often misused. Regardless, a properly drafted memorandum of appraisal protects on all parties.

D. Timeliness and Waiver In Demanding Appraisal

While the policy language dealing with appraisal does not address the timing of same, the Texas courts have addressed this issue. The demand for appraisal must be made within a reasonable time. *American Fire Ins. Co. vs. Stuart,* 38 S.W. 395 (Tex. Civ. App.-18996, no writ) (58 day delay); *Boston Ins. Co. vs. Kurley*, 281 S.W. 275 (Tex. Civ. App.—Eastland 1926, no writ) (59 day delay). An insurer must move promptly to determine the amount of loss. *Brodie*, 337 S.W.2d at 417. The reasoning to take from these cases is that once an insurer or insured recognizes that a dispute over the amount of loss exists and is not capable of resolution, the proponent of appraisal should promptly demand appraisal and do so in writing.

Furthermore, the demand for appraisal must be invoked properly; that is, the demand must not only be timely but in substantial compliance with the terms of the policy. In *Brodie*, the insurer improperly appointed one individual and two companies as appraisers. *Id*. The Court found this appointment not in compliance. *Id*. Brodie filed suit some forty-two (42) days after the insurer demanded appraisal. *Id*. The demand for appraisal took place seventy-two (72) days after the adjuster had viewed and examined the loss. *Id*. at 416. The *Brodie* court agreed the demand for appraisal was untimely, waived, and not in compliance with the policy.

Again, it is this writer's experience that insurers with repeated frequency do not seek appraisal in a timely manner. Appraisal is demanded often months after it is readily apparent that there is a disagreement on the amount of loss between the insurer and the insured. In other cases, the insurer demands appraisal *after* suit is filed. Texas authorities clearly support the argument in these circumstances that any right to appraisal has been waived for a lack of timeliness.

Waiver of the appraisal clause can occur in other ways. An acceptance of a proof of loss waives appraisal. *Springfield Fire & Marine Ins. Co. vs. Cannon*, 46 S.W. 375 (Tex. Civ. App. ñ Houston 1898, no writ); *Stuart*, 38 S.W. at 395. Likewise, retention of a proof of loss for unreasonable time without demanding appraisal waives this condition. *Gulf Ins. Co. vs. Carroll*, 330 S.W.2d 227, 231 (Tex. Civ. App.—Waco 1959, no writ); *Kurley, supra;* and *American Cent. Ins. Co. vs. Heath*, 29 Tex. 445, 69 S.W. 235 (Tex. Civ. App.—San Antonio 1902, no writ). An insurer who demands appraisal and fails to participate any further has waived the condition. *Northern Assurance Co. vs. Samuels*, 33 S.W. 239 (Tex. Civ. App.—San Antonio 1895, no writ). Where an invalid appraisal has occurred, no further appraisal is required. *Security Ins. Co. vs. Kelley,* 196 S.W.2d 874, 878 (Tex. Civ. App.—Amarillo 1917, writ ref'd); *Wells*, 919 S.W.2d at 686-687. And obviously, where the insurer flat out denies the claim, the appraisal clause is waived.

The prudent practitioner should evaluate all demands for appraisal on the basis on timeliness and waiver.

E. The Requirement of Competent and Disinterested Appraisers

If ever there is a more misused area of appraisal it is that of the requirement of a competent and disinterested appraiser. Insurers hire their pet appraisers over and over and see no problem with this practice. Insureds who are unrepresented and unfamiliar with the appraisal process are convinced by their roofers to hire them (that is those that will do the roofing work) to act as the insured's appraiser. One side acts out of ignorance while the other acts out of manipulation. The result is usually disagreement with an umpire's participation required.

The appraiser is not beholden to either party to the appraisal, not required to represent either party's views or position, and not to be biased. *Pennsylvania Fire Ins. Co. vs. W.T. Waggoner Estate*, 39 S.W.2d 593, 594-595 (Tex. Comm'n App. 1931, no writ). An appraiser is not the selecting party's expert or independent contractor.

> **The purpose of the clause is to secure a fair and impartial tribunal to settle the differences submitted to them. In their selection it is not contemplated that they shall represent either party to the controversy or be a partisan in the cause or either, nor is an appraiser expected to sustain the views or to be further the interest of the party who may have named him. And this is true, not only with respect to estimating the amount of loss but also with reference to the selection of an umpire. They are to act in a quasi-judicial capacity and as a court selected by the parties free from all partiality and bias in favor of either party, so as to do equal justice between them. The tribunal, having been selected to act instead of the court and in the place of the court, must, like a court, be impartial and non-partisan. For the term "disinterested" "does not mean simply lack of dispecuniary interest, but requires the appraiser to be not biased or prejudiced." And, if this provision of the policy was not carried out in this spirit and for this purpose, neither party is precluded from going to the courts, notwithstanding the agreement to submit their differences to the board of appraisers.**

Id., quoting *Delaware Underwriters vs. Brock*, 109 Tex. 4925, 429-30, 211 S.W.2d 779, 780-81 (1919).

Disinterested means without bias and prejudice as well as without pecuniary interest. *W.T. Waggoner Estate*, 39 S.W.2d at 595. Consequently, those who repeatedly perform appraisals on behalf of the same party certainly call into question issues of bias and prejudice. Thus far only one Texas case has directly addressed the bias and prejudice argument. In *Holt vs. State Farm Lloyds*, the insurer sought to enforce an appraisal award as an affirmative defense to Plaintiff's breach of contract and extracontractual claims. 1999 WL 261923 (N.D. Tex. 1999) at p. 1. At issue was whether Tim Marshall of Haag Engineering who received approximately one quarter of his income from State Farm appraisal work was biased and/or prejudiced. *Id*. at p. 4. The District Court declined to grant State Farm's summary judgment given Plaintiff's evidence, finding a fact issue for the jury existed. *Id*. *Holt* is the only Texas case specifically addressing this issue although the *W.T. Waggoner Estate* case includes a finding of a biased appraiser and umpire which invalidated an appraisal. *W.T. Waggoner Estate*, 39 S.W.2d at 594.

The *W.T. Waggoner Estate* does hold that the inadequacy of an award may be considered as *a factor* in evaluating bias and prejudice of an appraiser or umpire. *Id*. at 595. This factor alone though is insufficient to establish bias and prejudice. *Hennessey vs. Vanguard Ins. Co.*, 895 S.W.2d 794, 798-799 (Tex. App.-Amarillo 1995, writ denied). In *May vs. Foremost Ins. Co.*, 627 S.W. 2d 230, 233-234 (Tex. App.—San Antonio 1981, no writ), the Court denied enforcement of an appraisal award based on the insurer's summary judgment motion because of a continuing business relationship between the insurer and appraiser. The insurer was accused of acting in a concert with the appraiser in order to object to an umpire previously agreed upon. *Id*.

Other jurisdictions have different rules. In Michigan, an appraiser who has been asked to participate as an appraiser by the same Plaintiff on an ongoing basis is not evidence of bias. *Northern Assurance Co. v. Melinsky*, 237 Mich. 665, 670, 13 N.W. 70, 71 (Mich. 1927). In contrast, prior relationships may be considered in Pennsylvania. *Land v. State Farm Mut. Ins. Co.*, 410 Pa. Super 579, 584, 600 A.2d 605, 607 (Pa. Super Ct. 1991). In California, an insurer must disclose any current dealings with an appraiser. *Gibers v. State Farm General Ins. Co.*, 45 Cal. Rptr. 2d 725, 728 (Ct. App. 1995).

The lesson regarding bias and prejudice seems obvious. The more appraisals and the more longstanding relationship between an appraiser and the selecting party, the more likely a finding of bias and prejudice will be found or at least create a fact issue to prevent enforcement of an appraisal award. This is fertile ground to challenge an appraisal determination.

Competency should not be overlooked. An engineer is likely not competent as an appraiser for a jewelry case and a roofer probably will not suffice as an expert on foundations. These choices seem obvious. Yet, do not assume every roofer or engineer is competent to evaluate replacement for a roof damaged by hail. A public adjuster by virtue of his profession

is not competent to address all areas of home damage merely because he must now hold a license. The moral to this story is: carefully examine every appraiser's competency (expertise) in his/her appointment and subsequent award. A *Robinson* type challenge should be available to the party objecting to competency. In a summary judgment proceeding to enforce an appraisal decision, the appraiser's competency must be established. Competency is mandated by the policy.

F. Grounds for Avoiding An Appraisal Award

Prudent counsel should seek to prevent an improper claim from going to appraisal where issues of coverage, liability, and causation exist. This includes the use of injunctive relief. Undoing an appraisal is analogous to attempting to preserve privileged documents once they have already been produced. It is frequently an uphill battle with the obvious bias in preserving the appraisal award. Many trial courts view appraisal like mediated settlement agreements. With the necessary evidence, appraisal awards can be set aside.

In a summary judgment proceeding to enforce an appraisal decision, the appraiser's competency must be established.

Case law provides three basics instances where an appraisal award may be disregarded: (1) when the award was made without authority; (2) when the award was the result of fraud, accident, or mistake; and (3) when the award was not made in substantial compliance with the terms of the contract. *Providence Lloyds Ins. Co. v. Crystal City Indep. Sch. Dist.*, 877 S.W.2d 872, 875 (Tex. App.-San Antonio 1994, no writ); *Hennessey*, 895 S.W.2d at 798. All of these exceptions overlap each other. *Providence*, 877 S.W.2d at 878. Significantly, every reasonable presumption will be indulged in favor of an appraisal award. *Hennessey*, 895 S.W.2d at 798. However, in a summary judgment proceeding this presumption will not override summary judgment principles: that is, all reasonable inferences will be indulged in favor of the nonmovant and the evidence will be viewed in the light most favorable to the nonmovant. *Mays*, 627 S.W.2d at 233-234; *Hennessey*, 895 S.W.2d at 798.

Several cases in Texas have addressed an appraisal award made without authority. Unless the appraisers disagree about the amount of loss, an umpire has no authority to sign an appraisal award. *Fisch v. Transcontinental Ins. Co.*, 356 S.W.2d 186, 189-190 (Tex. Civ. App.-Houston 1962, writ ref'd n.r.e.) In *Fisch*, the record was silent as to whether there were any differences between the two (2) appraisers. *Id.* at 189. The Court of Appeals reversed a directed verdict in favor of the insurer because there was no evidence of any disagreement between the appraisers and therefore any award signed by the umpire was *without authority. Id.* at 189-190. "An appraiser's acts in excess of the authority conferred upon him by the appraisal agreement is not binding on the parties." *Id.* at 190.

For those who frequently oppose appraisal, the *Wells* case provides an excellent example of appraisers/umpires acting outside their authority. The Wells made a claim for foundation damage with their insurer, American States. *Wells*, 919 S.W.2d at 681. *Id.* The insurer denied the claim, demanded appraisal, and then sued to enforce appraisal. *Id.* The Wells counterclaimed for breach of contract and other claims. *Id.* The trial court abated the counterclaims until appraisal was completed. *Id.* Two appraisers and an umpire determined the damage was $22,875.94 but one appraiser and an umpire determined the foundation damage was not caused by a plumbing leak. *Id.* The lack of a plumbing leak precluded coverage and the trial court entered summary judgment in favor of the insurer. *Id.* Before any lawsuit was filed, the parties disagreed on the cause of the foundation damage and consequently coverage. *Id.*

Setting aside the issues of waiver of appraisal by denying the claim and no evidence of any disagreement on amount by the appraisers, the Court of Appeals reversed summary judgment in favor of the insurer finding that the appraiser and umpire exceeded their authority in determining the amount of loss: "[W]e conclude further that the appraisal section of the policy, as a matter of law, did not authorize and empower the appraisal panel to determine that the plumbing leak did not cause the loss to the Wells' property." *Id.* at 685. "[W]e conclude that the one appraiser and the umpire exceeded their authority when they determined that the plumbing leak did not cause the Wells' loss." *Id.*

In *Holt*, the District Court declined to grant the insurer summary judgment on enforcement of an appraisal award. 1999 WL 261923 at p.3. There, one appraiser and an umpire entered ain award for $565 for wind damage to Holt's roof. *Id.* Yet, in the award was a statement: "No evidence of damaging hail in the form of splits of impacts that broke the wood shingles in the past nine (9) to twelve (12) months." *Id.* This statement was "an expression of damage causation. It was made without authority because it was outside the scope of the appraisal process…" *Id.*

These two (2) cases illustrate an award made without authority. The appraisal award itself provided the necessary

evidence to demonstrate lack of authority. However, there is no requirement that the evidence must come from the award itself though the mental processes of the appraisers and umpire are likely insufficient to establish this factor. *Providence*, 877 S.W.2d at 878-879.

Appraisals which are a result of fraud, accident, and mistake can also be set aside or be made unenforceable. The most frequently cited case for this category is *Barnes v. Western Alliance Ins. Co*., 844 S.W.2d 264 (Tex. App.-Fort Worth 1992, writ dism'd by agr.) Barnes claimed roof hail damage to two (2) buildings he owned. *Id*. at 266. When Barnes and the insurer could not agree on the amount of loss, Barnes demanded appraisal. *Id*. at 267. An appraisal award signed by Barnes' chosen appraiser and the umpire was entered for $402,798.00. *Id*. The insurer neither challenged the award nor paid it forcing Barnes to file suit to enforce the award. *Id*. Following a trial, the jury awarded $67,834.89 and found that the award should be set aside for fraud, accident, or mistake. *Id.*

In the words of the Court of Appeals, the record "reveals numerous instances in which Barnes admitted in open court that he had previously lied about the hail damage to the roof and about the repair costs." *Id.* at 268-269. The evidence in addition to Barnes' own testimony was overwhelming in substantiating fraud. *Id.* at 270.

While the insured was the culprit in *Barnes*, an insurer can be equally guilty of fraud, accident, and mistake which will invalidate an appraisal award. In *Holt*, the District Court raised issues concerning the use of an independent and unbiased appraiser where the appraiser performed a substantial number of appraisals in favor of the appointing insurer. *Holt*, 1999 WL 261923 at pp. 3-4. In *May*, the insurer and the appraiser colluded on the appointment of an umpire and the appointed umpire had a prior employment relationship with the insurer. *May*, 627 S.W.2d at 234. The Texas Supreme Court reversed summary judgment in favor of the insurer and found a fact issue existed to preclude enforcement of the appraisal award. *Id.*

As previously pointed out, a gross disparity in an award versus repair cost is not by itself a basis to invalidate an appraisal award. *Hennessey*, 895 S.W.2d at 798-799.

The last category given to set aside an appraisal award is for all practical purposes a combination of the first two and anything else not in compliance with the policy. Obviously, appraisers and umpires determining causation, liability, and coverage are not in compliance with the policy; the same is true for an award based on fraud, accident, or mistake. An example falling perhaps outside the first two (2) categories is an appraisal where a disagreement exists over a partial loss versus a total loss. See *Peters*, 386 S.W.2d at 532. In *Hennessey*, the Court of Appeals reversed a summary judgment in favor of an insurer based on an appraisal award where the memorandum of appraisal and policy language conflicted. 895 S.W.2d at 801. Other areas of noncompliance with the policy include no written demand for appraisal, delay in proceeding with appraisal, payment of appraisers and umpire, etc.

The avoidance of an appraisal award may be accomplished. In almost all of the cases cited, the avoidance took place at the Court of Appeals. Therefore, the better practice is to avoid problems and issues before the appraisal and prevent an improper appraisal from ever going forward.

F. Eight Simple Rules for Appraisal For The Insured

1. Avoid appraisal if possible (some exceptions);
2. Confirm the appraisal was not requested after a complete denial of the claim or long after a dispute was evident;
3. Stop attempts for appraisal where issues of coverage, causation, and liability are evident;
4. Obtain a written memorandum of appraisal setting out the basis for appraisal;
5. Confirm the independence and competency of the appraisers and umpires;
6. Have the appraisers and umpire sign an oath that they will carry out their duties fairly and impartially and in accordance with their duties (can make this part of the memorandum of appraisal);
7. Make sure the record reflects any disagreement between the appraisers so the umpire's involvement is warranted; and
8. Look for statements on the appraisal award dealing with coverage, causation, and liability.

These rules should provide some guidance on the validity of an appraisal. Given the frequent misuse, misunderstanding, and misapplication of appraisal, it is this writer's view that there are too many minefields to obtain a valid appraisal award. While setting aside the award may be desireable, it may be time consuming. The irony of course is that this provision is designed for a speedy and efficient resolution of a claim which theoretically both the insurer and insured seek. The result is often the opposite. Unfortunately, the appraisal clause is one of the most frequently abused and misused provisions in an insurance policy. Participants would do well to abide by appraisal rules and limitations in order to achieve a valid and enforceable appraisal.

POINT COUNTER POINT

BY OLGA SEELIG
JORDAN, QUINN & CARMONA, P.C.
AUSTIN, TEXAS

Simply Wrong

Several months ago Michael Quinn and I published an essay in this journal entitled ***Ensuing Loss Clauses in Texas Insurance Jurisprudence***, 4:3 J. TEX. INS. L. 8 (Nov. 2003) ("Quinn-Seelig"). William J. Chriss, fancying himself a nemesis, has published a reply entitled ***Coverage for Ensuing Water Damage Under Texas Homeowners[']s Policies,*** 5:1 J. TEX. INS. L. 28 (Feb. 2004) ("Chriss"). This is a rejoinder.

Quinn-Seelig begin with an examination of the *ensuing loss* language of the homeowner's policy, analyze the meaning of that language, and then discuss cases in the light of what Quinn and I think is a sensible reading of the language of the policy. Chriss begins with what some cases have said, what TDI has said, how some insurers have "spoken" and behaved themselves in some claims and lawsuits, and concludes that the language of the policy must mean what has been a theme in some of these events. Clearly, these are different starting points.

Chriss criticizes Quinn-Seelig, for example, for taking the magistrate's opinion in the *Fiess* case to be "authoritative." *Fiess v. State Farm Lloyds*, No. H-02-1912 (S.D. Tex., June 4, 2003). It makes a similar point with respects to our discussion of the *Sharp* case. *Sharp v. State Farm Fire & Casualty Insurance Company*, 938 F.Supp. 395 (W.D. Tex. 1996), *aff'd*, 115 F.3d 1258 (5th Cir. 1997). The reader needs to reflect on various meanings of *authoritative*. On the basis of our reading, Quinn and I described several of the cases, themes, and documents Chriss regards as both important and authoritative as "simply wrong." What Quinn-Seelig are saying is that, as explications of the clear and unambiguous *ensuing loss* language of the policies, some of these things are *simply wrong*. They've got the meaning of the words wrong. They have misunderstood or misconstrued the language on the page. Quinn-Seelig start with language and then judge the cases. Chriss starts with cases and then interprets language.

I. SOME ERRORS

With something resembling religious fervor, Chriss suggests that Quinn-Seelig are something other than "sane." Furthermore, Chriss says that Quinn-Seelig are "brazen," "shocking," "bizarre," "strange," and, of course, "wrong." I don't think so. I suspect Quinn doesn't either. It is important to remember that Quinn-Seelig begin with language and then judge cases. Chriss focuses upon cases, TDI narratives, litigation, trends, and jurisprudential tendencies. Clearly, their approach and priorities are different. Once that is understood, Chriss errs on a number of points.

First, the true meaning of unambiguous contract language cannot be inferred from what courts have said it means. It means what it means. Courts, administrative agencies, adjusters, policyholders, and lawyers get the language either right or wrong. Language is the arbiter, not what people – even judges – have thought and said. The law can err, even upon questions of law. Groupthink can go badly wrong and then be stable. Linguistic data precedes interpretation, just as facts come before theory.

Second, "institutional memory"– whatever that is (and the concept is obscure) – is not dispositive with respect to meaning when the language is clear and unambiguous. The same is true with people and personal memory, of course. Memory can err. Linguistic data precede most memory. (By the way, language itself, independent of legal controversy, involves an independent institutional memory.)

Third, Chriss suggests that Quinn-Seelig must be wrong because, if it were not, then there would have been a "cataclysmic interpretive error" pursuant to which large amounts of money have erroneously exchanged hands. What Chriss rhetorically suggests could not possibly be true, is precisely what is true, if the rhetorical presuppositions of Chriss are correct. I myself doubt these presuppositions. For example, insurers sometimes pay claims they do not owe. I also wonder about the alleged cataclysmic-ness by the insurers of the error Quinn-Seelig observe.

I recently read a paragraph in an insurance contract which I expected to contain the word *not*. I read it to myself and inserted the word *not* where I thought it had to be. Then when asked to read it aloud, I unwittingly did it again. I subsequently realized that the word "not" was not actually there. What happened was that I finally stopped counting on what I thought I knew and attended religiously to the language itself. Thereupon, I grasped the genuine language of the policy. Institutional memory can resemble how I read this policy. Group-think is subject to self-deception, in some sense, just as individual thought is.

Fourth, Chriss contends that Quinn-Seelig endorsed an overruled case, to wit, the *Sharp* case. Chriss says that *Sharp* has been overruled by *Balandran v. Safeco Insurance Company of America*, 972 S.W.2d 738 (Tex. 1998). Such is not the case, so far as I can tell. Moreover, *Balandran* held that "language in Coverage B (the personal property section of the policy) creates an exception to exclusion 1(h)[, where the ensuing loss clause is,] when the structural damage results from a plumbing leak." On this basis, Chief Justice Phillips, speaking for a majority of the court-of which he is the only member still on the court, specifically declined to discuss the ensuing loss provision of the relevant exclusion, an exclusion very similar to the hypothetical exclusion Quinn-Seelig discusses. Besides, our focus was on language. If *Sharp* got the meaning of the language right, then it did.

Fifth, Chriss suggests that Quinn-Seelig are inconsistent with *Balandran*. They are not, precisely because of what *Balandran* declines to discuss. Even if it were discussed, we didn't (and don't) care. Even Justice Phillips can get words wrong. Of course, it is nice when courts get language right, as they often do. An Oregon District Court, citing many other courts put it quite simply:

> The ensuing loss clause 'does not reinsert coverage for excluded losses, but reaffirms coverage for secondary losses ultimately caused by excluded perils.' *Cooper v. American Family Mut. Ins. Co.*, 184 F. Supp.2d 960, 964 (D. Az. 2002), citing *Schloss v. Cinncinnati Ins. Co.*, 54 F. Supp.2d 1090, 1094-95 (MD Ala. 1999), *aff'd without the opinion*, 211 F.3d 131 (11 Cir. 2000); *McDonald v. State Farm Fire & Cas. Co.*, 119 Wash.2d 724, 734, 837 P.2d 1000, 1005 (1992); *Ames Privilege Assoc. v. Utica Mut. Ins. Co.*, 742 F. Supp. 704, 708 (D.Mass. 1990); *Brodkin v. State Farm Fire & Cas. Co.*, 217 Cal. App.3d 210, 218, 265 Cal. Rptr 710, 714 (1989).

Prudential Prop. & Cas. Ins. Co. v. Lillard-Roberts, 2002 WL 31488243, *8 (D. Or. June 14, 2002).

Sixth, Chriss suggests that Quinn-Seelig are inconsistent with TDI B-0032-97 (August 22, 1997). That bulletin says nothing about ensuing loss clauses. It does not attempt to analyze the unambiguous language of anything. It narrates some of the recent social and administrative history of Texas insurance contract hermeneutics. Consequently, Quinn-Seelig are not inconsistent with this document.

Seventh, Chriss claims: (1) that mold is not *caused by* water damage, but instead (2) that mold is *a form of* water damage. This suggestion is particularly intriguing. It has some superficial attractiveness. For example, it would obviate the entire controversy between Chriss and Quinn-Seelig. If mold is not *caused by* water damage, then it does not fall within the ensuing loss clause at all. The ensuing loss clauses in relevant Texas Homeowners' policies and in our hypotheticals are concerned with ensuing losses *caused by* water damage. This is, after all, what they expressly say. Their language is crystal clear on the point. Therefore, if mold is water damage rather than something caused by water damage, the ensuing loss clause becomes completely irrelevant. To put the matter slightly differently, if mold is a form of water damage instead of something caused by water damage, then it could not be included into the policy by the ensuing loss clause, because there would be nothing separate to ensue.

Eighth, Chriss submits that Quinn-Seelig argue that "'loss' must not be understood as an economic concept, but rather as "physical damage." In fact, Quinn-Seelig suggest that the word *loss* is ambiguous. Here is what the essay actually says: "The truth is, of course, that the ordinary English word *loss* is ambiguous as between physical loss and financial loss." Quinn-Seelig at 10. The essay also says, however, that it does not matter much which it is, since the meaning intended is clear from the context, as a general rule. The essay confidently posits that context itself disambiguates language in this instance. Undoubtedly, the proposition supporting Quinn-Seelig's posit is often true.

I find it difficult to discern why the point about the word *loss* creates trouble. Chriss suggests that if a physicalistic definition of the word *loss* were used, "all of the exclusions would go out the window [along with] the ensuing loss provision." Let's see if this suggestion is true.

An exclusion "goes out the window" only if it *could not* exclude anything. It does not "go out the window" if part of it *does not* in fact exclude anything. Suppose that the concept of *loss* is a financial/economic concept. If so, then the exclusion which has created all these problems would read:

> This insurance does not cover (financial/economic) losses caused by mold.

It is difficult to see how an economic/financial account of the concept of loss sends anything out any windows. Now let's try a physicalistic interpretation:

> This insurance does not cover (physical) losses caused by mold.

This is a more interesting problem, it seems. On a physicalistic reading, mold itself would not be excluded. Physical losses caused by mold would be excluded but not mold itself. Usually the policy is construed to exclude mold. Chriss appears not to doubt this. I myself have no difficulty thinking of separate, actual physical losses caused by mold, although there may not be many of them. Mold is something like smoke. It is odifirous. It could, therefore, cause ineradicable or difficult-to-eliminate odors in a physical structure or in personalty, such as clothes or furniture. These could constitute a separate physical loss caused by mold. At the same time, there is nothing about the insurance policy, however, which requires that such a state of affairs be envisageable. It is easy to conceive of such states of affairs being caused by other elements on the list. Here, the physicalistic interpretation has thrown nothing out the window either.

II. "OTHERWISE"

Ninth, at this point, we arrive at the most significant move in Chriss' argument. That paper submits that Quinn-Seelig can be correct only if it eviscerates the meaning of the word *otherwise* in the ensuing loss clause. The reader should remember how Quinn-Seelig hypothetically formulates the ensuing loss cause in general:

> Insuring Clause: This policy covers (all) risks of physical loss to insured objects. Exclusionary Clause: This policy does not cover losses caused by *X*. Ensuing Loss Exception: This exclusion does not apply to an ensuing loss caused by *Y*, which was itself caused by *X*, so long as the ensuing loss is a state of affairs **otherwise** covered by this insurance (i.e., included within the insuring agreement and not within any exclusion).

The meaning of the word *otherwise* is a profound and important issue, even though it appears to be so subtle as to be trivial. Chriss suggests that the word *otherwise* in this context can have no meaning unless it entails that the ensuing loss (exception) clause provides coverage for all of the states of affairs described in the exclusion it governs. This conclusion is simply wrong.

The ensuing loss clause says that coverage is provided for an ensuing loss caused by (among other things) water damage, if that loss would otherwise be covered under the policy. In other words, if a certain type of physical state of affairs would be covered under the policy, and if it has been caused by water damage, it does not matter what else caused it. Thus, if water damage and mold both cause a state of affairs, which is not otherwise excluded, there will be coverage for that consequent state of affairs. That truth does not imply that the mold itself is covered. Similarly, if water damage and wear-and-tear together cause a certain consequence, and if that consequence is not excluded from coverage, then there will be coverage for that resultant state of affairs, even though it is partially caused by wear-and-tear. Yet again, if an injurious state of affairs is caused by rats and water damage, and if that state of affairs is not itself excluded, then it is covered, even though the exclusion to which the ensuing loss clause is attached bars coverage for losses caused by rats.

Notice that Quinn-Seelig give a sensible reading to the ensuing loss clause. Notice also that they preserve the meaningfulness of the word otherwise.

III. A CONTRADICTION

Returning to the most interesting feature of Chriss and its focus on the concept of *loss*: if the concept of loss were purely economic, then any economic loss caused by water damage would be covered. The problem is that no economic loss caused by mold would be covered. Chriss' point is that mold is a form of water damage. If his argument worked, then the policy would be self-contradictory in an important respect. First, it would say that no financial losses caused by mold are covered. Second, it would say that all financial losses caused by water damage are covered. Third, it would say that all mold is a form of water damage. These three propositions cannot all be true at the same time. Carefully consider the following:

(i) No financial losses caused by mold are covered.

(ii) All financial losses caused by water damage are covered.

(iii) All mold is a form of water damage.

Proposition (i) can be reformulated using Proposition (iii). It would become following:

(iv) No financial losses caused by a form of water damage are covered. Propositions (ii) and (iv) are quite clearly logically inconsistent.

As Chriss correctly points out, all parts of insurance policies must be rendered meaningful. Consequently, no part of an insurance policy may be rendered meaningless by any valid interpretation. The trouble with Chriss is that it would render the exclusion in question quite meaningless in a variety of ways, if sets of self-contradictory assertions are meaningless. And-of course-they are.

V. CONCLUSION

Still, Chriss points in the direction of a very interesting point. The Texas Homeowners' Policy would be less confusing, and hence would require less attentive study, if various complex exclusionary clauses were broken up and listed separately. The fact that understanding a complex contract requires attention, though, does not entail that it is harmfully ambiguous. Moreover, context may not disambiguate the concept of *loss* as readily as Quinn-Seelig posited. If it did, the Quinn-Seelig v. Chriss exchange never would have occurred.

Comments FROM THE EDITOR

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

Once again, I am greatly indebted to this year's Chairman of the Section, Jim Cornell, for his invaluable assistance in getting out this issue of The Journal of Texas Insurance Law. Jim's incredible efforts with our authors, editing team, graphic artists, and printer all made this issue possible. Without Jim's efforts, you would not be reading this now.

In June, Jim will step down as Chairman and pass the reins to Pat Wielinski. Before Jim steps down, I want to publicly acknowledge the incredible job he has done as Chairman of the Section. His weekly e-mail notifications of new legal decisions in the insurance world is a unique Section resource and extremely valuable to all of our members. He has single-handedly brought accountability (and much needed assistance) to guarantee the regular quarterly publication of the JTIL. Additionally, his coordination with the State Bar, his tireless promotion of the Section, and his administration of the Section have all been incredible. His efforts have involved countless hours and weekly frustrations, and our Section is much stronger because of his great efforts. On behalf of the entire Section, I would like to thank Jim for all of his efforts, particularly his incredible contributions to this publication.

Christopher W. Martin
Editor-in-Chief

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STATE BAR OF TEXAS
Insurance Law Section
P.O. Box 12487, Capitol Station
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