Annual Survey of Texas Insurance Law

By Mark L. Kincaid & Elizabeth R. von Kreisler*

I. Introduction

The biggest case this term was the decision of the Texas Supreme Court in *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, No. 05-0832, 2007 WL 2459193 (Tex. Aug. 31, 2007). The court held that a liability insurer had to defend a homebuilder in a suit alleging bad construction. The court also held that a liability insurer's failure to defend would trigger penalties under the prompt payment of claims statute, which applies to "first party" claims.

In another important case construing the duties of uninsured motorist insurers, the court held they must pay prejudgment interest the tortfeasor would owe, but the insurer is not liable for attorney's fees or penalties unless the insurer fails to pay after the insured obtains a judgment establishing the uninsured motorist's liability. *Brainard v. Trinity Universal Insurance Co.*, 216 S.W.3d 809 (Tex. 2006).

The supreme court gave health insurers a significant benefit in *Fortis Benefits v. Cantu*, 234 S.W.3d 642 (Tex. 2007), holding that the insurer could recover benefits from the insured's tort recovery, even if the insured was not made whole.

II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile Insurance

In *Brainard v. Trinity Universal Insurance Co.*, 216 S.W.3d 809, 812-15 (Tex. 2006), the supreme court held that underinsured motorist coverage includes prejudgment interest that the underinsured motorist would owe. The court found that the purpose of prejudgment interest damages to compensate the injured party was consistent with the statutory purpose mandating UIM coverage. The court rejected the insurer's argument that contract and statutory language requiring that the insurer pay damages "because of bodily injury or property damage" did not encompass prejudgment interest. The court reasoned that such a narrow reconstruction would be inconsistent with the purpose of the statute to protect conscientious motorists from financial loss caused by negligent, financially irresponsible motorists.

The *Brainard* court distinguished its earlier decision in *Henson v. Southern Farm Bureau Cas. Ins. Co.*, 17 S.W.3d 652 (Tex. 2000). *Henson* addressed whether an insurer that promptly paid UM benefits owed prejudgment interest on those benefits. The *Henson* court concluded that there was no breach of the insurance contract, so the insurer was not liable for prejudgment interest. That was a different issue from whether the insurer owed prejudgment interest as part of the benefits that would be owed by the negligent driver.

The court then turned to the issue of how to calculate prejudgment interest. Four events affected this calculation. First, the plaintiffs recovered $5,000 in PIP benefits from their insurer. Second, after some delay, they recovered $1 million – the policy limits from the other driver's insurer. Third, the plaintiffs' insurer offered $50,000. Fourth, the jury awarded a net additional

amount of $5,000 in damages.

The plaintiffs argued that prejudgment interest should accrue on the entire $1,010,000. However, the court agreed with the insurer's argument that it was entitled to credits for the payments the plaintiffs already received. The court held that each payment would first reduce accrued prejudgment interest up to that point and then reduce the amount of principal that would continue to accrue prejudgment interest. Further, the insurer's offer, which exceeded the plaintiff's recovery, also stopped the accrual of prejudgment interest.

The final issue the *Brainard* court addressed was whether the plaintiffs seeking benefits under a UIM policy were also entitled to attorney's fees. The court recognized that an insured may recover attorney's fees in a successful breach of contract suit, but the court concluded that the insurer had not breached its contract. The UIM insurer was not obligated to pay damages until the trial court signed a judgment establishing the negligence and underinsured status of the other motorist. The court distinguished other insurance contracts where the insured is entitled to recover attorney's fees incurred in establishing the insurer's liability. The court concluded that there was no proper "presentment" of the claim prior to the judgment establishing the underinsured driver's liability. The early request for UIM benefits and filing of the suit did not trigger the insured's contractual duty to pay. *See also State Farm Mutual Auto Ins. Co. v. Nickerson*, 216 S.W.3d 823 (Tex. 2006).

The court's analysis leaves an analytical gap. The *Brainard* court recognizes that the insured may sue its UIM insurer to establish that the other driver was negligent and underinsured. However, the court also concludes that the insurer has not breached its contract by failing to pay those benefits before the time a judgment determines those issues. Thus, what theory is the plaintiff suing for? This would seem to be an appropriate instance to seek declaratory relief. The declaratory judgment statute allows a court to "declare rights, status, and other legal relations whether or not further relief is or could be claimed." Tex. Civ. Prac. & Rem. Code § 37.003. Furthermore, this statute provides: "A contract may be construed either before or after there has been a breach." § 37.004(b). Use of this statute provides a theoretical basis for the court to exercise jurisdiction, and it allows recovery of attorney's fees as provided in section 37.009. However, the statute might allow the insurer to seek its fees if the insured was unsuccessful.

The court applied its rulings in *Brainard* and reached another issue in *State Farm Mutual Automobile Ins. Co. v. Norris*, 216 S.W.3d 819 (Tex. 2006). In *Norris* the insured settled with the negligent driver for $40,000, which was $10,000 less than the driver's policy limit. A jury then found that the insured suffered damages of $51,200. The court held that the insured could recover prejudgment interest on the $40,000 up to the time it was paid and on the extra $1,200, but could not recover prejudgment interest on the $10,000 difference between the settlement and the driver's policy limits. The court found that the insured, by releasing that portion of his claim, also released any entitlement to prejudgment interest.

Following *Brainard*, a court of appeals held that an insurer did not owe attorney's fees or any penalty under the prompt payment statute where the insurer paid the claim two days after the judgment against the tortfeasor. *Mid-Century Ins. Co. v. Daniel*, 223 S.W.3d 586 (Tex. App.–Amarillo 2007, pet. denied).

A trial court committed reversible error by allowing an attorney for the insurer to falsely appear as attorney for an uninsured driver defendant in a suit brought by the insured. *Perez v. Kleinert*, 211 S.W.3d 468 (Tex. App.–Corpus Christi 2006, pet. filed). Perez was injured in a collision between Kleinert and Garza, while he was a passenger in Garza's car. Perez was insured by State Farm under a policy issued to persons who loaned the car to Garza. State Farm sued Garza and got a default judgment establishing that she had no coverage. When the case between Kleinert and Garza proceeded to trial, Garza was unrepresented. But an attorney for State Farm appeared, argued, and even examined witnesses in the role of attorney for Garza, even though he did not represent Garza and was representing State Farm. In addition, State Farm's attorney misrepresented to the jury that he represented Garza. The court of appeals found the trial court committed reversible error by allowing this, because of the conflict of interest it created with State Farm's primary duty to its insured, Perez.

The court relied on the supreme court's decision in *Allstate Insurance Co. v. Hunt*, 469 S.W.2d 151 (Tex. 1971), to hold that the insurance company had the burden to show no substantial conflict of interest with its insured, but had failed to do so. Relying on *Hunt*, the court further held that the proper way for State Farm to protect its interest against the uninsured motorist presenting an insubstantial defense or defaulting at trial would be to withhold consent to the suit between the uninsured and insured motorists.

In the *Hunt* case, the supreme court addressed the conflicts that arise when an insurer wants to defend an uninsured motorist to avoid having to pay, but simultaneously has a duty to defend its insured driver. In *Hunt*, the court was concerned about the conflict of interest between the insured driver's duty to cooperate with the insurer in his defense, and the insurer's competing desire to avoid liability for the uninsured driver. The insurer, and perhaps the uninsured driver, sought to avoid the prejudice of having the existence of insurance injected in the case.

In both *Perez* and *Hunt*, the courts concluded that the insurer may not overtly or covertly defend the uninsured driver, but in *Hunt*, the court pointed out that the insurer could defend its interest in a direct suit solely against the insurer.

In a case involving damage to an insured's parked car, the court held that the evidence was factually and legally sufficient to support a finding that the damage was caused by vandalism rather than a collision, thereby bringing the damage within the scope of coverage. *USAA County Mut. Ins. Co. v. Cook*, No. 01-06-00824-CV, 2007 WL 2332674 (Tex. App.–Houston [1st Dist.] Aug. 16, 2007, no pet.). An insured's car was parked in a parking lot and, when he returned, his car had been smashed in the front and moved fifteen feet away from its original place. There were no eyewitnesses. The insured had a comprehensive policy that covered vandalism, but did not have collision coverage. After the insurer denied coverage, the insured brought suit on various grounds. Because the policy did not define vandalism, the court interpreted it to mean damage caused by a deliberate – rather than a negligent – act. According to the court, the insured's testimony about the circumstances, including that the car had been moved, was sufficient to support the jury's finding that the damage was the result of a deliberate act and, hence, of vandalism.

A court held that insureds under an automobile insurance policy were not entitled to recover medical benefits from their insurer after they extinguished the insurer's right to subrogation by settlement with the third party. *Mendez v. Allstate Prop. & Cas. Ins. Co.*, 231 S.W.3d 581 (Tex. App.–Dallas 2007, no pet.). The policy required that the insureds refrain from any conduct after their loss that would prejudice the insurer's right to subrogation. According to the court, the policy did not condition this requirement on payment by the insurer. In settling their suit against the driver, the insureds executed general releases discharging the other driver from liability for any loss or claim arising out of the accident. The insureds then filed for medical benefits with their insurer. The court concluded that the insureds' settlement of their suit

prejudiced the insurer's right to subrogation in breach of the policy.

A mold assessment company's report was insufficient to create an issue of fact concerning the causes of damage in a house.

B. Homeowners Insurance

In *Crocker v. American National General Insurance Co.*, 211 S.W.3d 928 (Tex. App.–Dallas 2007, no pet.), the court held that the "surface waters" exclusion applied to damage from water that collected on an insureds' patio and then ran into their home. The court rejected the argument that surface water only included water that hit the ground, not water that hit a raised patio.

A mold assessment company's report was insufficient to create an issue of fact concerning the causes of damage in a house because the report did not purport to establish with certainty the actual causes of such damage. *Watson v. Allstate Tex. Lloyd's*, 224 F. App'x 335 (5th Cir. 2007). Accordingly, the engineer's report offered by the insurer was the only evidence on point, and the insurer was entitled to summary judgment.

The Fifth Circuit found that homeowners were not entitled to benefits under their homeowners insurance policy for fire damage because a vacancy clause applied and suspended coverage. *Barlow v. Allstate Texas Lloyds*, 214 F. App'x 435 (5th Cir. 2007) (per curiam).

Following the destruction of their homes by hurricane Katrina, plaintiffs sued their insurer and Xactware, the maker of Xactimate software, for antitrust violations, breach of contract, and fraud. Both defendants moved to dismiss all causes of action. *Schafer v. State Farm Fire & Cas. Co.*, No. 06-8262, 2007 WL 2388899 (E.D. La. 2007). The district court dismissed the antitrust claims as to both defendants because the plaintiffs failed to allege that the defendants had engaged in "economically irrational" activities. The court also dismissed the breach of contract claim as to Xactimate because the plaintiffs failed to rebut Xactimate's assertion that there was no contract between the parties. However, the court sustained the breach of contract claim as to the insurer. Finally, the court denied the defendants' motions to dismiss regarding fraud, finding that the plaintiffs had adequately alleged facts to support a fraud claim as to both defendants.

A court of appeals held that the manifestation trigger of coverage theory applies to a first-party claim made under a standard homeowners insurance policy based on continuing damage to the dwelling. In *Allstate Insurance Co. v. Hunter*, homeowners brought suit against their insurer after it denied their claim for mold damage discovered in their home. No. 2-07-027, 2007 WL 4126055 (Tex. App.–Fort Worth Nov. 21, 2007, no pet. h.). The homeowners detected a strange smell in their home. Months later, when the smell persisted, the homeowners had it investigated, but the results of the investigation were inconclusive. Around this time, their policy expired. Two months later, a general contractor discovered water damage and mold in the home, which was when the homeowners first learned of the mold damage. Shortly thereafter, the homeowners filed their claim with the insurer. The insurer denied the claim on grounds that the policy had expired several months earlier while the homeowners were aware of the smell but not its cause. Applying the manifestation trigger of coverage theory, the court found that the policy offered no coverage for the mold damage because the damage was not "easily perceived, recognized and understood" until after the policy expired. Furthermore, the court reasoned that even if the mold had manifested when the homeowners first detected the smell, they would be barred from coverage because they had delayed so many months in filing their claim.

C. Life Insurance

A life insurance company sought a declaratory judgment that a policy never took effect because of an alleged "good health" condition precedent. *Assurity Life Ins. Co. v. Grogan*, 480 F.3d 743 (5th Cir. 2007)[1]. The insured died of cancer, which he had at the time he applied for coverage, but which had not been diagnosed. The district court found the policy did not contain either a condition precedent or a warranty of good health that would have prevented the policy from taking effect. The district court found no misrepresentation by the insured and awarded policy benefits to the beneficiary.

Reversing, the Fifth Circuit found the policy contained a "good health" condition precedent and that the insured was not in good health at the time the first premium payment was made. Specifically, the court referred to language in a "Delivery Certificate" stating that, when the insured paid the first premium, "there ha[d] been no change in the good health of the Insured since the date of the application[.]" The court also referenced language in the insurance application that the policy "shall not take effect unless . . . [the] first full premium [is] paid during the Proposed Insured's lifetime and continued good health[.]" Reading these provisions together, the court determined that the policy contained a good health condition precedent. Furthermore, the court determined that the insured was not in good health because the insured had a lump on his neck at the time of the first payment – even though he was not diagnosed with Hodgkin's disease until months later.

The Fifth Circuit failed to address the equally likely reading of the language as a representation by the insured, rather than as a warranty or condition precedent. The court's reasoning conflicts with other case law. In *Riner v. Allstate*, 131 F.3d 530 (5th Cir. 1998), for example, the court found that policy language should not be construed to find a warranty or condition precedent unless the language allows no other construction.

The Fifth Circuit held that a life insurer proved the affirmative defense of suicide as a matter of law because the insured's wife witnessed the death and testified in deposition that she had no facts suggesting that the insured had slipped. *Needleman v. John Hancock Life Ins. Co.*, 204 F. App'x 373 (5th Cir. 2006).

The Fifth Circuit found the term "automobile" in a life insurance policy did not include all-terrain vehicles, because automobiles typically mean passenger vehicles and an ATV is not a passenger vehicle. *Smith v. Stonebridge Life Ins. Co.*, 217 F. App'x 360 (5th Cir. 2007).

The employer of an insured sued a life insurer that had paid the proceeds of the employee's policy to the employee's widow rather than the employer. *Rotating Services Indus., Inc. v. Harris*, No. 01-05-00874-CV, 2007 WL 1228482 (Tex. App.–Houston [1st Dist.] Apr. 26, 2007, pet. denied). The employer argued that it was entitled to the proceeds based on an earlier change-of-beneficiary designation and that the later one, which named the widow as beneficiary, was invalid. The court held the employer had no vested right in the proceeds and the earlier change-of-beneficiary designation that had purported to name the employer was ineffective because it was not signed by the original "irrevocable" beneficiary and thus was not in written form satisfactory to the insurer. Because the subsequent form naming the widow was signed by the original beneficiary, the court determined that the insurer's payment to the widow was proper.

A court of appeals held that the proceeds of a key man life insurance policy were payable to a "surviving company" after the policy's named beneficiary merged with the surviving company.

Allen v. United of Omaha Life Ins. Co., No. 2-06-187-CV, 2007 WL 1441007 (Tex. App.–Fort Worth May 17, 2007, pet. denied). The insured's employer took out a key man policy on the insured's life naming the employer as the beneficiary. Subsequently, the employer merged with another company, which became the surviving company. The policy was never modified to name a different beneficiary. After the insured died, the insurer paid the surviving company. The insured's widow then sued the insurer and its agent, contending that the proceeds should have been paid to the insured's estate because the named beneficiary no longer existed and because the surviving company had no insurable interest in the insured's life. The court found that the surviving company obtained the employer's right to the proceeds – whether characterized as a chose in action or as an expectancy – through the merger, which transferred all of the employer's assets and property interests to the surviving company. Also, the court found that the surviving company had an insurable interest in the insured's life because the insured himself signed the insurance application and designated that employer as the sole beneficiary. Thus the insurer properly paid the proceeds to the surviving company.

D. Disability Insurance

An employee sued her employer under ERISA to recover benefits from a long-term disability policy that had been offset by payments made under a business travel accident insurance policy. *Loggins v. Nortel Networks, Inc.*, 206 F. App'x 329 (5th Cir. 2006) (per curiam). Because both policies were employer-provided, the employee argued that the policies should be considered a single plan and single source of income, which would preclude offsets. The Fifth Circuit disagreed and held that the policy administrator could offset the employee's disability benefits by the amount she had received under the travel accident plan. The court found that, although the plans shared the same purpose of providing benefits to employees, they provided benefits in different situations and were, therefore, distinct policies and different sources of income, which justified the offsets.

An insured was not deemed physically disabled because medical reports submitted to the insurer indicated that the insured retained the physical ability to perform the duties of her occupation, even though she was approved for benefits under the mental illness provision of the policy. *Mills v. BMC Software, Inc.*, 205 F. App'x 297 (5th Cir. 2006) (per curiam).

E. Commercial Property Insurance

During the 9/11 attacks, an employment agency's clients were injured and suffered "physical loss or damage" while visiting the agency's New York branch. The employment agency filed a claim with its commercial property insurer to cover some of the loss sustained by its clients. However, the insurer denied the claim and maintained that the coverage was substantially less than alleged by the insured. *Snelling & Snelling, Inc. v. Federal Ins. Co.*, 205 F. App'x 199 (5th Cir. 2006). The Fifth Circuit agreed with the insurer and concluded that the Supplemental Declarations limited the amount of coverage available for each business site, notwithstanding the much larger coverage limit stated in the Declarations section.

A hospital district sued its property insurer on grounds that the insurer had miscalculated the applicable deductible in assessing the amount payable on the hospital district's claim for "time element loss" or business interruption. *Bexar County Hosp. Dist. v. Factory Mutual Ins. Co.*, 475 F.3d 274 (5th Cir. 2007). The hospital district and the insurer offered different interpretations of the policy's deductible provisions. While the court believed that the hospital district's interpretation was reasonable in isolation, the court found that the hospital district's interpretation was unreasonable as to the policy in its entirety. The court held that the policy was unambiguous, that the insurer's interpretation was the only one that gave meaning to the policy as a whole, and that the insurer had properly calculated the deductible.

By contrast, in a similar case the Fifth Circuit found that the "time element loss" provision was ambiguous as to the method for calculating the "100% daily Time Element value" of a piece of the insured's equipment. *Texas Indus., Inc. v. Factory Mutual Ins. Co.*, 486 F.3d 844 (5th Cir. 2007). Because both parties submitted reasonable interpretations, the court adopted the insured's interpretation.

An insured sought coverage under the property theft provision of its policy after an unknown person tricked the insured's employee into giving him property that belonged to the insured's customers. *Lone Star Heat Treating Co. v. Liberty Mut. Fire Ins. Co.*, 233 S.W.3d 524 (Tex. App.–Houston [14th Dist.] 2007, no pet.). The insured was forced to reimburse its customers and then filed a claim with its insurer. The insurer denied coverage under a "dishonesty exclusion," which barred coverage for "[d]ishonesty or criminal acts by you [or] any of your . . . employees . . . or anyone to whom you entrust the property for any purposes." The insured argued that the term "you" unambiguously meant the insured itself, and did not include any of its employees, and that the exclusion did not apply because the insured did not entrust the property to the unknown person.

The court agreed because the definition of "you" in the policy only named the insured, and the insurer's usage of the word "you" throughout the policy reinforced the definition as exclusive of employees of the insured. Furthermore, the court found that, under agency principles, the insured did not entrust the property to the unknown man, because the employee was acting without authority. Therefore, the dishonesty exclusion did not bar coverage for the incident.

F. Title Insurance

A flood plain designation of a portion of property was not a "defect in title" within the coverage of a title insurance policy. Even if the designation affected the value of the property, that was a defect only in the condition of the property, not the title. *Hanson Bus. Park, L.P. v. First Nat'l Title Ins. Co.*, 209 S.W.3d 867 (Tex. App.–Dallas 2006, pet. denied).

G. Other Policies

An insured sued his write-your-own flood insurer for breach of contract, fraud, and negligent misrepresentation. *Wright v. Allstate Ins. Co.*, 500 F.3d 390 (5th Cir. 2007). The district court dismissed the state law claims and refused to permit the insured to amend his petition to allege federal common law fraud and negligent misrepresentation claims. On appeal, the insured argued that the National Flood Insurance Act either expressly or impliedly permitted federal common-law rights of action, basing his argument on language in the Standard Flood Insurance Policy that disputes "are governed exclusively by the regulations issued by FEMA, [the NFIA], and Federal common law." The Fifth Circuit disagreed. The court found that neither the NFIA nor the SFIP explicitly permits an insured to bring extra-contractual claims against a write-your-own insurer. According to the court, the SFIP language cited by the insured merely "direct[ed] courts to employ standard insurance principles when deciding *coverage* issues." Furthermore, the Fifth Circuit found that the NFIA did not impliedly permit extra-contractual claims. The court reasoned that the primary purpose of the NFIA "is to reduce the overwhelming burden on the federal treasury," and not to provide protection to homeowners, and that allowing extra-contractual claims would increase the burden on the federal government.

Holders of a deed of trust in real property sued a flood insurer for equitable lien arising out of a flood insurance policy issued to the property owners. *Hanak v. Talon Ins. Agency, Ltd.*, 470 F. Supp. 2d 695 (E.D. Tex. 2006). The plaintiffs argued that the insurer knew or should have known that they had an interest in the property but failed to name them as payees, and that this failure constituted a breach of fiduciary duty that created an equitable lien. The court disagreed and held that the insurer had no affirmative duty to investigate the existence of encumbrances when it adjusted the flood damage claim.

A court determined that insureds could not recover for the injury and death of their horse that was insured as a pleasure horse but was injured while being used as a racehorse. *Harrison v. Great American Assurance Co.*, 227 S.W.3d 890 (Tex. App.–Dallas 2007, no pet.). The policy did not provide coverage where the horse was used as a racehorse. The insureds argued that the terms "racehorse" and "pleasure horse" were ambiguous, but the court disagreed. Because the horse was being trained for racing at the time she was injured, the horse was being used as a racehorse, despite the fact that she had never actually participated in a race.

III. FIRST PARTY THEORIES OF LIABILITY

A. Breach of Contract

A health insurer did not breach its contract by considering a home infusion therapy service to be a provider outside of its network. The contract between the insurer and service referred to the service as a "provider" but not as a "network provider." Moreover, the insurer wrote to the service before and after the effective date of the contract stating that the service was not a "network provider." *Quality Infusion Care, Inc. v. Health Care Service Corp.*, 224 S.W.3d 369 (Tex. App.–Houston [1st Dist.] 2006, no pet.). The case is noteworthy because it applies the general principle that the meaning of an ambiguous provision – in this case, "provider" – becomes a fact question. This general contract principle does not apply when an insured is suing on an ambiguous insurance contract. In such cases an ambiguous provision is construed as a matter of law in favor of the insured.

B. Unfair Insurance Practices, Deceptive Trade Practices & Unconscionable Conduct

Where a claim was excluded under a homeowners policy, the adjuster also could not be liable for an "outcome-oriented investigation" absent evidence of any breach or misrepresentation by the adjuster. *Crocker v. American Nat'l Gen. Ins. Co.*, 211 S.W.3d 928 (Tex. App.–Dallas 2007, no pet.).

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

Survivors of an insured sued a health insurer for breach of the duty of good faith and fair dealing, alleging that the insurer's denial of coverage for a particular treatment led to the insured's suicide. *Henry v. Mutual of Omaha Ins. Co.*, 503 F.3d 425 (5th Cir. 2007). The insured suffered from an immunological disease, for which two doctors believed the treatment was medically necessary. The insured's doctor requested a predetermination that the policy would cover the treatment. The insurer then had two doctors review the prescribed treatment. When its doctors found the treatment unnecessary, the insurer denied coverage. Both parties had other doctors review the treatment, with mixed results, and the insurer continued to deny coverage. In the midst of the debate, the insured committed suicide, and his parents brought suit. The Fifth Circuit held that the insurer did not breach the duty of good faith and fair dealing, because the insurer had a reasonable basis to deny coverage. Because doctors were in disagreement, the court found that there was a bonafide dispute as to the medical necessity of the treatment. The court dismissed the plaintiffs' argument that the insurer's doctors were biased in reaching their determinations, and found that the insurer's process was "sufficiently thorough and objective to satisfy the reasonable-basis standard."

D. Other Theories

A wrecker service sued a tractor and trailer owner and its insurer after they failed to pay the wrecker service for removing a tractor and trailer from a ditch and towing it to storage. *Canal Ins. Co. v. Hopkins*, No. 12-06-00411-CV, 2007 WL 3087678 (Tex. App.–Tyler Oct. 24, 2007, no pet. h.). The wrecker service based its suit against the insurer on Texas Occupations Code section 2303.156(b), which makes an insurer liable to a vehicle storage facility for money owed in relation to delivery and storage of a vehicle for which the insurer pays a claim of total loss. The insurance company argued that the statute was intended to impose liability on an insurer only where the insurer had received title of the vehicle after the tow. The court disagreed, finding that the unambiguous statutory language did not exempt insurers that had failed to obtain title. The insurer also argued that the statutory phrase "total loss" meant that the statute only applied where the vehicle had no value. Again, the court disagreed and reasoned that the legislative history revealed that "total loss" was equivalent to the vehicle being "totaled," or that the repair cost would exceed the vehicle's value. Additionally, the insurer argued that the statute only applied when the insurer abandoned the vehicle. The court also rejected this argument because the statute contained no language that would support the insurer's interpretation. Finally, the insurer argued that the statute was unconstitutional on several grounds, all of which the court rejected: the statute was not void for vagueness, did not impair the insurer's contractual obligations, and did not constitute a taking. Having found that the tractor and trailer were a total loss, the court held that the insurer was liable to pay the wrecker service for towing the tractor and trailer.

E. Negligence

An adjuster could not be sued for negligence based on its investigation of a homeowner's claim that was found to be excluded. The court held that an independent adjusting firm hired by the insurer has no relationship with, and therefore no duty to, the insured. *Crocker v. Am. Nat'l Gen. Ins. Co.*, 211 S.W.3d 928 (Tex. App.–Dallas 2007, no pet.).

IV. AGENTS, AGENCY & VICARIOUS LIABILITY

A. Individual Liability of Agents, Adjusters, and Others

The Fifth Circuit held that an attorney in fact was an agent of an insurance underwriter and, therefore, was not liable for any breach of contract by the underwriter. *Martinez v. State Farm Lloyds*, 204 F. App'x 435 (5th Cir. 2006).

In an arms-length, commercial transaction between an insurer and third party administrator, the administrator did not owe a fiduciary duty to the insurer and thus did not breach a fiduciary duty by marketing policies for another insurance company without first submitting the application to the initial insurer. *National Plan Administrators, Inc. v. National Health Ins. Co.*, 235 S.W.3d 695 (Tex. 2007). The court found nothing in the Insurance Code that gave rise to a fiduciary duty, and the contract between the parties limited the scope of the administrator's agency on behalf of the insurer. The court held that the parties could agree that the administrator would act as the insurer's agent only for specific purposes, and the contract between the parties specified that the administrator was an independent contractor whose activities in administering and marketing insurance products were not exclusive to the insurer.

B. Suits by agents

An insurance agency failed to state claims for tortious interference with existing and prospective contracts based on the rejection of certain health insurance contracts, which would have yielded the agency a higher commission. The school district rejected the contracts because they did not meet its requirements, so there was no evidence that the administrator's interference, if any, caused the agency to lose the contracts. Likewise, there was no evidence that any unfair insurance practice by the administrator caused damages to the agency. *Richardson-Eagle, Inc. v. William M. Mercer, Inc.*, 213 S.W.3d 469 (Tex. App.–Houston [1st Dist.] 2006, pet. denied).

V. THIRD PARTY INSURANCE POLICIES & PROVISIONS

A. Comprehensive General Liability Insurance

The Amarillo Court of Appeals held there was a genuine issue of material fact regarding the applicability of a "leased-in worker" exclusion. The court relied on evidence in the form of affidavits from an underwriter, a claims adjuster, and an employee who helped broker the policy. The court further held that the plaintiffs' position that the exclusion was ambiguous gave rise to a fact question regarding the proper interpretation of the contract and thus the trial court erred in granting summary judgment on coverage in favor of the plaintiffs. In addition, the court held that a determination of the coverage question was premature until the court resolved another fact issue on whether the insurers, as unauthorized surplus insurers, were precluded from raising contract defenses. *Yorkshire Ins. Co. v. Seger*, No. 07-05-00188-CV, 2007 WL 1771614 (Tex. App.–Amarillo June 20, 2007, pet. filed) ("*Yorkshire I*").

The *Yorkshire I* court erred in holding that ambiguity in the insurance policies raised a fact question regarding the proper interpretation of the contract. The court mistakenly relied on *Coker v. Coker*, 650 S.W.2d 391, 394 (Tex. 1983), which states this general composition. This general rule does not apply to insurance policies. If an insurance contract is ambiguous, the court "must resolve the uncertainty by adopting the construction most favorable to the insured." *See, e.g., State Farm & Cas. Co. v. Reed,* 873 S.W.2d 698, 699 (Tex. 1993).

The Amarillo Court of Appeals also found a fact issue on the parties' intent regarding the meaning of an exclusion for "leased-in employees/workers" in the related case, *Yorkshire Insurance Co. v. Diatom Drilling Co.*, No. 07-05-0386-CV, 2007 WL 1287720 (Tex. App.–Amarillo May 2, 2007, pet. filed) (not reported) ("*Yorkshire II*"). The court found the language ambiguous so that it was not clear whether it excluded a wrongful death claim by the survivors of a worker who is employed by another company but was providing services to the insured. The court then looked to extrinsic evidence of the intent of the parties at the time, after finding the contract was not sufficiently clear to support the insureds' construction as a matter of law.

The court of appeals in *Yorkshire II* committed the same error as in its *Yorkshire I* opinion and compounded it. When an insurance policy is ambiguous, it is construed in favor of coverage as a matter of law; there is no fact question on the parties' intent. *See, e.g., Grain Dealers Mutual Insurance Co. v. McKee*, 943 S.W.2d 455, 458 (Tex. 1997). This is in contrast to the general rule for other types of contracts, which the court mistakenly applied.

The court further erred when it found no coverage based on extrinsic evidence after finding the exclusion was not sufficiently clear to support the insurers' construction as a matter of law. The court overlooked the principle that exclusions are strictly construed against the insurer and liberally in favor of the insured. *See, e.g., National Union Fire Ins. Co. v. Hudson Energy Co.*, 811 S.W.2d 522, 555 (Tex. 1991).

An insured subcontractor brought a duty to defend and indemnify suit against its CGL insurer. *Williams Consol. I, Ltd./BSI Holdings, Inc. v. TIG Ins. Co.*, 230 S.W.3d 895 (Tex. App.–Houston [14th Dist.] 2007, no pet.). The subcontractor was sued by a homeowner for mold growth resulting from improper installation of vapor barrier. The effective date of the subcontractor's policy was August 1999. The home was built in 1991, and the claim was filed in 2002. The insurer argued that there was no coverage if any process leading to the ultimate damage claimed began before the effective date of the policy. The court held that there was no coverage for property damage that first occurred before the effective date of the policy. However, the court also held that if the property damage did not occur or begin before the effective date but the process leading to the ultimate injury began before that date, coverage was not excluded.

B. Excess Insurance

In a declaratory action brought by a primary insurer against an umbrella insurer, the Fifth Circuit held that the umbrella insurer was liable to the primary insurer for money the primary insurer paid in settlement of a claim for breach of warranty. *Scottsdale Ins. Co. v. Knox Park Constr., Inc.*, 488 F.3d 680 (5th Cir. 2007). The court found that the primary insurer could equitably subrogate to the rights of the insured to enforce the umbrella policy. The court additionally found that the umbrella policy provided coverage, even though the limits of the primary policy had not been exhausted, because the umbrella policy offered broader coverage than the primary policy. The court rejected the umbrella insurer's argument that the primary insured failed to meet the condition precedent that "ultimate net loss" be determined by trial or agreement. According to the court, the umbrella insurer waived its right to deny coverage on that basis because it had demanded settlement and thus had an opportunity to settle the amount of loss by agreement. However, one justice dissented on this point on grounds that the umbrella insurer's refusal to settle was an exercise of its rights under the policy, rather than a waiver of its rights.

A plaintiff obtained a judgment against a bankrupt, self-insured defendant. In addition, the first excess carrier was insolvent. Consequently, the plaintiff sued the defendant's second excess insurer to recover the judgment. The plaintiff argued that a MCS-90 endorsement in the policy placed the

second excess insurer "in the position of a surety because it was the first solvent insurer," and therefore it was liable for the total judgment. The Fifth Circuit held that the endorsement did not require the excess insurer to drop below its liability floor when it was the first solvent insurer. *Wells v. Gulf Ins. Co.*, 484 F.3d 313 (5th Cir. 2007). The court found that because the defendant was self-insured, no public policy compelled a finding that the second excess insurer should be liable for the total judgment, notwithstanding the defendant's bankruptcy. Additionally, the court found that the language of the endorsement retained the policy's liability limit.

The supreme court found that defective construction is an "occurrence" when the defect is the product of negligence.

An excess insurer sued two primary insurers, and the Fifth Circuit held that the excess insurer had a right of "conventional" subrogation based on the two primary insurers' contractual obligations, which did not require proof that the primary insurers were negligent. *Royal Ins. Co. v. Caliber One Indem. Co.*, 465 F.3d 614 (5th Cir. 2006). The court found that several instances of harm to a nursing home patient leading to visible injuries constituted an occurrence under the policies of both primary insurers. However, the incidents were deemed a single occurrence for one primary insurer whose policy defined "medical incident" to include all related acts or omissions, but were deemed multiple occurrences under the other primary insurer's policy. Furthermore, the court found that the excess insurer was not entitled to subrogation against the primary insurer whose policy period predated the excess insurer's. The excess insurer was only entitled to require exhaustion of the policy limits of the primary insurer for the same coverage period.

Two excess insurance carriers sued a primary insurer for violating the *Stowers* duty to settle and for negligently failing to settle an underlying lawsuit within its policy limits. *Continental Cas. Co. v. St. Paul Fire & Marine Ins. Co.*, No. 3:04-CV-1866-D, 2007 WL 2403656 (N.D. Tex. Aug. 23, 2007). The primary insurer moved for summary judgment on grounds that it had no duty to settle under *Stowers* because it was not in control of the case or the settlement proceedings until two weeks before the jury verdict, notwithstanding a subsequent offer to settle by the insured. The court denied summary judgment because the policy terms did not clearly reserve control of the defense to the insured, and because the primary insurer's conduct could not be said to be exclusively settlement negotiations as opposed to control over the defense. The court granted the primary insurer's summary judgment as to the excess carriers' non-*Stowers* claims. The court found that "Texas law does not recognize an equitable subrogation action by excess carriers against a primary carrier for negligent handling of the defense or settlement negotiations."

C. Title insurance

A claim against a landowner based on the neighbor's adverse possession of a strip of land between the two properties alleged facts that the neighbor's possession of the disputed strip of property was open and visible, notorious, exclusive, not merely constructive; therefore, the title insurer had no duty to defend, because the claim was excluded by the "rights of parties in possession" exception to coverage. *Koenig v. First American Title Ins. Co.*, 209 S.W.3d 870 (Tex. App.–Houston [14th Dist.] 2006, no pet.).

D. Other Policies

An aircraft liability policy provided $1 million per occurrence to cover the claims of the surviving children of a passenger who was killed, instead of just $100,000 per passenger. The court reasoned that the survivors' claims were subject to the higher limit and not the lesser limit because their claims were not "because of" the bodily injury to the passenger. *Global Aerospace v. Pinson*, 208 S.W.3d 687 (Tex. App.–Corpus Christi 2006, no pet.).

Passengers injured in a bus accident in Mexico sued the owner of the bus, which had an insurance policy that contained an MCS-90B endorsement. *Lincoln Gen. Ins. Co. v. De La Luz Garcia*, 501 F.3d 436 (5th Cir. 2007). The insurer refused to defend or indemnify because the accident occurred in Mexico, which was outside of the policy's coverage area, and argued that the endorsement did not expand coverage to include Mexico. As a matter of first impression, the Fifth Circuit held that the endorsement did not provide coverage for an accident occurring in Mexico. Looking to the endorsement's language, the court found that the coverage provided by the endorsement was the minimum required by the Bus Regulatory Reform Act of 1982, codified as 49 U.S.C. sec. 31138(a), to which the endorsement specifically referred. Because the Act only required minimum levels of financial responsibility for transportation of passengers by a commercial motor vehicle "in the United States," the endorsement offered no coverage for transportation in Mexico.

VI. DUTIES OF LIABILITY INSURERS

A. Duty to Defend

The Texas Supreme Court addressed the issue of whether allegations of construction defects by a homebuilder resulting only in damage or loss of use of the home itself allege to "property damage" caused by an "accident" or "occurrence" sufficient to trigger the duty to defend. The court held that they did. *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, No. 05-0832, 2007 WL 2459193 (Tex. Aug. 31, 2007).

In *Lamar Homes*, the insured, a construction builder, sold a new home that developed problems due to defects in the foundation. The buyers sued the builder, which forwarded the lawsuit to its insurance company seeking a defense and indemnification under its CGL policy. The insurer denied coverage and refused to defend. Consequently, the builder sought a declaration of its rights. The district court held that the insurer had no duty to defend. The builder then appealed to the Fifth Circuit, which asked the supreme court to decide the issue.

First, the supreme court found that defective construction is an "occurrence" when the defect is the product of negligence. According to the court, "a deliberate act, performed negligently, is an accident if the effect is not the intended or expected result; that is, the result would have been different had the deliberate act been performed correctly."

The court also rejected the argument that faulty workmanship damage could only be an occurrence if the damaged property belonged to a third party. The court found that the policy's definition of "occurrence" did not distinguish between ownership or character of the property damaged. Instead, the court emphasized that the relevant question is whether the injury was "intended or fortuitous." In this case, the court concluded that the complaint alleged an "occurrence" because it contended that the builder's defective construction resulted from its negligence.

Next, the *Lamar* court considered whether defective construction damaging only the builder's work is "property damage" within the policy's meaning. The court found that

the policy definition did not, on its face, eliminate the builder's work. Also, the "your work" exclusion did not eliminate coverage, because the subcontractor exception applied. Finally, the court found that the economic loss rule did not preclude coverage, because the policy made no distinction between tort and contract damages. Because the complaint alleged damages within the scope of coverage, the insurer had a duty to defend.

Three justices dissented, contending that the buyers "alleged broken promises and breached duties connected with the sale" of the home and that the economic loss rule precluded coverage.

An insurer had no duty to defend a suit against a used car dealership for damages sustained during repossession of a vehicle.

The Fifth Circuit held that a commercial general liability insurer did not owe a duty to defend a case against its insured, a daycare center, for injuries sustained by a child who was left in a parked van in the heat for several hours. *Lincoln General Ins. Co. v. Aisha's Learning Center*, 468 F.3d 857 (5th Cir. 2006). The insured owned the van and used it to transport children to and from the daycare facilities. The insurer sought a declaratory judgment that it owed no duty to defend because the policy excluded bodily injury "arising out of the … use" of automobiles owned or operated by the insured. The Fifth Circuit agreed, finding that Texas case law had interpreted the word "use" broadly. The court examined various cases from Texas and other jurisdictions and concluded that the child's injury fit within the automobile exclusion because the van was a direct cause of the child's injuries and the van's purpose of transportation had not been fulfilled as to the injured child.

An employee driving his employer's vehicle was in an auto accident on his way home from his birthday party. Persons injured by the employee sued the employer and employee, who then sought a defense and indemnity from the employer's insurer. The district court granted summary judgment for the insurer, declaring that it had no duty to defend or indemnify the employee. In rendering judgment, the district court considered evidence extrinsic to the policy and the pleadings in the underlying case to determine that the employee was not operating the vehicle with the employer's permission and that, therefore, the employee did not fit within the omnibus clause of the policy.

On appeal, the Fifth Circuit reversed the district court's decision. *Liberty Mutual Ins. Co. v. Graham*, 473 F.3d 596 (5th Cir. 2006). Between the summary judgment and the appeal, the Texas Supreme Court decided *Guideone Elite Insurance Co v. Fielder Road Baptist Church*, 197 S.W.3d 305 (Tex. 2006), upon which the Fifth Circuit relied in deciding this case. The court held that the district court's consideration of extrinsic evidence was improper because the petition alleged that the employer knew and approved of the employee's personal use of the vehicle, which put the employee within the scope of the omnibus clause and thereby stated a claim potentially within coverage. Therefore, the insurer had a duty to defend the employee.

The Fifth Circuit found that an insurer owed its insured a duty to defend in a suit against the insured for allowing pollutants to escape from the insured's oil and gas facilities. *Fair Operating, Inc. v. Mid-Continent Cas. Co.*, 193 F. App'x 302 (5th Cir. 2006). Although the petition in the underlying suit failed to specifically allege that the emissions had been "sudden," as required by the policy, the court found that the allegations in the petition were broad enough to encompass sudden emissions and thus potentially stated a cause of action within the policy.

According to the Fifth Circuit, a commercial general liability insurer had no duty to defend its insured, which manufactured cosmetic lip implantations, in a products liability case. *American Inst. of Intradermal Cosmetics, Inc. v. Maryland Cas. Co.*, 207 F. App'x 417 (5th Cir. 2006) (per curiam). The court found that the "products-completed operations hazard" exception applied, and that the policy provision referring to "cosmetics, toiletries and perfumes" merely identified the insured's business and did not extend coverage.

An insurer did not owe the insured a duty to defend in a suit alleging that the insured was an alter-ego of a co-defendant. The underlying event was not within the scope of the insured's business and, therefore, was not within the scope of coverage. *Gemini Ins. Co. v. S & J Diving, Inc.*, 464 F. Supp. 2d 641 (S.D. Tex. 2006).

An insurer had no duty to defend a suit against a used car dealership for damages sustained during repossession of a vehicle. *Classic Performance Cars, Inc. v. Acceptance Indem. Ins. Co.*, 464 F. Supp. 2d 652 (S.D. Tex. 2006). The insured argued that the "repossession operations" exclusion was ambiguous and should not encompass repossessions by third parties. The court disagreed, finding the exclusion to be clear on its face.

A court held that the eight corners rule did not apply in a duty to defend case because the policy lacked language obligating the insurer to defend a suit "even if the allegations of the suit are groundless, false, or fraudulent." *B. Hall Contracting Inc. v. Evanston Ins. Co.*, 447 F. Supp. 2d 634 (N.D. Tex. 2006). Although the eight corners rule did not apply, the insurer could not avoid a defense obligation by relying on "extrinsic facts" showing that "the insured is not liable in the underlying suit." However, the insurer was permitted to introduce extrinsic evidence to show that an exclusion applied, provided that it did not contradict the pleadings in the underlying case. Having permitted such extrinsic evidence, the court found that the insurer did not have a duty to defend.

An insurer did not have to defend its insured – a home builder – in a suit regarding faulty and improper construction, because the injuries claimed in the underlying suit were for breach of contract and, therefore, did not constitute an "occurrence." *Charlton v. Evanston Ins. Co.*, No. SA-06-CA-480-H, 2007 WL 2255210 (W.D. Tex. June 29, 2007). In reaching its decision, the court improperly applied the economic loss rule to conclude that the allegations did not trigger a duty to defend. In light of *Lamar Homes*, which was decided two months after this decision, the district court's holding is incorrect.

An insurer had no duty to defend a homebuilder who sought coverage as an additional insured under a subcontractor's policy. The policy provided coverage to the homebuilder only for liability arising out of the subcontractor's work. The plaintiffs' petition alleged defects, but did not allege they arose from the subcontractor's work. *D.R. Horton-Texas v. Markel Int'l Ins. Co., Ltd.*, No. 14-05-00486-CV, 2006 WL 3040756 (Tex. App.–Houston [14th Dist.] Oct. 26, 2006, pet. filed).

An employer's allegedly false report regarding a former truck driver employee's refusal to take drug tests was excluded from coverage under the employment related practices exclusion, so that the insurer had no duty to defend. The policy excluded coverage for injuries arising out of any "employment-related, policies, acts, or omissions[.]" The court concluded that statements made in response to routine employment inquiries are employment–related and thus are excluded. *Shipside Crating Co. v. Trinity Universal Ins. Co.*, No. 14-06-00229-CV, 2006, WL 3360499 (Tex. App.–

Houston [14th Dist.] Nov. 21, 2006, pet. denied).

The "fortuity doctrine" precluded a duty to defend in *Warrantech Corp. v. Steadfast Ins. Co.*, 210 S.W.3d 760 (Tex. App.–Fort Worth 2006, pet. filed). Warrantech was accused of purposefully manipulating the warranty program for CompUSA so that uninsured claims would nevertheless be covered by insurance. When the insureds sued Warrantech, the court held that Warrantech's own insurer had no duty to defend, because the facts alleged show that Warrantech knew of the loss. The fortuity doctrine precludes coverage for losses that are known and losses in progress. The court concluded that the suit against Warrantech alleged that it knew of the loss caused by its mispayment of warranty claims long before the inception of the liability policy.

The court rejected Warrantech's argument that applying the fortuity doctrine would conflict with the language of an exclusion, which excluded liability for claims based on knowing wrongful conduct, but required a defense up to the time that a judgment established that the insured was guilty of such conduct. The court reasoned that the fortuity doctrine only looks to whether the insured knew of the loss, not whether the insured knew it was wrongful, so the exclusion was not relevant.

In *Williams Consol. I., Ltd./BSI Holdings, Inc. v. TIG Ins. Co.*, 230 S.W.3d 895 (Tex. App.–Houston [14th Dist.] 2007, no pet.), a homeowner had sued a subcontractor for mold resulting from improper installation of a vapor barrier. The insurer argued that coverage was excluded under the prior incidents exclusion. The court found that the facts alleged by the homeowners were not sufficient to bring the claims within or without coverage. Therefore, the insurer had a duty to defend.

In *Gomez v. Allstate Texas Lloyds Insurance Co.*, an insurer argued it had no duty to defend its insureds in a suit brought after a child under the insureds' supervision was injured while riding the insureds' all-terrain vehicle. No. 2-06-233-CV, 2007 WL 3203112 (Tex. App.–Fort Worth Nov. 1, 2007, no pet. h.). The insurer argued that the policy did not provide coverage for bodily injury arising out of the use of recreational vehicles outside of the insured's property. The court disagreed and found that the allegations did not state whether the accident occurred on or off the insured's property. Construing the petition broadly in favor of coverage, the court found a duty to defend because the injury may have occurred on the residence premises.

An injured employee of a subcontractor sued the general contractor, which sought a defense and indemnity as an additional insured under the CGL policy of the engineering company that had hired the subcontractor. *Roberts, Taylor & Sensabaugh, Inc. v. Lexington Ins. Co.*, No. H-06-2197, 2007 WL 2582748 (S.D. Tex. Sept. 5, 2007), *rehearing denied*, 2007 WL 2964445 (S.D. Tex. Oct. 9, 2007). The insurer refused to defend the general contractor on grounds that the events giving rise to the suit were outside of scope of coverage. Both the general contractor and the insured agreed that extrinsic evidence was admissible to determine whether the general contractor was an additional insured.

The parties disputed whether and to what extent extrinsic evidence could be used to determine whether the general contractor's liability arose from the subcontractor's work under its contract with the engineering company. The court held that an exception to the eight-corners rule applied. The court found that the contracts between the general contractor and the engineering company and between the engineering company and the subcontractor were admissible to show whether the general contractor's liability arose from the subcontractor's work for the engineering company. The court reasoned that the contracts would not show any fault by any party, but rather would only establish the relationship between the parties and whether coverage existed.

In its subsequent denial of rehearing, the court stated that its decision comported with *Guideone Elite Insurance Co. v. Fielder Road Baptist Church*, 197 S.W.3d 305 (Tex. 2006), which distinguished between extrinsic evidence relevant only to coverage and extrinsic evidence relevant to the merits, because the contracts spoke only to the coverage issue.

B. Duty to Settle

The damage cap on a medical malpractice claim against a doctor did not limit damages when the plaintiff offered proof sufficient to invoke the *Stowers* doctrine for the insurer's failure to settle. *Phillips v. Bramlett*, No. 07-05-0456-CV, 2007 WL 836871 (Tex. App.–Amarillo March 19, 2007, no pet.). A defendant doctor complained that the trial court should have limited the plaintiffs' recovery in a wrongful death case, based on the Texas Medical Liability & Insurance Improvement Act, article 4590i, section 11.02(a), which caps damages at $500,000. The court rejected this argument, relying on section 11.02(c), which provides that the statute "shall not limit the liability of any insurer where facts exist that would enable a party to invoke that common law theory of recovery, commonly known in Texas as the '*Stowers* Doctrine.'" In reaching the conclusion that the cap would not apply, the court recognized that its decision conflicted with the decision in *Welch v. McLean*, 191 S.W.3d 147 (Tex. App.–Fort Worth 2005, no pet.). The court further concluded that the plaintiffs sufficiently presented proof on the *Stowers* element that the claim was one that a reasonable insurer would accept, by virtue of the verdict and finding that supported a judgment in excess of the caps.

C. Duty to Indemnify

Refinery employees were injured when a tank cleaning incident exposed them to various chemicals. The employer's umbrella insurer sought a declaratory judgment that the pollution exclusion precluded coverage for the tank owner's indemnification claim against the employer. *United Nat'l Ins. Co. v. Hydro Tank, Inc.*, 497 F.3d 445 (5th Cir. 2007). The court held that the insurer had no duty to indemnify. The court found that the language of the policy precluded coverage if the injury arose at least in part from a pollutant. Additionally, the court found that the policy defined the term "pollutant" broadly enough to include sludge in a refinery tank, despite the fact that the sludge was contained rather than released into the environment. Moreover, the court noted that even if the sludge were not considered a pollutant, the employee's simultaneous exposure to other pollutants triggered the concurrent causation doctrine and precluded coverage.

A court found that an act committed "knowingly" under the DTPA could constitute an "accident" or "occurrence" under a commercial umbrella insurance policy, provided that the actor neither intended nor had reason to expect the resulting harm. *Nat'l Union Fire Ins. Co. v. Puget Plastics Corp.*, 450 F. Supp. 2d 682 (S.D. Tex. 2006). The court also found that a rebuttable presumption of an accident or occurrence exists when there is evidence of property damage to third parties. When the presumption applies, the court may look beyond the judgment in the underlying case to determine if the insured intended or should have reasonably expected the harm.

After finding an insurer had no duty to defend a homebuilder, because the plaintiffs' petition did not allege that the defect arose from a subcontractor's work, which would have been covered, a court further concluded the insurer could have no duty to indemnify. *D.R. Horton-Texas v. Markel Int'l Ins. Co., Ltd.*, No. 14-05-00486-CV, 2006 WL 3040756 (Tex. App.–Houston [14th Dist.] October 26, 2006, no pet.). The court reasoned that if the underlying petition did not raise factual allegations sufficient to invoke the duty to defend, then even proof of all those allegations

could not invoke the insured's duty to indemnify.

In this holding, the court's analysis is wrong. The court correctly found no duty to defend, because the underlying petition did not specifically allege that the defects rose from the covered subcontractor's work. However, at trial, the plaintiffs could offer such proof, which would provide a basis for imposing a duty to indemnify. Alternatively, the underlying suit might not address the issue, so that in a subsequent coverage suit the homebuilder could litigate that issue against the insurer and establish a duty to indemnify. While the duty to defend is considered broader than the duty to indemnify, it is not always the case that the absence of a duty to defend also means there can be no duty to pay.

An insured engaged in a high-speed chase in an attempt to evade the police. During the course of the chase, the insured hit another vehicle, injuring its passengers. The insurer argued that it had no duty to defend or indemnify, because of the intentional-acts exclusion. The court held that the exclusion barred coverage because the insured should have known that a wreck and injuries were the natural and probable consequences of his reckless conduct during the high-speed chase. *Tanner v. Nationwide Mut. Fire Ins. Co.*, No. 11-05-00371-CV, 2007 WL 2274936 (Tex. App.–Eastland Aug. 9, 2007, pet. filed).

The *Tanner* case gives an example of when the facts that negate the duty to defend also negate the duty to indemnify. The conduct that was alleged – the high speed chase – would be intentional in either context and thus would be excluded in either context. *See Farmers Tex. Co. Mut. Ins. Co. v. Griffin*, 955 S.W.2d 81, 84 (Tex. 1997) (drive-by shooting allegations negate duties to defend and indemnify where no facts could be developed to prove covered claim).

In *Gomez v. Allstate Texas Lloyds Insurance Co.*, a child under the insureds' supervision was injured while riding the insureds' all-terrain vehicle. No. 2-06-233-CV, 2007 WL 3203112 (Tex. App.–Fort Worth Nov. 1, 2007, no pet. h.). The insurer argued that it had no duty to defend or indemnify because the homeowner's policy did not provide coverage for bodily injury arising out of use of recreational vehicles outside of the insured's property. The trial court found that the insurer had no duty to defend and therefore also had no duty to indemnify. The court of appeals reversed, and properly criticized the trial court's conflation of the two duties. Having held that the insurer owed a duty to defend because the petition stated a potentially covered claim, the court of appeals further determined that more facts needed to be ascertained at trial before the duty to indemnify issue could be decided.

A car dealership sued its insurer seeking indemnity for damages that the dealership had to pay following a suit for slander and intentional infliction of emotional distress. *DaimlerChrysler Ins. Co. v. Apple*, No. 01-05-01115-CV, 2007 WL 3105899 (Tex. App.–Houston [1st Dist.] Oct. 25, 2007, no pet. h.). The dealership had both commercial general liability and umbrella policies with the insurer that provided coverage for oral publication of defamatory material, but excluding situations where that publication was "done by or at the direction of the insured with knowledge of its falsity." The insurer argued that it had no duty to indemnify the dealership because vice principals of the dealership were found to have made defamatory statements with knowledge of their falsity and that such knowledge should be imputed to the dealership, which thereby triggered the exclusion for making knowingly false defamatory statements. However, the court disagreed on grounds that the policy language did not support the assertion that a vice-principal's knowledge is identical with that of the insured. Furthermore, even though tort law would impute liability onto the dealership through vicarious liability, the policy's express reference to knowledge of the insured meant that the dealership itself needed to actually have knowledge of the falsity of the statements for the exception to apply.

D. Settlements, Assignments & Covenants Not to Execute

An insured's settlement with the plaintiff in the underlying tort suit released the excess insurer from any liability, because the plaintiff agreed to release the insured in return for the payment by the primary insurer. Thus, even though the parties agreed to a settlement that exceeded the primary insurer's limits, the release meant the insured was no longer legally obligated to pay that sum, so the excess insurer was not liable. *American Nat'l Fire Ins. Co. v. Hammer Trucking, Inc.*, No. 2-04-327-CV, 2006 WL 3247906 (Tex. App.–Fort Worth Nov. 9, 2006, no pet.) (not reported).

VII. THIRD PARTY THEORIES OF LIABILITY

A. *Stowers* Duty & Negligent Failure to Settle

The Amarillo Court of Appeals addressed whether a demand was within policy limits, when the demand was less than the stated policy limits but more than the proportionate share of the two insurers. The court concluded that the demand satisfied the requirement of a demand within policy limits. The court reasoned that the claimant should be entitled to rely on the specific provisions of the insurance policy in making a settlement demand within the coverage of the policy. The court rejected the insurer's argument that the plaintiff had to make demands within each of their specific proportionate shares. *Yorkshire Insurance Co. v. Seger*, No. 07-05-00188-CV, 2007 WL 1771614 (Tex. App.–Amarillo June 20, 2007, pet. filed) ("*Yorkshire I*").

The *Yorkshire I* court went on to agree with the insurer's position that each underwriter in a Lloyd's policy has only several liability to the extent of its percentage of the coverage. From this, the court reasoned that if the insurers were negligent in failing to settle the plaintiffs' claims, then their liability would be limited to their proportionate share of the total coverage provided by the policy.

This last point by the court seems wrong. The evidence showed that several insurers each had a proportionate share of liability. Assuming nine of the ten insurers tendered their share, the tenth holdout insurer who negligently refused to settle would be responsible for causing *all* of the excess judgment, not just its proportionate share. It is not clear from the court's opinion whether both of the insurers were negligent so that each caused the excess judgment. However, it seems there would be a fact question on the percentage responsibility attributable to each insurer, so this would not be an issue to be decided as a matter of law.

The *Yorkshire I* court further held that the fact that the insured was insolvent, had no assets, and was judgment-proof did not mean that the insurers suffered no damages from the insured's negligent failure to settle. The court concluded that the insurers' inability to pay the damages awarded in the underlying judgment did not affect its liability under the judgment, and the policy required the insurers to pay sums for which the insured became liable.

The *Yorkshire I* court further held that the result was the same – that is, the insured was injured by the insurer's negligence – despite the fact that the plaintiffs had entered into a covenant not to execute on the judgment against the insured. *See YMCA of Metro. Fort Worth v. Commercial Standard Ins. Co.*, 552 S.W.2d 497, 504-05 (Tex. Civ. App.–Fort Worth 1977, writ ref'd, n.r.e.).

The *Yorkshire I* court then considered whether the judgment in the underlying suit established the amount of damages as a matter of law. At the trial of the underlying suit, the defendant was not represented by counsel, presented no opening or closing

argument, called no witnesses, and presented no evidence. The *Yorkshire I* court recognized the general rule that in a *Stowers* suit damages are fixed as a matter of law in the amount of the excess judgment, so that a directed verdict on the amount of damages would be proper, absent evidence that the underlying judgment was not reliable evidence of the damages suffered. However, the court recognized that the underlying judgment is not conclusive and is not admissible as evidence of damages unless it is rendered as the result of a "fully adversarial trial." *See State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696, 714 (Tex. 1996).

The prompt payment statute applies "when an insurer wrongfully refuses to promptly pay a defense benefit owed to the insured."

The *Yorkshire I* plaintiff argued that at the time of the underlying suit the parties were in a "fully adversarial relationship" and that an "actual trial" had occurred. The court of appeals concluded that this did not resolve whether the judgment was the result of a fully adversarial trial.

The court of appeals reasoned that a determination of whether there was a "fully adversarial trial" required a review of the extent to which the parties to the proceeding participated. Relying on *Gandy*, the court held that when the judgment is an agreed judgment, default judgment, or when the underlying defendant's participation is so minimal as to evidence that the hearing was not adversarial, the resulting judgment may not be admitted as evidence of damages in the subsequent *Stowers* suit. The court concluded that the evidence raised an issue of fact regarding whether the judgment was the result of a fully adversarial trial; therefore, the trial court erred in finding damages as a matter of law.

It is curious why the *Yorkshire I* court found there was a fact issue. Its analysis would seem to support the conclusion that, as a matter of law, there was not a fully adversarial trial.

B. Unfair Insurance Practices

The Fifth Circuit found that, under Texas law, a third party has no cause of action for an insurer's unfair settlement practices. *Marchant v. American Equity Ins.*, 195 F. App'x 261 (5th Cir. 2006). Therefore, the court dismissed a plaintiff's suit against a defendant's insurer for refusing to settle the plaintiff's claims.

C. Prompt Payment of Claims

The Texas Supreme Court for the first time answered the question of whether an insured's claim against a liability insurer for defense costs is a "first party claim" within the meaning of the prompt payment statute in *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, No. 05-0832, 2007 WL 2459193 (Tex. Aug. 31, 2007). Buyers of a home sued the homebuilder for construction defects. After the builder's CGL insurer refused to defend, the builder sought recovery under the prompt payment statute.

The Texas Supreme Court held that the prompt payment statute applies "when an insurer wrongfully refuses to promptly pay a defense benefit owed to the insured." The court provided several reasons for finding that its holding "accurately reflects the Legislature's purpose for enacting the prompt-payment statute." First, the court found that claims for a defense were "first-party" claims, and not third-party claims, because of the claimant's relationship to the loss. The court stated: "Without the defense benefit provided by a liability policy, the insured alone would be responsible for these costs."

Second, the court found that the language of the statute supports its application to defense claims. Specifically, the court rejected the argument that "first party claims" means claims brought under first-party insurance policies. According to the court, the language "first party" modifies "claim" and does not, therefore, place any limitation on the types of policies or insurers to which the statute applies. Furthermore, the statute expressly states that it applies to "any insurer" and does not exempt liability or third-party insurance.

Third, the court considered irrelevant the fact that payment of a defense claim is ordinarily paid to the defense lawyer rather than to the insured. Many other types of claims are paid directly to service providers and yet fall within the statute's scope. Additionally, to distinguish between whether an insured or his attorney is paid contradicts the legislative intent that the statute be "liberally construed."

Finally, the court rejected the argument that the prompt payment statute is unworkable with respect to claims for a defense and explained how the statutory deadlines would apply.

In contrast to the prompt payment statute applying to claims for duty to defend, the statute does not apply to a claim for indemnity under a liability policy, because that is not a first party claim. *See American Nat'l Fire Ins. Co. v. Hammer Trucking, Inc.*, No. 2-04-327-CV, 2006 WL 3247906 (Tex. App.–Fort Worth Nov. 9, 2006, no pet.) (not reported).

In *State Farm Life Insurance Co. v. Martinez*, 216 S.W.3d 799 (Tex. 2007), the court considered the effect of an interpleader on the successful beneficiary's ability to recover penalties. The court held that a life insurer would be liable for penalties under the prompt payment statute up to the time it filed an interpleader, but that an interpleader filed in the face of rival claims would stop the accrual of penalties and interest. The court reasoned that interpleading the funds was "payment" sufficient to satisfy the purpose of the statute and thus avoid punishment after that date. The court found no purpose would be served by continuing to accrue penalties after the interpleader and up to the date of judgment.

Interestingly, the supreme court has now twice emphasized that an insurer's payment of a claim – either a partial payment or the filing of an interpleader – is the event that stops accrual of penalties, not the later judgment date. *See State Farm v. Martinez*, 216 S.W.3d at 806-07; *Republic Underwriters Ins. Co. v. Mex-Tex, Inc.*, 150 S.W.3d 423, 427-28 (Tex. 2004). This conclusion seems correct, given that it furthers the purpose of the statute to encourage payment. This reasoning would also support the conclusion that the penalty should not stop on the date of judgment if the insurer had not yet paid. *See* Mark L. Kincaid & Christopher W. Martin, *Texas Practice Guide: Insurance Litigation § 1732* (West 2007) (Available at Westlaw TXPG-INS 17:32).

The court did state that if there were no rival claims then the interpleader would merely delay payment and would not toll the statute's penalties.

On motion for rehearing, three justices dissented from the court's holding on the prompt payment statute. Lamar Homes, Inc. v. Mid-Continent Cas. Co., No. 05-0832, 2007 WL 4357554 (Tex. 2007). They dissented on grounds that the term "first-party claim" should not be construed to include duty to defend claims. First, the dissenting justices found that "first-party claim" was a technical term that excludes claims brought under liability policies. Second, the dissenting justices found that the Legislature did not intend the prompt payment statute to apply to these types of claims. Third, although the term "first-party claim" is not defined in the prompt payment statute, the dissenting justices noted that it appears in other parts of the Insurance Code

that list liability policies separate from first-party claims. Fourth, the dissenting justices determined that common usage of the term excludes liability insurance. Finally, the dissenting justices found that the statute's deadlines were unworkable in the context of liability policies.

D. Other Theories

A subcontractor's employee was injured on the job and sued the general contractor. The subcontractor's primary insurer and the general contractor's primary insurer split the costs of settlement, after which the general contractor sued the subcontractor and its excess insurer to recover the amount the general contractor's insurer had paid. *Gilbane Bldg. Co. v. Keystone Structural Concrete, Ltd.*, No. 01-05-00988, 2007 WL 2130373 (Tex. App.–Houston [1st Dist.] July 26, 2007, no pet.). The general contractor argued that the subcontractor had breached several contractual provisions, including an indemnity provision, a provision requiring the subcontractor to provide primary insurance on the general contractor's behalf to cover losses caused by the subcontractor's work, and a provision that the subcontractor ensure safe conditions.

The court found that the contractual indemnity provision did not apply because the general contractor was sued for its own negligence and the provision did not indemnify the general contractor for its own negligence. The court also found that no provision expressly required the subcontractor to maintain an insurance policy that would have priority over the general contractor's other insurance. Accordingly, the court declined to read such a requirement into the policy and likewise refused to reform the policy.

Additionally, the court overruled the general contractor's argument that the subcontractor had assumed the responsibility of ensuring safe conditions. The court found that the general contractor was, in essence, trying to seek indemnity, which was improper under Texas workers' compensation law because the indemnity agreement failed to comply with the express negligence rule.

Finally, the *Gilbane* court held that the subcontractor had no contractual duty to inform the general contractor of the existence of an insurance policy under which the general contractor was an additional insured.

VII. SUITS BY INSURERS

A. Constructive Trust & Conspiracy Regarding Life Insurance Bought With Stolen Funds

Where an employee embezzled large sums of money and used some of the money to pay premiums on life insurance, the employer was entitled to a constructive trust on those funds. Further, once it was shown that the embezzler commingled the funds and paid any part of the premium with embezzled funds, the employer was entitled to a constructive trust on funds paid out as well as funds still retained. *Paschal v. Great Western Drilling, Ltd.*, 215 S.W.3d 437 (Tex. App.–Eastland 2006, pet. denied).

In addition, the *Paschal* court held there was sufficient evidence to support the finding that the wife conspired with the employee/husband, based on evidence that they purchased large amounts of women's jewelry without sufficient funds from other sources, and the husband and wife entered into an odd marital agreement requiring payments to the wife, just before the embezzled amounts increased dramatically.

B. Subrogation

The Texas Supreme Court held that the equitable "made whole" doctrine does not apply to a health insurer's contractual right to subrogation or reimbursement. Thus, the insurer could recoup its prior payments for medical benefits from the insureds' tort recovery even though the settlement amount was insufficient to cover the insureds' past medical expenses, future medical expenses, and other damages. *Fortis Benefits v. Cantu*, 234 S.W.3d 642 (Tex. 2007).

A homebuilder's property insurer brought a subrogation action against a land developer to recover monies it paid on claims for damage to homes. *Nathan A. Watson Co. v. Employers Mut. Cas. Co.*, 218 S.W.3d 797 (Tex. App.–Fort Worth 2007, pet. denied). The contract between the homebuilder and the land developer, upon which the insurer brought suit through subrogation, stated that the non-prevailing party in any final judgment would pay the other party's attorney's fees. After the insurer lost at trial, the land developer sought its attorney's fees. The insurer argued that, while it was entitled to assert the homebuilder's rights under the contract, it was not subject to the homebuilder's liabilities under the contract and thus should not have to pay attorney's fees. The court of appeals disagreed and held that "[a]s a matter of public policy,… when an insurer sues in subrogation under a contract, it is entitled to all of the rights of its subrogee and likewise exposed to all of its liabilities." Additionally, the court reasoned that awarding attorney's fees to prevailing defendants in subrogation actions would not increase any risk to insurers, nor would it discourage insurers from pursuing subrogation rights.

C. Contribution Between Insurers

In a case of first impression, the Texas Supreme Court held that one primary insurer did not have a right of contribution or subrogation against another primary insurer that was alleged to have underpaid its share of a settlement. *Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co.*, No. 05-0261 2007 WL 2965401 (Tex. October 12, 2007). Mid-Continent and Liberty Mutual each had $1 million liability policies insuring a highway general contractor. Mid-Continent assessed the insured's liability lower and would only pay $150,000, while Liberty Mutual assessed the liability higher and thought they should split a $1.5 million settlement. Liberty Mutual was also concerned because it had the excess policy. Liberty Mutual funded the $1.35 million, which required its $1 million primary limit and $350,000 from its excess policy. Liberty then sued Mid-Continent, asserting that the latter insurer underpaid and should have to pay its pro rata share. The supreme court held that one primary insurer has no right against another primary insurer for reimbursement. The court reasoned there was no right of contribution, because the "other insurance" clauses in both policies meant the insurers had separate obligations.

The court also held that Liberty Mutual was not subrogated to any right the insured had. Mid-Continent had not breached any contractual duties to the insured. Once the insured's entire loss was paid, it had no contractual right against Mid-Continent to which Liberty Mutual could be subrogated. The court declined to create any common law right or duty, other than the *Stowers* duty to accept a reasonable settlement offer within policy limits. The court noted that plaintiff's $4.5 million settlement offer was not within Mid-Continent's policy limits, so Mid-Continent did not breach its *Stowers* duty. The court declined to create any other duty.

D. Fraud by insured

A court of appeals upheld a jury's finding that an insured had committed insurance fraud in *Abbott v. State*, No. 12-04-00085, 2007 WL 172078 (Tex. App.–Tyler Jan. 24, 2007, no pet.). The insured filed a claim for over $16,000 for the theft of his vehicle, which he claimed was stolen from a hotel parking lot. The prosecution presented the following evidence: no broken glass was found in the parking lot; the vehicle had been stripped in an unusually "clean" manner; the insureds retrieved the vehicle

from the wrecker service, which was unusual; the insured never called the police to check the status of the investigation; and after the police sequestered the vehicle from the insured, they found installed several of the truck's original parts, which had previously been stripped. The insured, owner of an auto repair shop, testified that he had placed an ad offering a reward for the return of the parts after his insurer denied the claim, thereby explaining how the truck's original parts were replaced. However, the court found that the evidence was factually and legally sufficient to support the jury's verdict.

The evidence was sufficient to support an insurance fraud conviction, where there was testimony that the insured took his car to a repair shop and then later reported it stolen. *Adelaja v. State*, No. 14-05-00544-CR, 2006 WL 386856 (Tex. App.–Houston [14th Dist.] December 5, 2006, no pet.) (not reported).

E. Declaratory judgment suits

An injured third party claimant was not bound by res judicata to a default judgment in favor of the insurer finding no coverage, where the injured third party was not named in the declaratory judgment suit. *El Naggar Fine Arts Furniture, Inc. v. Indian Harbor Ins. Co.*, No. 01-05-01069-CV, 2007 WL 624535 (Tex. App.–Houston [1st Dist.], March 1, 2007, pet. filed).

An insurer could seek a declaration that the claim in a *Stowers* suit was excluded, where that issue would not necessarily be reached in the *Stowers* suit. *Yorkshire Ins. Co. v. Diatom Drilling Co.*, No. 07-05-0386-CV, 2007 WL 1287720 (Tex. App.– Amarillo May 2, 2007, pet. filed) (not reported) ("*Yorkshire II*"). The plaintiffs in the *Stowers* suit argued that the insurer could not raise any contractual defenses because it was an unauthorized surplus lines insurer. The court reasoned that if this argument succeeded, the exclusion might not be reached in the *Stowers* suit, so the request for declaratory relief was more than a mere denial of the plaintiffs' claim.

An insurer could not recover attorney's fees for its declaratory judgment that merely was a denial of the insured's suit for breach of a duty to defend. *Warrantech Corp. v. Steadfast Ins. Co.*, 210 S.W.3d 760 (Tex. App.–Fort Worth 2006, pet. filed).

A plaintiff who was sued by the defendant's insurer in a declaratory judgment action and then was nonsuited was entitled to recover her attorney's fees and mediation costs. *State & County Mut. Fire Ins. Co. v. Walker*, 228 S.W.3d 404 (Tex. App.–Fort Worth 2007, no pet.). The court held the evidence was sufficient to show the fees were reasonable, based on testimony from the plaintiff's attorney as to his background, experience, time spent, and reasonable hourly rates. The same testimony also supported the award of fees for an appeal.

The *Walker* court also found the award was "equitable and just" because if she was properly joined, the plaintiff needed to protect her rights and the fees were necessarily incurred, or if the insurer improperly joined her, then the fees should not have been incurred but were necessary to protect her rights. Still, the court did not address whether the plaintiff/injured third party was a proper party in the declaratory suit.

IX. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Punitive Damages

A car dealership sued its insurer seeking indemnity for damages – including punitive damages – that the dealership had to pay following a suit for slander and intentional infliction of emotional distress. *Daimler-Chrysler Ins. Co. v. Apple*, No. 01-05-01115-CV, 2007 WL 3105899 (Tex. App.–Houston [1st Dist.] Oct. 25, 2007, no pet. h.). The insurer argued that public policy prevented it from indemnifying the dealership for the punitive damages award. To do so, the insurer maintained, would allow the wrongdoers to escape punishment. The court disagreed with this argument. Instead, the court found that public policy does not prohibit insurance coverage for punitive damages in all cases. In this case, the court determined that providing coverage for punitive damages would not violate public policy. First, the court noted that the policy unambiguously provided coverage and was the product of an arm's-length transaction that was not dictated by a statutory requirement. The public policy of respecting liberty to contract thus supported enforcement of coverage, in the court's view. Second, the court found that, because the wrongdoers in this case were the employees, rather than the dealership itself, the punitive damages would not be punishing the right person. Therefore, the court held that the dealership was entitled to indemnity for the punitive damages award.

B. Prejudgment & Postjudgment Interest

In *State Farm Life Insurance Co. v. Martinez*, 216 S.W.3d 799 (Tex. 2007), as noted above, the court considered the effect of the life insurer's interpleader on the accrual of penalties under the prompt payment statute. The *Martinez* court also held that an insurer's filing of an interpleader would halt the accrual of prejudgment interest. The court reasoned that the beneficiary could recover interest on the proceeds in the registry of the court, so that continuing to allow recovery of interest from the insurer would be double recovery.

C. Attorney's Fees

A plaintiff's settlement agreement superseded a prior Rule 11 agreement and thus precluded the plaintiff's lawyers from recovering a fee from the insurer based on recovery of a worker's compensation lien. *Yasuda Fire & Marine Ins. Co. v. Criaco*¸ 225 S.W.3d 894 (Tex. App.–Houston [14th Dist.] 2007, no pet.).

An insured filed claims for healthcare benefits from his health insurer after he was in a car accident. After the insurer delayed investigating and paying his claims, the insured brought suit under former article 21.21 of the Insurance Code. The jury found for the insured on his statutory claim and awarded damages for future physical impairment and for conduct committed knowingly. However, the jury failed to award attorneys' fees. On appeal, the insured argued that he was entitled to fees because the evidence was uncontroverted. While the court agreed that article 21.21 mandated recovery of attorneys' fees to a prevailing plaintiff who recovers damages on a claim, the court found the insured failed to establish as a matter of law that his attorneys' fees were reasonable and necessary. According to the court, the testimony

of the insured's lawyer, which referred to the amount and described it as "reasonable" for the work completed, merely raised a fact issue. The court found that the insured's lawyer controverted her own testimony by providing several alternatives to the amount she opined was reasonable. The lawyer also failed to perform a step-by-step calculation of a total amount and acknowledged that her figures were estimates. The court concluded that the lawyer's equivocation on the amount of attorneys' fees prevented a determination as a matter of law and raised a fact issue for the jury to resolve. *Rosenblatt v. Freedom Life Ins. Co. of America*, No. 01-05-01107-CV, 2007 WL 2215157 (Tex. App.–Houston [1st Dist.] Aug. 2, 2007, no pet.).

An unauthorized insurer that does not meet the statutory requirements for an exception is precluded from asserting its contract based defenses.

D. Personal Injury Damages

In a suit for underinsured motorist benefits the court found sufficient evidence to support the award of $15,000 for future medical expenses, based on testimony from the treating physician that the insured's back could easily fail and that in all medical probability she would require further interventions. *Bituminous Casualty Corp. v. Cleveland*, 223 S.W.3d 485 (Tex. App.–Amarillo 2006, no pet.).

The *Cleveland* court also found sufficient evidence to support a $35,000 award for past and future lost earning capacity. The insured offered evidence comparing her actual earnings before and after the injury, based on payroll records, and she provided evidence of restrictions on her daily activities and unfavorable prognosis for recovery.

The *Cleveland* court did reverse the award for past medical expenses, because there was no proof of reasonableness. The court held that proof of the expenses was not proof they were reasonable. The affidavits offered to support reasonableness were insufficient, because they were not filed at least thirty days before presentation of the evidence.

X. DEFENSES & COUNTERCLAIMS

A. Appraisal Award

An insurer waived its right to demand appraisal of a hail damage claim by denying coverage. *In re Acadia Ins. Co.*, No. 07-07-0211-CV, 2007 WL 1976111 (Tex. App.–Amarillo July 9, 2007, orig. proceeding). The trial court did not abuse its discretion by denying appraisal, based on evidence that the insurer denied the claim and had taken the position in writing that it was not required to agree to appraisal because it did not want to waive its coverage issue.

In another appraisal case, a court held there was a fact issue on whether the damages in the appraisal award were caused by covered "water damage" as stated in the award or were caused by excluded mold, as contended by the insurer. Thus, the trial court erred by granting summary judgment for the insurer finding that it had paid all the amounts caused by water damage and was not required to pay amounts caused by mold. *Timberlake v. Metropolitan Lloyds Ins. Co.*, 230 S.W.3d 798 (Tex. App.–Dallas 2007, pet. denied).

B. Limitations

The two-year contractual limitations period in a homeowner's policy prevented the insureds from suing their insurer over its denial of their claim for roof and water damage in *Watson v. Allstate Texas Lloyd's*, 224 F. App'x 335 (5th Cir. 2007). The insureds' house had a leaking roof several years before, and the insurer denied coverage to repair it because the leak was due to wear and tear. The insureds did not repair the roof after their claim was denied. Subsequently, a portion of the ceiling collapsed, and the insureds filed a claim. Again, the insurer denied the claim. The court held that, because the roof collapse was due to worsening of the leak damage for which the insurer had denied coverage three years before, the insureds' new claim was simply a reinstatement of their earlier claim. As such, the limitations period did not start over, and the insureds' claim was time-barred.

C. Preemption

Holders of a deed of trust in real property sued a flood insurer for an equitable lien arising out of a flood insurance policy issued to the property owners in *Hanak v. Talon Ins. Agency, Ltd.*, 470 F. Supp. 2d 695 (E.D. Tex. 2006). The court granted summary judgment in favor of the insurer on grounds that the plaintiffs' claims were preempted by the National Flood Insurance Act (42 U.S.C. 4001, *et seq.*), because the terms of the policy so provided and because the state law conflicted with the NFIA.

D. Res Judicata & Collateral Estoppel

A bank sued its insurance company, as issuer of a fidelity bond, after the bank had to pay $845,000 to settle a suit brought by a partnership after a partner improperly deposited partnership funds into his separate account at the bank. *Citibank Texas v. Progressive Cas. Ins. Co.*, No. 07-10142, 2007 WL 4126779 (5th Cir. Nov. 21, 2007). The insurer did not participate in the underlying suit, though it had the right to do so. The bond provided coverage for losses resulting from the bank's acceptance or payment of negotiable instruments with unauthorized signatures or endorsements. Settlement in the underlying case was precipitated by the trial court's finding that the bank was liable for honoring unauthorized endorsements. In the bank's suit against the insurer, the district court held the insurer liable to the bank on grounds that collateral estoppel barred the insurer from relitigating the issue of the bank's liability to the partnership. On appeal, the Fifth Circuit affirmed the district court's holding, finding that the insurer was collaterally estopped from relitigating the issue of the bank's liability. The court noted that "[a]n insurer that has the right or duty to defend a suit against an insured but fails to do so is generally bound by the judgment in that suit." Because the insurer had the right to participate in the bank's defense under the bond agreement, but chose not to, the insurer was bound by the trial court's findings in the underlying suit.

E. Waiver

In a suit brought by life insurance beneficiaries, the insurer sought summary judgment arguing that the beneficiaries waived their rights by negotiating a check refunding the insured's premiums. The court denied the insurer's motion, finding that the evidence did not prove, as a matter of law, that the beneficiaries knew of their rights to pursue a claim to benefits under the policy. *Kirk v. Kemper Investors Life Ins. Co.*, 448 F. Supp. 2d 828 (S.D. Tex. 2006).

F. Insurer's Waiver of, or Estoppel to Assert, Defenses

An insured was sued for failing to preserve the plaintiff's funds, which were initially labeled "premium funds" but in an amended petition were called "business assets." *Nat'l Fire Ins. Co. v. Entm't Specialty Ins. Services, Inc.*, 485 F. Supp. 2d 737

(N.D. Tex. 2007). Prior to the amended petition, the insured sought a defense from its insurer. The insurer denied any duty to defend. After the amended petition was filed, the insurer sought a declaratory judgment that it had no duty to defend under a "care, custody or control" exclusion that was not listed in its letter. The insured argued that the insurer had waived its right to assert the "care, custody or control" exclusion by failing to list it. The court, however, disagreed for two reasons. First, the insurer could not have knowingly waived its right to assert the exclusion because the letter was written prior to the amended petition, at which time the insurer lacked information revealing the applicability of that exclusion. Second, the insurer's letter included disclamatory language that effectively reserved other defenses to coverage. Because the "care, custody or control" exclusion applied, the insurer had no duty to defend.

G. Preclusion of Defenses By An Unauthorized Insurer

In a dispute over liability coverage, the plaintiffs as assignees of the insured defendant argued that the liability insurers were unauthorized surplus lines insurers and, therefore, were precluded from asserting any contractual defenses. The court of appeals agreed that an unauthorized insurer that does not meet the statutory requirements for an exception is precluded from asserting its contract based defenses. *Yorkshire Insurance Co. v. Seger*, No. 07-05-00188-CV, 2007 WL 1771614 (Tex. App.–Amarillo June 20, 2007, pet. filed) ("*Yorkshire I*"). The court concluded there was a fact issue on whether the insurers met their burden to prove the insurance had been procured through a licensed surplus lines agent.

The *Yorkshire I* court also noted that the insurers would be precluded from an asserting contract based defenses if the plaintiffs established any violation of the surplus lines requirements that were material and intentional. However, because the plaintiffs did not allege material and intentional violations, they were not entitled to summary judgment on this issue.

H. Late Notice

A showing of prejudice was required where the policy expressly said that late notice would only bar coverage if the insurance company was prejudiced. *Coastal Refining & Mktg., Inc. v. United States Fidelity & Guar. Co.*, 218 S.W.3d 279 (Tex. App.–Houston [14th Dist.] 2007, pet. filed). That court found no evidence that the insurer was prejudiced, even though it was belatedly brought into a case that was being defended, with ongoing settlement negotiations by another insurer. There was no showing that the defense was deficient or that the complaining insurer's investigation was impaired.

The *Coastal Refining* court also rejected the argument that the settlement was a voluntary payment and that settlement without the insured's consent would bar coverage. The insurer could not show how it was prejudiced by the settlement, which the evidence showed to be "more than reasonable" given the potential liability of the insured defendant. Finally, the *Coastal Refining* court rejected the insurer's argument that, by giving late notice and by demanding coverage, the insured failed to cooperate. The court also found the insurer did not show it was otherwise prejudiced by any failure to provide information.

I. Misrepresentation By Policyholder

In a suit brought by life insurance beneficiaries, the insurer sought summary judgment on grounds that the insured had misrepresented her health conditions. The court denied summary judgment on the element of intent to deceive. The court concluded that "an insured's intent to deceive may not be proved by summary judgment evidence of the insured's knowledge of their [sic] actual health condition or of even substantial disparity between the representations made on the insurance application and the insured's knowledge." *Kirk v. Kemper Investors Life Ins. Co.*, 448 F. Supp. 2d 828 (S.D. Tex. 2006).

X. PRACTICE & PROCEDURE

A.Standing

A court of appeals addressed whether a third party claimant had standing to sue the defendant's liability insurer for breach of contract, fraud, and negligent misrepresentation in *Cessna Aircraft Co. v. Aircraft Network, L.L.C.*, 213 S.W.3d 455 (Tex. App.–Dallas 2007, pet. denied). Cessna damaged a plane that belonged to Aircraft Network. Cessna's insurer, AAU, undertook to resolve Cessna's liability, including damages resulting from the cost of leasing replacement aircraft while repairs were made. The insurer promised to reimburse Aircraft Network, but the parties then disagreed on the proper amount. The jury found for Aircraft Network on its claims against the insurer for fraud, negligent misrepresentation, and breach of the reimbursement contract. The court nevertheless held, relying on decisions holding that an injured third party does not have standing to sue under the Insurance Code, that Aircraft Network lacked standing to sue the insurer.

The court's analysis is wrong. The cases it relied on addressed an injured third party's standing to sue for unfair insurance practices in the context of settling a third party claim. *See Transp. Ins. Co. v. Faircloth*, 898 S.W.2d 269 (Tex. 1995); *Allstate Ins. Co. v. Watson*, 876 S.W.2d 145 (Tex. 1994). These cases say nothing about whether an insurer may be liable to a third party claimant, when the insurer engages in conduct that establishes a contract, fraud, or negligent misrepresentation, as the jury found. The concern the supreme court had, that imposing duties on an insurer toward a third party claimant might conflict with the duties already owed to the insured, are not implicated in this type of case. Nothing in the duties the insurer owes its insured allows it to make misrepresentations to the injured third party.

The Fifth Circuit held that a plaintiff in an underlying case lacked standing to appeal a judgment against the defendant's liability insurer in *Scottsdale Ins. Co. v. Knox Park Constr., Inc.*, 488 F.3d 680 (5th Cir. 2007). Although the insurer had joined the underlying plaintiff as a co-defendant in the insurer's declaratory judgment action, the plaintiff never filed a claim against the insurer, but instead joined a co-defendant's motion for summary judgment. The court held that the underlying plaintiff "cannot champion a claim" brought by a co-defendant when it had not itself filed a claim against the insurer. Furthermore, the court reasoned that because the underlying plaintiff was neither the insured nor the insurer in the dispute, it had no direct financial stake in the outcome of the case.

An estate representative brought suit against a fire insurer under the Texas Insurance Code regarding the insurer's denial of the decedent's claim for fire damage to his home. *Launius v. Allstate Ins. Co.*, No. 3:06-CV-0579-B, 2007 WL 1135347 (N.D. Tex. April 17, 2007). The insurer argued that the estate representative lacked standing to bring claims under the Insurance Code on behalf of the estate. The district court agreed, finding that the punitive damages available under the Insurance Code are personal in nature and, thus, do not survive and cannot be brought by a representative of the decedent's estate.

B. Removal

A federal court remanded a case because the parties lacked complete diversity in *Jones v. Ace American Ins. Co.*, No. 1:06-CV-616, 2006 WL 3826998 (E.D. Tex. Dec. 22, 2006). The defendants argued that the federal court had jurisdiction because

the plaintiff, a Texas citizen, fraudulently joined the insurance adjuster, also a Texas citizen, to defeat diversity. The court disagreed and found that the adjuster was properly joined. The adjuster was a "person" who could be sued under the Texas Insurance Code, and the facts alleged by the plaintiff set forth viable claims as to the adjuster.

By contrast, another federal court denied the plaintiff's motion to remand because it found that a nondiverse adjuster was improperly joined in *Frisby v. Lumbermens Mutual Cas. Co.*, No. H-07-015, 2007 WL 2300331 (S.D. Tex. Feb. 20, 2007). The plaintiff did not separate actions attributable to the insurance company from those attributable to the adjuster. The court looked to the record as a whole – rather than to the plaintiff's state court petition alone – to assess whether the adjuster was properly joined. The court found no evidence showing that the adjuster "personally committed any of the acts which [the plaintiff] accuses her of committing." The court found that the plaintiff alleged no viable claims against the adjuster, making her joinder improper and her citizenship irrelevant for diversity purposes.

After the initial denial of remand, the plaintiff in *Frisby* reurged remand based on the defendants' motions for summary judgment. *Frisby v. Lumbermens Mutual Cas. Co.*, No. H-07-015, 2007 WL 2141388 (S.D. Tex., July 25, 2007). This time, the court found that the defendants had aligned their defenses with that of the adjuster. Because the "only proffered justification for improper joinder is that there is no reasonable basis for predicting recovery against the in-state defendant, and that showing is equally dispositive of all defendants rather than to the in-state defendants alone," the defendants failed to show that the non-diverse adjuster was joined solely to defeat diversity. Therefore, the adjuster's citizenship was relevant, and remand was necessary.

C. Jurisdiction

The wife and child of a deceased insured sued his insurer and its adjuster on grounds that the insurer improperly denied their claim for workers' compensation survivor death benefits in violation of Texas law. *Gasch v. Hartford Accident & Indem. Co.*, 491 F.3d 278 (5th Cir. 2007). Both the plaintiffs and the adjuster were Texas citizens. Nevertheless, the insurer removed to federal court on diversity grounds, asserting that the adjuster had been improperly joined. The plaintiffs did not seek a remand, and the district court granted summary judgment in favor of the insurer and the adjuster. On appeal, the Fifth Circuit considered *sua sponte* whether the adjuster was improperly joined and whether the federal court actually had jurisdiction over the case. The court found that the adjuster was properly joined because the Texas Insurance Code permits suits against adjusters in their individual capacities and because the allegations and evidence against all defendants was identical. Therefore, the parties were not completely diverse, the federal court lacked subject matter jurisdiction over the case, and the district court's summary judgment was vacated.

D. Discovery

In a suit for hail damage brought by a hotel owner, the trial court properly allowed discovery of financial records from the insured's banker and accountant. However, the court's order was overly broad as to the insured's son, who had no ownership interest. The court's order was also overly broad in ordering production of tax returns, because it was not clear the information could not be obtained from the other financial records. Finally, the court held that, assuming there is a statutory accountant privilege, the court's order was sufficient to allow discovery of financial records from the accountant. *In re Patel*, 218 S.W.3d 911 (Tex. App.–Corpus Christi 2007, orig. proceeding).

The court held that the attorney general had to meet the normal class action requirements – numerosity, commonality, typicality, and adequacy of representation.

A court of appeals granted mandamus relief on grounds that the trial court abused its discretion by requiring disclosure of a reservation of rights letter to the plaintiff. The court found that the reservation of rights letter was not a part of the "existence and contents" of the insurance policy at issue and, therefore was not discoverable under Rule 192.3(f). Additionally, the letter was deemed not to be discoverable under Rule 192.3(a), because the plaintiff had already received a copy of the insurance policy and the policy limits and thus the letter was not reasonably calculated to lead to the discovery of admissible evidence. Even assuming the letter was discoverable, the court found that the work product privilege under Rule 192.5(b)(2) applied because the plaintiff failed to show he had a substantial need for the letter. *In re Madrid*, No. 08-06-00319-CV, 2007 WL 2965782 (Tex. App.–El Paso Oct. 11, 2007, orig. proceeding).

E. Experts

In a suit by an employer to trace embezzled funds to impose a constructive trust on life insurance proceeds, the trial court properly allowed expert testimony from a CPA. The accountant provided testimony tracing the embezzled funds to the payment of premiums using a method that assumed the employee first paid family expenses, not including the life insurance premiums, with his legitimate income so that all of the premiums were paid from embezzled funds. *Paschal v. Great Western Drilling, Ltd.*, 215 S.W.3d 437 (Tex. App.–Eastland 2006, pet. denied).

F. Class Actions

In 1973, the legislature gave the attorney general the power to bring an insurance class action. Finally, one was tried, thus prompting the supreme court to consider the standards the attorney general had to meet, in *Farmers Group, Inc. Lubin*, 222 S.W.3d 417 (Tex. 2007). The Texas Department of Insurance found Farmers guilty of inadequate disclosure and discrimination in its homeowners rating practices. After the department issued a cease-and-desist order and initiated proceedings to collect administrative penalties, Farmers announced it would withdraw from the Texas homeowner's insurance market. Ultimately, the parties agreed to a settlement, and the attorney general filed a class action seeking approval of the settlement. Five policyholders intervened and objected to the class certification and settlement.

The supreme court rejected the argument by the attorney general that it had authority under the doctrine of *parens patriae* to bring a class action without meeting the normal certification requirements. The court found no evidence that the legislature intended such an exception when it authorized a class action to be brought by the attorney general.

The court held that the attorney general had to meet the normal class action requirements – numerosity, commonality, typicality, and adequacy of representation – because those are what make a suit a class action.

On the other hand, the court rejected the intervenors' argument that the attorney general had to actually join individual policyholders as class representatives. The attorney general could

bring a class action by meeting the four normal requirements applied to the claims, not to the attorney general as a party.

A trial court properly applied the Texas Securities Act to class action claims against a Texas insurer on behalf of policyholders worldwide. The court reasoned that because the specific claim was for violating the Texas Securities Act, that statute would govern the dispute, without the need to conduct an extensive choice of law analysis or decide which jurisdiction had the most significant relationship. *Citizens Ins. Co. v. Daccach*, 217 S.W.3d 430 (Tex. 2007). The plaintiffs alleged that the insurer failed to register with the Texas Securities Board before offering or selling securities from Texas.

A party injured by a subcontractor's negligence could sue the party who hired the subcontractor as a third party beneficiary for failing to obtain liability coverage.

The court also held that the trial court did not abuse its discretion in concluding that there were enough contacts with Texas so that application of Texas law did not offend any constitutional requirements. The defendants were Texas residents, the insurer maintained its principal place business in Texas, advertising materials were created and sent from Texas and a significant portion of the dispute activities occurred in Texas.

The *Daccach* court also considered whether the abandonment of certain claims by the class representative would bar class members from individually pursuing those claims, and if so, whether that abandonment made the class representative inadequate or made a class action inappropriate. The court concluded that res judicata would apply to any claims the class representative abandoned, under the same principles applicable to non-class cases. However, the court also found that it could be tactically proper to abandon those claims. The court further held that to protect absent class members from the preclusive effect of res judicata it was important that they be given notice and the opportunity to opt out and preserve claims that the class representative abandoned. Finally, the court concluded that the trial court had to consider the risk that a judgment might preclude subsequent litigation of claims not alleged, when deciding adequacy of representation requirement.

The supreme court decertified another class in a suit brought on the equitable theory of money had and received to recover premiums the class representatives allege were charged in a uniform, misleading telemarketing scheme. The court concluded that common issues would not predominate. The equitable claim of money had and received required a showing that the insurer had premiums which in equity and good conscience belonged to the plaintiffs. The court reasoned that the defendant was entitled to show any facts regarding the individual plaintiffs – such as knowledge regarding the insurance – that would show it was not inequitable for the defendant to keep the premiums. *Stonebridge Life Ins. Co. v. Pitts*, No. 06-0655, 2007 WL 2457626 (Tex. August 31, 2007).

G. Severance & Separate Trials

A trial court abused its discretion by granting a bifurcation, instead of severance, of extracontractual claims and contact claims against an underinsured motorist insurer. *In re Allstate County Mut. Ins. Co.*, No. 12-06-00164-CV, 2006 WL 3735116 (Tex. App.–Tyler December 12, 2006, orig. proceeding) (not reported). The court of appeals concluded that when coverage is disputed but the insurer has made settlement offers, severance is the only option to protect the rights of the claimant to introduce evidence of settlement offers on the extracontractual claims, and the right of the insurer to exclude such evidence on the contract claims. However, the court held that the trial court did not abuse its discretion by refusing to abate the extracontractual claims until the contract claim was determined. The court reasoned that the trial court did not abuse its discretion by allowing discovery to go forward on both claims.

H. Court's Charge

A trial court properly rendered judgment n.o.v. against an insured, despite the jury's finding that the insurance agent breached its contract by failing to obtain insurance, where the insured did not obtain a jury finding that the breach caused damages. The jury's finding of damages in response to a question conditioned on other liability theories was not sufficient. *Triumph Trucking, Inc. v. Southern Corporate Ins. Managers, Inc.*, 226 S.W.3d 466 (Tex. App.–Houston [1st Dist.] 2006, pet. denied).

The *Triumph* court also held that the insured did not conclusively show damages, because the issue was disputed and the insurance agent offered proof that the insured trucking company actually saved money by operating without insurance.

A court held that a property insurance policy was ambiguous as to whether a building collapse caused by corrosion was a covered loss, and that the issue was properly submitted to the jury. *Certain Underwriters at Lloyd's Subscribing to Policy No. WDO-10000 v. KKM Inc.*, 215 S.W.3d 486 (Tex. App.–Corpus Christi 2006, pet. denied). The policy excluded coverage for damage caused by "corrosion,… [or] decay" but provided additional coverage for a building collapse caused by "[d]ecay that is hidden from view." The insured's building collapsed due to corrosion, leaving open the question of whether corrosion could be considered decay under the policy. Because the policy failed to define these terms and because their plain meanings are similar, the court held that the policy was ambiguous, so the coverage issue was properly submitted to the jury. The court remanded the case because the jury was not instructed on the fortuity doctrine even though there was conflicting evidence regarding whether the insured knew or should have known of ongoing corrosion in the building.

I. Causation

A party injured by a subcontractor's negligence could sue the party who hired the subcontractor as a third party beneficiary for failing to obtain liability coverage. However, because the injured party had dismissed the subcontractor, who had filed bankruptcy, and limitations would bar any claim against the subcontractor, the injured party could never obtain a judgment against the subcontractor. Without a judgment, she could not show that the failure to get liability insurance caused her any damages. Thus, summary judgment for the defendant who should have obtained coverage was proper. *Howell v. TS Communications, Inc.*, 209 S.W.3d 921 (Tex. App.–Dallas 2006, no pet.).

J. Enforcement of Final Probate Order

A probate court that approved a settlement for $50,000 also properly granted an order to enforce that award when the insurer refused to pay and contended the policy limits were only $25,000. *Metropolitan Cas. Ins. Co. v. Foster*, 226 S.W.3d 597 (Tex. App.–Houston [1st Dist.] 2007, no pet.). The probate court approved a settlement involving a minor in a wrongful death suit, based on the insurer's agreement to pay $50,000. The insurer later discovered the policy limits were $25,000 and tried to withdraw its consent. The probate court granted an order enforcing the

prior order. The court of appeals affirmed, holding that the initial order approving the settlement was final and appealable. Because the insurer took no action within the required time, it was too late to raise the argument that the policy limits were less.

K. Disqualification of Attorney As Witness

In a *Stowers* suit, the insurer argued that the plaintiff's lawyers who tried the underlying case were disqualified because they were material witnesses and were to be paid on a contingent fee basis. The court rejected both arguments. First, the court held that even if the lawyers were disqualified, the insurer could not show actual prejudice. Second, the insurer failed to identify any evidence establishing that the attorneys were being paid on a contingent basis. *Yorkshire Ins. Co. v. Seger*, No. 07-05-00188-CV, 2007 WL 1771614 (Tex. App.–Amarillo June 20, 2007, pet. filed) ("*Yorkshire I*").

L. Notice of Appeal

An appellate court held that it could not consider an insurer's issues on appeal because the insurer failed to file a notice of appeal. *Warwick Towers Council of Co-Owners v. Park Warwick, L.P.*, 218 S.W.3d 149 (Tex. App.–Houston [14th Dist.] 2007, pet. denied). The insurer and the insured were independent parties in the trial, and the trial court's judgment was entered against each on independent grounds. Therefore, the court found that the insured's notice of appeal filed solely under its name did not relate to the trial court's disposition of the insurer's claims.

XII. Other

A. Insurance Regulation

An automobile insurer and an auto body shop brought suit to challenge the constitutionality of a Texas statute – House Bill 1131, codified as Tex. Occ. Code § 2307.001, et seq. – that generally prohibits automobile insurers from owning any interest in body shops in Texas. *Allstate Ins. Co. v. Abbott*, 495 F.3d 151 (5th Cir. 2007). The insurer and body shop argued that the statute violates both the Commerce Clause and the First Amendment of the United States Constitution. The Fifth Circuit held that the statute did not violate the Commerce Clause, but portions of it did violate the First Amendment.

As to the Commerce Clause challenge, the court found that the legislative history revealed that the statute was motivated by legitimate consumer protection concerns and was not intended to discriminate against out-of-state companies. Additionally, the statute's distinction between independent auto body shops and insurer-owned ones was constitutionally permissible.

As to the First Amendment challenge, the court found that portions of the statute prohibiting insurers from giving an exclusive recommendation to a body shop owned by the insurer violated the First Amendment as excessive restraints on commercial speech. The court reasoned that it was not illegal for the insurer to have a business affiliation with the body shop and thus there was no legal prohibition preventing the insurer from communicating that affiliation to consumers. Furthermore, the court found that the restrictions on commercial speech were not narrowly tailored to achieve the government's legitimate interest.

*Mark L. Kincaid is a partner with Kincaid & Horton, L.L.P. in Austin. He graduated with honors from the University of Texas Law School and teaches Texas Insurance Litigation there as an adjunct professor. He is board-certified in Consumer Law, Civil Trial Law, and Civil Appellate Law. He is co-author of West's Texas Practice Guide on Insurance Litigation, and has written and spoken frequently on insurance and consumer issues. Elizabeth R. von Kreisler is an associate with Kincaid & Horton, L.L.P. She graduated from Reed College with a B.A. (2002), and the Texas Tech University School of Law (2007).

1. An author of this paper was the attorney of record for the beneficiary in this case.