# ANNUAL SURVEY OF TEXAS INSURANCE LAW

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## I. INTRODUCTION

This year was marked by incremental changes, with no landslide decision. After several recent years of legal avulsion, precedent by accretion was something of a relief.

Many cases grappled with issues arising out of settlements. For example, the Texas Supreme Court was called on to decide whether a liability insurer can settle a non-covered claim and then get paid back by the insured.

In a pair of cases, plaintiffs asked trial courts to punish insurers for their lack of good faith in court-ordered mediations. In other cases, insurers sought to avoid liability in subsequent suits, by embracing or disavowing underlying settlement agreements, as the need arose.

A few cases had recipients of shoddy construction trying to tap the builders' insurers – unsuccessfully.

Another handful of cases showed the meanness of drivers – assaulting a passenger in one case, and accosting a driver in another.

## II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

### A. Automobile

An automobile insurer did not breach its contract, act in bad faith, nor commit unfair or deceptive acts by tendering its uninsured/underinsured benefits to claimants who were willing to settle, even though that substantially depleted the amount remaining to pay other claimants. The court found the insurer's settlements with the willing claimants were reasonable. *Carter v. State Farm Mut. Auto. Ins. Co.*, 33 S.W.3d 369 (Tex. App.–Fort Worth 2000, no pet.).

When an insurer elected to repair damage done to a stolen vehicle, the insurer was not also liable for the diminished value of the car caused by extra miles the thief put on the car nor diminished market value based on buyers' preference for a car that has never been damaged. *Carlton v. Trinity Universal Ins. Co.*, 32 S.W.3d 454 (Tex. App.–Houston [14th Dist.] 2000, no pet.).

The court reached this conclusion based on the plain language of the policy, which obligated the insurer to pay "for direct and accidental loss to your covered auto." The policy said the limit of liability was the lesser of the actual cash value of the property, the

"amount necessary to repair or replace the property with other of like kind and quality," or the amount stated in the declarations. The insured argued that the insurance company should be liable not only for the cost of repairs but also for the "inherent diminished value" resulting from the extra mileage and the negative market perception. The court agreed with the insurer's argument that its liability was limited to the cost to repair or replace the car.

Although the decision is presented as being based on the plain language of the policy, the court's conclusion is plainly wrong. The plain language limits the insurer's liability to the amount necessary to repair or replace the property *with other of like kind and quality*. Leaving the insured with a car that has 3500 extra miles on it after the theft and that has a diminished market value because of buyers' preference for undamaged vehicles, does not constitute repair or replacement "with other of *like kind and quality*." In this case, the insurance company chose to repair the vehicle, but that still left a difference in value. The error of the court's analysis would be shown more clearly if the insurer had opted to replace the vehicle. No one would seriously contend that substituting a car with 3500 more miles that had been damaged and repaired was the same kind and quality as the vehicle the insured had before the theft.

An insured had coverage while using a temporary substitute vehicle, even though he did not have permission to use it. *Sink v. Progressive Co. Mut. Ins. Co.*, 47 S.W.3d 715 (Tex. App.–Texarkana 2001, no pet. h.). The insured was involved in a wreck while using a borrowed car after his insured truck became disabled. There was some evidence that he did not have permission to use the borrowed vehicle. The policy provided there was no coverage for any person using a vehicle without a reasonable belief that the person was entitled to do so. The policy stated this exclusion did not apply to an insured using a "covered auto," which included "any auto (while used as a temporary substitute for any other vehicle)" that was out of service because it was broken down. The court found this language plainly did not exclude coverage in these circumstances.

The court rejected the insurer's argument that the court should read a permission requirement into the use of the temporary substitute vehicle, because that is how a prior policy had read. The insurer tried to rely on an order from the State Board of Insurance stating that the new policy form should be construed in light of the old policy language. The court concluded that it could not ignore the plain language of the contract by reading in a requirement that was no longer present.

### B. Homeowners

An insured entered into a contract to sell his house. Before closing, the house sustained fire damage. The buyer bought the home anyway, at the agreed price. The insured filed a claim for the damage caused by the fire, and the insurer denied coverage. The court found that the insured sustained no loss because the buyer paid the same amount he contracted to pay before the fire. However, the court refused to grant summary judgment against the insured's claim for "loss of use" for extra living expenses after the fire. *Chambless v. Travelers Lloyds of Tex. Ins. Co.*, 123 F. Supp. 2d 1028 (N.D. Tex. 2000).

### C. Life Insurance

In *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), the Supreme Court held that ERISA preempts a state law that revokes a life insurance beneficiary designation when spouses divorce. The Washington statute provided that if the life insurance beneficiary designation of the ex-spouse was made before the divorce, that designation was considered revoked. Because the insurance was part of an employee benefit plan, the Supreme Court held that ERISA preempted state law so that the benefits would be paid in accordance with the plan documents. The insured had not changed the beneficiary designation according to the plan, so his ex-wife received the benefits. Texas has a similar provision in Texas Family Code section 9.301, which would also be preempted. *See* Tex. Fam. Code Ann. Sec. 9.301 (Vernon 2001).

An insurer that paid life insurance benefits in good faith to the wrong, common-law wife could nevertheless be liable to the proper beneficiary. *J.C. Penny Life Ins. Co. v. Heinrich*, 32 S.W.3d 280 (Tex. App.–San Antonio 2000, no pet.). The insurer argued that article 3.48, which discharges an insurer that pays benefits to a designated beneficiary, insulated it from liability for its good faith payment to the insured's second common-law wife. The court rejected this argument, finding no good faith exception to the statutory requirement that the insurer must pay to the "designated beneficiary." In this case, that person was the first common-law wife.

The *Heinrich* court also held that the proper beneficiary was not estopped to assert a claim, because there was no evidence she had any knowledge that there was a life insurance policy until after the payment was already made to the wrong wife.

In *J.C.Penny Life Ins. Co. v. Baker*, 33 S.W.3d 417 (Tex. App.–Fort Worth 2000, no pet.), the evidence supported the jury's finding that the insured died from an accident "directly and independently of all other causes" when his truck drove into a lake and he drowned. While there was some evidence that the insured had a heart condition, his widow offered expert testimony that if his death was caused by those conditions, he would not have been able to escape from the cab of the truck as he had before drowning.

The court also found sufficient evidence that the accident occurred while the insured was "occupying" the vehicle. Witnesses testified about the difficulty a driver would have in escaping from a submerged vehicle, and other witnesses testified to the delay between the time the truck went into the water and when they saw the insured appear at the surface. This evidence allowed the jury to infer that the insured started drowning while still in the truck.

According to his divorce decree, the decedent was required to maintain a life insurance policy of no less than $200,000, designating his daughter as the irrevocable beneficiary. Proof of insurance was to be provided by December 31st of each year. After providing proof of insurance, the decedent changed the designated primary beneficiary of the policy from his daugh-

ter. In finding that the daughter could impose a constructive trust on the insurance proceeds, the court held that when an insured agrees for valuable consideration to irrevocably designate a certain beneficiary, the designated beneficiary has a vested equitable interest in the policy proceeds. Based on the terms of the decedent's divorce decree, the daughter had a vested interest in the policy. *Sunlife Assurance Co. of Can. v. Dunn*, 134 F. Supp. 2d 827 (S.D. Tex. 2001).

A life insurer did not act improperly in denying coverage on a policy that had lapsed for nonpayment of the premium. The court held that when the insured died prior to any attempt by the beneficiary to reinstate the policy, estoppel could not be used to revive the contract. *MacIntire v. Armed Forces Benefit Ass'n*, 27 S.W. 3d 85 (Tex. App.–San Antonio 2000, no pet.). The court also found the insurer was not liable for breach of contract, breach of implied warranty, breach of the duty of good faith and fair dealing, deceptive or unfair insurance practices, or negligence.

### D. Health Insurance

An outpatient rehabilitation facility that provided services to a former federal judge, sought review of an Office of Personnel Management claim denial. The Fifth Circuit affirmed the OPM's interpretation of the plan, concluding that the facility was a "non-covered facility." Moreover, this exclusion did not conflict with other policy provisions that allow a covered provider to submit claims for covered services. *Transitional Learning Cmty. at Galveston, Inc., v. U. S. Office of Pers. Mgmt.*, 220 F.3d 427 (5th Cir. 2000).

### E. Commercial Property

In a case of first impression, the court of appeals in *Betco Scaffolds Co. v. Houston United Cas. Ins. Co.*, 29 S.W.3d 341 (Tex. App.–Houston [14th Dist.] 2000, no pet.) (en banc), considered the meaning of the "inventory exclusion" in a commercial property policy. Houston United issued a commercial property policy to Betco covering all risks of physical loss, subject to certain exclusions. Betco suffered two burglaries in June and July and reported the losses to the police at about $11,000. That September, an inventory revealed greater losses, which Betco reported to the insurer as $158,000. The insurer denied the claim, relying on an exclusion for "loss or shortage disclosed upon taking inventory."

Betco argued the exclusion was ambiguous and should be applied only to losses that were reflected solely by an inventory, independent of any proof of the cause of loss. The majority disagreed and held that the exclusion applied to Betco's loss, even though the loss resulted from thefts, which were a covered cause of loss.

Four justices dissented, finding that the policy was ambiguous and it could be interpreted as suggested by Betco. The dissenters found the ambiguity supported by at least four other decisions, and at least one respected commentator.

A "Blowout" insurance policy was ambiguous and potentially provided coverage for an uncontrolled flow of oil, gas, or water. The loss occurred in the Austin Chalk formation. Coverage depended on whether the flow occurred between two or more separate formations. An accepted industry definition of "formation" would treat the area as a single formation. The insured offered expert testimony from an experienced petroleum engineer that the area could be considered more than one formation. The court reasoned that this was a specialized area where expert testimony was appropriate, and the competing definitions made the term ambiguous. *Mescalero Energy, Inc. v. Underwriters Inden. Gen. Agency, Inc.*, ___ S.W.3d ___, No. 01-96-01590, 2001 Tex. App. LEXIS 6352 at *31 (Tex. App.–Houston [1st Dist.], Aug. 31, 2001, no pet. h.).

## III. FIRST PARTY THEORIES OF LIABILITY

### A. Unfair Insurance Practices, Deceptive Trade Practices & Unconscionable Conduct

Valdez bought a car and insured it through Colonial. He later sold the car to his son. After the car was stolen, the insurer denied coverage because Valdez no longer owned it. The jury found the insurer committed deceptive and unfair practices. *Colonial Co. Mut. Ins. Co. v. Valdez*, 30 S.W.3d 514 (Tex. App.–Corpus Christi, 2000, no pet.).

Valdez's main complaint was that the insurer never disclosed to him that his coverage would end if he sold the car to his son. The court contrasted liability for nondisclosures under DTPA section 17.46(b)(23) and under the Insurance Code. The court found no evidence to hold the insurer liable under the DTPA, because that statute forbids failing to disclose information with an intent to induce the consumer into a transaction the consumer otherwise would not enter into. Valdez never disclosed to the insurer that he intended to transfer the car, so there was no showing that the insurer withheld this information to induce Valdez into the transaction.

On the other hand, the insurer was liable under article 21.21 of the Insurance Code for failing to disclose the information. That statute imposes liability for failing to state material facts that are necessary to make other statements not misleading, making statements in a manner that misleads a person to a false conclusion of material fact, or failing to disclose the full terms of the policy. The policy stated that Valdez was insured and that the vehicle was covered, but did not state anything about limits on coverage if the car was sold.

The court also found sufficient evidence that the insurer was guilty of misrepresentations. The policy itself indicated that the vehicle was insured at the time the claim arose. This amounted to an affirmative misrepresentation. The court rejected the argument that Valdez's claim was a "mere breach of contract."

Further, the court held that the insurer was liable for unfair settlement practices, including failing to promptly provide Valdez with a reasonable explanation of the basis for its denial of the claim and failing to affirm or deny coverage within a reasonable time. Significantly, the court held that the time limits imposed in article 21.55 for the insurer to acknowledge, investigate, and accept or reject the claim could be used as the standards for determining what was "prompt" and what was "within a reasonable time" to determine unfair settlement practices under article 21.21. More is said about that below.

The court did find no evidence that the insurer

"knowingly" committed the wrongful conduct. Because Valdez never told the insurer he intended to sell the car to his son, the court could not find that the insurer acted with actual awareness of the falsity or deceptiveness of its conduct.

An automobile insurer was liable for failing to act in good faith to settle once its liability became reasonably clear when it chose to appeal the judgment establishing the liability of the underinsured motorist, instead of paying. The court rejected the insurer's argument that it had no duty extending beyond the judgment. The insured suffered when surgery was delayed while the case was on appeal. *Mid-Century Ins. Co. v. Boyte*, 49 S.W.3d 408 (Tex. App.–Fort Worth, 2001, no pet. h.).

In *Lias v. State Farm Mut. Auto. Ins. Co.*, 45 S.W.3d 330 (Tex. App.–Dallas, 2001, no pet.), the court held an insurer was not liable for unfair settlement practices under article 21.21 for failing to promptly and reasonably pay an underinsured motorist claim, because suit was filed before the effective date of the amendments that prohibited this conduct.

This holding by the court is wrong. While these practices were codified into article 21.21 in 1995, the same conduct was prohibited by the statute through of rules and regulations before 1995. In *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W. 2d 129, 133 (Tex. 1988), the supreme court recognized a cause of action for failing to settle once liability became reasonably clear, under the pre-1995 version of the statute. The error of the court of appeals in this case did not affect the outcome. The court concluded that there was no evidence that the insurer failed to settle, once its liability became reasonably clear. This is discussed in more detail below.

When statutory bad faith claims are premised on the same evidence as the common-law bad faith claim, a summary judgment denying coverage under the policy that precludes common-law liability will also preclude statutory liability. *Gates v. State Farm Co. Mut. Ins. Co.*, ___ S.W.3d ___, No. 05-99-02085-CV, 2001 Tex. App. LEXIS 5406 at *13 (Tex. App.–Dallas, Aug. 9, 2001, no pet. h.).

An insurer was not liable for deceptive or unfair practices by failing to disclose the "vacancy" clause in its policy. The insured bought a fire policy to insure occupied rental property. The property was destroyed by a fire. The insurer refused to pay, based on an exclusion when the building is vacant for sixty days. The insured said he did not know about the vacancy clause, because the agent never told him about it and because he never received a copy of the policy. The court of appeals upheld the summary judgment for the insurer, finding no specific misrepresentations were made and no material information was withheld from the insured with the intent to induce him to enter the transaction. The court reasoned that even if knowledge of the sixty-day vacancy clause might have been material to the insured's decision to purchase the policy, it lost its materiality when the insured represented that his property would not be unoccupied for more than thirty days per year. Under these circumstances the insurer had no duty to advise the insured that the policy contained a vacancy clause. *Nwaigwe v. Prudential Prop. & Cas. Ins. Co.*, 27 S.W.3d. 558 (Tex. App.–San Antonio, 2000, no pet.).

Where a life insurance policy lapsed before the insured's death, for nonpayment of the premium, the court held the insurer was not liable on the contract. The court also held the insurer was not liable for deceptive trade practices or unfair insurance practices. The court concluded that even if billing errors committed by the insurer were misrepresentations, there was no evidence that they caused the insured or beneficiary to let the policy lapse. For this reason, the court concluded the insurer was not liable. *MacIntire v. Armed Forces Benefit Ass'n*, 27 S.W. 3d 85 (Tex. App.–San Antonio 2000, no pet.).

The court went on to state in dicta that a "mere breach of an insurance contract does not give rise to liability under the Insurance Code or DTPA," and that conduct prohibited by the Insurance Code is actionable only if the plaintiff has sustained actual damages as a result of that conduct "beyond the injury that would always occur when an insured is not promptly paid [her] demand." On these points, the court relied on its earlier decision in *Walker v. Fed. Kemper Life Assurance Co.*, 828 S.W.2d 442 (Tex. App.–San Antonio 1992, writ denied.)

Both this decision and *Walker* are in conflict with decisions from the Texas Supreme Court. A breach of the insurance contract can support liability for unfair insurance practices and deceptive trade practices, and the plaintiff has no obligation to show damages different from those normally suffered. For example, in *Aetna Cas. & Sur. Co. v. Marshall*, 724 S.W.2d 770 (Tex. 1987), the insurer was liable for misrepresenting the benefits it would pay in the contract. The representation was the contract itself. The supreme court held this was exactly the kind of conduct prohibited by the DTPA.

**An automobile insurer was liable for failing to act in good faith to settle once its liability became reasonably clear.**

Similarly, in *Vail v. Tex. Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129 (Tex. 1988), the unfair settlement practice was failing to pay the policy benefits. In other words, the insurer's failure to comply with the contract was the same conduct that violated the Insurance Code and DTPA.

It is clear from Insurance Code article 21.21 that a primary goal was to protect insureds and beneficiaries and to make sure they receive the benefits owed under the contracts. It makes no sense to suggest that the statute only comes into play to allow the insured to recover damages for some other type of unusual injury, and not the benefits themselves. The supreme court held just the opposite in *Vail*. In that case, the court held that policy benefits are damages as a matter of law, recoverable under the statute.

### B. Prompt Payment of Claims – Article 21.55

The Texas Supreme Court considered in *Allstate Ins. Co. v. Bonner*, 51 S.W.3d 289 (Tex. 2001), whether an insurer that does not comply with the claim acknowledgment deadline must pay attorney's fees when

the insured is awarded uninsured motorists benefits that do not exceed personal injury protection benefits previously paid by the insurer. Bonner was injured and submitted a PIP claim to Allstate, which Allstate paid. Bonner then submitted an uninsured motorist claim. Allstate failed to acknowledge that claim within fifteen days as required by the statute and denied the claim. Ultimately, the jury found Bonner was entitled to less in damages than Allstate had already paid, so she got no recovery on her UM claim. Nevertheless, Bonner argued that Allstate's violation entitled her to recover attorney's fees under the statute.

The supreme court rejected this argument and held that for an insurer to be held liable under article 21.55, "a party must establish three elements:

> (1) a claim under an insurance policy;
> (2) that the insurer is liable for the claims;
> (3) that the insurer has failed to follow one or more sections of article 21.55 with respect to the claim."

*Bonner*, 51 S.W.3d at 291. The court based this holding on the language of section 6 that provides an 18 per cent penalty and attorney's fees "[i]n all cases where a claim is made pursuant to a policy of insurance and the insurer *liable therefore* is not in compliance with the requirements of this article." Tex. Ins. Code Ann. Sec. 21.55, § 6 (Vernon 2001) (emphasis added).

**The plain language of the statute supports the conclusion that proving the invalidity of the claim is not a defense to any violation, except the sixty-day payment provision.**

The court concluded that Bonner failed to satisfy the second element, because she could not show the insurer was liable for the claim. The court's opinion is troubling, if it is read too broadly. The paramount goal of statutory construction is to fulfill the legislative intent. The language, structure, and purpose of article 21.55 make it clear that the Legislature intended some form of penalty for an insurer that fails to promptly investigate and make a decision on even an invalid claim. Within fifteen days after receiving notice of a claim, an insurer must acknowledge the claim, commence the investigation, and request any information from the claimant the insurer reasonably believes will be required. Tex. Ins. Code Ann. Sec. 21.55, §§ 2(a)(1)-(3) (Vernon 2001). Obviously, at that point the insurer does not know whether the claim is one for which it will be liable. That is the whole point of beginning the investigation, to make that determination.

Within fifteen business days after the insurer receives all information it has requested, the insurer has to accept or reject the claim and must give the insured reasons for any rejection. Tex. Ins. Code Ann. Sec. 21.55, §§ 3(a)-(c) (Vernon 2001). Obviously, again, this requirement applies to both valid and invalid claims. The Legislature thought it was important to timely reject claims and to explain the reason for the rejection. If the insurer has done its job correctly, this requirement will only apply to claims for which the insurer is not liable.

Other duties, such as accepting the claim, paying after accepting, and paying after all information is received, necessarily depend on the validity of the claim. If the claim is not valid, the insurer cannot be faulted for failing to pay after receiving the requested information. The statute specifically recognizes this situation. In section 3(g), the Legislature has provided that the insurer's failure to pay within sixty days after receiving the requested information is excused, if the claim is not valid.

Significantly, the Legislature did not make proving invalidity of the claim an excuse for failing to comply with the other deadlines. Thus, the plain language of the statute supports the conclusion that proving the invalidity of the claim is not a defense to any violation, except the sixty-day payment provision.

If there is no penalty for failing to comply with the other deadlines, merely because the insurer ultimately proves it does not owe the claim, then the other deadlines in the statute are severely undercut. For example, an insurer could simply ignore all claims and thumb its nose at the acknowledgment requirement, sneer at the deadline for accepting or rejecting the claim, and perform no investigation whatsoever. As long as the insurer could muster its resources and defeat the claim in litigation, the insurer could ignore with impunity. This is not what the statute says, and certainly cannot be what the legislature intended. Nevertheless, the court's opinion leaves open that very possibility. Perhaps in future cases, the supreme court and courts of appeals will further develop their construction of the statute to address these situations. For further discussion, see Mark L. Kincaid & Christopher W. Martin, *Texas Practice Guide: Insurance Litigation* §§ 17:1-17:46 (West 2001) (available on Westlaw in the TXPG-INS database)

An insurer that wrongly denies a claim is automatically liable for the 18 percent penalty under article 21.55 of the Texas Insurance Code, even if the insurer's denial was in good faith. The court of appeals reached this conclusion in *Cater v. United Serv. Auto. Ass'n*, 27 S.W.3d 81 (Tex. App.–San Antonio 2000, no pet.), based on the plain language of the statute and similar holdings under the predecessor statute.

The *Cater* court further held that the 18 percent penalty accrues as simple interest, and there is no basis in the statute to compound it annually. The court then concluded that the penalty began on the date the insurer wrongly denied the claim (to which the parties agreed) and continued up to the date the insurer paid the claim.

In *Colonial County Mut. Ins. Co. v. Valdez*, 30 S.W.3d 514 (Tex. App.–Corpus Christi 2000, no pet.), the court held that an insurer's unreasonable request for information did not delay the deadline for the insurer to accept or reject the claim. The court further held that the time limits imposed by article 21.55 can be used to determine whether an insurer acted "promptly" and accepted coverage within a "reasonable time," to establish unfair settlement practices in violation of article 21.21.

In this case, after a car was stolen, the insurer asked for several items, including service records, recent photographs of the car, a copy of the bill of sale, a copy of the title, and all sets of keys to the vehicle. Although Valdez provided other information, he did not

provide these items. The insurer argued that it had not received "all items, statements and forms required by the insurer to secure final proof of loss," and thus the time for accepting or rejecting the claim did not begin to run.

The court rejected this argument and held that these items were not reasonably required to secure final proof of loss. The insurer offered no explanation why it needed these materials. The court held that common sense indicates the materials were irrelevant to proving the loss of the vehicle. The jury could rightly conclude that the insurers failure to comply with these deadlines was an unfair settlement practice in violation of article 21.21.

The court in *J.C. Penny Life Ins. Co. v. Heinrich*, 32 S.W.3d 280 (Tex. App.–San Antonio 2000, no pet.), held that prejudgment interest is not allowed on the 18 per cent penalty under article 21.55. The court reasoned that the statutory penalty, even though it is called "damages," is akin to exemplary damages, so that prejudgment interest is not allowed.

The *Heinrich* court also considered the insurer's argument that it should not be liable for failing to timely respond to the claim. The insurer argued it should be excused from liability under the statute because the claimant's delay in seeking the life insurance proceeds deprived the insurer of an opportunity to file an interpleader action, and because the insurer never generally denied liability for the policy proceeds. The court rejected both arguments.

An insurer was not liable for failing to settle within sixty days after receiving all necessary information, where it settled within sixty days after receiving requested information on the insured's impairment rating. The court found no evidence that this request for information was unreasonable for the insurer to determine the claim. *Lias v. State Farm Mut. Auto. Ins. Co.*, 45 S.W.3d 330 (Tex. App.–Dallas 2001, no pet.).

## C. Breach of the Duty of Good Faith and Fair Dealing

In *Betco Scaffolds Co., Inc. v. Houston United Cas. Ins. Co.*, 29 S.W.3d 341 (Tex. App.–Houston [14th Dist.] 2000, no pet.) (en banc), the court held that an insurer did not breach its duty of good faith by denying a claim that was not covered. The evidence also showed that the insurer conducted an investigation that revealed evidence sufficient to legitimately sustain denial of the claim. The court recognized it is possible that an insurer could commit an act so extreme as to cause injury independent of the policy claim, but the court found no such evidence in this case. The court found that the insured's allegation that the insurer spoiled papers in the claim file was not so extreme as to constitute bad faith. For the same reasons, the court rejected the insured's extracontractual claims under the Insurance Code and DTPA.

Another court of appeals recognized that generally the absence of coverage on a policy precludes any recovery for bad faith, because that gives the insurer a reasonable basis for denying the claim. *Gates v. State Farm Co. Mut. Ins. Co.*, ___ S.W.3d ___, No. 05-99-02085-CV, 2001 Tex. App. LEXIS 5406 at *13 (Tex. App.–Dallas, Aug. 9, 2001, no pet. h.). Because the insurer got summary judgment dismissing the contract claims, the insurer was also entitled to summary judgment dismissing the bad faith claims.

The *Gates* court also recognized that even without coverage under the policy, an insurer may be liable if it commits some extreme act in handling the claim that would cause injury independent of the policy claim. In this case, the only conduct alleged by the plaintiffs was related to a Rule 11 agreement with the insurer, which was entered into after the claim was denied and after suit was filed. The court concluded this was not evidence of extreme conduct during the claims process.

In *Lias v. State Farm Mut. Auto. Ins. Co.*, 45 S.W.3d 330 (Tex. App.–Dallas 2001, no pet.), the court held that a tort suit for breach of the duty of good faith and fair dealing was not precluded by the insured non-suiting his breach of contract claim. The insurer had paid the claim, so the insured non-suited his breach of contract claim and was suing for the insurer's bad faith in delaying payment. The insurer argued that this non-suit on the contract claim precluded any suit for bad faith. The court disagreed. The court held that a separate contract cause of action is not necessary to pursue a breach of good faith and fair dealing claim, because the plaintiff can establish policy coverage in the tort action. The non-suit was not a determination on the merits of policy coverage.

Although the insured in *Lias v. State Farm* could bring suit, the insurer was entitled to summary judgment because there was no evidence that it failed to attempt a prompt, fair settlement once its liability became reasonably clear. The evidence showed that the insurer delayed payment for four months while it was attempting to establish whether the America Medical Association disability rating supported the insured's claim. Eventually, the insurer stated the impairment was not evaluated according to the AMA guidelines and disputed the value of the claim. The court held that a dispute between medical opinions regarding the value of a claim is a reasonable basis for delay. Although the insured demanded $25,000, ultimately the insurer paid $11,000.

The *Lias* court erroneously stated that the insured would have to raise a fact issue about when it became reasonably clear that the $25,000 demanded should have been offered and paid. This is wrong. The statute imposes a duty on the insurer to attempt in good faith to offer a prompt, fair, and equitable settlement once its liability becomes reasonably clear. This is also the standard for common-law bad faith. The focus is on the insurer's offer – not the insured's demand. The relevant issues are when the insurer's liability for any amount was reasonably clear and whether the insurer's offer at that point was reasonable, not whether its liability for the insured's demand became reasonably clear. The court's error did not affect the outcome. Based on the court's reasoning, the insurer did promptly pay once its liability – for the $11,000 – became reasonably clear.

## D. Unfair Discrimination

The Austin Court of Appeals held that unfair discrimination under article 21.21-8 is shown by proof of disparate treatment of members within the same class and does not require proof of discrimination based on membership in a protected class. *Cortez v. Progressive Co. Mut. Ins. Co.*, ___ S.W.3d ___, No. 03-00-00846-

CV, 2001 Tex. App. LEXIS 6294 at *10 (Tex. App.–Austin, Sept. 13, 2001, no pet. h.) (on rehearing). Cortez sued the insurer for charging different premiums and paying different commissions for policies sold to members of the same class.

The Austin Court of Appeals originally held that a violation of article 21.21-8 required proof of discrimination based on membership in some protected class as defined by article 21.21-6. On rehearing, the court recognized this was not the proper construction of the statute. The court's decision carries particular weight, because venue under article 21.21 is mandatory in Travis County.

### E. Negligence

An insured could not maintain a suit for negligent misrepresentation against an insurer that it alleged wrongfully drew on a letter of credit to pay premiums that were owed. The court found no evidence of any misrepresentation. ***Zipp Indus., Inc. v. Ranger Ins. Co.***, 39 S.W.3d 658 (Tex. App.–Amarillo 2001, no pet.).

An employer alleged that the worker's compensation servicing agent negligently handled claims. The court held there is no cause of action for negligent claims handling. The court observed that negligent claims handling is subsumed into breach of contract, except under very limited circumstances. The court reached a similar conclusion on the employer's fraud claims. ***North Winds Abatement, Inc. v. Employers Ins. of Wausau***, 258 F.3d 345 (5th Cir. 2001).

### F. ERISA

In ***Aboul-Fetouh v. Employee's Benefits Comm.***, 245 F.3d 465 (5th Cir. 2001), the court rejected the beneficiary's claim that the insurer abused its discretion by declining not to tie together as a single continuing period of disability the beneficiary's knee injury and depression claims. The court also found the insurer did not abuse its discretion in terminating benefits. The denial was tied to a functional capacity test result and two independent medical evaluations that concluded the beneficiary could perform at the level required for his position.

An insured employee suffering from angina and coronary artery disease sued his disability insurer/plan administrator under ERISA, challenging the denial of his claim for long-term benefits. ***Gooden v. Provident Life & Accident Ins. Co.***, 250 F.3d 329 (5th Cir. 2001). The court noted that the analysis of whether the insurer abused its discretion was informed by the insurer's role as both the insurer and administrator of the long-term disability plan. As such, the insurer has a conflict of interest because it potentially benefits from every claim denied. Therefore, the court applied a sliding scale standard and accorded the insurer's decision less deference.

Nevertheless, the court concluded that the insurer did not abuse its discretion. The court found evidence that the insured was capable of fulfilling his job duties. The court held that the insurer could not be faulted for failing to give overriding significance to a letter from the insured's doctor stating that the insured was disabled, because it was unaccompanied by medical evidence and was written after the insured learned he was terminated.

The court also rejected the insured's argument that the insurer unduly relied on a report from another doctor who never physically examined the insured, did not speak to the insured's other doctor, and did not have all of the insured's doctor's notes. The court noted that the non-treating doctor had copies of the insured's hospital records, his most recent stress test and arteriography, a statement of disability from the insured's doctor, and the insured's doctor's most recent letter.

In ***Thomas v. AIG Life Ins. Co.***, 244 F.3d 368 (5th Cir. 2001), a widow contested the denial of accidental death benefits after the plan participant died from complications following stomach-stapling surgery. The court concluded that the plan administrator did not abuse its discretion by finding the beneficiary's injury was attributable to a "disease" rather than an "accident." The court found no basis to separate the beneficiary's injury from the complications of his obesity, holding that the death was the foreseeable result of treatment for his disease.

## IV. AGENTS, AGENCY, AND VICARIOUS LIABILITY

### A. Insurer's Own Liability

An insurer fired its agent after investigating a kickback scheme. Based on the way the company's investigator conducted the investigation and the way the company continued to pursue him after his firing, the agent successfully sued for negligence and intentional infliction of emotional distress. ***Texas Farm Bureau Ins. Co. v. Sears***, ___ S.W.3d ___, No. 10-00-050-CV, Tex. App. 2001 LEXIS 5006 at *13-14 (Tex. App.–Waco, July 25, 2001, pet. filed). The court found that the insurance company owed a duty to conduct a reasonable investigation into the kickback allegations. In recognizing a duty, the court considered the foreseeability of harm from the investigation, the social utility of the investigation, and the relatively light burden of imposing on the insurer a duty to act reasonably.

The court found evidence that the insurer was negligent. For example, the insurer apparently gave little weight to the fact that the agent had reported the kickback scheme several times, which was inconsistent with him being involved. After considering all the evidence, the court found it was factually insufficient to support the jury's verdict.

In contrast, the court did find sufficient evidence that the insurer intentionally inflicted emotional distress on the agent. In particular, the court considered evidence that, even after the agent was fired, the company continued to pursue him, reported him to various federal agencies, such as the IRS, that could take punitive action against the agent, and attempted to persuade the Texas Department of Insurance to revoke his license. There was evidence that this conduct had a severe impact on the agent.

### B. Individual Liability of Agents, Adjusters, and Others

An agent's felony conviction for conspiracy to commit mail and wire fraud that stole $800,000 justified denial of his application for a license to sell insurance. ***Locklear v. Texas Dept. of Ins.***, 30 S.W.3d 595 (Tex. App.–Austin 2000, no pet.). In addition, the agent's material misrepresentations on his previous applica-

tion supported the denial.

In another case, the court held that an agent's four convictions for theft by check justified revocation of his license. *Brown v. Texas Dept. of Ins.*, 34 S.W.3d 683 (Tex. App.–Austin 2000).

In *North Winds Abatement, Inc. v. Employers Ins. of Wausau*, 258 F.3d 345 (5th Cir. 2001), the court held that a servicing company was not the agent of Texas Worker's Compensation Insurance Facility, thus denying the company statutory immunity. The court found no evidence that the Legislature intended to protect servicing companies. The Insurance Code section that gives TWCIF immunity does not even mention servicing companies. The section that mentions servicing companies contains no exemption.

## V. THIRD PARTY INSURANCE POLICIES & PROVISIONS

### A. Automobile Liability Insurance

The death of a woman struck by another vehicle as she was fleeing a van to escape a sexual assault by the driver did not involve "use" of the van, so there was no coverage. *State & Co. Mut. Fire Ins. Co. v. Trinity Universal Ins. Cos.*, 35 S.W.3d 278 (Tex. App.–El Paso 2000, no pet.). The court considered the following factors to determine whether the injury arose from the "use" of the vehicle: (1) whether the accident arose out of the inherent nature of the automobile, as such; (2) whether the accident occurred within the natural territorial limits of the automobile, and whether the actual use, loading, or unloading had terminated; and (3) whether the automobile merely contributed to cause the condition that produced the injury, or itself produced the injury.

The court found the first two factors were satisfied. But for the vehicle's position on the highway, the injury would not have occurred. However, the court found the third element was not satisfied. The use of the van was merely incidental in producing the women's death. The van itself did not produce the injury.

There was no coverage for a plaintiff's injuries when she fell from a trailer being used for a hayride. The policy covered any trailer that was attached to the truck identified in the policy, but not trailers in general. The evidence showed the trailer was attached to a truck other than the covered one. *Lyons v. State Farm Lloyds*, 41 S.W.3d 201 (Tex. App.–Houston [14th Dist.] 2001, pet. denied).

A policy did not provide coverage for the insured's conduct in getting out of his car and shouting at, and kicking the door, of another driver, causing the other person to speed into the intersection and hit another car. There was no "auto accident" involving the insured, because his conduct was intentional. *Collier v. Allstate Co. Mut. Ins. Co.*, ___ S.W.3d ___, No. 2-00-116-CV, 2001 Tex. App. LEXIS 3814 at *16-17 (Tex. App.–Fort Worth, June 7, 2001, no pet.).

In *T.H.E. Ins. Co. v. Larson Intermodal Serv., Inc.*, 242 F.3d 667 (5th Cir. 2001), a motor carrier and liability insurer sued a trucking company for reimbursement of amounts paid in a settlement of third party personal injury claims arising from a collision. The policy contained a federally mandated endorsement for motor carrier policies of insurance for public liability, referred to as Endorsement MCS-90. That endorsement makes the insurer liable to third parties for any liability resulting from the negligent use of a motor vehicle by the insured, even if the vehicle is not covered under the insurance policy.

The insurer argued that its right to reimbursement from the insured was a federal right specifically reserved in the endorsement itself, and required that the court only look to federal law to evaluate the insurer's rights. The court rejected this argument, holding that the right to reimbursement under the MCS-90 is triggered only if there is no coverage under the policy. After reviewing Louisiana law to determine coverage, the court concluded that the insurer had a duty to defend the insured. Because the MCS-90 did not alter existing duties between the insured and insurer, the court held that the insurer was not entitled to be reimbursed for defense costs.

In *Empire Fire & Marine Ins. Co. v. Brantley Trucking, Inc.*, 220 F.3d 679 (5th Cir. 2000), an insurer for a truck owner denied coverage following an auto accident. Relying on the "business use" exclusion of the insured's bobtail policy, the court denied coverage because the truck was under lease, and the driver was en route to the lessee's yard to pick up a load at the time of the accident.

### B. Homeowners Liability Insurance

In *State Farm Lloyd's v. Goss*, 109 F. Supp. 2d 574 (E.D. Tex. 2000), the plaintiffs in the underlying suit brought a claim against the insured for the death their two-year-old daughter in a house fire. The plaintiffs were in the process of buying the house from the insured. The insured then sought defense and indemnity from State Farm under a business policy and a homeowner's policy.

Based on an exclusion in the homeowner's policy, the court observed that the insured was not entitled to defense and indemnity if (1) she owned the premises, and (2) the premises were not the "insured location." The insured admitted the premises were not the insured location listed on the declarations page. However, the insured contended that she was not the owner of the property because her contract for sale with the plaintiffs transferred a superior right to them. The court rejected this argument, concluding that the exclusion was unambiguous.

**The insured contended that she was not the owner of the property because her contract for sale with the plaintiffs transferred a superior right to them.**

### C. Comprehensive General Liability Insurance

A liability insurer was obligated to pay for property damage caused when the insured's repairs to a parking garage caused chunks of concrete and dust to damage cars on the levels below. The evidence showed the insured's work was not yet completed. Further,

the fact that the damages were foreseeable did not preclude them being the result of an "accident." ***Stumph v. Dallas Fire Ins. Co.***, 34 S.W.3d 722 (Tex. App.–Austin 2000, no pet.).

The court of appeals was called on to distinguish its decision in ***Stumph*** in a later case seeking coverage for defective construction. In ***Devoe v. Great Am. Ins.***, 50 S.W.3d 567 (Tex. App.–Austin 2001, no pet.), the Devoe's sued their homebuilder alleging defective and shoddy construction. The builder's liability insurer refused to defend or indemnify, contending there was no "occurrence" under the policy. The court of appeals held that shoddy construction is not covered by a liability policy. This conduct was not an "accident," because the construction is a voluntary and intentional act by the insured, even though the deficient and substandard construction was not expected, foreseen, or intended. The court contrasted its holding in ***Stumph***, where the insured's construction activities resulted in separate property damage that was not the natural and probable consequence of the repairs.

In a similar case, the court concluded that a builder's liability for breaching an implied warranty of good and workmanlike construction was not an "accident" or "occurrence." ***Hartrick v. Great Am. Lloyds Ins. Co.***, ___ S.W.3d ___, No. 01-99-00215 2001 Tex. App. LEXIS 5253 at *16-17 (Tex. App.–Houston [1st Dist.], August 2, 2001, no pet. h.); ***accord Malone v. Scottsdale Ins. Co.***, 147 F. Supp.2d 623 (S.D. Tex. 2001).

A plaintiff's injuries when she fell from a trailer being used for a hayride involved "use" of an automobile and were thus excluded from coverage under the insured's general liability policy. ***Lyons v. State Farm Lloyds***, 41 S.W.3d 201 (Tex. App.–Houston [14th Dist.] 2001, pet. denied). The court reasoned that the accident arose from the plaintiff's entry onto the trailer, and entry is part of the inherent nature of a vehicle. Second, her fall occurred within the natural territorial limits of the trailer. Third, the trailer produced the injury. Fourth, the plaintiff's intent was to use the trailer as a vehicle.

A shopping center was an "additional insured" under a plumbing company's liability policy, so that it was entitled to coverage when a plumbing company employee was injured. The employee was injured as he rode a conveyor belt in the parking garage to return to his car after completing the job. The court reasoned that the employee's injury occurred while he was on the premises to do the work of his employer and that his injury arose out of that work; therefore, the claim was within the coverage afforded to the shopping center as an additional insured. ***Highland Park Shopping Vill. v. Trinity Universal Ins. Co.***, 36 S.W.3d 916 (Tex. App.–Dallas 2001, no pet.).

An exclusion for injuries "arising out of" operations performed by subcontractors excluded any liability that was causally related to the work of the subcontractor, even though the named insured's negligence also contributed to the injuries. ***Gen. Agents Ins. Co. v. Arredondo***, 52 S.W.3d 762 (Tex. App.–San Antonio 2001, pet. denied). An employee was injured when he was struck by a crane. The crane was being operated by a subcontractor, but the jury found the insured was negligent in failing to provide proper safety equipment. The court nevertheless found the loss excluded under the provision excluding any liability for injuries "arising out of" operations performed by a subcontractor. The exclusion also prohibited liability for acts or omissions in connection with the general supervision of the subcontractor.

In denying coverage, the insurer argued, among other things, that there was no "occurrence" as required by the insurance contract. The insurer relied upon the settlement agreement and argued that as a matter of law there has been no "occurrence" because the basis of liability is a settlement contract following the first suit. The court rejected this argument, finding that the basis of liability was the general contractor's negligence in constructing the hospital.

In a case involving the pollution of an oil and gas lease, the insured exploration company claimed it was entitled to a defense and indemnity. ***Harkin Exploration Co. v. Sphere Drake Ins.***, 261 F.3d 466 (5th Cir. 2001). The insurer asserted that there was no "occurrence." In rejecting the insurer's argument, the court noted that the policies defined an occurrence as an "accident." An accident occurs when action is intentionally taken, but is performed negligently, and the effect is not what would have been intended or expected had the action been performed non-negligently. In this case, operation of the oil facilities was action deliberately taken, but the contaminated water, dead cattle, etc., caused by the pollutants were alleged as the unintended and unexpected effects of the negligent operation of the facility.

Next, the court rejected the insurer's argument that it had no duty to defend or indemnify because the underlying suit alleged both negligent and malicious conduct. The court noted that if an insurer has a duty to defend any portion of the suit, the insurer must defend the entire suit.

Finally, the insurer argued that it had no duty to defend because the injury did not occur during the policy period. The insurer argued that there was no allegation in the complaint expressly alleging coverage during a particular policy. The court held that it could review extrinsic evidence to determine coverage if sufficient facts were not contained in the petition. Reviewing the date of the lease in the underlying lawsuit, the court concluded that the damages alleged in the underlying lawsuit occurred during one of the policy periods.

A general contractor sued a subcontractor's insurance broker and underwriter on a comprehensive general liability policy seeking damages for the subcontractor's accidental pipeline break. The insurer argued that there was no coverage because the general contractor must be "legally liable" before the insurer was obligated to pay. ***Ins. Co. of N. Am. v. Aberdeen Ins. Services, Inc.***, 253 F.3d 878 (5th Cir. 2001). The court rejected this argument, observing that the subcontractor was responsible for the damage pursuant to the underlying Department of Energy contract.

The court also rejected the insurer's argument that the general contractor failed to give notice of the claim. The court observed that notice to an insurer need not be made by the insured. It was uncontroverted that the subcontractor made a claim on the cover note, which satisfied the requirement of prompt notice to the insurer. Moreover, the record supported the gen-

eral contractor's contention that the insurer did deny the claim. The general contractor presented the fax from the insurer to its broker indicating that the cover note had been cancelled and that the claims were outside the policy, as well as the broker's letter stating that claims based on the incident were "of no concern" to the broker.

In *Ins. Co. of North Am. v. McCarthy Bros. Co.*, 123 F. Supp. 2d 373 (S.D. Tex. 2000), a general contractor entered into a settlement agreement with a children's hospital resolving claims about construction defects. A second suit was brought when the general contractor failed to perform the settlement agreement. The general contractor then sought indemnification from its insurer for expenses incurred to remedy its negligent work.

The insurer argued it had no liability because the event that gave rise to the suit was the settlement agreement, not the underlying negligence. The court rejected this argument, finding the reality of the situation was that the contractor would not be liable for anything but for the fact it built a hospital that "leaked like a sieve."

For similar reasons, the court rejected the insurer's argument based on an exclusion for liability assumed under a contract. The exclusion doesn't apply if the insured would be liable even without the contract.

### D. Personal Injury & Advertising Injury Liability Insurance

A seller of repair parts that was sued for patent infringement was not entitled to a defense under the "advertising injury" and "advertising liability" provisions of its insurance policy. *Cigna Lloyds Ins. Co. v. Bradleys' Elec. Inc.*, 33 S.W.3d 102 (Tex. App.–Corpus Christi 2000, pet. denied). Bradley's sold repair kits for compressors patented and sold by Copeland. Copeland sued for patent infringement claiming that Bradley's kits could be used for the unauthorized remanufacturing of Copeland's compressors.

The court found no duty to defend under the "advertising injury" language of the Cigna policy, which provided coverage, inter alia, for "infringement of copyright, title or slogan." There was no allegation that the patent infringement arose out of Bradley's advertising activities.

The court reached the same conclusion under two other policies that covered "advertising liability," defined as, inter alia, "piracy, unfair competition or idea misappropriation."

Allegations that an insured wrongfully misrepresented another company's corporate name and logo, in violation of a dissolution agreement between the two entities, did not state a claim for "advertising injury." *Southstar Corp. v. St. Paul's Surplus Lines Ins. Co.*, 42 S.W.3d 187 (Tex. App.–Corpus Christi 2001, no pet.). The policy provided coverage for the unauthorized taking or use of any advertising idea, material, slogan, style, or title of others. However, the policy excluded advertising injury that resulted from the failure of any protected person to do what was required by a contract or agreement. This exclusion had an exception if the unauthorized taking or use of advertising ideas was not specifically prohibited by the relevant contract or agreement.

In this case, the petition alleged that the insured misappropriated the title of the other company, in violation of their dissolution agreement. The court held this conduct fit within the exclusion and not within the exception. The court limited the exception solely to unauthorized taking or use of advertising ideas, not the unauthorized taking of a logo or title.

### E. Directors & Officers Liability Insurance

The insurer sought a declaration that the insured, an officer of the corporation, was not entitled to coverage under any of the three directors, officers, and corporate liability insurance policies. *Nat'l Union Fire Ins. Co. v. Willis*, 139 F. Supp. 2d 827 (S.D. Tex. 2001). The insurer claimed that no coverage existed because the defendant failed to give timely notification of the lawsuit brought against him in 1998. The defendant officer contended that he had no duty to notify the insurer until the petition was amended to add an additional claim that would be covered under the policy.

In rejecting the officer's claim to coverage under any of the policies, the court first noted that the policies are "claims made" policies as opposed to the more customary "occurrence" policies. In order to invoke coverage under such policies, a claim must be made against the insured during the policy period, and the insured must notify the insurer of the claim during the same period. Thus, in contrast to an "occurrence" policy, and insurer may deny coverage for untimely notice under "claims made" policy without a showing of prejudice.

In reviewing the 1998 petition, the court concluded that some of the causes of action pled were potentially covered by the 1998 policy. The original petition in the underlying lawsuit alleged that the defendant officer acted intentionally and recklessly when making certain misrepresentations and promises. The 1998 policy explicitly provides coverage to the defendant officer for misstatements, misleading statements, omissions, and other wrongful acts. Although the policy excludes a "deliberate fraudulent act" from the scope of coverage, a "reckless" act is not necessarily the equivalent of "deliberate" act, as specified in the exclusion.

**In rejecting the officer's claim to coverage under any of the policies, the court first noted that the policies are "claims made" policies as opposed to the more customary "occurrence" policies.**

Because not all of the claims asserted against the defendant officer were excluded under the 1998 policy, it was incumbent upon him to give notice to his insurer to trigger the insurer's obligation for the advance of defense costs and indemnity. Because he failed to do so, he could not look to the 1998 policy for coverage. Furthermore, he was foreclosed from relying on the 2000 policy, as the claims asserted in the amended

petition arose out of, were based on, or were attributable to pending or prior litigation and thus were expressly excluded from coverage.

### F. Employment Liability Insurance

In *Ran-nan, Inc. v. Gen. Accident Ins. Co. of Am.*, 252 F.3d 738 (5th Cir. 2001), the operator of a convenience store sued the insurer for the insurer's refusal to pay two claims under an employee dishonesty insurance policy. The insurer urged there was only one "occurrence" under the policy, arguing that the convenience store operator lost only a single sum of cash. The court rejected this argument, holding that the two thefts by two employees working separately and independently constituted two "occurrences" under the store's employee dishonesty insurance policy.

### G. Product Liability Insurance

An insurer was not liable for personal injuries caused by equipment that was sent to Mexico. The "policy territory" was defined as the United States, and "anywhere in the world with respect to damages because of bodily injury or property damage arising out of a product which was sold for use or consumption within the territory described[.]" The court rejected the insured's argument that there was coverage for products (1) sold for use or consumption, or (2) sold within the territory described. The court found the policy only provided coverage for products sold for use or consumption within the territory described. Because the product was sold for use in Mexico, there was no coverage. *Commercial Union Assurance Co. v. Silva*, ___ S.W.3d___, No. 04-00-00536-CV, 2001 Tex. App. LEXIS 3482 at *7-8 (Tex. App.–San Antonio, May 30, 2001, no pet.).

### H. Professional Liability Insurance – Errors & Omissions

A Chapter 7 debtor's professional liability insurers sued for declaratory judgment as to whether the policy had been effectively cancelled, and as to whether it provided coverage for claims asserted against the debtor. *In re Sensitive Care, Inc.*, 256 B.R. 585 (N.D. Tex. 2000). In denying the insurer's motion for summary judgment, the court noted that the insurer had notice of claims under the policy before coverage lapsed. The subsequent attempt to retroactively cancel the policy does not preclude coverage for prior noticed acts.

### I. Other Liability Policies

A sublessee was not an "omnibus" insured under a liability policy issued by the insurer to an insured operating a fixed-base operation at an airport. *Jun v. Lloyds*, 37 S.W.3d 59 (Tex. App.–Austin 2000, pet. denied).

## VI. DUTIES OF LIABILITY INSURERS

### A. Duty to Defend

In *Pilgrim Enter., Inc. v. Maryland Cas. Co.*, 24 S.W.3d 488 (Tex. App.–Houston [1st Dist.] 2000, no pet.), the court held that a liability insurer had a duty to defend a dry cleaner that was sued for injuries and property damage caused by the release of toxic chemicals. The court held that the "occurrence" was when the exposure caused injuries, even if the contamination happened earlier.

In *E&R Rubalcava Constr., Inc. v. Burlington Ins. Co.*, 148 F. Supp. 2d 746 (N.D. Tex. 2001), the insurer argues that it has no duty to defend the insured subcontractor in an underlying lawsuit that arose from claims by the purchasers of homes against their general contractors. The general contractors then brought third party claims against the insured. First, the insurer argues that it did not owe the subcontractor a duty to defend based on the business risk exclusion in the general commercial liability policy. The court noted that the business risk exclusion applies only to the cost for repair to work performed by the insured, not the cost of repair of other damage to the homes. Because the homeowners in the underlying lawsuit sought damages due to the subcontractor's defective foundation work that effected property other than the foundation, the business risk exclusion did not apply. Second, the insurer argued that it had no duty to defend the subcontractor based on the contractual liability exclusion. Essentially, the subcontractor's policy excludes liability assumed by the subcontractor under any contract or agreement by which the subcontractor agrees to indemnify a third party for that party's sole negligence. However, in the underlying lawsuit, the subcontractor was not being sued as a contractual indemnitor, but rather for its own conduct. Therefore, the contractual liability exclusion is inapplicable.

In *Reaud, Morgan & Quinn, Inc. v. Old Republic Ins. Co.*, 144 F. Supp. 2d 680 (E.D. Tex. 2001), the insured law firm sought recovery from its malpractice insurance carrier for the cost of defending itself in various proceedings stemming from an underlying malpractice suit against the law firm and a former client. The law firm represented the client in a worker's compensation action against its employer and its worker's compensation insurers. The law firm developed a large file of discovery and other materials regarding the allegations against the employer and its insurers. That case ended in settlement.

The law firm concurrently pursued a class action against the same defendants when the original client sought representation on an unrelated matter. When the client requested the earlier case file from the law firm, the law firm refused on the basis that the material in the file was essential to the ongoing representation of the class action and that some of the material was under protective order. The client then sued the law firm for malpractice, and tried to disqualify the law firm from acting as class counsel in the class action. The law firm was also asked to produce the same file in a licensed revocation proceeding against one of its contract attorneys.

Under its insurance policy, the law firm retained outside counsel to defend itself in the various actions brought by the former client. The insurance company denied the law firm's claims for any professional services rendered in connection with the class action and the license revocation proceedings, arguing that those actions were separate and distinct from the underlying malpractice action and thus not covered under the policy. The court rejected this argument, concluding that the claim for damages included in the underlying

malpractice action was sufficient to activate the insurer's duty to defend the law firm against the demands for discovery and production of materials in the other two cases.

In *Malone v. Scottsdale Ins. Co.*, 147 F. Supp. 2d 623 (S.D. Tex. 2001), the underlying lawsuit alleged that the insured failed to properly construct commercial improvements to an office and warehouse complex. The insurer denied coverage on the grounds that the damages sustained by the plaintiff in the underlying suit were caused by the insured's faulty workmanship, and thus were not the result of an "occurrence" as that term was defined in the commercial general liability policy. In accepting this argument, the court noted that the plaintiff in the underlying suit alleged that the insured "failed to construct the improvements in accordance with the architects plans and specifications which were … approved by the City of Conroe." The court concluded these failures were omissions, which could only be considered voluntary and intentional, and not accidental. The court noted that the failure to comply with implied warranties, i.e. promises implied as a matter of law, are not accidental, but results from not doing what one must do. The fact that the underlying petition alleges "negligent" construction of improvements does not alter this conclusion.

Additionally, the court found that the property damage exclusions in the policy preclude coverage. The damage alleged in the underlying lawsuit is none other than that caused by the insured's failure to use proper building materials or properly constructed various components of the structure. Because the damages "arose out of" the insured's operations, coverage was precluded.

In *Martin Marietta Materials Southwest, Ltd. v. St. Paul Guardian Ins. Co.*, 145 F. Supp. 2d 794 (N.D., Tex 2001), the insured diverted a creek without a valid permit. In doing so, it deprived a downstream owner of the water it needed to operate its company. That company brought a suit in state court alleging that diversion caused production and sales losses exceeding $150,000.00. The insured then brought suit seeking a declaration that the insurer had a duty to defend and to indemnify them in the underlying suit.

The court rejected the argument that the insured negligently diverted the waters of the creek, concluding that the diversion was indisputably intentional. The court noted that it is not the cause of action alleged that determines coverage but the facts giving rise to the alleged actionable conduct.

Next, the insured argued that because they never intended to injure the downstream company, the injury was accidental and thus created a duty to defend. The court rejected this argument, concluding that the natural and predictable result of diverting or damming a river is a reduction of downstream waters, which could foreseeably harm downstream users. An opposite conclusion would present a moral hazard, permitting water users who neglect to consult with water authorities or investigate the existence of downstream users to shift all resulting cost and liabilities on their insurers. The court held that public policy compels a finding that the existing water permit systems suffices to inform water users that their upstream action has natural and probable downstream impacts. Ignorance of those consequences, whatever the cause, does not automatically render later events fortuitous or accidental.

The insurer had no duty to defend an employer that was sued for negligence resulting in its employee's intentional assault. *King v. Dallas Fire Ins. Co.*, 27 S.W.3d 117 (Tex. App.–Houston [1st Dist.] 2000, pet. granted), the court reasoned that the assault was not an "accident" from the perspective of the employee and thus was not an "occurrence" within the meaning of the policy. The plaintiff sued the employer for negligent hiring, lack of adequate training, lack of adequate supervision, and negligently failing to check the employee's background. The court concluded that the employer's conduct was also not accidental.

While the court recognized that the authorities split on this issue, the court followed the line of Texas and Fifth Circuit cases that hold there is no coverage when the injury is the result of a negligent act of the principal that is related to and interdependent on the intentional conduct of the agent.

The *King* court also held that the result was not changed by the "separation of insureds" clause, which provided that the policy applied separately to each insured against whom a claim was made. The employer argued that this language meant its negligence had to be considered apart from any intentional act by the employee. While the court found "considerable merit" in this argument, the court nevertheless felt bound by authorities rejecting this view.

**An insurer that discovered a coverage defense could not withdraw from defending its insured without giving timely notice of its intent to withdraw.**

Although the court found there was no duty to defend because there was no "occurrence," the court did state in dicta that it did not believe conduct would be excluded as an "intentional" act, because nothing in the petition suggested that the employer expected or intended the injury.

One justice dissented and would hold that the separation of insureds clause supported the employer's argument. The supreme court has granted review in this case. For additional discussion of this issue, See Lee H. Shidlofsky, *Coverage for Vicarious & Derivative Liability Under Texas Law*, Univ. of Texas, 6th Annual Insurance Law Inst. 9 (Sept. 2001).

To the same effect is the decision in *Folsom Inv., Inc. v. Am. Motorists Ins. Co.*, 26 S.W.3d 556 (Tex. App.–Dallas 2000, no pet.). The court held insurers had no duty to defend an employer sued for negligent hiring, training, supervision, and retention of an employee that was accused of gender-based discrimination and sexual harassment.

A leak in oil well tubing caused by a defective weld that caused an increase in pressure over a period of time was not "sudden" to fit within the exception to exclusions for damage to the insured's product or the injured party's property. Therefore, the insurer had no duty to defend. *Saint Paul Surplus Lines Ins. Co. v. Geo Pipe Co.*, 25 S.W.3d 900 (Tex. App.–Houston [1st District], 2000, no pet.).

An insurer that discovered a coverage defense

could not withdraw from defending its insured without giving timely notice of its intent to withdraw. ***Providence Wash. Ins. Co. v. A & A Coating, Inc.***, 30 S.W.3d 554 (Tex. App.–Texarkana 2000, pet. denied). The insurer provided coverage from 1988 through 1989. When the insured was sued, the insurer reserved the right to withdraw from the defense upon reasonable notice should it be determined that there was no coverage or any obligation to defend. Later, the trial court issued a memoranda opinion that barred all claims during the coverage period. The insurer then refused to pay any more defense costs.

The court of appeals upheld summary judgment in favor of the insured for its attorney's fees. The court found the insurer's duty to defend was properly invoked. The insurer failed to give proper notice of its intent to withdraw. In fact, the insurer continued to participate in the defense of the case and even contributed toward the final settlement. The court found the insurer's delay and failure to give proper notice were detrimental to the rights of the insured and thus the insurer had not effectively withdrawn.

An insurer did not have a duty to defend an engineering company sued for negligence in failing to supervise an excavation, negligent design, and misrepresenting its qualifications, even though the plaintiffs alleged the work was done by both engineers and non-engineering personnel. The court found the exclusion for "professional services" clearly applied to the conduct alleged. ***Utica Lloyd's of Tex. v. Sitech Eng'g Corp.***, 38 S.W.3d 260 (Tex. App.–Texarkana 2001, no pet.).

A liability policy potentially provided coverage for property damage that resulted when an insured's repairs to a parking garage caused chunks of concrete and dust to fall on cars below. The allegations showed that the insured's work was not yet completed, so the claim fell within coverage, even though the complaints about the work came after it was completed. ***Stumph v. Dallas Fire Ins. Co.***, 34 S.W.3d 722 (Tex. App.–Austin 2000, no pet.).

A liability insurer had no duty to defend its insured against allegations of conduct that occurred before the policy inception date. Travis was sued for intentional conduct in establishing a competitor to his former business. All of the alleged conduct occurred before the new corporation was formed and had purchased insurance. Therefore, the insurer had no liability. ***Scottsdale Ins. Co. v. Travis***, ___ S.W.3d ___, No. 05-99-01831, 2001 Tex. App. LEXIS 2892 at *12-13 (Tex. App.–Dallas May 2, 2001, pet. filed).

A bankruptcy trustee sued the debtor's attorney and liability insurer for malpractice or breach of their duty of reasonable care. ***In re Segerstrom***, 247 F.3d 218 (5th Cir. 2001). In rejecting the trustee's malpractice claim, the court observed that Texas law requires that insurance companies act with reasonable care in fulfilling their duty to defend under their insurance contract. However, the court found no authority that the insurer's duty of reasonable care requires that the insurer independently identify conflicts of interest and takes steps to address them prior to or at the same time as appointing legal counsel. Unless the insurer disregarded notice from their appointed counsel of the conflict, any liability imposed on the insurer would be vicarious and, hence, not recognized by Texas law. Moreover, even assuming that the insurer had a duty to prevent the conflict, the trustee provided insufficient evidence linking the judgment against the debtor to that breach.

In ***St. Paul Fire & Marine Ins. Co. v. Greentree Fin. Corp.***, 249 F.3d 389 (5th Cir. 2001), an insurer argued it had no duty to defend against or indemnify a mobile home purchaser's claims for wrongful debt collection, negligence, and deceptive trade practices. The insurer argued that the underlying suit did not allege any offense within the personal injury coverage. Rejecting this argument, the court held that a third party's pleadings need not allege a specific offense to invoke an insurer's duty to defend. The duty arises if the factual allegations potentially state a cause of action covered by the policy. The factual allegations of the underlying case described a pattern of abusive telephone calls, which supported a cause of action for invasion of privacy.

### B. Duty to Indemnify

In ***Ins. Co. of N. Am. v. Aberdeen Ins. Serv., Inc.***, 253 F.3d 878 (5th Cir. 2001), a general contractor on a pipeline project sued a subcontractor's insurance broker and underwriter seeking coverage for damages for the contractor's settlement with the Department of Energy arising from the subcontractor's accidental pipeline break. The insurer argued the settlement entered was not reasonable, prudent, or in good faith.

The court rejected this argument, holding that when an indemnitee enters into a settlement with a third party, it may recover from the indemnitor by showing that potential liability existed. The indemnitee need not prove actual liability to the third party. Because the general contractor was liable through its DOE contract for the subcontractor's acts, and the subcontractor's policy covered liquidated delay damage, the general contractor acted reasonably and prudently in settling with the DOE for the cost of delays.

In ***Malone v. Scottsdale Ins. Co.***, 147 F. Supp. 2d 623 (S.D. Tex. 2001), the court concluded that the insurer had no duty to indemnify when the insurer had no duty to defend. The same reasons that negated the duty to defend negated any possibility that the insurer would ever have a duty to indemnify. The policy clearly excluded any liability for faulty workmanship, and that was all the plaintiffs alleged.

### C. Settlements, Assignments & Covenants Not to Execute

An automobile liability insurer and the negligent driver insured could challenge the tort judgment against the driver on the grounds that the parties had entered into an oral settlement agreement before suit was filed. That contract claim was not a collateral attack on the tort judgment. ***Harris v. Balderas***, 27 S.W.3d 71 (Tex. App.–San Antonio 2000, pet. denied). The $5 million underlying tort judgment against the negligent driver/insured did not establish the insurers liability for amounts in excess of the policy limits, and it did not resolve the settlement agreement question, which had been severed. The insurer and driver argued that the parties had reached an agreement to settle the plaintiff's claim for $20,000. The court of appeals found there

were fact issues on whether there had been an offer and acceptance and whether the parties intended to settle one claim or two.

Plaintiffs who made a *Stowers* demand that was accepted could not avoid the settlement agreement on the grounds of mutual mistake or unilateral mistake on the basis that before the settlement was consummated, a hospital lien was filed. *Green v. Morris*, 43 S.W.3d 604 (Tex. App.–Waco 2001, no pet.). The Greens made an unconditional offer to settle within policy limits, which was accepted by the defendant's liability insurer. They testified that if the hospital lien had been filed before, they would not have made the settlement demand. The insurer sought to enforce the settlement agreement. The court agreed with the summary judgment for the insurer. The court reasoned that a mistake about future facts was not the kind of mistake that would relieve a party from a contract.

## VII. THIRD PARTY THEORIES OF LIABILITY

### A. Breach of Contract

In *DeLeon v. Lloyd's London*, 259 F.3d 344 (5th Cir. 2001), the estate of a deceased employee brought a breach of contract action against a life insurer that paid the proceeds on a group policy to the employer as the named beneficiary. The estate argued that reformation of the policy was appropriate under provisions of the Texas Insurance Code. The court observed that when an insurer pays the proceeds of a policy to a beneficiary having no insurable interests, Texas courts have consistently held that a constructive trust is the appropriate remedy.

Texas courts have refrained from invalidating policies for want of an insurable interest, to avoid windfalls to insurers at the expense of lawful beneficiaries. In this case, however, the court rejected the estate's argument to reform the contract so that the estate could sue on the employer's policy. The court observed that the estate could either sue the employer for a constructive trust on the proceeds, or could sue the insurer for breach of contract.

The first option presented little difficulty, unlike the suit against the insurer. The second option, the court observed, could require the insurer to pay policy proceeds twice: first to the employer on the policy, then to the estate for breach of contract. The court noted that requiring an insurer to pay twice would be inconsistent with the insurable interest doctrine. Thus, the court concluded that estate did not have a claim against the insurer, but was left to seek a constructive trust against the employer.

In *Morris County Nat'l Bank v. John Deere Ins. Co.*, 254 F.3d 538 (5th Cir. 2001), a mortgagee brought suit after the fire insurer refused its claim for destruction of a mortgaged "buncher" because the policy had expired and had not been renewed by the insured before the date of loss. The mortgagee claimed it should have been given notice of the policy expiration. The court recognized that article 6.15 of the Texas Insurance Code granted the mortgagee an independent contract with rights independent of the mortgagor, but in this case the policy expired by its own terms prior to the date of loss. Because the insurer had no obligation to notify the mortgagor of the policy's expiration, it similarly had no obligation to identify the mortgagee of the expiration.

### B. *Stowers* Duty & Negligent Failure to Settle

An automobile insurer, whose insured filed bankruptcy after being sued over an automobile accident, filed an adversary proceeding seeking a declaration that no *Stowers* claim existed. *In re Davis*, 253 F.3d, 807 (5th Cir. 2001). The court held that the *Stowers* claim was not part of the bankruptcy estate, since no judgment was rendered against the debtor in the underlying action until three years after the debtor's bankruptcy. Moreover, the insured had not suffered any legal injury cognizable under *Stowers* because he was no longer personally liable for any judgment in excess of the policy.

In a concurring opinion, Judge Garwood emphasized the financial condition of the insured at the time of bankruptcy. Judge Garwood held open the possibility that a *Stowers* claim might exist when the insured has non-exempt assets well in excess of all debts other than the outstanding. Judge Garwood observed that in such a scenario it is certainly open to reasonable argument that the insured had in substance used a portion of his nonexempt assets to pay the excess judgment.

### C. Other Negligence

In *Ford v. Cimarron Ins. Co.*, 230 F.3d 828 (5th Cir. 2000), the insured sued his insurer for negligently handling his claim. In the underlying suit, the insured had sued a fire extinguisher certification company for fire damage at his business. The insurer then sent a letter to a third party that was also injured in the fire, alleging that the insured was negligent in causing the fire.

In this suit, the insured argued that the negligence of the insurer diminished the value of the insured's suit against the certification company. The court rejected this argument, stating that Texas courts recognize only one tort duty in third party insurance cases, that being the duty stated in *Stowers.* The court rejected a more expansive reading of the *Stowers* duty to include negligent claims handling.

### D. Unfair Insurance Practices, Deceptive Trade Practices & Unconscionable Conduct

An insurer was properly found liable for misrepresentations, nondisclosures, and unconscionable conduct by misrepresenting that its agent was "a good man" and that the insured should continue sending his premiums to the agent, even though the insurer had withdrawn the agent's authority. It turned out the agent had been pocketing the premiums so that no renewal policy was issued to the insured, and the agent had a history of 366 fraud complaints filed against him. The insurer's misrepresentations about the agent made the insurer liable, apart from any vicarious liability for conduct of the agent. *Stumph v. Dallas Fire Ins. Co.*, 34 S.W.3d 722 (Tex. App.–Austin 2000, no pet.). The insurer thus could be liable for defense costs and liability payments made by the insured to resolve a claim that would have been covered under the policy.

Because a liability policy did not cover an alleged advertising injury, the insured had no claim based on

the insurer's refusal to defend. However, the absence of liability on the contract did not resolve the question of the insurer's possible liability for misrepresentations. *Southstar Corp. v. St. Paul's Surplus Lines Ins. Co.*, 42 S.W.3d 187 (Tex. App.–Corpus Christi 2001, no pet.).

### E. Prompt Payment of Claims – Article 21.55

If an insurer breaches its duty to defend, the claim for defense costs becomes a first-party claim, and the statutory penalty under article 21.55 will apply. *E&R Rubalcava Const., Inc. v. Burlington Ins. Co.*, 148 F. Supp. 2d 746 (N.D. Tex. 2001).

### F. Other Theories

In *DeLeon v. Lloyd's London*, 259 F.3d 344 (5th Cir. 2001), the estate of a deceased employee brought a breach of contract action against a life insurer for policy proceeds paid to the employer. The estate sought to recover policy proceeds on the basis that the employer did not have an insurable interest in the employee's life. After the estate filed suit, the court stayed the action pending a resolution of a case in state court involving virtually the same dependents.

When the state court action was decided, the district court lifted the stay. The estate then argued that the insurer was collaterally estopped from arguing that the employer was the lawful beneficiary of the policy. The insurer argued that the earlier state court decision lacked preclusive effect for two reasons. First, the earlier decision was not a final judgment. Second, the estate's "wait and see" attitude ought to bar resort to this equitable doctrine.

In rejecting the first argument, the court found that the conclusions in the first case were procedurally definite and were the final word of that court on the matter. Moreover, the court's conclusions were well-reasoned and the parties were fully heard. As for the second argument, the insurer failed to identify any specific dilatory tactics on the part of the estate. Thus, the court concluded the insurer was collaterally estopped from trying to litigate issues essential to the earlier state court decision.

## VIII. SUITS BY INSURERS

### A. Reimbursement

In a case of first impression, the Texas Supreme Court held that an insurer may not obtain reimbursement from its insured for an amount paid to settle a claim that is later determined to be excluded from coverage. *Texas Ass'n of Counties Gov't Risk Mgmt Pool v. Matagorda Co.*, 52 S.W.3d 128 (Tex. 2000). TAC acted as insurer for Matagorda County and defended a suit under a reservation of rights. The plaintiffs offered to settle for $300,000. The insurer sent another letter saying it would settle the case but was not waiving any claim for reimbursement, based on its assertion that the claim was not covered.

The supreme court held that the insurance policy did not give TAC the right to reimbursement, and the court was not willing to imply any such right based on equitable principals. The court reasoned that TAC's second reservation letter was simply a unilateral offer to append a reimbursement provision on to the insurance contract and was not binding on Matagorda County.

The court reasoned that allowing such unilateral amendments would allow insurers to extract coercive arrangements from their insureds. The court found that an insured would be forced to choose between rejecting a settlement within policy limits or accepting a possible financial obligation to pay an amount that may be beyond its means at a time when the insured was most vulnerable. The court concluded that insurers have the ability to seek a quick determination of coverage in a declaratory judgment suit, and insurers are better able to either draft policies that specifically provide for reimbursement or to account for the possibility they may occasionally pay uncovered claims by adjusting their rates.

## IX. DAMAGES & OTHER ELEMENTS OF RECOVERY

### A. Policy Benefits

In *Colonial County Mut. Ins. Co. v. Valdez*, 30 S.W.3d 514 (Tex. App.–Corpus Christi 2000, no pet.), the court held that an insured was entitled to "benefit of the bargain" damages when he learned that his son's stolen vehicle was excluded from coverage, but had been misled to think the loss would be covered. The court allowed recovery of the value of the vehicle.

### B. Mental Anguish

In *Colonial County Mut. Ins. Co. v. Valdez*, 30 S.W.3d 514 (Tex. App.–Corpus Christi 2000, no pet.), the court found sufficient evidence to support the jury's award of $20,000 in mental anguish damages. The insured sold his car to his son. The car was then stolen. The insurer denied the claim, because the father no longer had an insurable interest in the car. The court held the mental anguish award was supported by testimony from the insured that he felt deceived, "very mad," and powerless, and he said the claim denial affected his health in the form of high blood pressure and sleeping disorders.

In another case, the evidence was sufficient to support the jury's award of damages to the insured for physical pain and suffering and mental anguish resulting from the insurer's delay in paying the excess amount of a judgment against an underinsured motorist. The evidence showed that while the insurer appealed that judgment unsuccessfully, the insured had to delay necessary surgery for his back injuries and was in constant pain. *Mid-Century Ins. Co. v. Boyte*, 49 S.W.3d 408 (Tex. App.–Fort Worth 2001, no pet.).

### C. Statutory Penalties

In *DeLeon v. Lloyd's London*, 259 F.3d 344 (5th Cir. 2001), the court concluded that the estate of an employee could not bring a claim against an insurer on an accidental death policy when the named beneficiary of the policy was the employer. The court observed that a claim under article 21.55 was only triggered by filing a first party claim. While article 21.55 is to be liberally construed, the estate was not the named beneficiary of the policy. Because the court rejected the estate's argument to reform the policy to place the estate in the position of the policy's beneficiary, the court also rejected the estate's claim that the insurer violated article 21.55.

### D. Exemplary Damages

In a case involving federally underwritten flood insurance, the court held that a prevailing plaintiff cannot recover exemplary damages or statutory penalties. In finding that exemplary damages were unnecessary, the court reasoned that a private insurer does not have pecuniary incentive to deny a claim, because any claim is paid by the federal government. ***Jamal v. Travelers Lloyds of Tex. Ins. Co.***, 129 F. Supp. 2d 1024 (S.D. Tex. 2001).

### E. Prejudgment & Postjudgment Interest

A state employee seeking benefits under the Employee Retirement System was not entitled to prejudgment interest. In a case where ERS finally paid a claim after denying it for seven years, the court denied prejudgment interest. The court reasoned that article 3.50-2 of the Insurance Code vests with the executive director of ERS the exclusive authority to decide "all questions relating to enrollment and/or payment of claims arising from programs or coverages provided under authority of this act." Because the statute does not grant prejudgment interest, the court concluded that the ERS has discretion to not allow interest. ***Perkins v. Group Life & Health Ins. Co.***, 49 S.W.3d 503 (Tex. App.–Austin 2001, pet. filed).

In ***Harkin Exploration Co. v. Sphere Drake Ins.,*** 261 F.3d 466 (5th Cir. 2001), the court held that when the insurance policy did not establish a prejudgment interest amount, the appropriate rate was 10%.

In a case involving federally underwritten flood insurance, the court held that the prevailing plaintiff may recover prejudgment interest. Under the federal program, the amount of damages is based upon the readily ascertainable value of services and property. Accordingly, fair compensation to the plaintiff can only be accomplished by including an award of prejudgment interest. ***Jamal v. Travelers Lloyds of Tex. Ins. Co.***, 129 F. Supp.2d 1024 (S.D. Tex. 2001).

### F. Attorney's Fees

In ***Colonial County Mut. Ins. Co. v. Valdez***, 30 S.W.3d. 514 (Tex. App.–Corpus Christi 2000, no pet.), the court held that an insured in a suit for unfair insurance practices could properly recover attorney's fees he incurred in defending a declaratory judgment suit filed by the insurer. The court reasoned that if the insurer had not misrepresented coverage, the declaratory judgment lawsuit would not have been necessary.

An attorney's fees award was supported by testimony from the attorney regarding the time and labor required, the fee customarily charged, the nature and length of the professional relationship, the amount involved and the results obtained, and the experience, reputation, and ability of the lawyer. The insured was not required to segregate attorney's fees where the claims were so interrelated that they required proof of the same facts. ***Mid-Century Ins. Co. v. Boyte***, 49 S.W.3d 408 (Tex. App.–Fort Worth 2001, no pet. h.).

In ***North Winds Abatement, Inc. v. Employers Ins. of Wausau***, 258 F.3d 345 (5th Cir. 2001), a servicing company attacked an award of attorney's fees, alleging insufficient evidence to support the award of a fixed rate fee. The servicing company attempted to limit attorney's fees to those established by the contingency fee contract. This amount would have been considerably less than the fixed rate, hourly fee award. The court found this argument meritless, noting that under Texas law a fact finder must award attorney's fees as a dollar amount.

Next, the servicing company attacked the award of $712,000 in attorney's fees as excessive. The court held the most critical factor in determining an award of attorney's fees is the "degree of success obtained" by the victorious plaintiff. The requested fees must bear a reasonable relationship to the amount in controversy and the complexity of the case. In this case, the award of attorney's fee was more than nine times the actual damages. Such disparity alone does not render the fee award excessive. The court noted that the attorneys were not very successful in this suit, with the actual damages awarded being a tiny fraction of the multimillion dollar recovery sought. The only part where the employer succeeded was in convincing the jury to award the full amount of fees. On the other hand, this was a complex case, involving two separate appeals, pursuit of administrative remedies, and a full trial. The court sustained the fee award.

In ***Jamal v. Travelers Lloyds of Tex. Ins. Co.,*** 129 F. Supp. 2d 1024 (S.D. Tex. 2001), the court held that prevailing plaintiffs cannot recover attorney's fees under state law for breach of contract claims relating to a Standard Flood Insurance Policy. The court further rejected the argument that attorney's fees were recoverable based on equitable considerations pursuant to federal common law. The court reasoned that a prohibition against such an award of attorney's fees serves to reduce the cost to the federal government of operating these insurance programs.

### G. Costs

A product seller was entitled to indemnity from the product manufacturer for its attorney's fees incurred in defending a lawsuit, even though those fees were paid by the seller's insurer. The court held that the collateral source rule applied so that the seller incurred the fees and expenses even though they were paid by the seller's insurer. The court did conclude that the seller was the proper party to recover judgment against the manufacturer for those fees, not the seller's insurer. ***Graco, Inc. v. CRC, Inc. of Tex.***, 47 S.W.3d 742 (Tex. App.–Dallas 2001, pet. denied).

In a case where the court concluded that the insurer has a duty to defend the insured, the insurer argued that the award of costs was too high and that there was not sufficient documentation to justify the award. ***Harkin Exploration Co. v. Sphere Drake Ins.***, 261 F.3d 466 (5th Cir. 2001). In rejecting this argument, the court noted that the lower court granted summary judgment sua sponte in favor of the insured on the duty to defend and awarded damages. Because the insurer did not come forward with contrary evidence opposing the award of costs, the court concluded that the award was proper.

## X. DEFENSES & COUNTERCLAIMS

### A. Arson

The trial court did not err in excluding evidence of three prior fires involving the insured, in a case where

the insurer alleged arson. *Allstate Tex. Lloyds v. Potter*, 30 S.W.3d 658 (Tex. App.–Texarkana 2000, no pet.). Allstate argued that the prior fires showed a continuing scheme by Potter to commit insurance fraud, because she was the last person at each scene and stood to gain financially each time.

The court noted that the first fire took place at the home of Potter's mother and was twenty years before the fire in this suit. The other two fires occurred a year before the fire in question, but there was no evidence of any wrongdoing by Potter, and they weren't shown to have been the result of arson. The court reasoned that it would not be unusual for Potter to be the last person present before a fire at property she owned, nor would it be unusual for her to gain financially from insurance proceeds, if she were the insured. Thus, the trial court did not abuse its discretion by excluding the evidence, because introduction of the evidence would have caused unfair prejudice to Potter.

### B. Breach of Policy Condition by Insured

An insured's failure to sign and return the transcript of his examination under oath gave the insurer a contractual basis for denying his claim and precluded liability for bad faith. *Perrotta v. Farmers Ins. Exch.*, 47 S.W.3d 569 (Tex. App.–Houston [1st Dist.] 2001, no pet.). Because the insurer had repeatedly called the failure to the insured's attention and because the insured offered no reason for failing to sign and return the examination under oath, the court found the contractual requirement was valid and enforceable.

In a case involving a general contractor's claim for indemnity, the insurer argued that it was prejudiced by the contractor's failure to give it notice of an earlier lawsuit. *Ins. Co. of N. Am. v. McCarthy Bros. Co.*, 123 F. Supp. 2d 373 (S.D. Tex. 2000). Principally, the insurer contended that the general contractor settled the first lawsuit without the insurer's consent. The court concluded that the insurer had to prove that it was prejudiced. Only a material breach of a contract excuses performance. The insurer suggested that it was prejudiced per se by the insured's settlement of the earlier lawsuit. However, the mere fact that the insurer might now owe money it did not wish to pay did not constitute prejudice as a matter of law. The insurer provided no other evidence of prejudice.

### C. Limitations

An insured's suit under a homeowner's policy for damages caused by a plumbing leak was barred by limitations where suit was filed more than two years after the insurer closed its claim file. The court rejected the insured's argument that limitations was tolled because the insurer never said whether the claim had been rejected. The court reasoned that closing the file unambiguously indicated that the insurer intended not to pay the claim. This constituted the "legal injury" that began limitations running. The court rejected the insured's reliance on the footnote in *Murray v. San Jacinto Agency, Inc.*, 800 S.W. 2d 826, 828 n 2 (Tex. 1990), where the supreme court said there may be a fact issue on limitations when there is no outright denial of the claim, if the insurer strings the insured along. The court of appeals found no evidence that the insurer did anything to string along the insured. The parties did not communicate with each other after the file was closed. *Kuzniar v. State Farm Lloyds*, 52 S.W.3d 759 (Tex. App.–San Antonio 2001 no pet. h.).

In a suit brought by an insurer against a psychiatric hospital for RICO violations, the hospital claimed the suit was barred by limitations. *Love v. Nat'l Med. Enter.*, 230 F.3d 765 (5th Cir. 2000). The insurer alleged that the hospital's scheme to defraud was not a "continuing violation" but a new and independent claim accruing with each submission of fraudulent insurance claims. The hospital argued that in 1991, outside of limitations, the insurer knew or should have known the facts forming the basis of the claims. Because the insurer had not shown any conduct within the limitations period that was distinguishable from the conduct outside, the hospital argued that all of the insurer's claims should be barred.

The court rejected the hospital's arguments, adopting instead the "separate accrual" rule, which allowed recovery for each injury caused by the commission of a separate predicate act within limitations. The court concluded that each time the insurer became obligated to pay a fraudulent insurance claim submitted by the hospital, a separate RICO injury accrued. Thus, had the insurer filed suit in 1991, when the hospital asserted the insurer knew or should have known of the alleged fraudulent scheme, the insurer could not recover damages for the future fraudulent insurance claims.

Finally, the court addressed whether the limitations periods were tolled by fraudulent concealment. Under the theory of fraudulent concealment, limitations is tolled until the plaintiff discovers, or with reasonable diligence should have discovered, the concealed fraud. After reviewing the summary judgment evidence, the court concluded that an issue of material fact existed as whether the insurer exercised reasonable diligence in determining whether it was a victim of fraudulent conduct.

### D. Misrepresentation or Fraud by the Isured

The evidence was sufficient to convict an insured of criminal fraud in filing a false claim, but the State failed to offer sufficient proof of the amount fraudulently claimed. Therefore, the insured could only be guilty of a misdemeanor, not a felony. *Logan v. State*, 48 S.W.3d 296 (Tex. App.–Texarkana 2001, no pet.). The evidence showed that Logan obtained a fire policy five days before her house burned. Afterwards, she submitted an inventory listing items with a replacement cost of $180,000. Investigators found in her rent house many of the items she claimed were lost in the fire. The court found sufficient evidence to support Logan's conviction for fraud.

One point of disagreement was whether the State had to prove the amounts of the items fraudulently claimed or whether it was enough to show the total amount claimed. The court reasoned that in many cases the two amounts will be the same. For example, when a claim is entirely bogus, the amount claimed and the amount fraudulently claimed will be the same. In this case, only a portion of the items claimed as lost in the fire were found to exist. There was evidence supporting the value of only a few of these items. The court held that the State had the burden of proving the

value of the items fraudulently claimed. Otherwise, an insured could be convicted of feloniously filing a $200,000 claim, even though only $20 was fraudulent. Because there was not sufficient evidence to support the higher amounts in this case, the insured's conviction was reduced to a misdemeanor.

**E. Bankruptcy**

A judgment rendered while a bankruptcy stay was in place was void even though the trial court was unaware of the bankruptcy stay. Further, the bankruptcy court order lifting the stay did not validate the void judgment. However, the bankruptcy court's order was not res judicata determining the validity of the judgment in the state court, either. *In re Sensitive Care, Inc.*, 28 S.W.3d 35 (Tex. App.–Fort Worth 2000, no pet.).

**F. ERISA Preemption**

A former independent sales representative brought a state court breach of contract and bad faith suit against two disability insurers based upon the termination of benefits under two policies. One of the policies was paid for by the employer, with that insurer asserting ERISA preemption. The Fifth Circuit held that the policy was covered by ERISA. The court rejected the insured's argument that this policy was not part of an ERISA plan because he picked the insurance provider. The court held that the insured was a "beneficiary" within the scope of ERISA, even if he was an independent contractor.

The court also rejected the insured's argument that a beneficiary is limited to people such as the worker's spouse and children. The court reasoned that accepting this argument would create the anomaly where some insureds could pursue claims under state law while others covered by an identical policy would have to proceed under ERISA. This result would frustrate the intent of achieving uniformity in the law governing employment benefits. *Hollis v. Provident Life & Accident Ins. Co.*, 259 F.3d 410 (5th Cir. 2001).

In *Armstrong v. Columbia/HCA Health-Care Corp.*, 122 F. Supp. 2d 739 (S.D. Tex. 2000), an employee took out a life insurance policy on her co-employee husband. When her husband died, the employer informed the employee that she had impermissibly insured her husband in contravention of a plan rule prohibiting one employee for purchasing dependent life insurance coverage for another employee. The employer thus denied her claim. When the employee sued for deceptive and unfair practices, the defendants removed the case to federal court, asserting ERISA preemption.

In finding that the employee's claims were preempted by ERISA, the court first rejected the employee's argument that the spousal life insurance program was not itself a benefit plan. The court held that a reasonable person could ascertain that life insurance benefits in a particular dollar amount were available, that the employee was the intended beneficiary, that the spousal benefits were to be paid by payroll deductions, and that a specific claims procedure existed.

The court next rejected the employee's argument that the plan came within the "safe harbor" and thus must be exempt from ERISA. While noting that the employee opted to insure her husband, and that the employee paid for this protection with payroll deductions, the court concluded that the employer paid for the cost of insurance on the employee's life. Only by accepting the insurance paid for by the employer could the employee then choose to either increase her own coverage or insure the lives of her dependents. Because the dependent coverage could not be severed from the remainder of the life benefits package, the court concluded that the plan failed to satisfy the first criteria of the ERISA "safe harbor."

Next, the court examined the employer's role in the benefits plan. The court concluded that the employer's role was more than merely collecting premiums and remitting them to the insurer. The employer paid for the employee's personal life insurance with the potential benefit equal to the employee's salary. Moreover, the life insurance benefit was incorporated in the employee's flexible benefits plan, which is sponsored and administered by the employer. Thus, the plan also fails the third "safe harbor" criteria.

The employee then contended that because the employer failed to comply with the federal regulations concerning the plans claim procedures, the employer was ineligible for the protection of ERISA. The court noted that even if the employee were correct, the employee cited no authority suggesting that a failure to comply with the prescribed claims procedures eliminates ERISA protection.

**Most often, the determination that the defendant plan is an ERISA plan is tantamount to a determination that the state law causes of action are barred.**

The court then asked whether the plaintiff's claims related to an ERISA plan. Most often, the determination that the defendant plan is an ERISA plan is tantamount to a determination that the state law causes of action are barred. Unfortunately, the court noted, this bar may often leave a victim of fraud or misrepresentation without a remedy. Because the plaintiff's claims related to denied benefits, the court concluded that the plaintiff's claims related to an ERISA plan and as such ordinary preemption applies.

In *Orthopaedic Surgery Assoc. of San Antonio, P.A. v. Prudential Health Care Plan, Inc.*, 147 F. Supp. 2d 595 (W.D. Tex. 2001), a group of doctors and their professional association entered into an agreement with Prudential that a specified sum of money be paid for each of the services the doctors rendered. While Prudential paid the plaintiffs for services rendered, they did not pay the agreed upon amount and short changed the physicians in their group on most, if not all the services that were provided. The doctors brought a breach of contract claim against Prudential, with Prudential removing the case to federal court based on ERISA preemption. In rejecting Prudential's claim, the court stated that the critical question for

the courts is whether the providers claim is based on a direct cause of action against the managed care company, in which case it is not preempted or whether it is derivative to the patient's cause of action, where ERISA applies. Because the doctors' claims in this case were derived from a separate provider agreement, the court concluded that their claims were not preempted by ERISA.

### G. Other Preemption

In *Hanlin v. United Parcel Serv.*, 132 F. Supp. 2d 503 (N.D. Tex. 2001), the plaintiff contracted with UPS to ship a welding machine. The machine was not shipped on time and was damaged during transit. The plaintiff brought suit against UPS claiming, among other things, that UPS fraudulently collected an insurance fee and operated as an insurance company without authorization, in violation of article 21.21-2 of the Texas Insurance Code.

UPS moved to dismiss plaintiff's claim arguing that his claims were preempted by the Carmack Amendment. That amendment governs the liability of carriers for goods lost or damaged during the interstate shipment of property, permitting a shipper to recover the actual loss or damage to property caused by any of the interstate carriers involved in the shipment. The court held that the Carmack Amendment superseded all state regulation regarding interstate carrier liability. Because the Carmack Amendment is the shipper's sole remedy for damages resulting from the loss of property shipped in interstate commerce by a carrier under a receipt or bill of lading, any claim for damages relating to the loss of property must be brought under the Carmack Amendment.

In this case, although the plaintiff alleged that his property was damaged in transit, he asserted no claim under the Carmack Amendment. Instead, plaintiff asserted a claim solely under the state common and statutory law. Because plaintiff only asserts claims under state law, such claims are preempted.

In a case involving federally underwritten flood insurance, the insurer asserted that the insured's state law claims were preempted by federal law. *Jamal v. Travelers Lloyds of Tex. Ins. Co.*, 129 F. Supp. 2d 1024 (S.D. Tex. 2001). The court noted that the case law clearly indicates that federal common and statutory law preempt state principles of contract law for purposes of interpretation of policies issued pursuant to the National Flood Insurance Act of 1968.

The court observed the Fifth Circuit case law provides that Standard Flood Insurance Policy contract and coverage disputes are governed exclusively by federal law. By contrast, actions complaining of misrepresentations made to induce the purchase of insurance do not constitute "coverage" disputes, thus state law tort claims for fraud and misrepresentation are not preempted. Accordingly, the court rejected the insured's claim for breach of the duty of good faith and fair dealing, classifying them as claims-handling or "coverage" claims that are preempted by federal law. The court also rejected the insured's claims under the Texas Insurance Code that related to the claims handling process.

In *Halfmann v. USAG Ins. Servs., Inc.*, 118 F. Supp. 2d 714 (N.D. Tex. 2000), the insured experienced a loss on a policy issued under the Federal Crop Insurance Act. When the insured's case was removed to federal court, the court concluded that no federal question exists and that the state law claims were not completely preempted.

### H. Res Judicata & Collateral Estoppel

Miller was involved in a car wreck with an underinsured motorist. Miller's insurer was State & County Mutual, which was reinsured by Windsor. Miller asserted he was owed $300,000; Windsor offered only $100,000 and filed a declaratory judgment suit. In that suit, the court concluded that Windsor owed only $100,000.

Miller had filed a second suit against State & County alleging various theories, such as delay in payment and DTPA violations. The issue was the extent to which the first suit barred litigation of the issues in the second suit. In *State & County Mut. Fire Ins. Co. v. Miller*, ___ S.W.3d ___ , No. 99-0501, 2001 Tex. LEXIS 2 at *5 (Tex. 2001), the court held the prior suit was not res judicata as to any issues in the second suit. In the first suit State & County and Miller were co-parties rather than opposing parties. Thus, Miller was not required to raise any issues as compulsory counterclaims because no cross-actions have been filed between them.

The court also held the first suit collaterally estopped Miller from litigating only issues that were identical. Miller's rights against the reinsurer were derivative of State & County Mutual's, so to the extent the obligations under the policy were litigated in the first suit, Miller was collaterally estopped from relitigating them. However, Miller was entitled to pursue his extracontractual claims against State & County Mutual that related to misrepresentations in issuing the policy and handling his claim.

An insured was judicially estopped from taking a position in a lawsuit that was different from a position that had been taken in bankruptcy court. The insured had a bond with Ranger, which was supported by a letter of credit. After the insured filed for bankruptcy protection, Ranger collected premiums that were due by drawing on the letter of credit. The insured successfully objected to Ranger's claim in bankruptcy court by arguing that Ranger was already satisfied by the draw on the letter of credit. The court held this judicially estopped the insured from ascertaining in a separate lawsuit that Ranger was not entitled to draw on the letter of credit. *Zipp Indus., Inc. v. Ranger Ins. Co.*, 39 S.W.3d 658 (Tex. App.–Amarillo 2001, no pet.).

### I. Other Defenses

In a case involving the federally underwritten flood insurance, the insurer defended on the grounds that the insured failed to comply with the proof of loss requirement in the policy. *Jamal v. Travelers Lloyds of Tex. Ins. Co.*, 131 F. Supp. 2d 910 (S.D. Tex. 2001). The policy required that proof of loss be submitted within sixty days of the loss. The insured submitted a proof of loss almost eight months after the loss. In granting summary judgment based on this defense, the court noted that because flood losses are paid out of the National Flood Insurance Fund, a claimant under this

program must strictly comply with the terms and conditions that Congress has established for payment. Congress, through a valid act of delegation to FEMA has authorized payment of flood insurance funds to only those claimants that submit a timely sworn proof of loss. The sixty days sworn proof of loss requirement is a condition precedent to payment for which all claimants are strictly accountable. An insured's failure to provide a complete sworn proof of loss statement, as required by the flood insurance policy, relieves the federal insurers obligation to pay what otherwise might be a valid claim.

## XI. PRACTICE & PROCEDURE

### A. Choice of Law

A Texas class action against State Farm for failing to pay dividends, despite huge surpluses, was governed by Texas law, not Illinois law. But even if Illinois law applied, the court concluded that it did not limit enforcement of contract rights to a suit by the Illinois director of insurance. Therefore, the Texas trial court had jurisdiction over the suit. *State Farm Mut. Auto. Ins. Co. v. Lopez*, 45 S.W.3d 182 (Tex. App.–Corpus Christi 2001, no pet.).

### B. Jurisdiction

Ordinarily, Texas jurisdiction is determined by looking to the plaintiff's well pleaded complaint and ascertaining whether or not it raises issues of federal law. *Armstrong v. Columbia/HCA HealthCare Corp.,* 122 F. Supp. 2d 739 (S.D. Tex. 2000). A defendant typically cannot invoke federal jurisdiction by asserting a federal defense to a plaintiff's cause of action. However, ERISA provides an exception to this rule. Concluding that all of the plaintiff's claims were cognizable under the ERISA civil enforcement provision, the court held that it had federal question jurisdiction.

In a case involving federally backed crop insurance, the court concluded that incidental federal issues are not sufficient to grant federal jurisdiction. *Halfmann v. USAG Ins. Serv., Inc*., 118 F. Supp. 2d 714 (N.D. Tex. 2000). Removal cannot be based simply on the fact that federal law may be referred to in some context in the case. If the claim does not "arise under" federal law it is not removable on federal questions grounds. The court concluded that the federal requirements applicable to the policies were not so substantial that the claims could be said to "arise under" federal law.

### C. Venue

Venue was proper in Cameron County, where the insured purchased his insurance, the alleged misrepresentations were made, the car was stolen, and the insured made his claim there. *Colonial Co. Mut. Ins. Co. v. Valdez*, 30 S.W.3d. 514 (Tex. App.–Corpus Christi 2000, no pet.).

### D. Experts

An internist was qualified to testify about the insured's cause of death, even though he was not a pathologist. The internist had experience in observing cardiac problems, which the insured was alleged to have, and he was aware of the effects those cardiac problems would have on a person. He thus could testify as an expert that the insured's ability to escape from a submerged vehicle was inconsistent with death caused by those conditions. *J.C. Penny Life Ins. Co. v. Baker*, 33 S.W.3d 417 (Tex. App.–Fort Worth, 2000, no pet.).

Where the term "formation" in an oil and gas policy was a specialized term, a petroleum engineer was competent to testify about the meaning of the term, based on his extensive education and experience in the oil and gas industry. The expert offered a reasonable construction of the term, which made the policy ambiguous. *Mescalero Energy, Inc. v. Underwriters Indem. Gen. Agency, Inc.*, ___ S.W.3d ___, No. 01-96-01590-CV, 2001 Tex. App. LEXIS 6352 at *31 (Tex. App.–Houston [1st Dist.], Aug. 31, 2001, no pet. h.).

### E. Class Actions

In a class action against State Farm for failing to pay dividends to its policyholders, despite record surpluses, the court of appeals affirmed the trial court's order certifying the class. The court of appeals held that the claims of the class members were typical of the class claims. The plaintiffs alleged that State Farm breached its contract and committed fraud by promising dividends and then failing to pay a fair amount. While State Farm attacked the merits of the claim, the court of appeals held that determining typicality does not require the trial court to determine the merits of the suit. The court concluded that the claims of the class representatives were essentially identical and were based on virtually identical language in each class member's policy, and the same actions of the company in setting its rates so as not to declare a dividend and then failing to declare a dividend or declaring an adequate dividend. *State Farm Mut. Auto. Ins. Co. v. Lopez*, 45 S.W.3d. 182, 192 (Tex. App.–Corpus Christi 2001, no pet.).

The *Lopez* court also found that the class representatives would adequately represent the interests of the class. The court rejected State Farm's argument that the interests of present and past policyholders were antagonistic since past policyholders would want a large dividend, while current policyholders would prefer a larger corporate surplus to cover claims. The court concluded this was not a conflict that went to the subject matter of the litigation and thus would not defeat the adequacy of the representation.

**The *Lopez* court also found that the class representatives would adequately represent the interests of the class.**

### F. Mediation

A trial court could properly order an insurance company representative to appear for a deposition to answer whether he had left a mediation without the mediator's permission as a possible basis for being held in contempt of the trial court's order sending the parties to mediation. *In re Daley*, 29 S.W.3d 915 (Tex. App.–Beaumont 2000, no pet.).

In another case, the court of appeals found the trial court abused its discretion by conducting a hearing at which an insurance adjuster was questioned about her

conduct at mediation as a possible basis for sanctions or contempt. The court of appeals held the trial court acted improperly by failing to give written notice of the possible basis for contempt or sanctions. Further, the trial court had no authority to order the parties to negotiate in good faith, so any inquiry into whether the adjuster had done so was improper. Finally, the adjuster testified that she complied with the trial court's order to appear with full authority to offer policy limits. *In re Acceptance Ins. Co.*, 33 S.W.3d 443 (Tex. App.–Fort Worth 2000, no pet.).

### G. Motions for Summary Judgment

A trial court did not abuse its discretion by refusing to grant a continuance to give the insured more time to respond to the insurer's motion for summary judgment. The court held that a plaintiff is expected to have investigated his own case prior to filing suit. The claim was denied a year and a half before the insured filed suit, the suit was pending for seven months, and the trial court had already denied an agreed motion for continuance, which gave the insured some indication his motion would not be granted. *Perrotta v. Farmers Ins. Exch.*, 47 S.W.3d 569 (Tex. App.–Houston [1st Dist.] 2001, no pet.).

### H. Burden of Proof

The Austin Court of Appeals recognized that its prior decision on the burden of proof was wrong, but concluded that the claimant lost anyway. In *Nobles v. Employees Ret. Sys. of Tex.*, ___ S.W.3d ___, No. 03-00-00769, 2001 Tex. App. LEXIS 4997 at *22-23 (Tex. App.–Austin, July 26, 2001, no pet. h.), the court considered a claim under a life insurance policy issued through the ERS and whether the loss was excluded by the felonious activity exclusion. Nobles and McGarver both died in a wreck involving Nobles' truck. Both were legally intoxicated. If Nobles was the driver, his widow would not be entitled to additional life insurance benefits, because his drunk driving, which caused McGarver's death counted as felonious activity within the exclusion period. On the other hand, if McGarver was the driver, then Nobles was guilty of no crime by riding around drunk.

**The Austin Court of Appeals recognized that its prior decision on the burden of proof was wrong, but concluded that the claimant lost anyway.**

ERS denied the claim, and the administrative law judge affirmed, finding that Nobles was the driver. As an initial matter, the widow complained that the ALJ misapplied the burden of proof. Relying on the earlier decision in *Employee's Ret. Sys. v. Cash*, 906 S.W. 2d 204 (Tex. App.–Austin 1995, writ denied), the ALJ held it was the insured's burden to negate the exclusion. The court of appeals recognized that *Cash* was in conflict with article 21.58 of the Insurance Code, which imposes on the insurer the burden of pleading and proving any exclusion. The court also held that article 21.58 applies to ERS, in the absence of any specific agency rule to the contrary. Nevertheless, the court found the ALJ's decision was not affected by misplacing the burden of proof, because the ALJ affirmatively found that Nobles was driving. Although the evidence was conflicting, there was substantial evidence, the court found, to support that finding.

## XII. OTHER ISSUES

### A. Excess & Primary Coverage

An excess policy did not cover defense costs, even though the primary policy did. Thus, settlements by the primary insurer that included defense costs did not erode the primary insurers limits enough to require the excess insurer to drop down and provide coverage. *Westchester Fire Ins. Co. v. Stewart & Stevenson Serv., Inc.*, 31 S.W.3d 654 (Tex. App.–Houston [1st Dist] 2000, no pet.).

### B. Subrogation

There was a material fact question whether a contractors work was performed under an agreement that waived any subrogation rights or whether it was done under a separate contract that did not. The court found some evidence to support the argument that there was a separate contract that did not waive subrogation and thus reversed summary judgment against the insurer and remanded for trial. *Eslon Thermoplastics v. Dynamic Sys., Inc.*, 49 S.W.3d 891 (Tex. App.–Austin 2001, no pet.).

### C. Reinsurance

A conservation order enjoining suits against the primary insurer did not preclude a suit going forward against a reinsurer. *In re Liberty Mut. Ins. Co.*, 24 S.W.3d 637 (Tex. App.–Texarkana, 2000, no pet.). The court reasoned that any concerns about preserving the assets of the insurer in conservation did not apply to a direct suit against the reinsurer based on its own contractual liability.

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