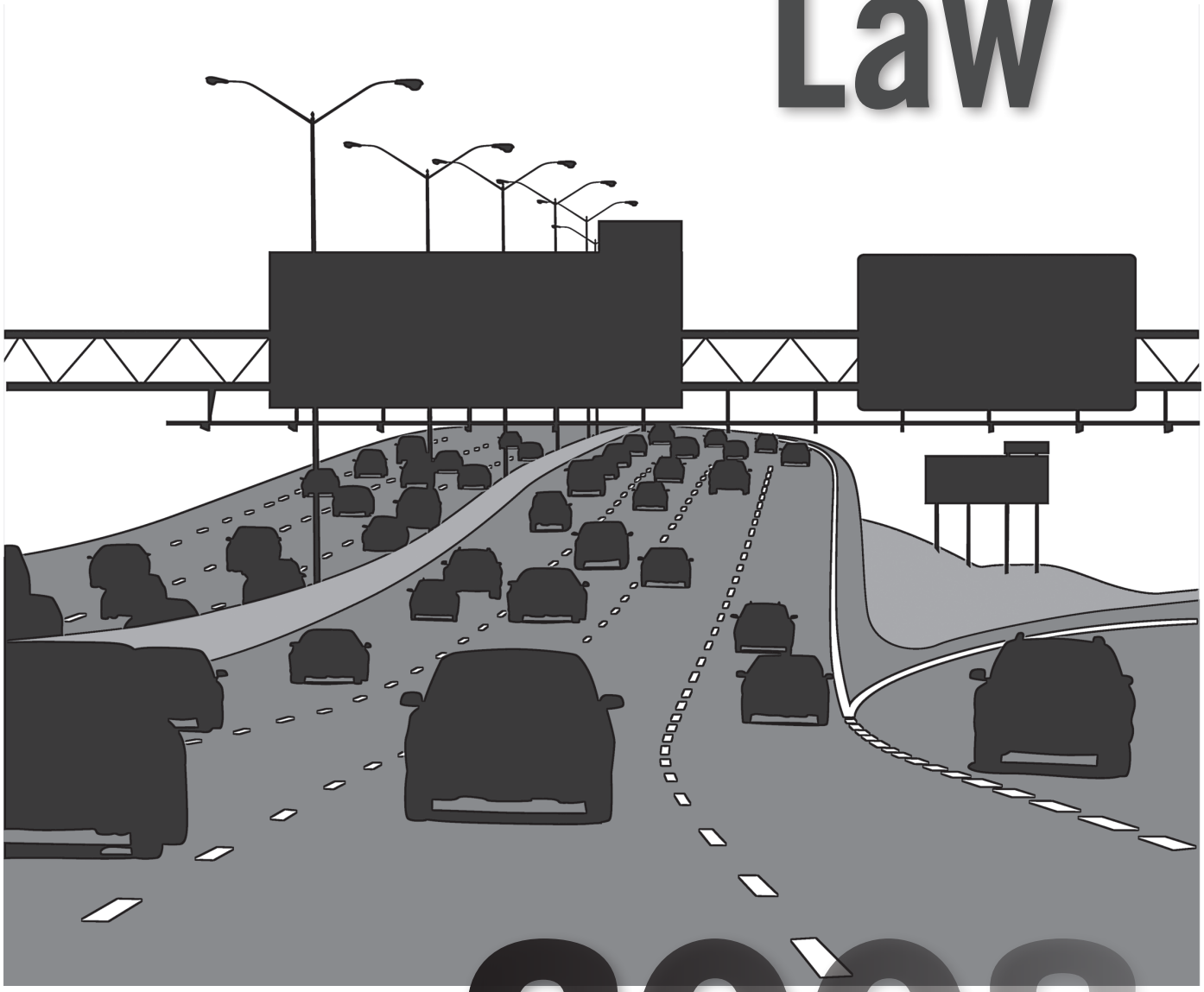
Annual Survey of

Texas Insurance Law



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I. INTRODUCTION

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This survey period included an unprecedented number of significant decisions from the Texas Supreme Court. Significantly, many of the decisions favored insureds. For example, in a particularly important decision, *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008), the court clarified the limits of *Gandy* and the options available to defendants/insureds to protect themselves from insurers' breaches. The court revived its decision from *Employers Casualty Co. v. Block*, to hold that the insurer's denial of coverage barred it from challenging the reasonableness of the settlement.

In another important decision, the court held that an insurer was not estopped to assert lack of coverage, and did not waive the argument that a claim outside the coverage period was not covered. *Ulico Cas. Co. v. Allied Pilots Ass'n*, 262 S.W.3d 773 (Tex. 2008). The court rejected the "*Wilkinson* exception," which held that a liability insurer waives the argument that a claim is not covered when it assumes control of the defense without an effective reservation of rights. The court also held that an insurer may use its own staff attorneys to defend a claim against an insured, if the insurer's interest and the insured's interest are "congruent," but not otherwise. *Unauthorized Practice of Law Comm. v. American Home Assurance*, 261 S.W.3d 24 (Tex. 2008). And in *National Union Fire Insurance Co. v. Crocker,* 246 S.W.3d 603 (Tex. 2008), the court held that a liability insurer has no duty to inform an additional insured that coverage may be available and no duty to tender a defense unless one is demanded, even though the additional insured was unaware of coverage.

The court finally decided in *Excess Underwriters at Lloyd's v. Frank's Casing Crew & Rental Tools, Inc.,* 246 S.W.3d 42 (Tex. 2008), that a liability insurer that settles a claim on which coverage is disputed has no right of reimbursement, and reaffirmed its holding in *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, 242 S.W.3d 1 (Tex. 2007), in *Grimes Construction, Inc. v. Great American Lloyds Insurance Co.,* 248 S.W.3d 171 (Tex. 2008). In *Grimes,* the court held that claims for defective construction by a homebuilder potentially state claims for an "occurrence" or "property damage" covered by a builder's commercial general liability policy.

The court also held that homeowners waived their right to arbitration by initially opposing arbitration, litigating for fourteen months, conducting extensive discovery, and then invoking arbitration shortly before trial. *Perry Homes v. Cull*, 258 S.W.3d 580 (Tex. 2008). In another homeowner case, the court adopted the "actual injury" or "injury in fact" rule to hold that damages "occurred" during the policy year when actual physical damage to the property occurred, not when the damage was or could have been discovered. *Don's Bldg. Supply, Inc. v. OneBeacon Ins. Co.*, 51 Tex. Sup. Ct. J. 1367, 2008 WL 3991187 (Tex. Aug. 29, 2008).

Finally, in an employment liability policy case, the court held that the employer's liability policy would cover exemplary damages in certain contexts and then held that such coverage would not violate public policy. *Fairfield Ins. Co. v. Stephens Martin Paving, L.P.*, 246 S.W.3d 653 (Tex. 2008).[1]

II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile Insurance

An automobile's collision with an axle-wheel assembly that separated from an unidentified semi-trailer truck was not "actual physical contact" by an unknown "motor vehicle" as required to invoke coverage under the driver's uninsured/underinsured motorist coverage. *Nationwide Ins. Co. v. Elchehimi*, 249 S.W.3d 430 (Tex. 2008). The UM statute provides coverage for injury caused by an unidentified motorist when "actual physical contact" occurred between the motor vehicle owned or operated by the unknown person and the personal property of the insured. The court reasoned that the detached axle and wheels were not a "motor vehicle." The court distinguished prior cases that allowed recovery when an unknown car strikes another car, which then strikes the insured vehicle. The court relied on other cases where objects fell from an unknown vehicle but coverage was denied. While most of the prior courts considered cargo, one prior decision did involve a part of the vehicle itself but held this was not enough to satisfy the "strict" statutory requirement.

Justice O'Neill dissented. She found that the statute provided coverage if there was contact with an integral part of the unknown vehicle, and that doing so was consistent with liberally construing the statute to protect insureds. The majority disagree with this approach, finding the legislature "drew a relatively bright line, and we decline to fuzz it up."

It seems the dissenting justice has the better of the argument. A statute is to be construed liberally to promote its un-

derlying purpose. In this instance, the purpose is to protect financially responsible drivers from those who lack resources. The legislature extended this principle to include unknown drivers, whose resources would therefore be unavailable. The majority's holding calling for a "strict" construction is unjustified. The Code Construction Act provides that all statutes are to be liberally construed. *See* Tex. Gov't Code § 312.006. This has been the law for quite some time. *See Farmers' & Mechanics' Nat'l Bank v. Hanks*, 104 Tex. 320, 325, 37 S.W. 1120-1123 (1911) (citing 1895 statute). Further, the majority's holding would lead to absurd results. For example, if an insured driver collided with the front of an unknown vehicle, arguably that would not be contact with the "motor vehicle" but only contact with its front bumper. Surely it is consistent with the legislative purpose to conclude that part of a motor vehicle colliding with an insured vehicle is enough.

Surely it is consistent with the legislative purpose to conclude that part of a motor vehicle colliding with an insured vehicle is enough.

An excess insurer sued an automobile insurer seeking a declaration that the automobile insurer's policy provided coverage for claims in an underlying suit. *Gulf Underwriters Ins. Co. v. Great West Cas. Co.*, 278 F. App'x 454 (5th Cir. May 22, 2008). The automobile insurer attempted to exclude coverage of an accident because the operator did not have permission to use the insured trailer. The Fifth Circuit held that summary judgment should not have been granted to the automobile insurer as there was a genuine issue of material fact regarding whether an operator had permission to load and unload an insured trailer.

Insureds under an auto policy sued the insurer for not meeting the filing requirements of Texas Insurance Code section 912.201 in regards to the installment payment plan fees that the insureds were charged. *Farmers Tex. Co. Mut. Ins. Co. v. Romo*, 250 S.W.3d 527, 530-531 (Tex. App.–Austin 2008, no pet.). The insureds argued that it was illegal to collect these fees because a schedule of fees had not been filed with the Department of Insurance. The court held that former article 17.25, section 6 and its successor section 912.201 did not apply to the installment payment plan fees at issue in this case.

A tree fell on Walker's car. The insurer paid her for the car repairs. However, the car needed re-repair due to shoddy work. The policy specifically defined collision as "the upset, or collision with another object." However, the necessity of re-repairs due to poor work did not constitute a "collision." *Walker v. Travelers Indem. Co.*, No. 14-07-00238-CV, 2008 WL 123869 (Tex. App.–Houston [14th Dist.] Jan. 15, 2008, pet. filed).

One court declined to invalidate the "owned vehicle" limit on underinsured motorist benefits to allow a family member whose liability claim was limited to recover UM benefits. *Charida v. Allstate Indem. Co.*, 259 S.W.3d 870 (Tex. App.–Houston [1st Dist.] 2008, no pet.). Charida was injured while riding in a car owned and driven by her father who was insured by Allstate. He had $100,000 in liability coverage, but that was limited to $20,000 because of the family member exclusion. She then sought to recover under the UM benefits of the policy, but the policy provided that UM benefits did not include any vehicle owned by, furnished to, or available for use of the policyholder. Charida argued this limitation should be void as against public policy. The court rejected this argument.

An uninsured driver took possession of a car from an insured car dealership. Before taking possession, the driver signed a purchase order and temporary bailment agreement. The day after taking possession, he was involved in an accident with a pedestrian. Subsequently, the uninsured driver completed the remaining paperwork for the sale of the car with the dealership. The pedestrian then filed suit against both the driver and the dealership. The dealership's insurer defended the dealership but did not defend the driver. After obtaining a judgment against the driver, the pedestrian sued the insurer, arguing that the driver should be considered an insured under the dealership's policy. The policy provided coverage to customers without insurance, but did not provide coverage if the dealership no longer owned the car. In *Trull v. Service Casualty Insurance Co.*, No. 14-07-00314-CV, 2008 WL 2837775 (Tex. App.–Houston [14th Dist.] July 22, 2008, no pet.) (mem. op.), the court held that the transfer of possession and control of the vehicle, pursuant to the parties' intent to effect the sale, determined ownership for insurance purposes. Therefore, the dealership no longer owned the car at the time of the accident, and the insurer was not liable to the pedestrian.

A truck passenger was injured when the driver drove it into a fence. The driver's father owned the truck. The passenger sought coverage from the father's insurer. The insurer paid the policy limits under the father's liability coverage. The passenger then sought additional money under coverage for uninsured motorists. The insurer denied this claim. The court agreed with the insurer in *Upson v. Allstate Indemnity Co.*, No. H-08-01449, 2008 WL 3020880 (S.D. Tex. Aug. 5, 2008). The court determined that the truck was not uninsured. Because the passenger's injuries were caused by the son's negligence while driving the truck, the passenger was not within the coverage for uninsured motorists.

An insured husband was injured in an accident with an underinsured driver, and his insured wife witnessed the accident. *Haralson v. State Farm Mut. Auto. Ins. Co.*, 564 F. Supp. 2d 616 (N.D. Tex. 2008). The husband and wife filed separate state-court suits against their underinsured motorist carrier for breach of contract and statutory violations after they settled their claims against the driver. The UM insurer removed both actions, which were then consolidated. A jury awarded the wife damages for bodily injury as a result of witnessing the accident. The insurer renewed its motion for judgment as a matter of law on the wife's claim. The district court held that physical manifestations of emotional distress, in the form of migraines, stomach aches, and nausea, constituted a bodily injury sufficient to trigger UM coverage. However, the court determined that loss of consortium and loss of household services were not "bodily injury" under the policy, and the insurer was entitled to offset the jury award by the amount of available coverage remaining under the tortfeasor's policy.

B. Homeowners Insurance

The Fifth Circuit held that mold damage is excluded under the standard HO-B policy, despite the policy's "exclusion repeal" provision, which provides that the mold exclusion does not apply to loss caused by water. The court reasoned that this exclusion repeal provision only applies to damaged personal property, not

damage to the dwelling. *Carrizales v. State Farm Lloyds*, 518 F.3d 343 (5th Cir. 2008). The court distinguished the Texas Supreme Court decision in *Balandran*, which held that the "exclusion repeal" provision did apply to limit the exclusion for shifting, cracking, and settling, when the damage to the dwelling was caused by water. *See Balandran v. Safeco Ins. Co.*, 972 S.W.2d 738 (Tex. 1998). The *Carrizales* court distinguished *Balandran* on a basis that the court's construction in the earlier case was required to avoid rendering policy terms meaningless.

The *Carrizales* court also addressed whether the insureds' failure to mitigate their damages was a condition precedent that barred coverage, or just a defense that limited the recovery of any damages that could have been avoided. The court opted for the latter interpretation. The court determined that the duty to mitigate contained in the policy is not a condition precedent but is an affirmative defense that will only limit the insured's recovery to the extent the insurer shows damages that could have been avoided.

In *Salinas v. State Farm Lloyds*, 267 F. App'x 381 (5th Cir. 2008), a couple sought coverage for damage caused by several leaks. The insurer denied some claims, but paid for one. The trial court granted the insurer's motion for summary judgment based on the mold exclusion. The insureds appealed contending that the "exclusion repeal provision" did not exclude mold damage caused by a plumbing leak. The Fifth Circuit disagreed, and held that the interaction between the mold exclusion and the exclusion repeal provisions created no ambiguity and that mold damage is not covered. The Fifth Circuit also concluded that denial of appraisal and abatement was appropriate because coverage and causation issues existed. Appraisal would be improper before those issues were resolved.

Where homeowners had separate leaks in different parts of their house, the insurer was entitled to a deductible for each separate loss. *Garza v. Allstate Texas Lloyd's Co.*, 284 F. App'x 110 (5th Cir. Feb. 6, 2008).

An insured's claim for mold damage was not covered, despite the claim that the damage resulted from water that entered the house after a tree fell on the house, which was a covered claim. The court rejected the argument that the mold exclusion of the policy was somehow overcome by a provision in State Farm's Adjuster's Guide, which stated that if an original claim is covered, such as the damage from wind or a tree, any loss that proximately resulted was covered. *Justice v. State Farm Lloyds Ins. Co.*, 246 S.W.3d 762 (Tex. App.–Houston [14th Dist.] 2008, no pet.).

Another insured faired better on a claim for mold damage resulting from a plumbing leak. *Page v. State Farm Lloyds*, 259 S.W.3d 257, 259 (Tex. App.–Waco 2008, pet. filed). The policy provided coverage for any "physical loss … caused by a peril listed below," including a loss caused by the "accidental discharge, leakage or overflow of water or steam from within a plumbing, heating or air conditioning system or household appliance." The court stated that the named peril was the plumbing leak. The court held that the policy covers any loss (including mold) to the dwelling or its contents resulting from a plumbing leak, subject to the limits of liability shown in the declaration page.

In *Laird v. CMI Lloyds*, 261 S.W.3d 322, 324 (Tex. App.–Texarkana 2008, pet. filed), an insured made a claim after several water leaks appeared in his home. An umpire rendered an appraisal award. However, the insurance company disputed coverage on certain issues. The appeals court stated an appraisal does not bind the insurance company to pay these amounts when questions of causation and coverage remain. The appeals court found that there were fact issues concerning the cause of certain damages that would suggest that the insurer could owe more money on the loss. Therefore, it affirmed the portion of summary judgment relating to extracontractual damages, but otherwise reversed the trial court's summary judgment and remanded the cause to the trial court.

In *State Farm Lloyds v. Hamilton*, No. 05-06-01032-CV, 2008 WL 3984045 (Tex. App.–Dallas Aug. 29, 2008, no pet. h.), the homeowners began to notice signs of structural distress to their foundation, which they reported to State Farm. A leak was found by plumbers whom State Farm sent. State Farm then sent out engineers who concluded that the leaks did not cause the foundation problems. The insureds hired an engineer who stated that the plumbing leak under the living room did cause the foundation damage. State Farm denied the Hamiltons' claim, and a jury found in favor of the Hamiltons. The appeals court upheld the award finding that the Hamiltons' expert was sufficiently reliable and that mental anguish damages were appropriate.

An insurance claim was brought by insureds who filed a claim for mold damage to their home. *Sullivan v. State Farm Lloyds*, 3:05-CV-2000-L, 2008 WL 1775407 (N.D. Tex. April 15, 2008), the court held that the insurance company paid additional living expenses to the insured as required under the policy. However, after the insured sold the residence, he was no longer entitled to additional living expense benefits because his loss was no longer caused by an insured peril under the policy. The court granted the insured's motion for summary judgment on the claim for breach of contract and the related statutory claim for delay in payment.

In *Mao v. State Farm Lloyds, Inc.*, No. 6:07-CV-310, 2008 WL 2148081 (E.D. Tex. May 20, 2008), an individual applied for and executed a property insurance policy. The insured property was owned by the individual's corporation. The individual was the sole shareholder. The corporation leased the property to another entity owned by the individual. After the property burned, the individual filed a claim for lost rents. The insurer denied the claim, asserting that the property belonged to the corporation, which was a separate legal entity from the individual and was not covered by the policy, because the insured listed on the policy was the individual. The court agreed and held that the individual could not collect on a policy insuring property owned by her corporation.

C. Life Insurance

The Fifth Circuit again held that language in a life insurance policy was a warranty and not a good health condition precedent based on language that incorporated representations by the insured. *Qiuhong Liu v. Fidelity & Guaranty Life Ins. Co.*, 282 F. App'x 304 (5th Cir. 2008). The insured applied for insurance signing an application that said statements were complete, true, and correctly recorded, and also stated that no insurance would take effect unless the policy was delivered during the insured's lifetime and while the insured's health was as stated in the application. In the application, the insured stated he had not been diagnosed with cancer. Before the policy was issued, the insured was diagnosed with lung cancer, and he later died from it. The Fifth Circuit repeated the numerous prior cases distinguishing between warranties and conditions precedent. *See Riner v. Allstate Life Ins. Co.*, 131 F.3d 530 (5th Cir. 1997). The court concluded that because the language referred to representations, it would be construed to be a warranty, despite other language that could be construed to be a condition precedent. Because of this construction, the court did not reach the question whether the "general provisions" section of the policy would make statements in the application representations.

The "slayers rule," which bars a beneficiary from recovering if he or she willfully brings about the insured's death, applies even if the slayer's conviction is not final. *In re Estate of Stafford*, 244 S.W.3d 368 (Tex. App.–Beaumont 2008, no pet.).

As part of a divorce decree, an insured had to purchase a life insurance policy naming his ex-wife as an irrevocable beneficiary to be the trustee for the benefit of their daughter. The policy was considered "additional child support." The insured later remarried and submitted a change of beneficiary form to his life insurer. Subsequently, the divorce court terminated the insured's child support obligations. After the insured died, the insurer filed an interpleader action against the ex-wife and the current wife. In *Gray v. Nash*, 259 S.W.3d 286 (Tex. App.–Fort Worth 2008, pet. denied), the court held that the ex-wife was entitled to the proceeds because she remained the designated beneficiary. The court further held that the divorce court's termination of child support did not nullify the designation of the ex-wife as the beneficiary: only a divorce decree or annulment nullifies beneficiary designations. Additionally, the court found that the ex-wife had a continuing insurable interest in the insured's life.

An ex-wife named as beneficiary in a policy issued four years after the divorce had an insurable interest and was entitled to recover life insurance proceeds. The court relied on article 3.49-1 of the Texas Insurance Code, which allows an insured to name any person as a beneficiary. The insured named his ex-wife as beneficiary, without restriction or limitation to any alimony obligation he had. *McCall v. Smith*, 252 S.W.3d 663 (Tex. App.–Houston [14th Dist.] 2008, pet. denied).

A life insurer filed an interpleader action four years after the death of the insured. One of the interpleader defendants challenged the propriety of the interpleader. The court of appeals held that the late filing of the interpleader action was irrelevant. The rules of procedure make no requirement of timeliness. The court similarly held that the rules of procedure do not require a stakeholder to be wholly disinterested in order to bring an interpleader action. *Sparkman v. Reliastar Life Ins. Co.*, No. 13-03-500-CV, 2008 WL 2058216 (Tex. App.–Corpus Christi May 15, 2008, pet. denied) (mem. op.).

In *Reliastar Life Insurance Co. v. Thompson*, No. M-07-140, 2008 WL 4327259 (S.D. Tex. Sept. 16, 2008), Reliastar filed an interpleader against the estate of the spouse of the insured and against the insured's parents to determine who was entitled to the policy proceeds. The parents maintained that the estate should not receive the proceeds because the spouse of the named beneficiary apparently murdered the insured before killing himself. The estate argued that the spouse was never convicted of murdering the insured and that the evidence offered by the parents, such as the police report, was insufficient to prove murder. The court disagreed, noting that the parents only needed to establish by a preponderance of the evidence that the beneficiary had murdered the insured. Portions of the insured's death certificate and the police report were sufficient to establish that the beneficiary willfully brought about the insured's death. Therefore, the beneficiary and his estate were disqualified from receiving the policy proceeds, and the proceeds had to be paid to the parents as the insured's nearest relatives.

D. Disability Insurance

A professional football player injured his ankle and, although it appeared to heal, he was eventually removed from his team's roster. The athlete filed a claim with his disability insurer. The insurer denied coverage, asserting that the athlete was not "totally disabled" and unable to participate in team sports for twelve consecutive months, because the athlete had participated in training camps and pre-season games. The trial court granted summary judgment for the insurer. The athlete argued that his involvement in the camps and pre-season games did not amount to "rehabilitation" as defined by the policy and thus he could not have "participated" in a team sport. The Fifth Circuit rejected this argument as a "complete re-writing of the policy's 'participate' definition" and an unreasonable construction. *Mitchell v. Ace American Ins. Co.*, 265 F. App'x 420 (5th Cir. 2008).

E. Commercial Property Insurance

Where hail damaged roof tiles that were crummy to begin with, the insurer was obligated to pay only the amount necessary to replace the tiles damaged by hail, even though the condition of the other tiles required that the entire roof be replaced. *All Saints Catholic Church v. United Nat'l Ins. Co.*, 257 S.W.3d 800 (Tex. App.–Dallas 2008, no pet.). The court held that to the extent replacement was necessary because of the poor condition of the tiles and not because of hail damage, they were not "damaged property" resulting from the hail storm. The court also reasoned that to the extent the church insisted on treating the roof as a single integrated unit, the doctrine of "concurrent causation" would apply. The court stated that under that doctrine when covered and noncovered perils combined to create a loss, the insured is entitled to recover only that portion of the damages caused solely by the covered peril.

Where a policy clearly excluded damage from "water that backs up or overflows from a sewer, drain, or sump," recovery was limited to the $25,000 allowed by an endorsement that provided for such coverage. The endorsement did not have the effect of repealing entirely the exclusion so that the insured could seek more extensive damages under the general coverage language. *For Kids Only Child Development Center, Inc. v. Philadelphia Indemnity Ins. Co.*, 260 S.W.3d 652 (Tex. App.–Dallas 2008, pet. filed).

F. Other Policies

A policy that covered damage to an offshore drilling platform did not cover "standby" charges incurred when repair vessels were delayed due to tropical storms in the Gulf of Mexico. *Wellington Underwriting Agencies, Ltd. v. Houston Exploration Co.*, No. 14-07-00970-CV, 2008 WL 2834931 (Tex. App.–Houston [14th Dist.] July 17, 2008, pet. filed). The court found "decisive" the fact that the policy had contained a section that covered standby charges, but that provision was lined through by the parties. The court found it was proper in considering the four corners of the policy to consider language that had existed but was struck. The court also found it could disregard an exclusion that would exclude the first forty-eight hours of standby charges. The court rejected the insured's argument that this forty-eight hour limit meant that other standby charges would be covered. The court also reasoned that the express language that would have covered standby charges meant that other provisions in the policy would not; otherwise, the stricken language would have been surplusage.

An insured sued when her insurer delayed preauthorization of treatment for toe surgery. *Schwartz v. Ins. Co. of the State of Penn.*, No. 01-07-00193-CV, 2008 WL 4670516 (Tex. App.–Houston [1st Dist.] Oct. 23, 2008, no pet. h.). The appeals court held that the trial court properly granted the insurance company's plea to the jurisdiction because the Texas Workers' Compensation Commission must have determined that the medical treatment was entitled to preauthorization.

In *Bobbora v. Unitrin Insurance Services*, 255 S.W.3d 331 (Tex. App.–Dallas 2008, no pet.), convenience store owners bought bonds from Unitrin under which Unitrin, as surety, guaranteed payment of fuel taxes owed by the stores. The store owners agreed to indemnify Unitrin for disbursements made by Unitrin in good faith under the bonds. When the stores failed to pay fuel taxes, the State sued Unitrin, seeking payment under the bonds. After settling with the State, Unitrin sued the owners, seeking indemnity for the amounts it paid the State under the bonds. The store owners asserted a counterclaim for "breach of duty of

good faith and fair dealing" from "failure to properly evaluate and investigate" the State's claims. The jury found in Unitrin's favor. On appeal, the store owners argued that the jury instruction was improper for including a statement that good faith "does not require proof of a 'reasonable' investigation by the surety." The court of appeals disagreed, and found that the statement was a proper instruction or definition, and was not a comment on the weight of the evidence.

The Fourteenth Court of Appeals considered whether a letter obligated a bonding company to issue bonds in connection with a construction project, or whether the letter was a "bondability" letter indicating that the builder could obtain such bonds. *Hartford Fire Ins. Co. v. C. Springs 300, Ltd.*, No. 01-06-00065-CV, 2008 WL 2208887 (Tex. App.–Houston [14th Dist.] May 29, 2008, no pet.). The owner of the construction project sued the bonding company for breach of contract and fraud when the bonding company did not issue the bonds described in the letter. The letter stated that "upon receipt of an acceptable contract," the bonding company was ready to issue bonds in the amount of the contract. However, the builder and the project owner never entered into a contract because of the builder's subsequent financial difficulties. The project owner was thus forced to contract with another builder at a higher price and sued the bonding company for the difference, alleging breach of contract and fraudulent misrepresentation. The court of appeals held that the letter did not comply with the statute of frauds because the consideration could not be ascertained, and therefore was not an enforceable contract. The court further held that the project owner could not have justifiably relied on the letter because it did not represent that the builder's line of credit would continue to exist into the indefinite future.

In *Insurance Corp. of Hannover v. Polk*, 262 S.W.3d 120 (Tex. App.–Eastland 2008, pet. granted), owners of a race horse had an equine-livestock mortality policy that provided coverage for one year. The policy also had a thirty-day extension clause that would cover the death of the horse within thirty days after the policy's expiration "as the result of any accident occurring, or illness or disease manifesting itself" during the policy period. The horse fractured his knees during the policy period, and a surgery was performed within the thirty-day extension period. Two weeks after the surgery, and also during the extension period, the horse developed colitis and had to be euthanized. The owners asserted that the horse's death resulted from the surgery that had been performed to repair the knee injury that occurred during the policy period and was covered. The insurer disagreed, arguing that the colitis did not result from a condition that manifested itself during the policy period.

The court of appeals found that the evidence was legally and factually sufficient to support the trial court's finding that the horse's colitis resulted from the surgery. Thus, the horse died as a result of an accident that occurred or an illness or disease that manifested itself during the policy period, and was covered under the thirty-day extension clause.

The court also held that the evidence presented was sufficient to show that the insurer failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement after its liability had become reasonably clear, and also failed to pay a claim without conducting a reasonable investigation. The insurer denied the claim even though it received an opinion from one of the treating veterinarians that the colitis resulted from the surgery, and without ever receiving an opinion one way or another from the second treating veterinarian. The court also held that the evidence was sufficient to prove that the insurer had acted knowingly.

In *Interspan Distribution Corp. v. Liberty Insurance Underwriters*, H-07-1078, 2008 WL 905354 (S.D. Tex. March 31, 2008), Interspan sued Liberty for failing to pay claims under a special coverages policy for kidnapping and extortion by bodily injury. Interspan alleged that its Uzbekistan tea-importation business was the target of a scheme planned by one of Uzbekistan's most powerful families, the Karimovas, to force Interspan to stop doing business in the country and to abandon business assets so that this family could take them over. Several of Interspan's owners and spouses were arrested and held under illegitimate charges until Interspan surrendered its assets to Gulnara Karimova. The court held that Interspan's factual allegations claimed a "loss" covered by the Liberty policy. The motion to dismiss was denied.

III. FIRST PARTY THEORIES OF LIABILITY

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

The Houston Court of Appeals, First District, erroneously held that a third party could not rely on oral representations in a certificate of insurance stating that its property was covered while in the insured's warehouse, because those statements contradicted the policy. *Brown & Brown of Texas, Inc. v. Omni Metals, Inc.*, No. 01-05-01190-CV, 2008 WL 746522, (Tex. App.–Houston [1st Dist.] March 20, 2008, no pet.). Omni stored steel in a warehouse owned by Port Metal. Omni requested and received certificates of insurance that stated that the insurance coverage included property of others and the custody of the insured and covered all risks. The certificates contained a disclaimer stating: "This certificate is issued as a matter of information only and confers no rights on the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policies below." Omni's president testified that he spoke on several occasions with the insured to ask if his property was insured, and the insured testified that he asked the insurance agent to make sure the property was insured and was told that it was. The jury found the insurance company and agency were guilty of negligent misrepresentations and unfair and deceptive practices based on misrepresenting coverage. The court of appeals reversed, holding that the customer had an obligation to exercise due care and could not rely on this certificate of service and could not rely on oral representations. Thus the court of appeal reversed the judgment for the customer for the value of its destroyed property.

One justice dissented, criticizing the majority for creating a new rule that displaced common law and statutory liability for misrepresentations.

The dissent is correct. The law is well-settled that agents and insurers can be liable for misrepresenting benefits, even though the misrepresentations directly contradict the coverage in the policy. *See Royal Globe Ins. Co. v. Bar Consultants*, 577 S.W.2d 688 (Tex. 1979) and *Celtic Life Ins. Co. v. Coats*, 885 S.W.2d 96 (Tex. 1994). Probably a hundred other cases could be cited for this proposition, but none were cited by the majority in reaching this erroneous conclusion. The majority incorrectly relied on the decision in *Via Net v. TIG, Inc.*, 211 S.W.3d 310 (Tex. 2006). However, the court addressed the role of a certificate of insurance in the context of when a third party should have discovered it was not insured, and did not reach the conclusion the court of appeals did in this case.

A workers compensation insurer was properly found liable for failing to settle once its liability was reasonably clear and failing to conduct a reasonable investigation. The evidence showed that the insurer conducted a biased investigation aimed at denying the claim, repeatedly ignored medical records, failed to contact the worker's treating physician, and misled its own reviewing physician about the worker's medical history and records. *Texas Mut. Ins. Co. v. Morris*, No. 14-06-00651-CV, 2008 WL 4092921 (Tex. App.–Houston [14th Dist.] Aug. 26, 2008, no pet.).

The court also found the evidence sufficient to support the award for mental anguish and to support treble damages based on evidence that the insurer acted knowingly.

The *Morris* court held that to establish liability for failure to conduct a reasonable investigation, the plaintiff must also show that the investigation would have shown the insurer lacked a reasonable basis for denying the claim. The court reached this conclusion after noting that the Texas Supreme Court has equated the common law duty of good faith and fair dealing with a statutory standard for unfair settlement practices.

Significantly, the *Morris* court noted that the insured's reliance on expert testimony from its doctor did not insulate it from liability, because the insurer had not given the doctor adequate information.

Another court held that the accrual of the limitations period for a bad faith claim does not await the outcome of the administrative process, but rather begins at the same time as any other bad faith claim not connected to the Worker's Compensation Act remedies, and that accrual is on the date the insurer wrongfully denies coverage. *Childers v. Gallagher Bassett Servs., Inc.*, No. 2-07-296-CV, 2008 WL 902796 (Tex. App.–Fort Worth 2008, pet. denied). However, if timely claims for additional payments by an insured can give rise to the statute of limitations running anew, then it follows that additional denials of coverage after an initial denial has been fully and finally resolved starts the running of the statute of limitations on the new denial. Therefore, the lawsuit filed by Childers, was not barred by the statute of limitations.

A law firm sued an insurer for unfair insurance practices after they failed to agree upon the amount of attorney's fees owed to the law firm. *Law Offices of Miller & Bicklein v. Deep East Texas Self-Ins. Fund*, No. 11-06-00187-CV, 2008 WL 3865071 (Tex. App.–Eastland Aug. 21, 2008, no pet. h.) (mem. op.). The law firm had essentially represented the interests of the insurer in a third-party action that resulted in the insurer's recovery of a subrogation interest for worker's compensation benefits that had been paid to the law firm's client. The court of appeals held that evidence of refusal to negotiate or pay attorney's fees owed under the Texas Labor Code was not evidence of misrepresentation, unfair settlement practice, or any other violation of former article 21.21 of the Texas Insurance Code.

In *Texas Mutual Insurance Co. v. Ruttiger*, No. 01-06-00897-CV, 2008 WL 2930096 (Tex. App.–Houston [1st Dist.] July 31, 2008, pet. filed), a plaintiff sustained hernias after heavy lifting at his job. He sued his employer's worker's compensation insurer after it denied him timely payment of benefits and necessary medical treatment. The court of appeals affirmed and found the evidence was sufficient to prove that the insurer failed to reasonably investigate the claim and thus engaged in unfair settlement practices and breached its duty of good faith and fair dealing. In particular, the court noted that the adjuster failed to speak with the plaintiff or his doctor. Instead, the adjuster spoke only with the employer, even though the insurer's policies required otherwise, and the employer had financial motivations for classifying the injury as occurring off the job. The insurer also failed to call or request records from the hospital where the plaintiff sought treatment. When the hospital called the insurer, the insurer did not ask the names of the treating doctors, the plaintiff's injuries, or the plaintiff's contact information. By relying exclusively on information from the employer – some of which was flatly contradicted – the insurer unreasonably investigated and denied the claim. A reasonable jury could have concluded that the insurer denied the claim when there was no information supporting a bona fide coverage dispute. Based on the same record, the court concluded that the evidence was sufficient to show that the insurer acted knowingly.

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

The Fifth Circuit reaffirmed that if the claim is not covered, there is no liability for breach of good faith and fair dealing, because the insurer has a reasonable basis for denying benefits under the policy. *Columbia Cas. Co. v. Georgia & Florida Railnet, Inc.*, 542 F.3d 106 (5th Cir. 2008). Interestingly, the Fifth Circuit made this point in a liability insurance case, overlooking the Texas Supreme Court's decision that there is no duty of good faith and fair dealing in the liability insurance context. *See Maryland Ins. Co. v. Head Indus. Coatings & Servs., Inc.*, 938 S.W.2d 27 (Tex. 1996).

C. Negligence

An insurance agency was sued for failing to get "communicable disease" coverage for a restaurant, which later was sued by customers who contracted hepatitis from eating the restaurant's food. *Insurance Network of Texas v. Kloesel*, No. 13-05-680-CV, 2008 WL 907479 (Tex. App.–Corpus Christi April 3, 2008, pet filed.). On appeal, the agency challenged the jury's finding that it was negligent. The court agreed with the agency that an insurance agency does not have a duty to refer an insured to another agency. The court also agreed with the agency that an insurance agent does not have a legal duty to explain the terms and conditions of an insurance policy. The court of appeals noted that the Texas Supreme Court has suggested that there may be such a duty when there is an explicit agreement or course of dealing or other evidence establishing an undertaking by the agent to determine the customer's insurance needs and to counsel the customer, but there was no such evidence in this case. Nevertheless, the court found the insurance agency did not challenge the negligence finding based on a failure to procure proper coverage, so the plaintiffs could recover on that basis.

The *Kloesel* court engaged in a lengthy analysis of whether the insureds should be barred as a matter of law from recovering based on their negligence in failing to read their insurance policy and other documents that disclosed there was no coverage for communicable diseases. On the side of the agency, the evidence showed that the insurance applications, binders, and policies all stated that communicable diseases were excluded. However, there was also evidence that the insureds told the agent that they wanted "full coverage" including coverage if a customer got sick or if there was anything wrong with the food. The insureds further testified that they did not read all of the insurance policy provisions and assumed the agency complied with the instructions given regarding coverage. The insured's expert testified that an agent absolutely should provide communicable disease coverage for a restaurant, and the agent's expert testified that an agent should provide such coverage, unless it was not available.

The court concluded that a jury could reasonably find the insureds were not negligent, based on their reasonable reliance on the agent to get the coverage they ask for. Further, a jury could find the insureds were reasonable in relying on the agent to get the type of policy that an agent exercising the appropriate degree of skill and knowledge would obtain.

A plaintiff failed to state a claim for negligent misrepresentation, because she could not show reliance on representations of coverage that contradicted the language of the policy and application. *Jefferies v. Pat A. Madison, Inc.*, No. 11-07-00185-CV, 2008 WL 4516647 (Tex. App.–Eastland Oct. 9, 2008, no pet. h.). The plaintiff alleged she was told her condition would not be excluded as a preexisting condition, but the court held she could not rely on the misstatement by the agent, because of written documentation clearly excluding coverage.

While the court's conclusion might be correct on a claim

of negligent misrepresentation, which requires reliance, it would not be correct for misrepresentation brought under the Texas Insurance Code where the standard is whether their representation was a producing cause of damages. On more than one occasion, the supreme court has affirmed recovery based on misrepresentations by agents that were directly contradicted by the written policy. *See Royal Globe Ins. Co. v. Bar Consultants*, 577 S.W.2d 688 (Tex. 1979) and *Celtic Life Ins. Co. v. Coats*, 885 S.W.2d 96 (Tex. 1994).

IV. AGENTS, AGENCY & VICARIOUS LIABILITY

A. Individual Liability of Agents, Adjusters, and Others

An insured brought suit against its insurance broker arising out of the broker's procurement of comprehensive general liabilities insurance policies that did not provide coverage for patent and trademark claims asserted against the insured. The insured asserted claims of negligence, fraud, Insurance Code violations, and breach of fiduciary duty. The court held that the insured's negligence, Insurance Code, and fraud claims were barred by the statute of limitations. The court further held that neither a formal nor an informal fiduciary relationship existed between the insured and the broker. *Envt'l Procedures, Inc. v. Guidry*, No. 14-05-01090-CV, 2008 WL 1746087 (Tex. App.–Houston [14th Dist.] April 17, 2008, no pet.).

V. THIRD PARTY INSURANCE POLICIES & PROVISIONS

A.Commercial General Liability Insurance

A liability insurer has no duty to inform an additional insured that coverage may be available and no duty to tender a defense unless one is demanded, even though the additional insured is unaware of coverage. *National Union Fire Ins. Co. v Crocker*, 246 S.W.3d 603 (Tex. 2008). The court relied on its earlier decision in *Weaver v. Hartford Accident & Indemnity Co.*, 570 S.W.2d 367 (Tex. 1978), to reason that an insured has a duty to give the insurer notice of a suit and that the insurer owes "no duty to provide an unsought, uninvited, unrequested, unsolicited defense." The court concluded that the question of prejudice to the insurer was not the issue. The court distinguished the decision in *PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 630 (Tex. 2007), which held that late notice is no defense if it does not prejudice the insurer. In this case, there was no notice.

The court's decision begs the question of how the additional insured is to know he has coverage and that he should inform the insurer that he has been sued, if no one tells him. The court speculated that perhaps the additional insured did not give notice because he preferred to be defended by his own counsel. This speculation seems odd, considering the additional insured allowed a default judgment to be taken against him for $1 million. That hardly seems like he was being defended by his own counsel. The court does not have to conclude that an insurer has a duty to defend someone who has not demanded of defense, to impose a requirement that an insurer inform any known insured or additional insured of the potential for coverage. Surely the insurer is not harmed by advising other parties that they may have contractual rights owed by the insurer.

Following *Crocker* a court of appeals held that an insurer had no duty to indemnify an additional insured that gave notice of the claim after it had been settled. *Maryland Cas. Co. v. American Home Assurance Co.*, No. 01-07-00711-CV, 2008 WL 4530698 (Tex. App.–Houston [1st Dist.] Oct. 9, 2008, no pet. h.).

Claims for a defective construction by a homebuilder potentially stated claims for an "occurrence" or "property damage"

A liability insurer has no duty to inform an additional insured that coverage may be available and no duty to tender a defense unless one is demanded, even though the additional insured is unaware of coverage.

covered by builder's commercial general liability policy. *Grimes Construction, Inc. v. Great American Lloyds Ins. Co.*, 248 S.W.3d 171 (Tex. 2008) (per curiam). The *Grimes* decision followed the court's holding in *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1 (Tex. 2007).

This case involved an insurance coverage dispute arising from the settlement of a wrongful death case filed against Cooper Industries, and its wholly-owned subsidiary, Cooper B-Line, Inc. *Cooper Indus., L.L.C. v. Amer. Int'l Specialty Lines Ins. Co.*, No. 07-20468, 2008 WL 900958 (5th Cir. April 3, 2008). Two employees of B-Line were killed in the course and scope of their employment at a B-Line plant, and representatives of the decedents sued B-Line and its parent corporation, Cooper. *Id*. Cooper and B-Line carried primary employer's liability insurance from ACE American Insurance Company which provided the "insured" with a $1 million primary coverage limit and a $1 million deductible, as such it was merely a fronting policy. Cooper also carried a comprehensive excess liability coverage policy with American International Specialty Lines Insurance Company, AISLIC. The AISLIC policy provided excess coverage to the $1 million ACE employer's liability policy and a $5 million self-insured retention for general commercial liability (GCL) coverage. Therefore, Cooper maintained employer's liability coverage from the ACE primary policy with a $1 million deductible and the AISLIC excess policy, and it maintained GCL coverage from the AISLIC excess policy (over and above a self-insured retention of $5 million).

The underlying suit was settled, with Cooper and B-Line paying the $1 million deductible under the ACE policy and AISLIC paying $2.6 million, which was the additional amount it attributed to B-Line's liability. Cooper and AISLIC also each agreed to pay half of the remaining amount, $1.35 million, the amount that AISLIC attributed to Cooper as general commercial liability. However, each party funded this portion of the settlement with the reservation of its right to recover in later proceedings. Cooper and B-Line brought a breach of contract suit against AISLIC arguing that they are jointly covered as a single collective insured under the ACE employer's policy and sought 50% of the $1.35 million and ad litem fees that the entities paid in settlement of the underlying suit. The district court granted summary judgment to AISLIC after determining that the employer's policy was not susceptible to Cooper's single collective insured interpretation. The plaintiffs appealed arguing that the district court erred by denying Cooper coverage under its employer's liability policy, and, in the alternative, by failing to allocate the settlement between the covered and uncovered claims. The court held that Cooper's single collective insured construction of the policy was unreasonable, as the plain language of the ACE employer's policy only covered the claims of the decedents' representatives against the decedents' employer B-Line, not B-Line's parent company, Cooper. Moreover, under Texas law, absent exceptional circumstances, parent

and subsidiary corporations are recognized separate entities. *Id.* The Fifth Circuit reversed the judgment and remanded, so that the district court could properly allocate the $1.35 settlement amount between B-line and Cooper, rather than Cooper paying half of the settlement on its own.

A defendant's "knowing" violation of the Deceptive Trade Practices Act by providing defective plastic parts nevertheless could be an "occurrence" or "accident" within the meaning of its liability policy. *National Union Fire Ins. Co. v. Puget Plastics Corp.*, 532 F.3d 398 (5th Cir. 2008). The jury found the plastic parts knowingly deviated from guidelines regarding the melting temperature of the plastic. This led to the failure of water heaters that incorporated the plastic parts. The insurer argued that a knowing violation of the DTPA cannot be an "accident." The court rejected this argument under the reasoning of the decision in *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1 (Tex. 2007). The court held that conduct falls outside the meaning of "accident" if (1) the resulting damage was highly probable; (2) the insured intended the injury; or (3) the insured's acts constitute an intentional tort. While the finding of knowing misconduct showed that the insured acted deliberately, it did not establish any of these other elements.

The *Puget* court also concluded that the policy covered consequential damages resulting from the property damage, even though damage to the water heaters themselves would not be covered because it was excluded by the "impaired property" exclusion.

A contractor breached its contractual obligation to provide coverage for a property owner as an additional insured, when it purchased a "fronting" policy that contained a deductible equal to the policy limits. *Amtech Elevator Svc. Co. v. CSFB 1998-P1 Buffalo Speedway Office, Ltd.*, 248 S.W.3d 373 (Tex. App.–Houston [1st Dist] 2007, no pet.). A building owner contracted with an elevator service company to maintain its elevators. The contract required the service company to name the building owner as an additional insured on a liability policy "adequate to protect the interest of the parties hereto." The service company did name the building owner as an additional insured on a liability policy, but the policy was a "fronting," policy, which provided a $1 million liability limit, but then also provided $1 million deductible, requiring the property owner to pay back the policy limits.

An insurance policy for an apartment complex included replacement cost coverage. The complex burned. Instead of rebuilding the complex, the insured chose to purchase another commercial property that was not an apartment complex. The insured then requested that the insurer pay the additional replacement cost coverage. The court held that the insured was required to replace the damaged property as a condition precedent and that its failure to do so negated its entitlement to recover replacement cost. *Fitzugh 25 Partners, L.P. v. Kiln Syndicate KLN 501*, 261 S.W.3d 861 (Tex. App.–Dallas 2008, pet. filed).

The real party in interest, El Naggar, brought this suit pursuant to an assignment of claims from the former insured seeking to recover on a $3.6 million judgment from the underlying suit. *In re Gen. Agents Ins. Co. of Am., Inc.*, 254 S.W.3d 670, 672 (Tex. App.–Houston [14th Dist.] 2008, no pet.). The insurance company and the insured, executed a policy buy-back agreement wherein the insurer paid the insured $50,000 in exchange for the insured's transfer to the insurer of all its interests in the policy and release of insurer from all claims, demands, and causes of action arising out of the policy. This was done before the $3.6 million judgment. The trial court held that the buy-back agreement between the insured and the insurer was void as against public policy. The appeals court granted a petition for writ of mandamus and directed the trial court to vacate its order denying the insurance company's motion to sever and abate. The court of appeals required the trial court to sever the summary judgment on the validity of the buy-back agreement from the other claims. The court stated that all requirements were met to sever the declaratory judgment and lack of a severance in the case would cause manifest injustice to the insurer because it would be prejudiced as it would not be able to fully develop its defenses.

B. Excess Insurance

A primary insurer's payment of its $25 million primary limit did not exhaust coverage sufficient to trigger the excess insurer's duty to pay, where less than the entire $25 million was paid for covered claims. *Service Corp. Int'l v. Great American Ins. Co.*, 264 F. App'x 431 (5th Cir. Feb. 1, 2008) (per curiam). SCI, a funeral service company with cemeteries throughout the United States was sued by several individuals and class action plaintiffs alleging grave desecration and improper burials at two cemeteries. SCI's primary insurer determined that covered claims would likely exceed its $25 million primary limit and tender the full amount in an attempt to accomplish a global settlement. Ultimately, SCI paid $100 million to settle the claims, but allocated only $13.75 million to claims arising during the primary policy year. When SCI then had other claims and asked its excess insurer to pay, the excess insurer refused, contending that the underlying limits were not exhausted.

The court agreed with the excess insurer, holding that only payment for "claims" would exhaust the primary limits. The fact that the primary insurer paid more and even did so reasonably and in good faith, did not change the contractual obligations of the excess insurer only to pay when the primary limits were exhausted by payment of claims. Because part of the policy limits was paid for claims outside the primary policy year, the primary insured's payment did not exhaust the limits.

Claims against a nursing home could be covered by the primary commercial general liability policy with a $2 million aggregate limit or the care providers professional liability coverage with a $1 million limit, so the higher limit applied before the umbrella insurer's liability was triggered. *U.S. Fire Ins. Co. v. Scottsdale Ins. Co.*, 264 S.W.3d 160 (Tex. App.–Dallas 2008, pet. denied). The court rejected the primary insurer's argument that professional liability claims had to be excluded from the CGL coverage to avoid rendering the CPPL coverage surplusage. While CGL polices can contain a professional liability exclusion, this one did not.

An excess insurer proved its right to recover reasonable settlements that were within the primary insurer's limits. The court held the excess insurer had to show the settlements were made in good faith, upon a reasonable basis, and for a reasonable amount. Affidavits from the excess insurer's defense lawyer and claims adjuster stating that the settlements were necessary, reasonable, and in good faith, were sufficient. *U.S. Fire Ins. Co. v. Scottsdale Ins. Co.*, 264 S.W.3d 160 (Tex. App.–Dallas 2008, pet. denied).

C. Financial institution bond

A surety on a financial institution bond was collaterally estopped to challenge coverage for paying checks on an "unauthorized" signature, even though its insured was found liable for "unauthorized" payments. *Citibank Texas, N.A. v. Progressive Cas. Ins. Co.*, 522 F.3d 591 (5th Cir. 2008). The court further held that the surety bond coverage for "unauthorized" payments would cover someone who had no authority, but not, as in this case, someone who had authority but exceeded it. The court noted that surety bonds are not construed in favor of the insured and against the insurer, because they are viewed as the product of joint negotiations between bankers and insurers.

D. Other Policies

A railroad's liability policy exclusion for bodily injury arising out of "pollutants" excluded a claim by a locomotive engineer who alleged injury from inhaling exhaust fumes and hazardous dust. *Columbia Cas. Co. v. Georgia & Florida Railnet, Inc.*, 542 F.3d 106 (5th Cir. 2008). The court rejected the argument that the claim should be covered because it was brought under the Federal Employers Liability Act and two other exclusions had specific exceptions for FELA suits. The exceptions to the exclusions did not create coverage, and the pollution exclusions did not create coverage, and the pollution exclusion had no exception for FELA claims.

VI. DUTIES OF LIABILITY INSURERS

A. Duty to Defend

The Texas Supreme Court held that a liability insurer may defend its insured through the use of staff attorneys employed by the insurer without engaging in the unauthorized practice of law, as long as the insurers and insured's interests are congruent, but not otherwise. *Unauthorized Practice of Law Committee v. American Home Assurance Co.*, 261 S.W.3d 24 (Tex. 2008). The majority reasoned that a corporation may hire attorneys to represent its own interests. When there are not coverage disputes that create a conflict of interest between the insurer and the insured, the court reasoned that the insurer is not practicing law by representing the insured in a case where both hope to defeat the claim, as the insurer hopes to defeat its duty to indemnify. The court recognized that there are potential conflicts such as violations of the *Stowers* duty to settle or the *Tilley* duty of unqualified loyalty, but found these concerns were not different than with defense lawyers employed by private law firms and not employed directly by the insurer. The court also found that many of the concerns may fall within its administrator responsibilities to regulate the practices of law, but not within its authority to declare the insurer's conduct improper in this case.

The majority further held that a "routine reservation of rights" letter would not create the kind of conflict that would mean a staff attorney could never represent an insured. On the other hand, when the insurer identifies "a serious coverage issue" … "[d]eclining representation is a safer course to avoid conflicts that destroy the congruence of interest between the insurer and insured that allows for the use of staff attorneys." 261 S.W.3d at 40.

The court also noted that a conflict may arise when the defense lawyer obtains confidential information that the insured could expect not to be disclosed to the insurer.

The court further concluded that a staff lawyer must fully disclose to an insured the identity of the lawyer's employer. The court did not reach the question of whether the staff attorney could use a name similar to a law firm, as that issue was not before it.

Two justices dissented, based on their view that while the insurer can hire lawyers to fight this law on its own behalf, that does not allow them to represent anyone else, including the insured.

The court declined to address the related question of whether an insurer engages in the unauthorized practice of law when it employs staff attorneys to represent insureds who are insured by an affiliate. The court found the issue had not been addressed by the trial court so it could not be considered on appeal. *Unauthorized Practice of Law Committee v. Nationwide Mut. Ins. Co.*, 51 Tex. Supp. Ct. J. 1451, 2008 WL 4370725 (Tex. Sept. 26, 2008).

The Texas Supreme Court adopted the "actual injury" or "injury in fact" rule to hold that damages "occurred" during the policy year when actual physical damage to the property occurred, not when the damage was or could have been discovered. *Don's Bldg. Supply, Inc. v. OneBeacon Ins. Co.*, 51 Tex. Sup. Ct. J. 1367, No. 07-0639, 2008 WL 3991187 (Tex. Aug. 29, 2008). A seller and distributor of synthetic stucco products was sued after siding was installed on various homes, which then allegedly suffered moisture damage because the siding was defective. The claims all alleged that the damage occurred within six months to one year after the siding was applied, but did not manifest and was not discovered until several years later. The question was when the loss "occurred" – i.e., when the damage was observable. The court held that the plain language of the policy supported the conclusion that the damage "occurred" when there was damage to the property, even if that damage was not discovered until later. Nothing in the policy focused on when damage was discovered. The court stressed that it was not attempting to fashion a universally-applicable rule for determining when an insurer's duty to defend was triggered under all policies, because other policies might have different language. In this case, however, the insurers that had coverage at the time the property was damaged had the duty to defend. *See also Union Ins. Co. v. Don's Building Supply*, No. 05-06-00884, 2008 WL 4308343 (Tex. App.–Dallas Sept. 23, 2008, no pet. h.).

Liability insurers had a duty to defend cell phone manufacturers in class actions that allege "biological injury" from radiation admitted by telephones. *Zurich American Ins. Co. v. Nokia, Inc.*, 2008 WL 3991183, 51 Tex. Sup. Ct. J. 1340 (Tex. Aug. 29, 2008). After restating the traditional rules for construing duty to defend, the court found that claims of "biological injury," which detailed adverse effects at the cellular level, alleged to have been caused by radio frequency radiation from the telephones stated a claim for "bodily injury" within the meaning of the policy. In addition, because the complaints sought damages, the court found they asserted potentially covered claims for "damages because of bodily injury." In the one case where the plaintiffs specifically disclaimed any claims for damage, other than the cost of head sets, the court found no duty to defend.

The court also refused to consider extrinsic evidence to determine whether the insurer had a duty to defend Nokia. The extrinsic evidence was statements found and briefs filed in multidistrict litigation. The court repeated its prior ruling refusing to allow an exception for extrinsic evidence, even when there is a "fundamental issue of coverage which does not overlap with the merits of or engage the truth of falsity of any facts alleged in the underlying case."

Finally, the *Nokia* court held that just because the petition also sought property damage, which would be excluded, that did not negate the duty to defend. Because the complaints alleged potentially covered claims, the inclusion of excluded claims did not negate the duty to defend.

The court reached the same conclusion in *Federal Ins. Co. v. Samsung Electronics America*, 51 Tex. Sup. Ct. J. 1352, 2008 WL 4000812 (Tex., Aug. 29, 2008), and in *Trinity Universal Ins. Co. v. Cellular One Group*, 51 Tex. Sup. Ct. J. 1363, 2008 WL 4000811 (Tex. Aug. 29, 2008).

An insurer had a duty to defend claims against an additional insured that was alleged to be responsible for bad work that was subcontracted on an aircraft. The policy covered "your work," which was defined as "work or operations performed by you or on your behalf." "Your" referred to the insured, whose operations and work included the additional insured subcontractor. *Gore Design Completions v. Hartford Fire Ins. Co.*, 538 F.3d 365 (5th Cir. 2008).

The *Gore* court considered whether the claims fit within several exclusions. The first exclusion was for property damage in the "care, custody, or control" of the insured. The court found this exclusion is limited to the area being repaired by an insured.

In this case, the claim alleged damage to the wiring that was being worked on, but also further damage to the aircraft in which the wiring was being installed.

The result was not changed by the claimant's allegation that the aircraft was in the "care" of the additional insured, because the petition did not allege the plane was in the care of the additional insured at the time of the wrongdoing.

The *Gore* court also rejected the argument that the loss was excluded by the exclusion for property damage to that particular part of any property that must be restored or repaired because "your work" was incorrectly performed. The court found the insurer's interpretation was too broad because it was not limited to "that particular part" where the work was being performed.

Finally, the *Gore* court rejected the argument that the "professional services" exclusion applied. The complaint did allege some problems that would be design "professional services," but the claims were broad enough to include mistakes in implementation of the design, which could be ordinary negligence.

The *Gore* court pointed out that the trial court's determination that because there was no duty to defend there was also no duty to indemnify, was "premature."

Courts often repeat the cliché that the duty to defend is broader than the duty to indemnify. This is partially true, because the duty to defend encompasses claims that may be covered, while the duty to indemnify covers only claims that are actually covered. However, the duty to indemnify may actually be broader, in some instances, as the *Gore* court recognized. The court noted that even if the pleading did not allege matters within coverage sufficient to invoke a duty to defend, "it did not preclude a situation where evidence at trial implicated [the insured's] conduct and its Policy's coverage," thus triggering the duty to indemnify.[2]

A fire caused when gas fumes escaped from waste carried in trucks, causing the truck engines to race and then explode was excluded by the "pollution" exclusion, so that the insurer had no duty to defend. *Noble Energy, Inc. v. Bituminous Cas. Co.*, 529 F.3d 642 (5th Cir. 2008). The court found the injuries resulting from the explosion were caused by the discharge or release of pollutants, which were defined to include any gaseous fumes and waste.

The *Noble* court also rejected the argument that the claim fit within an exception to the pollution exclusion for hostile fires. That exception provided that the pollution exclusion does not apply to "bodily injury … caused by heat, smoke, or fumes from a hostile fire." In turn, "hostile fire" means one that becomes uncontrollable or breaks out from where it was intended to be. The court reasoned that the exception applied only if a preexisting fire caused the pollution. Here the opposite occurred – the pollutant caused the fire. This holding by the court seems questionable. Nothing in the quoted language of the exception requires the sequence that the fire occur first. It would thus appear that the exception would apply to the sequence alleged by the plaintiffs.

Plaintiffs did not allege sufficient control over another defendant's activities to allege vicarious liability as to additional insureds, so there was no duty to defend them. *Indian Harbor Ins. Co. v. Valley Forge Ins. Group*, 535 F.3d 359 (5th Cir. 2008).

An insured subcontractor's policy excluded claims arising from operations involving "membrane roofing." *Hall Contracting, Inc. v. Evanston Ins. Co.*, 2008 WL 942937 (5th Cir. April 8, 2008). While the insured subcontractor was installing a membrane roofing, some demolition workers' efforts generated sparks that fell onto the membrane roof and ignited a fire. The subcontractor was sued, and the insurer refused to defend based on a "membrane roofing" exclusion. The Fifth Circuit stated that the meaning of "membrane roofing" needed to be determined before deciding the coverage issue. Therefore, the court vacated the district court's summary judgment ruling in favor of the insurer on the issue that the insurer had no duty to defend the insured. The case was remanded to allow the parties to proffer expert testimony on the meaning of the term "membrane roofing," as the court said this needed to be determined before deciding the coverage issue.

A court held the insurer had a duty to defend when a claimant was willfully detained by an insured doctor to engage in unwanted "closed door" hypnosis sessions while on the job. *Maryland Cas. Co. v. S. Tex. Med. Clinics, P.A.*, No. 13-06-089-CV, 2008 WL 98375 (Tex. App.–Corpus Christi Jan. 10, 2008, pet. denied). The court found that this fell under the false imprisonment coverage in the policy.

An insurer had a duty to defend when the claims based on the insured's allegedly defective inspection services were covered by the policy and do not fall within any of the policy's services-related exclusions. *Davis-Ruiz Corp. v. Mid-Continent Cas. Co.*, No. 07-40727, 2008 WL 2330982 (5th Cir. June 2, 2008). The exclusion stated, "With respect to any professional services shown in the Schedule…[t]his insurance does not apply to 'bodily injury' … due to the rendering of or failure to render any professional service." Therefore, the court held that the exclusion did not apply to all professional services, but only to those in the schedule.

In *Lexington Insurance Co. v. Autobuses Lucano, Inc.*, 256 F. App'x 682 (5th Cir. 2007) (per curiam), the court held that a bus company was not an insured, because, although the bus at issue was a covered auto, the bus company was not listed as an insured and was not named in any schedule or declaration that would have made it an additional insured.

A pleading that supported an inference that a "well stub" and "net protector" were damaged stated a potential claim for coverage, even though the policy excluded damage to "underground resources and equipment." The court rejected the insurer's argument that the references to these two parts were simply allegations made by way of factual background that were not tied to any particular cause of action. The court found the precise function of these parts was not described, so it was not clear whether they were part of a well, which would fit within the exclusion. Thus, the insurer had a duty to defend. *General Star Indem. Co. v. Gulf Coast Marine Associates, Inc.*, 252 S.W.3d 450 (Tex. App.–Houston [14th Dist.] 2008, pet. denied). The court also held that an expert affidavit defining the meaning of "well stub" and "net protector" was not pertinent to a determination of the insurer's duty to defend.

A liability insurer had a duty to defend a claim for "assault" by a person suffering from Alzheimer's and dementia, based on the court's conclusion that the allegations regarding the person's condition made the injuries the result of an "accident." *Hochheim Prairie Cas. Ins. Co. v. Appleby*, 255 S.W.3d 146 (Tex. App.–San Antonio 2008, pet. filed). Justice Simmons dissented, finding that the lack of capacity did not make the assault accidental. She compared this to other cases where a child's lack of capacity and a drunk's lack of capacity, did not make conduct accidental.

The *Appleby* court also held that the decision whether there was a duty to defend had to be based only on the eight corners of the pleading and policy, and that it was improper to consider an affidavit from a neurologist who opined that the insured was not responsible for his actions

If "the insured" made or directed defamatory statements with knowledge of their falsity, policies did not provide coverage. *Daimler Chrysler Ins. Co. v. Apple*, No. 01-05-01115, 2008 WL 963653 (Tex. App.–Houston [1st Dist.] April 10, 2008). Because defamatory remarks were made by vice-principals of the insured, the court held the exclusion did not apply then because the remarks were not made by officers or directors of the corporation;

therefore, there was a duty to indemnify.

An insured was sued for trademark infringement, unfair competition, deceptive and unfair trade practices, fraud, and breach of contract after the insured violated a licensing agreement that allowed it to use the plaintiff's registered marks in its advertising on condition that it purchase a minimum amount of its inventory from the plaintiff. The insured sought a defense from its insurer. The policy provided coverage for claims involving "advertising injury," defined as injury "caused by an offense committed in the course of advertising your goods, products or services." However, the policy excluded advertising injury "arising out of" a breach of contract. In *Yates Carpet, Inc. v. Travelers Lloyds Insurance Co.*, No. 07-06-0478-CV, 2008 WL 2467881 (Tex. App.–Amarillo June 19, 2008, pet. denied) (mem. op.). The court held the insurer had no duty to defend because "the purported breach of contract has at least an incidental relationship to all the other acts of which [the plaintiff] complains." Thus the suit was excluded as arising out of a breach of contract.

When a company unintentionally misunderstands the job it was asked to do, resulting in a work product wholly to the dissatisfaction of those who requested the work, the actions are negligent, and are results of an accident that constitutes an "occurrence" under the policy, even though the end result was a natural and probable consequence of excavating pipes across the plaintiff's property. *Admiral Ins. Co. v. Little Big Inch Pipeline Co., Inc.*, 523 F.Supp. 524 (W.D. Tex. 2007). When both an intentional tort and negligence appear adequately pleaded in a lawsuit, the insurance company has a duty to defend. However, in this case, all of the alleged property damage was barred by policy exclusions. The exclusions that applied included a "your work" exclusion, which barred coverage for damage to foundations and concrete slabs, and piling up of leftover debris. Another exclusion that applied was the exclusion for damage to property not physically injured, arising out of insured's failure to perform the contract, which excluded coverage for diminution of value of adjacent property. Therefore, the insurer had no duty to defend the defendants.

B. Duty to Indemnify

The Texas Supreme Court held that an employer's liability policy covers exemplary damages in certain contexts and that such coverage does not violate public policy. *Fairfield Ins. Co. Stephens Martin Paving, L.P.*, 246 S.W.3d 653 (Tex. 2008). The court first considered the dual coverage provided by workers' compensation and employers' liability policy in the standard form mandated by the Texas Department of Insurance. The court reasoned that the employer's liability coverage reveals a legislative intent to provide insurance coverage for an employer's gross negligence, which would include punitive damages. The court found this coverage to be part of the legislature's express intent that Texas public policy does not prohibit insurance for claims of gross negligence in the workers' compensation/liability context.

The court went further and outlined the public policy considerations that would determine whether it is against public policy to insure punitive damages in other contexts. The court noted that freedom of contract is a paramount consideration, arguing in favor of allowing insurance for punitive damages. On the other hand, a court should consider the purpose of punitive damages to punish. The court recognized a tension between these competing policies. The court then discussed cases finding it is against public policy to insure punitive damage in an underinsured motorist policy, because that would shift the risk to other policyholders, while it may not be against public policy to allow a business to insure against punitive damages for conduct by an employee. The court offered these general considerations but declined to make a broad proclamation of public policy.

The Texas Supreme Court held that an employer's liability policy covers exemplary damages in certain contexts and that such coverage does not violate public policy.

Justice Hecht, joined by three others would have gone further to elaborate on the considerations for deciding whether punitive damages are against public policy. The concurring Justices agreed that public policy should not allow coverage of punitive damages by an uninsured motorist policy, but the consideration weigh differently when a business is insured against punitive damage for the conduct by one or more employees. The concurring justices expressed reluctance to allow punitive damages to be covered when that would shield the wrongdoer himself.

The Fifth Circuit got an opportunity to apply these public policy factors in *American International Specialty Lines Ins. Co. v. Res-Care, Inc.*, 529 F.3d 649 (5th Cir. 2008). The insured nursing home was sued by the survivors of a resident who was severely injured when an employee doused her with bleach and left her unattended, resulting in chemical burns that ultimately caused her death. The insurer settled the claims for $9 million, with an agreement that it could seek reimbursement from the insured for any amounts determined not to be covered. In the suit that followed, the district court allocated $4 million to actual damages and $5 million to punitive damages.

The Fifth Circuit assumed that the primary policy covered punitive damages and then turned to whether it was against public policy to allow coverage for punitive damages. The court found, based on the policy considerations outlined in *Fairfield*, that this was exactly the type of case where the need to punish by prohibiting insurance for punitive damages outweighed the freedom of contract. In this case the evidence showed "extreme circumstances" including systemic problems of care at the nursing home.

Liability insurers had no duty to indemnify a contractor who was an additional insured under a subcontractor's policy, for shoddy work the subcontractor performed that caused the contractor to incur expenses. The contractor's status as additional insured required the insurers to indemnify it for claims for which it was liable, not for a claim against the insured's subcontractor. *Ohio Cas. Ins. Co. v. Time Warner Enter. Co.*, 244 S.W.3d 885 (Tex. App.–Dallas 2008, pet. granted).

Two employees of a repair company were injured when repairing a tank owned by the plaintiff. *Lubrizol Corp. v. Gray Ins. Co.*, No. H-07-3301, 2008 WL 1767711 (S.D. Tex. April 8, 2008). The repair company by contract was required to indemnify the plaintiff for all damages arising out of the work which resulted from the repair company's negligence. The two injured repair company employees sued the plaintiff. The repair company's insurance company attempted to read the contract to require the plaintiff to be an additional insured only to the extent of the repair company's indemnity. The court held that the coverage was not limited to the indemnity obligation. The repair company had named the plaintiff as an additional insured under its policy with its insurer. Therefore, the repair company's insurer was responsible for the plaintiff's legal expenses plus interest arising

from the underlying suit filed against it by the repair company's employees.

A commercial general liability insurer had no duty to indemnify an injured employee of its insured where the policy contained a "Classification Limitation" stating that the insurer owed no duty to defend its insured for injuries resulting from operations not classified in the declarations page, and the employee was injured from an activity other than one listed in the declarations page. *Atlantic Cas. Ins. Co. v. McCormick Bros. Constr. Co.*, No. H-07-2849, 2008 WL 2965169 (S.D. Tex. July 30, 2008).

An oil company discovered an 18th century shipwreck in the Gulf of Mexico while inspecting a site for a pipeline. Unaware of the shipwreck, the insured/engineering company hired by the oil company disturbed and destroyed several archeological artifacts at the shipwreck site. As a result, the federal government required the oil company and the engineering company to pay $4.87 million to Texas A&M University for historical preservation of the site. Thereafter, the oil company threatened suit against the engineering company. The engineering company settled the dispute for $3 million of services. Upon learning of the threatened litigation, the engineering company sought indemnity from its general and excess liability insurers. The general liability carrier agreed to indemnify the engineering company for policy limits of $1 million. However, the excess carrier denied coverage, arguing that the general insurer improperly provided coverage and that the claim was not "property damage" arising from an "occurrence."

In *American Home Assurance Co. v. Oceaneering International, Inc.*, H.-06-2105, 2008 WL 2169411 (S.D. Tex. May 22, 2008), the court determined that the excess policy provides coverage for the claim. The excess policy contained a "following form" provision, according to which excess coverage would be provided for the same things that the general policy covered. The general policy provided coverage for risks arising out of "Specialist Operations," which included "maintenance" of oil pipelines. At the time the engineering company encountered the shipwreck, it was conducting a pipeline inspection to check its integrity, which constituted "maintenance" under the "Specialist Operations" provision. The excess insurer could not establish that an exclusion applied. Finding coverage under the general policy, the court rejected the excess carrier's argument that the general carrier had improperly paid the engineering company's claim. However, the court found questions of fact regarding the scope of coverage.

C. Settlements, Assignments & Covenants Not to Execute

When an insured under a liability policy believes the insurer has breached its duty to defend, negligently failed to settle, is going to refuse to indemnify, or has committed some other unfair insurance practice, when and to what extent can the insured protect himself by making an agreement with the plaintiff? One approach that once was fairly common was for the defendant to agree to a judgment in favor of the plaintiff and agree to assign to the plaintiff all claims against the insurer. In return, the plaintiff would agree not to execute on the judgment against the defendant and to pursue only the insurer.

In *State Farm Fire & Casualty Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996), the court declared such agreements void as against public policy, based on factors present in that case. The court's overarching concerns were that the assignment skewed the resulting coverage litigation by causing the plaintiff and defendant to alter their positions. The court also disapproved the practice of plaintiffs and defendants attempting to establish the amount of the insurer's liability by an agreed judgment between them, or by any other means that fell short of a "fully adversarial trial."

The *Gandy* decision did not categorically forbid assignments and covenants not to execute. At the same time, the court did not commit to any circumstances when such agreements would be upheld. Thus, plaintiffs, defendants, and insurers were left with uncertainty about what options are available to a defendant that is denied, or loses confidence in, the insurer's protection.

After a decade of uncertainty, the supreme court decided *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008), and clarified the limits of *Gandy* and the options available to defendant/insureds to protect themselves from insurers' breaches.

ATOFINA was sued over the death of a worker who was employed by another company. ATOFINA contended that it was an additional insured under an excess policy issued by Evanston. Evanston refused to provide coverage, contending that ATOFINA's sole negligence was the cause of the loss and was excluded. ATOFINA then settled with the plaintiffs and sought to collect from Evanston.

The court first found that ATOFINA was covered by the Evanston policy as an additional insured. The court then considered the insurer's argument that it was not bound by the settlement because ATOFINA failed to show the settlement was reasonable. ATOFINA responded that the insurer's wrongful denial of coverage barred it from challenging the reasonableness of the settlement.

The court reached back to – and revived – its decision in *Employers Casualty Co. v. Block*, 744 S.W.2d 940 (Tex. 1988), to hold that the insurer's denial of coverage barred it from challenging the reasonableness of the settlement. The *ATOFINA* court reaffirmed the holding in *Block* that the insurer "was barred from collaterally attacking the agreed judgment by litigating the reasonableness of the damages recited therein . . . [.]" The *Block* decision bound the insurer to an amount set by an agreed judgment, which was not the result of a fully adversarial trial. The *ATOFINA* court extended this reasoning to include a settlement agreement between the plaintiffs and the defendant/insured [ATOFINA].

The *ATOFINA* court held that the equitable principles of estoppel and waiver found in *Block* were triggered by the insurer's denial of coverage by letter and by its assertion of no coverage in its pleadings throughout the coverage suit. The *ATOFINA* court further held that an insurer would be estopped to challenge the settlement whether it attempted to rely on a policy provision or to assert that the amount was unreasonable.

In *Block*, the insurer was estopped to challenge the judgment, because the insurer had violated its duty to defend. In *ATOFINA*, the excess insurer had no duty to defend, but had wrongfully denied coverage. The *ATOFINA* court held this distinction was unimportant. What was important, and justified barring the insurer's ability to challenge the settlement, was that the insurer had notice and an opportunity to participate in the settlement discussion.

The court cited with approval the court of appeals decision in *Ranger Insurance Co. v. Rogers*, 530 S.W.2d 162, 167 (Tex. Civ. App.–Austin 1975, writ ref'd n.r.e.), for the proposition that "[h]ad [the insurer] accepted the defense, it would have had, of course, the opportunity to conduct the defense in a manner most likely to have defeated the plaintiff's claim or at least to have reduced the amount of damages." The *ATOFINA* court reasoned that if the insurer, Evanston, had not denied coverage it would have been able to influence the amount of the settlement.

The *ATOFINA* court also reaffirmed the decision in *United States Aviation Underwriters, Inc. v. Olympia Wings, Inc.*, 896 F.2d 949 (5th Cir. 1990), which it cited for the proposition that an insurer that flatly refuses to defend cannot contest the reasonableness of a consent judgment agreed to between the defendant/

insured and the plaintiff, while an insurer that offers a defense under a reservation of rights can contest the reasonableness of a settlement.

The court in *Evanston v. ATOFINA* found *Gandy* was not controlling. The *ATOFINA* court found that *Gandy*'s holding was "explicit and narrow, applying only to a specific set of assignments with special attributes" and that *Gandy*'s invalidation applies only to cases that present its "five unique elements."

First, this case did not fall within *Gandy*'s holdings, because the "key factual predicate" of an assignment was missing. This removed the case from the "formal bounds of *Gandy.*"

Second, the court reasoned that *Gandy* was concerned about assignments that made evaluating the merits of the plaintiff's claim difficult by prolonging disputes and distorting trial litigation motives, but not all cases implicate those concerns. Invoking *Gandy*'s own language, the *ATOFINA* court noted, "We should not invalidate a settlement that is free from this difficulty [of fairly evaluating a plaintiff's claims] simply because it is structured like one that is not."

The *ATOFINA* court found that barring the insurer from challenging the settlement shortened litigation, instead of prolonging it. Further, the settlement did not distort the litigation. Because ATOFINA settled without knowing if the claim was covered, it had an incentive to minimize the settlement in case it had to pay. The court concluded that the insurer was liable for the settlement amount.

It appears that *Gandy* is limited to cases where the insurer has tendered a defense, while *ATOFINA* – and the revived *Block* – will control whenever the insurer breaches its duty to defend or duty to pay. Logically, the court might also extend the reasoning of *ATOFINA* to other breaches by an insurer, such as breach of the duty to settle.

A court of appeals held that an assignment of an insured's claim against its agent for failing to get proper coverage, which was given in exchange for a covenant not to execute by the plaintiffs who sued the insured, was not void as against public policy. *Insurance Network of Texas v. Kloesel*, No. 13-05-680-CV, 2008 WL 907479 (Tex. App.–Corpus Christi April 3, 2008, pet. filed). The court held that the assignment was not void under the supreme court's holding in *Gandy* because the claims were assigned after the plaintiffs adjudicated the claim against the defendant/insured in a fully adversarial trial.

VII. THIRD PARTY THEORIES OF LIABILITY

A. Fraud

A court found that even if a doctor stated a claim for fraud based on a liability insurer's agent assuring him his policy would be renewed, there was no evidence that the nonrenewal caused damages. The evidence showed that the doctor's income rose after his policy was not renewed, there was no evidence his surgical privileges were restricted in any way as a result of the nonrenewal, and the insurer did not tell anyone that it was not renewing his coverage. Further, the doctor's expert's testimony linking his alleged damages to the alleged fraud was based on mistaken assumptions that his privileges had been restricted and that the insurer had told others about the nonrenewal. *Medical Protective Co. v. Herrin*, 235 S.W.3d 866 (Tex. App.–Texarkana 2007, pet. denied).

In *Quintinsky v. Texas Mutual Insurance Co.*, No. 03-07-00299-CV, 2008 WL 1911319 (Tex. App.–Austin April 3, 2008, no pet.) (mem. op.), the insurer sued the owner of an insured company for fraudulently inducing the insured to issue policies by misrepresenting the company's payroll to evade the insurer's experience-rating system. The defendant had provided an incorrect address for the insured company and had provided a payroll estimate that was millions of dollars off from that provided to the Texas Workforce Commission. The court held that this evidence was legally and factually sufficient to support the jury's finding of fraud.

It appears that *Gandy* is limited to cases where the insurer has tendered a defense, while *ATOFINA* – and the revived *Block* – will control whenever the insurer breaches its duty to defend or duty to pay.

B. Unfair Insurance Practices

The Fifth Circuit recognized it is an unfair insurance practice for a liability insurer to "fail within a reasonable time … to affirm or deny coverage of the claim to a policyholder." *Columbia Cas. Code v. Georgia & Florida Railnet, Inc.*, 542 F.3d 106 (5th Cir. 2008) (citing Tex. Ins. Code. § 541.060(a)(4)). The court held that as a consequence of the duty to indemnify being based on the facts proved in the underlying suit, not on the pleadings, a liability insurer "must decide the issue of coverage within reasonable time after judgment or settlement." The court found that the liability insurer's denial letter that was filed some two years after the underlying suit was filed, but before the underlying suit was tried, did not support liability under this statutory provision.

The court's analysis on this point is questionable. The statute is to be liberally construed, and nothing in the quoted statutory language says an insurer can wait until after the judgment. It can be very important for an insured to know while a case is being defended what the insurer's coverage position is. This may affect settlement, because the insurer has no duty to settle a noncovered claim. This may also affect the insured's right to choose its own counsel, if the insurer reserves the right to deny coverage. A late letter reserving the right to deny coverage may also estop the insurer to deny coverage under the *Wilkinson* exception, discussed elsewhere in this paper.

It may be the court reached the right result for the wrong reason. The facts described did not show how the insured was prejudiced by the delay, so it may be that even if the insurer violated the statute that violation did not cause damages. It may be that the insured would have been better served by suing under the provision that makes it an unfair insurance practice to fail to promptly send a reservation of rights letter. *See* Tex. Ins. Code § 541.060(4)(B). Clearly that provision does not allow the insurer to wait until after the judgment.

C. Prompt Payment of Claims

An insurance company appealed an award arising out of a claim for hail damage to a church's roof. *Guideone Lloyds Ins. Co. v. First Baptist Church of Bedford*, No. 2-07-176-CV, 2008 WL 4445699 (Tex. App.–Fort Worth Oct. 2, 2008, no pet. h.). The insurance company unconditionally tendered $155,000 to the church before trial. The trial court awarded the church $765,105.44, consisting of actual damages, 18% interest under section 542.055 of the Texas Insurance Code, common law prejudgment interest, additional damages, attorney's fees, and court costs. By the trial court's award of $188,398.71 as an 18% statutory interest penalty on the full amount of the $286,596.63 award

for the insurance company's breach of contract, the trial court disregarded the jury's finding that the insurance company made an unconditional tender to the church. Therefore, the appeals court held that the trial court erred by disregarding the effect of the jury's finding in calculating the section 542.055 interest penalty, and reduced the interest penalty. The award was modified by the appeals court to reflect this decision, but the remainder of the trial court's judgment was affirmed as modified. Because the evidence was undisputed that the insurer failed to comply with the information request requirement, as it never requested any items, statements, and forms required within 15 days of receiving the notice of loss, the church was not required to obtain a jury finding determining when the insurer received all items, statements, and forms reasonably requested and required in order to recover any penalty interest for failing to comply with the statute.

D. Other Theories

A supplier was liable for failing to provide adequate product liability coverage for a distributor of nutrition and weight loss supplements, where the coverage it provided excluded an ephedra, which was included in many of the supplier's products. *Advocare Int'l, LP v. Horizon Laboratories, Inc.*, 524 F.3d 679 (5th Cir. 2008).

An insured does not have a cause of action against a liability insurer for negligent defense. *Cain v. Safeco Lloyds Ins. Co.*, 239 S.W.3d 895 (Tex. App.–Dallas 2007, no pet.). A passenger who was injured in a car wreck obtained a $4 million judgment against the insured driver and then took an assignment and filed suit against the insurer, asserting negligent defense. The plaintiff relied on language from *Ranger County Mutual Insurance Co. v. Guin*, 723 S.W.2d 656, 659 (Tex. 1987), stating that insurers have a duty of ordinary care that includes "investigation, preparation for defense of the lawsuit, trial of the case and reasonable attempts to settle." The court of appeals noted that the supreme court has since described this language as dicta and held that the *Stowers* duty to settle is the only tort duty recognized in liability insurance cases. The insurer in this case did not breach its *Stowers* duty, because it offered its policy limits and the plaintiff refused to take them.

VIII.SUITS BY INSURERS

A. Subrogation

A workers compensation insurer had the right to be reimbursed from the first money recovered and thus was entitled to intervene and recover from a settlement that was structured to send all of the money to the worker's estate. *Texas Mut. Ins. Co. v. Ledbetter*, 251 S.W.3d 31 (Tex. 2008). After receiving workers compensation benefits related to the electrocution death of an insured worker, the widow and children nonsuited their claims after the workers compensation insurer intervened, and then they were dismissed from the case, leaving the court to approve a settlement that awarded payments to the decedent's estate, the plaintiffs' attorneys, and an attorney ad litem for the minor child of the worker. The supreme court held this settlement improperly denied the insurer's statutory right to be repaid first from any money received from the tortfeasor.

The court further held that while the plaintiffs were entitled to nonsuit their own claims, they could not affect the insurer's claims and could not be dismissed from the case so as to defeat the insurer's claims against them.

Finally, the court held that when an injured worker settles a case without reimbursing a compensation carrier, everyone involved is liable to the insurer, including the plaintiffs, the plaintiffs' attorney, and the defendants. In this case, the court held the insurer should receive payment from the plaintiffs' recovery, which was sufficient, not a second recovery from the defendants.

A subcontractor and his liability insurer that paid a property owner for damage caused by a defective valve had an equitable subrogation claim to be repaid by the valve manufacturer. *Frymire Engineering Co. v. Jomar International, Ltd.*, 259 S.W.3d 140 (Tex. 2008). The court reasoned that the payments were "involuntary," even though they were paid pursuant to the engineering company's contract with the hotel where the work was done.

An excess insurer had no right of equitable subrogation against a primary insurer from a different coverage year. *North Am. Spec. Ins. Co. v. Royal Surplus Lines Ins. Co.*, 541 F.3d 552 (5th Cir. 2008). The court also considered the excess insurer's arguments for "stacking" the underlying policies. The court first held that under *American Physicians Ins. Exchange v. Garcia*, 876 S.W.2d 842 (Tex. 1994), it is improper to stack liability policies for different years, by adding the policy limits, before determining whether the excess carrier's limits were impacted. The excess insurer argued that the plaintiffs alleged a number of separate torts sufficient to trigger coverage under three different policy years. The court rejected this argument, finding that the plaintiffs had alleged related conduct, and the primary policies all defined related conduct to constitute a single claim.

The court also rejected the excess insurer's argument that defense costs and liability payments should be "stacked" under the policies. The court reasoned that this would improperly give two policy limits – one for defense costs and one for liability payments – when the policies had a single limit that was "eroded" by defense payments and liability payments.

Finally, the court rejected the excess insurer's argument that coverage should be "stacked" under the hospital professional liability and commercial general liability portions of the primary policies. The excess insurer argued that each of the separate coverages had to be exhausted before its limits were impacted. The court found that liability payments were properly made under the hospital professional liability, based on claims for bad medical care, so that only one primary limit was triggered.

A homeowner's insurer that paid more to settle mold claims than the insureds/homeowners recovered from the builder and more than they received in settlement from other defendants was entitled to subrogation against the settlement proceeds. *Osborne v. Jauregui*, 252 S.W.3d 70 (Tex. App.–Austin 2008, pet. denied). The court applied the "one satisfaction" rule to conclude that, because the insured only suffered one injury, the insurer was entitled to be repaid from the settlement proceeds. The court rejected the argument that the insurer had judicially admitted that the insured suffered more damages, even though the insurer had taken that position at trial and on appeal in attempting to help the insureds recover more in damages from the builder. The court also seemed to suggest that the insurer's right of subrogation would apply even if the plaintiffs were not made whole, based on policy language stating that the insurer "may require an assignment of rights of recovery for a loss to the extent that payment was made by us."

The Austin court of appeals reached a similar result in *Galle, Inc. v. Pool*, 262 S.W.3d 564 (Tex. App.–Austin 2008, pet. filed), finding that a mold remediation contractor was entitled to a settlement credit for amounts paid by the homeowners' insurer. The homeowners had alleged negligent misrepresentation as to all defendants and sought recovery from the defendants for common harm related to mold.

An employee of a repossession company, Innovative, went to repossess a car that was insured by Allstate. *Empire Indemnity Ins. Co. v. Allstate County Mut. Ins. Co.*, 3:06-CV-1415-O, 2008 WL 1989452 (N.D. Tex. May 8, 2008). After picking up the car, the employee was involved in an accident while street racing

the car. Empire insured Innovative under a commercial liability policy. Empire filed this suit seeking to recover from Allstate the amounts paid to settle the underlying claims, defense costs, and attorney's fees. The court found that Allstate did not have any duty to defend Innovative or its employee, as the allegations in the petition triggered the exclusion in the Allstate policy when a person uses a covered auto without a reasonable belief he was entitled to use the car in the manner it was being operated at the time of the accident. The court also held there was no duty to indemnify Empire, the insurer of Innovative.

B. Contribution Between Insurers

A homeowner's association ("HOA") had two insurance policies. Everest provided commercial general liability coverage. The Everest policy was a primary policy and allowed for contribution from other primary insurers. The second policy was issued by Federal and covered claims against the HOA's directors and officers for "wrongful acts." The Federal policy excluded coverage based on property damage and construction defects, and only provided excess coverage.

Several homeowners sued the HOA for failure to pay for repairs to the foundations of their homes, alleging that the HOA's nonpayment was a misrepresentation. Everest defended the HOA. After that lawsuit was settled, Everest sought to recover a portion of its settlement and attorney's fees from Federal. The court held that the suit against the HOA was not covered by the Federal policy because the Federal policy did not cover construction defects or property damage, and but for the alleged foundation damage – a construction defect – there would be no suit against the HOA. Because the HOA had no cause of action against Federal, Everest could have no subrogated claim against Federal. Also, Everest had no right to contribution from Federal because the policies did not insure the same risks. *Federal Ins. Co. v. Everest National Ins. Co.*, 257 S.W.3d 771 (Tex. App.–Dallas 2008, pet. filed)

A builder had several commercial general liability insurance policies from various insurers. After the builder was sued, it notified all of the insurers. All but one of the insurers, Employers' Mutual Casualty Company (EMC), agreed to defend the builder. In *Trinity Universal Insurance Co. v. Employers Mutual Casualty Co.*, No. H-07-0878, 2008 WL 2078202 (S.D. Tex. May 15, 2008), the defending insurers sued EMC for breach of contract and contribution. The trial court determined that EMC had a duty to defend the builder, but also determined that the defending insurers had no right of contribution from EMC because their policies contained pro rata clauses, which precluded a direct claim for contribution by making the contracts several and independent of each other.

Two insurers – Lexington Insurance Company and Chicago Insurance Company – issued consecutive primary professional liability policies to a health care agency. Both insurers paid to defend the healthcare agency in a medical malpractice suit. Each insurer contributed half of the amount necessary to settle the suit. In *Lexington Insurance Co. v. Chicago Insurance Co.*, No. H-06-1741, 2008 WL 3538700 (S.D. Tex. Aug. 8, 2008), Lexington sought reimbursement from Chicago on grounds that Lexington's policy did not cover the underlying lawsuit. Chicago argued that Lexington had no claim for reimbursement under *Mid-Continent Insurance Co. v. Liberty Mutual Insurance Co.*, 236 S.W.3d 765 (Tex. 2007). The district court determined that both policies covered the claim. The Chicago policy provided coverage because it did not suffer prejudice due to the underlying plaintiff's delay in providing notice, which was the only ground Chicago relied on in denying the claim. The Lexington policy provided coverage because the wrongful act occurred during the policy period and Lexington could not establish mutual mistake to justify reformation of the policy to reflect a different coverage period. Because neither insurer could show that its policy did not provide coverage for the underlying suit, the court held that, under *Mid-Continent*, Lexington, as an insurer of a covered lawsuit against its insured, could not obtain reimbursement from a coinsurer for the amount contributed to settle that lawsuit.

C. Declaratory judgment suits

Texas Windstorm Insurance Association ("TWIA") is legally authorized to file suit and bring a declaratory judgment action to determine whether it has an obligation to appraise its insureds' loss. *Texas Windstorm Ass'n v. Poole*, 255 S.W.3d 775 (Tex. App.–Amarillo 2008, pet. filed). Comparing TWIA to a platypus, the court found the association has both private and governmental characteristics but functions as a business. Thus TWIA reasonably could be required to seek judicial resolution of disputes, and allowing such suits is not inconsistent with the statutes authorizing its existence.

D. Indemnity

An insurer was not entitled to indemnity from its agent that submitted incomplete data, resulting in a reinsurer rescinding a contract. The court held that "only a vestige of common-law indemnity remains" under Texas law, and this was not such a case. While there might be indemnity for vicarious tort liability, in this case the reinsurer elected to forgo tort damages and chose rescission instead. The court concluded that, because the insurer was not vicariously liable for the tortious conduct of the agent, the insurer was not entitled to indemnity. *TIG Ins. Co. v. Aon Re, Inc.*, 521 F.3d 351 (5th Cir. 2008).

IX. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Punitive Damages

A trial court did not err by granting a directed verdict on the insured's punitive damage claim, where there was no evidence that the insurer's demands for financial documents to support its arson defense were fraudulent, grossly negligent, or resulted in extraordinary harm. *Munoz v. State Farm Lloyds of Texas*, 522 F.3d 568 (5th Cir. 2008).

B. Attorney's Fees

Homeowners whose claims against a builder were entirely offset by prior settlements with other defendants did not "prevail" on their DTPA claims and thus could not recover attorney's fees. *Osborne v. Jauregui*, 252 S.W.3d 70 (Tex. App.–Austin 2008, pet. denied) (en banc). Two justices dissented noting that the consumers were entitled to recover their attorney's fees and that to hold otherwise would reward the builder for refusing to settle, even though his work caused substantial harm.

C. Mental anguish

Evidence did not support a doctor's award for mental anguish resulting from his liability insurer's refusal to renew his coverage after he had been with them for almost forty years. The doctor alleged he was forced into retirement at the age of seventy after the insurer's nonrenewal. The jury awarded the doctor $250,000 for his mental anguish, but the court agreed with the insurer that there was no evidence to support this award. The doctor testified he felt "terrible" when he received the nonrenewal notice and was "tremendously upset" by a letter from the insurer saying his malpractice claims were frequent and severe. The doctor also testified that he felt he could no longer get his work done as easily as he once could, that the work was no longer as pleasant as it once had been, and that his work became more difficult instead of being

enjoyable. He also noted that he engaged in uncharacteristically risky behavior by driving his new motorcycle at an excessive rate of speed. The doctor presented no evidence of any detriment to his physical health, did not present evidence that he sought professional assistance or took medication to cope with his mental anguish, and offered no testimony from any other witnesses regarding the severity of any anguish or a substantial disruption in his daily routine. The court concluded the evidence showed nothing more than mere worry, anxiety, vexation, embarrassment, or anger, which are not sufficient. *Medical Protective Co. v. Herrin*, 235 S.W.3d 866 (Tex. App.–Texarkana 2007, pet. denied).

Homeowners waived their right to arbitration by initially opposing arbitration, litigating for fourteen months, conducting extensive discovery, and then invoking arbitration shortly before trial.

Evidence was sufficient to support an award of mental anguish to a worker whose compensation claim was unfairly denied. The insurer denied payment for surgery related to a back injury. The worker testified that he was scared and worried because he knew he could not pay his medical bills. After he was discharged from the hospital and had to return because of a potentially life-threatening infection, he was told to "get out" because he had no coverage. He testified that it made him sick and he felt the world was crashing down on him. He further testified to his credit rating dropping, being unable to get credit, being unable to be listed on the mortgage with his new wife, which made him feel like a nothing. His testimony was supported by testimony by his wife that he was "a basket case" and from a friend who testified that he was no longer happy and something had "totally broken him down." *Texas Mut. Ins. Co. v. Morris*, 2008 WL 4092921, No. 14-06-00651-CV (Tex. App.–Houston [14th Dist.] Aug. 26, 2008, no pet.).

A homeowner, Spears, contracted with a construction company to remodel his home, and the work was financed by a promissory note. *CA Partners v. Spears,* No. 14-07-00057-CV, 2008 WL 3931401 (Tex. App.–Houston [14th Dist.] Aug. 26, 2008). The deed listed an incorrect lot number as Spears's real property. Spears defaulted on the note, and the note and deed were assigned to CA Partners, who attempted to collect, purchased the property at a foreclosure sale, and tried to evict Spears. The court of appeals upheld an award for mental anguish. This action was found to be wrongful because Johnson, the managing partner of CA Partners, represented in the Trustee's Deed that the Deed created a lien on Spears' personal property (which it did not) and represented that Spears owed a debt that originated from a contract executed with Western Building and Supply Co. (which it did not). This evidence showed that Johnson knowingly engaged in conduct that violated that Texas Deceptive Trade Practices and Consumer Protection Act. Moreover, CA Partners showed no evidence that it instituted reasonable procedures to prevent the error that caused the violations of the Fair Debt Collection Practices Act and the Texas Finance Code, and therefore the bona fide error defense was not available to it. An award of mental anguish damages to Spears was allowed in this case as his testimony constituted direct evidence of the nature, duration, and severity of his mental anguish and established a substantial disruption in his daily routine. The evidence included that he was devastated when the court granted the forcible entry and detainer suit, he was unable to sleep and not hardly able to eat, he was devastated because he was faced with the realization that he did not have any place to go, and he only had seven days to figure out how to fight the eviction. The appeals court affirmed the mental anguish award.

D. Damage to credit reputation

Evidence was insufficient to support an award for damage to a worker's credit reputation from his compensation insurer's claim denial. While he offered proof that his credit rating was harmed, the court found he did not offer specific proof to establish the dollar amount of injury he sustained. *Texas Mut. Ins. Co. v. Morris*, No. 14-06-00651-CV, 2008 WL 4092921 (Tex. App.–Houston [14th Dist.] Aug. 26, 2008, no pet.).

X. DEFENSES & COUNTERCLAIMS

A. Arbitration

Homeowners waived their right to arbitration by initially opposing arbitration, litigating for fourteen months, conducting extensive discovery, and then invoking arbitration shortly before trial. *Perry Homes v. Cull*, 258 S.W.3d 580 (Tex. 2008). The homeowners originally sued their builder and the home warranty companies. The defendants sought to compel arbitration, which the homeowners resisted. After litigating as described above, the homeowners decided they preferred arbitration, got the trial court to compel arbitration, and were successful in arbitration. The defendants argued successfully that the court should reverse the arbitration award, because the homeowners had waived their right to arbitrate. In reaching its conclusion that the homeowners had waived arbitration, the court also held that the warranty companies waived their right to arbitrate by their "extensive co-participation in months of discovery."

The Fifth Circuit held that treaties such as the Convention on the Recognition and Enforcement of Foreign Arbitral Awards do not constitute an "Act of Congress" within the meaning of the McCarran-Ferguson Act and thus are not reverse preempted by state statutes that prohibit arbitration agreements in insurance contracts. *Safety Nat'l Cas. Corp. v. Certain Underwriters at Lloyd's London*, 543 F.3d 744 (5th Cir. 2008). In a contract dispute among three insurers from different countries, in which the contracts contained arbitration clauses, the insurers disagreed as to whether their dispute should go to arbitration rather than to court. The district court concluded that, although the Convention on the Recognition and Enforcement of Foreign Arbitral Awards would otherwise require arbitration, a Louisiana statute that prohibited arbitration agreements in insurance contracts was controlling. In support of its conclusion, the district court reasoned that the McCarran-Ferguson Act caused the statute to reverse preempt the Convention, since the statute had "the purpose of regulating the business of insurance." The Fifth Circuit disagreed. The McCarran-Ferguson Act states, "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance." The court held that treaties are not included within the scope of an "Act of Congress," as the McCarran-Ferguson Act uses those words. Because the Convention is a treaty, and not an "Act

of Congress," the Louisiana statute did not reverse preempt the Convention. Therefore, the arbitration agreements were enforceable. The Fifth Circuit made no determination as to whether the Louisiana statute actually regulated the "business of insurance."

A homeowner challenged the validity of an arbitration clause in his home insurance policy in *In re Farmers & Ranchers Mutual Insurance Co.*, No. 04-08-00128-CV, 2008 WL 2133116 (Tex. App.–San Antonio May 21, 2008, no pet.). The court held that the arbitration clause was valid and enforceable, even though the homeowner did not sign the arbitration agreement. Furthermore, the insurer's uncontradicted affidavit stating that the policy containing the arbitration clause was mailed to the homeowner and not returned was sufficient to show that the homeowner had notice. Finally, the court held that the arbitration clause was not unconscionable.

B. Breach of Policy Condition

Breach of a policy condition that does not cause damage or the accident is no defense, held the supreme court in *Puckett v. US Fire Insurance Co*., 678 S.W.2d 936, 938 (Tex. 1984). That decision was controversial at the time, coming as it did in a five-four decision authored by Justice Spears over a vigorous dissent by Chief Justice Pope. A generation later the issue is raised again, and the San Antonio Court of Appeals reaffirmed that *Puckett* is still the law, in *AIG Aviation (Texas), Inc. v. Holt Helicopters, Inc.*, 198 S.W.3d 276 (Tex. App.–San Antonio 2007, pet denied). That decision was controversial, coming with a two-one split and a majority opinion authored by Justice Simmons (who years earlier was a briefing attorney for Justice Spears), over a vigorous dissent by Justice Duncan. The supreme court declined to review the decision, but not without a dissent by Justice Willett, who objected that, by engrafting a causal connection requirement into the policy, the court was not enforcing the contract as written.

C. Contractually-assumed liability

An excess insurer's policy did not provide coverage for liability a contractor had under a contract with a governmental entity, where the contractor was immune from tort liability. The court found that the plain language of an exclusion for "assumption of liability in a contract" applied and that, because the contractor obtained summary judgment on its tort immunity claim, its liability did not fit within the exception for liability the contractor otherwise had. The court rejected the contractor's argument that the exception should apply to potential liability, not just adjudicated liability. The court also rejected the argument that applying the exclusion created an irreconcilable conflict because if the contractor won on its immunity defense as to tort liability, that negated coverage that otherwise existed for contract liability. The court concluded that such conflict could not form the basis for coverage that otherwise would not exist. *Underwriter at Lloyd's of London v. Gilbert Texas Construction, L.P.*, 245 S.W.3d 29 (Tex. App.–Dallas 2007, pet. filed).

D. Equitable reformation of policy

A court rejected a primary insurer's claim for equitable reformation to exclude professional liability claims from its comprehensive general liability coverage and limit them to the care provider's professional liability policy with a lower aggregate limit. The court found the insurer failed to offer any evidence that the insured and the primary insurer agreed to such a limit and that it was mistakenly not included in the written contract. *U.S. Fire Ins. Co. v. Scottsdale Ins. Co.*, 264 S.W.3d 160 (Tex. App.–Dallas 2008, pet. denied).

E. ERISA Preemption

An employer's payment of premiums for health insurance for one employee (who was also half owner) was not sufficient to establish an ERISA plan, so that his claims under state law for misrepresentation and unfair insurance practices were not pre-empted. *Shearer v. Southwest Service Life Ins. Co.*, 516 F. 3d 276 (5th Cir. 2008).

Whether ERISA preempts depends on whether there is an "employee benefit plan." The deciding factor in this case was whether the arrangement was "established or maintained by the employer with the intent to benefit employees." This factor has two parts – whether the employer established or maintained the plan, and whether the employer intended to provide benefits to its employees. The evidence showed that the employer paid the premium for this employee who was also half owner, and the company paid the premium for health insurance for his mother, who was the other half owner, but with a different insurance company. The employer did not provide health insurance for any of the other employees. The court found this evidence was insufficient to demonstrate that the employer intended to establish an ERISA plan.

In *Ambulatory Infusion Therapy Specialist, Inc. v. North American Administrator's, Inc.*, 262 S.W.3d 107 (Tex. App.–Houston [1st Dist.] 2008, no pet.), an employee had insurance through the employee healthcare plan and needed home medical services. AITS alleged that it called the third-party claims administrator to verify that the medical services would be covered, and was told that the services would be reimbursed. However, the administrator only paid a fraction of the cost. AITS argued that it was not seeking benefits under the plan, but was seeking damages based on an independent promise by the administrator to pay, and, therefore ERISA did not preempt its state law claims. The court held that AITS's failure to obtain assignment of benefits on which its claim against the insured's employer the plan's insurer was premised did not preclude ERISA preemption. Federal courts have drawn a distinction between cases where the existence of coverage is in dispute, which are not preempted, and those where the dispute is merely over the extent of coverage, which are preempted. Even if the case was not pre-empted, AITS did not timely file suit within the statute of limitations, and, therefore, its state law claims would be time-barred.

An insurer approved the medical necessity of the services proposed by a hospital for an employee under an employee benefit plan. After the services were provided, the insurer notified the insured it would not pay. It was undisputed that the employee was not covered by the terms of the policy at the time of her hospitalization. Because she was not covered, ERISA did not preempt the hospital's state-law claim. *College Station Hosp., L.P. v. Great W. Healthcare Ins. Co.*, No. H-08-460, 2008 WL 954166 (S.D. Tex. 2008).

F. Exhaustion of Administrative Remedies

A court lacked jurisdiction to consider a worker's compensation claim where the worker did not first exhaust her administrative remedies. Schwartz was injured and contended she needed surgery on her foot related to those injuries. The insurer originally denied authorization for the surgery, contending it was not work related. She ultimately got the surgery, and the insurer ultimately agreed to pay for the surgery, but she sued for damages for additional harm caused by the delay. The court held that even though the insurer agreed to pay for the surgery, the worker still had to first get the Workers Compensation Commission to determine whether that initial denial was improper. Because she failed to get a Commission determination, and the time had lapsed for doing so, the court did not have jurisdiction to consider her complaint.

Schwartz v. Insurance Co. of Penn., No. 01-07-00193-CV, 2008 WL 4670516 (Tex. App.–Houston [1st Dist.] Oct. 23, 2008, no pet. h.).

A plaintiff obtained an adverse decision from a Texas Workers' Compensation Commission hearing examiner. However, the Commission did not send a copy of its decision to the plaintiff's counsel, as required by its own administrative rule, until more than a month had passed. The plaintiff's attorney then immediately filed a request for review with the appeals panel. The appeals panel determined that the plaintiff had failed to timely file her request for review and dismissed her administrative appeal. The plaintiff then sued in district court for judicial review of the appeals panel's determination. The workers' compensation insurer moved to dismiss the plaintiff's suit for lack of subject matter jurisdiction, arguing that she had failed to exhaust her administrative remedies by timely seeking review from the appeals panel. The court of appeals held that the plaintiff did not receive the hearing officer's decision until it was finally sent to her attorney, and that she therefore complied with the 15-day deadline to request review by an appeals panel. Accordingly, the plaintiff exhausted her administrative remedies, and the district court had jurisdiction over the suit. *Frank v. Liberty Ins. Corp.*, 255 S.W.3d 314 (Tex. App.–Austin 2008, pet. filed).

In *Combined Specialty Insurance Co. v. Deese*, No. 05-06-01580-CV, 2008 WL 4491555 (Tex. App.–Dallas Oct. 8, 2008, no pet. h.), a workers' compensation carrier sued to set aside two decisions: a decision by a hearing officer of the Workers' Compensation Commission finding that the claimant had sustained a compensable, work-related injury and ordering the carrier to pay benefits; and a decision by a WCC appeals panel finding that the carrier's appeal was untimely. The trial court entered judgment dismissing the carrier's action for lack of jurisdiction. However, the court of appeals held that the carrier satisfied the WCC's mailbox rule. The carrier mailed its request for review, and the WWC received a faxed copy of the request within twenty days after the carrier received the hearing officer's decision. Accordingly, the carrier's appeal was timely. Because its appeal was timely, the carrier exhausted its administrative remedies before filing suit, and the trial court had jurisdiction.

G. Government Immunity

A fire truck collided with another vehicle, resulting in severe injuries to the passengers in the vehicle. The passengers sued the firefighter driving the truck and received a judgment in excess of $1.5 million. The trial court also found that the firefighter engaged in reckless conduct and was not entitled to official immunity. The firefighter appealed, arguing that the trial court erred in refusing to apply the damages cap set forth in section 108.002(a)(2)(C) of the Texas Civil Practice and Remedies Code. That section provides that a $100,000 liability cap applies if the damages result from an act within the scope of a public servant's work and where the public servant has insurance coverage for $100,000. The firefighter argued that if the city paid its policy's $100,000 self-insured retention, then the firefighter should be considered insured for purposes of section 108.002 and that the liability cap should apply. The court of appeals disagreed.

In *Green v. Alford*, No. 14-05-00407-CV, 2008 WL 2744232 (Tex. App.–Houston [14th Dist.] July 15, 2008, no pet.), the court compared the policy's terms to the requirements of the statute. The city's policy described its coverage as "excess" insurance above a $100,000 self-insured retention, which had to be paid by the "assured" before the policy would indemnify the assured. The definition of "assured" included both the city and the firefighter. Because the obligation to pay the self-insured retention applied to the firefighter and because the firefighter could not establish that the city had to pay the first $100,000 in damages, the court concluded that the firefighter failed to establish that he was covered for the first $100,000. Accordingly, the statutory cap on liability did not apply.

H. Late Notice

An insured's failure to timely notify its insurer of a liability claim does not defeat coverage under the policy unless the insurer is prejudiced. *PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 630 (Tex. 2008). A majority of the supreme court reaffirmed its holding in *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691, 692 (Tex. 1994), that an immaterial breach does not deprive the insurer of the benefit of the bargain and thus cannot relieve the insurer of the contractual coverage obligation. The court rejected the argument that it made a difference whether the policy language requiring notice was a condition precedent or a covenant. However characterized, if there was no prejudice, the failure to give timely notice would provide no defense.

The court noted that its position was consistent with the "modern trend" adopted by at least thirty-eight states. The court further reasoned that the timely notice provision was not an essential part of the bargained for exchange under the occurrence based policy. Notice under an "occurrence" policy is subsidiary to the event that triggers coverage. Finally, the majority held that allowing late notice to provide a defense without prejudice would impose "draconian" consequences for even minor deviations from the duties the policy places on insureds.

I. Limitations

Limitations began to run when an insurance agent provided incomplete loss data on behalf of an insurer to a reinsurer, which resulted in the reinsurer rescinding the contract. The court held that the insurer was "legally injured" at this point, even though its full damages did not occur until later. Thus, the claim was barred by limitations. *TIG Ins. Co. v. Aon Re, Inc.*, 521 F.3d 351 (5th Cir. 2008).

The court in *TIG v. Aon* then considered whether the discovery rule delayed the accrual of the cause of action, but found it did not. Under Texas law, the court reasoned that the discovery rule applies only when the nature of the injury is inherently undiscoverable and the injury itself is objectively verifiable. The court noted that under Texas law whether an injury is inherently discoverable is determined "categorically," meaning that the court considers not the merits of an individual case but cases in general. Under this standard, the court found the injury was not inherently undiscoverable. TIG's vice-president had expressed concerns about the adequacy of the bid at the time it was first made. The court held this evidence exemplified that the injury was not "categorically" the type of injury that was inherently undiscoverable.

The court next considered whether any fiduciary relationship between the agency and the insurer made the injury inherently undiscoverable. The court noted Texas cases holding that "[f]acts which might ordinarily require investigation likely may not excite suspicion where a fiduciary relationship is involved." The court also noted that fiduciaries are presumed to possess superior knowledge, and the injured party – the client – is presumed to possess less information. Thus, in the fiduciary context the nature of the injuries is presumed to be inherently undiscoverable. Despite this "categorical" rule, the court concluded that in TIG's specific circumstances its own injury was not inherently undiscoverable.

J. Reimbursement

After almost three years on rehearing, the Texas Supreme Court decided in *Excess Underwriters at Lloyd's v. Frank's Casing*

Crew & Rental Tools, Inc., 246 S.W.3d 42 (Tex. 2008), finding that a liability insurer that settles a claim on which coverage is disputed has no right of reimbursement. The majority noted that this issue had been resolved in *Tex. Ass'n of County Gov't Risk Mgmt. Pool v. Matagorda County*, 52 S.W.3d 128 (Tex. 2000). The majority found no reason to depart from its prior ruling. The court relied on its prior reasoning that determining the risk of coverage is best placed with the insurer.

The majority further held that there was no implied agreement by Frank's Casing to allow the insurer to settle and seek reimbursement. The court rejected the argument that the insurer created such an obligation by making it a condition of the settlement. The court found no implied agreement to reimburse the insurer, in light of Frank's Casing's consistent position that the insurer was responsible for the claim. The majority also refused to recognize any equitable right of reimbursement, because doing so would rewrite the contract.

Justice Hecht dissented and would hold that an insurer does have an equitable right of reimbursement to avoid unjust enrichment. Justice Wainwright also dissented based on his view that Frank's Casing had in fact agreed that the insurer could seek reimbursement, by acquiescing to a settlement where the insurer asserted such a right.

Interestingly, both the majority and Justice Hecht emphasized that an insurer may avoid this dilemma by seeking a prompt resolution of disputed coverage issues. This continues a point the supreme court has made many times, urging insurers to resolve disputed coverage issues before the underlying liability is established. However, clear holdings from the supreme court severely limit the circumstances under which coverage can be litigated before the underlying suit. *See Farmers Texas County Mutual Ins. Co. v. Griffin*, 955 S.W.2d 81, 84 (Tex. 1997). The court has not yet resolved this conflict.

The Fifth Circuit revisited the issue of reimbursement and allocation between covered and noncovered claims in *American International Specialty Lines Insurance Co. v. Res-Care, Inc.*, 529 F.3d 649 (5th Cir. 2008). First, the court held that the nursing home/insured and the insurer entered into a valid nonwaiver agreement that allowed the insurer to settle with the tort plaintiffs and then seek reimbursement of any noncovered amounts from the nursing home.

After the insurer settled with the plaintiffs for $9 million, the insurer and nursing home litigated the issue of the proper allocation of the settlement between covered and noncovered claims. The plaintiffs had sued for actual damages and punitive damages based on severe injuries a nursing home resident suffered when a nursing home employee doused her with bleach and left her unattended so that she suffered chemical burns that ultimately caused her death.

The Fifth Circuit relied on its prior decision in *Ensearch Corp. v. Shand Morahan & Co.*, 952 F.2d 1485 (5th Cir. 1992), regarding how a district court should conduct a trial to determine allocation of a settlement. The district court was not to conduct a full-blown trial but instead would try to determine how the parties viewed the merits of the plaintiffs' claims at the time of the settlement.

The court rejected the nursing home's argument that the district court could only consider evidence that would be admissible at a trial of the underlying tort suit. The court held that the district court has more leeway to consider any evidence that might have influenced the parties' settlement decision.

However, the court agreed that the district court should not have considered evidence of the criminal conviction of the nursing home employee for recklessly causing serious bodily injury to a disabled individual, because that conviction did not establish an intentional act. The court also agreed that the district court should not have considered the opinion of the insurer's expert as to the value of the plaintiffs' actual damages. However, the court found both errors were harmless because the district court awarded $4 million in actual damages, where the insurer had asserted that only $2.5 million of the settlement was for actual damages.

The court also held that the plaintiffs' claim did not involve multiple occurrences sufficient to trigger multiple primary policies. Although the plaintiffs amended their pleading just before trial, and just before the case settled, to allege seventy-five injuries, the district court properly found that the settlement was motivated by the one single injury occurring in a single policy year.

K. Restitution

If a bankruptcy debtor used undisclosed prepetition funds to buy a life insurance policy, the bankruptcy trustee might have a property interest in the insurance purchased with those funds. *In re McClain*, 516 F.3d 301 (5th Cir. 2008). The court relied on the Restatement of Restitution section 210, as adopted in other cases, that "A person who wrongfully uses stolen or fraudulently obtained funds to purchase an insurance policy shall hold that policy and its proceeds in trust for the benefit for the one from whom the funds were stolen or taken."

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

An insurer was not estopped to assert lack of coverage, and did not waive the argument that a claim made outside the coverage period was not covered. *Ulico Cas. Co. v. Allied Pilots Ass'n*, 262 S.W.3d 773 (Tex. 2008). The court rejected the "*Wilkinson* exception," which held that a liability insurer waives the argument that a claim is not covered when it assumes control of the defense without an effective reservation of rights. *See Farmers Texas Co. Mut. Ins. Co. v. Wilkinson*, 601 S.W.2d 520 (Tex. Civ. App.–Austin 1980, writ. ref'd, n.r.e.). Ulico provided liability insurance to APA under a "claims made" policy. APA submitted a claim after the coverage period expired, but Ulico agreed to reimburse APA for defense costs. When the insurer later denied coverage and asserted it did not owe defense costs, APA asserted and obtained jury findings that Ulico was estopped to deny coverage or had waived the argument that the claim was not covered.

The supreme court reiterated the rule that the doctrines of waiver and estoppel cannot be used to expand coverage under a policy. *See Washington Nat'l Ins. Co. v. Craddock*, 130 Tex. 251, 109 S.W.2d 165 (1937) (no waiver); *Texas Farmers Ins. Co. v. McGuire*, 744 S.W.2d 601 (Tex. 1988) (no estoppel). The court recognized that waiver and estoppel may operate to avoid a forfeiture such as by preventing the insurer from arguing late notice, but the doctrines could not be used to extend coverage to a risk that was not covered.

The court disagreed with the holding in *Wilkinson* that an insurer that assumes the insured's defense without obtaining a reservation of rights and with knowledge of facts indicating noncoverage waives all policy defenses, including the defense of noncoverage, and is estopped from raising the defense. The court held that, for estoppel to prevent the assertion of a defense of noncoverage, there must be a showing of prejudice. The court specifically disagreed with *Wilkinson's* statement that "non-coverage" of a risk is the type of right an insurer can waive and thereby effect coverage for a risk that was not covered by the contract. The court also seemed to disagree with *Wilkinson's* assumption that defending without an effective reservation of rights necessarily created prejudice. The court contrasted the decision in *Tilley* where the insured suffered actual prejudice from the insurer asserting a coverage defense of late notice that was developed by the defense

attorney hired by the insurer. *See Employers Cas. Co. v. Tilley*, 496 S.W.2d 552 (Tex. 1973).

Because the court found no evidence that APA was prejudiced, and because it was undisputed that the claim was made outside the coverage period, the court reversed and rendered judgment that APA take nothing.

Chief Justice Jefferson, joined by Justice O'Neill, concurred to clarify their understanding that the court's opinion would allow estoppel if the insured showed prejudice, and the appropriate measure of damages would be the benefits that would have been paid had the insurer not denied coverage. The concurring opinion noted that the rule that coverage cannot be created by waiver or estoppel has not been applied when the insurer assumes the insured's defense, and that when an insurer assumes a defense without an effective reservation of rights the loss of the insured's right to control the matters of defense is presumed to be prejudicial.

In a suit between an insured and insurer to allocate settlement payments between covered and noncovered claims, with the insurer seeking reimbursement of the noncovered amounts, the insured argued that the insurer had waived, or was estopped to assert, noncoverage. The insured argued that the insurer had defended the case without an effective reservation of rights, despite being aware of facts indicating noncoverage. The Fifth Circuit rejected this argument, because the insurer and insured entered into a specific agreement allowing the insurer to settle with the plaintiffs and then seek reimbursement for any noncovered claims. *American Int'l Spec. Lines Ins. Co. v. Res-Care, Inc.*, 529 F.3d 649 (5th Cir. 2008).

The *Res-Care* court also rejected the insured's argument that its agreement to the nonwaiver agreement was "forced." The court found the insured was at all times represented by competent coverage counsel and exercised a voluntary choice to execute the nonwaiver agreement.

An insurer was not estopped to deny coverage by defending without a reservation of rights, where the evidence was disputed as to when the reservation of rights was sent and the insurer never assumed or continued the defense, because it was not obligated under its policy to defend. *Columbia Cas. Co. v. Georgia & Florida Railnet, Inc.*, 542 F.3d 106 (5th Cir. 2008).

A liability insurer's breach of its duty to defend or indemnify did not waive the requirement that the insured first pay a self-insured retention. The court recognized the rule that an insurer that breaches the contract cannot insist on compliance with the conditions of the policy, but found that principle did not apply to waive the self-insured retention. The insurer owed no duty to defend or indemnify until after the insured's self-insured retention was exhausted. *U.S. Fire Ins. Co. v. Scottsdale Ins. Co.*, 264 S.W.3d 160 (Tex. App.–Dallas 2008, pet. denied).

The insured in *Underwriter at Lloyd's of London v. Gilbert Texas Construction, L.P.*, 245 S.W.3d 29 (Tex. App.–Dallas 2007, pet. filed), argued that the insurer had waived or was estopped to assert the exclusion for contractual liability. The insured's argument was based on the fact that it would have tort liability, which was an exception to the exclusion, but the insurer pressured it to file a motion for summary judgment that successfully asserted governmental immunity as a defense to tort liability. As a result, the insured was left with only contractual liability, which was excluded. The insured argued that this pressure by the insurer, under the threat of invoking the cooperation clause if the insured did not move for summary judgment, estopped the insured from asserting this coverage defense. The insured relied on the rationale of the *Wilkinson* exception, arguing that the insurer had undertaken its defense without informing it of the effect of this coverage defense.

The Dallas court rejected this argument, finding that the excess insurer had the right to associate with the insured in the defense, but had not thereby undertaken its defense. Interestingly, the court stated that the insured's failure to pursue its governmental immunity defense, which would plead it out of coverage, "may or may not be" a violation of the cooperation clause. Nevertheless, the court reasoned that the insured was free to refuse to pursue summary judgment on the immunity defense and challenge the insurer's denial of coverage later.

Whatever the cooperation clause means, clearly it cannot require an insured to engage in conduct in the underlying liability suit that will preclude coverage later. Cooperation is not self-sacrifice.

XI. PRACTICE & PROCEDURE

A. Standing

A contractor had no standing to sue its subcontractor's liability insurers prior to obtaining a judgment against the insured's defendant. Time Warner sued its subcontractor for poor work that caused Time Warner to spend money to fix the errors. Although Time Warner sued the subcontractor, it also sued the insurers to get paid, before resolving its suit against the subcontractor. The court held this was improper, because a claimant has no direct action against a defendant's liability insurer. *Ohio Cas. Ins. Co. v. Time Warner Entertainment Co.*, 244 S.W.3d 885 (Tex. App.–Dallas 2008, pet. granted). The court held this result was not changed by the fact that Time Warner was an additional insured under the policy.

B. Justiciability

A district court properly determined that a liability policy pollution exclusion would exclude coverage for a claim by an employee for injuries from inhaling hazardous fumes and dust. *Columbia Cas. Co. v. Georgia & Florida Railnet, Inc.*, 542 F.3d 106 (5th Cir. 2008). The Fifth Circuit held that normally the issue of indemnity is not justiciable in a declaratory judgment suit until after the underlying liability suit has been resolved, because the duty to indemnify depends on the actual facts that establish liability. However, the court recognized there are exceptions and found the duty to indemnify was justiciable in this case. The insurer had no duty to defend under its policy, and it was apparent before liability was resolved in the underlying case that the policy could not cover the claim. The court reasoned that if the injuries happened as alleged, they would be excluded by the pollution exclusion, and if injuries did not happen as alleged, then they would not be employment-related and still would not be covered.

C. Removal

In *Harp v. Liberty Mutual Insurance Co.*, No. SA-08-CV-0655, 2008 WL 4200312 (W.D. Tex. Sept. 11, 2008), a worker's compensation case, the federal court denied the plaintiff's motion for remand. The plaintiff asserted a claim for breach of the duty of good faith and fair dealing, which made the claim removable under Fifth Circuit case law stating that such claims against a workers' compensation carrier are not immunized against removal by 28 U.S.C. § 1445(c). The plaintiff argued that the case should be remanded because the insurer did not establish that the amount in controversy exceeded $75,000. The court disagreed, finding that the plaintiff had asserted that the insurer failed to pay a claim for $60,000 and also requested several other types of damages, which would more than likely exceed $15,000.

A court granted an insured plaintiff's motion to remand, finding that the insurer failed to meet its burden of establishing improper joinder of the non-diverse claims adjuster. *Woloshen*

v. State Farm Lloyds, No. 3:08-CV-0634-D, 2008 WL 4133386 (N.D. Tex. Sept. 2, 2008). The insured asserted a theory of aiding and abetting against the adjuster, which the insurer contended was inapplicable because the insurer owed no fiduciary duty to the insured and because the insured had not alleged any "antisocial or dangerous behavior." The court held that the insurer failed to show that there was a principled distinction between the fiduciary duty and the duty of good faith and fair dealing such that, as a matter of law, aiding and abetting liability can be imposed in one context but not the other. Accordingly, the insurer failed to demonstrate that there was no reasonable basis for the court to predict that the insured might be able to recover against the adjuster.

There was no proof that the defendant rather than is lawyer was responsible for the misconduct, so it would be improper to punish the defendant for its lawyer's misconduct.

Similarly, in *Warren v. State Farm Mutual Automobile Insurance Co.*, No. 3:08-CV-0768-D, 2008 WL 4133377 (N.D. Tex. Aug. 29, 2008), the court granted a plaintiff's motion to remand, finding that the defendant insurer failed to meet its burden of establishing improper joinder of the non-diverse claims adjuster. The plaintiff had sued the adjuster for unfair insurance practices. The insurer contended that the plaintiff's petition failed to sufficiently plead facts that would entitle him to relief. Applying Texas's notice pleading standard, the court held that the factual allegations in the petition were sufficient to state a claim against the adjuster individually for unfair insurance practices.

D. Joinder

In *Alba v. Southern Farm Bureau Casualty Insurance Co.*, No. 3:08-CV-0842-D, 2008 WL 4287786 (N.D. Tex. Sept. 19, 2008), a federal court determined that the plaintiffs should not be permitted to add a non-diverse defendant, which would have destroyed jurisdiction and required remand. The court determined that the plaintiff's purpose in adding the non-diverse party was solely to defeat diversity jurisdiction. The court also determined that the plaintiffs were dilatory in seeking to add the non-diverse party, and would not be prejudiced if the joinder was denied.

E. Discovery

In a suit by an insurer that paid a fire loss, the insurer complained of several errors after the jury ruled against it. *Richmond Condominiums v. Skipworth Commercial Plumbing, Inc.*, 245 S.W.3d 646 (Tex. App.–Fort Worth 2008, pet denied). First, the insurer complained that the lawyer for the defendant improperly contacted members of the insured joint venture that had assigned its claims to the insurer. The court of appeals agreed that the lawyers did improperly contact represented parties by contacting individual joint ventures, and agreed that this was an abuse of discovery that should have been sanctioned. However, the court disagreed with the insurer's argument that the case should be remanded for a new trial without testimony from these "tainted" witnesses. The court reasoned that there was no proof that the defendant rather than his lawyer was responsible for the misconduct, so it would be improper to punish the defendant for its lawyer's misconduct.

A law firm filed a petition for writ of mandamus to vacate a discovery order directing the firm to produce billing records from a case in which it defended an insured in silicosis litigation. The firm had sued its client's liability insurer, claiming over $1 million in unpaid legal fees generated during the firm's representation of the insured. The insurer claimed that the firm's invoicing would not be supported by the underlying documentation from which those invoices were prepared. The insurer thus sought discovery of the particulars of the billings. The firm resisted discovery on grounds that there were millions of pages of material responsive to the request. The trial court ordered discovery responses limited to certain timekeepers over a specific period of time. The firm sought mandamus relief. *In re Beirne, Maynard & Parsons, LLP*, 260 S.W.3d 229 (Tex. App.–Texarkana 2008, orig. proceeding). The court of appeals held that the offensive use doctrine applied in this case, and that the firm should not be permitted to prevent the parties from examining the documents supporting its claim for reimbursement.

F. Severance & Separate Trials

Insureds sued property insurers for breach of contract and extra-contractual claims. The insurers moved for severance of contractual and extra-contractual claims, alleging that their offer of settlement to the insureds – which was admissible as to the extra-contractual claim – would be prejudicial and inadmissible as to the contractual claim. The trial court ordered bifurcation of contractual and extra-contractual claims. The insurers petitioned for mandamus relief. On rehearing en banc, the court of appeals held that the insurers were not entitled to severance and abatement and that the trial court could conduct a single, bifurcated trial. *In re Travelers Lloyds of Texas Ins. Co.*, No. 04-07-00878-CV, 2008 WL 4239493 (Tex. App.–San Antonio Sept. 18, 2008, orig. proceeding).

The Austin court concluded that eleven separate lawsuits against an insurer based on eleven certificates of accidental death and dismemberment insurance coverage were really one claim, so that the trial court abused its discretion by failing to consolidate them. *In re Stonebridge Life. Ins. Co.*, No. 03-08-00124-CV, 2008 WL 2119671 (Tex. App.–Austin March 21, 2008, no pet.). The insured had obtained eleven certificates of insurance in response to direct mail solicitations for various credit card companies. He claimed benefits when his hand and wrist were amputated after an auto accident. The insurer denied each claim, contending that the amputation resulted in part from a prior chainsaw accident, and his claim was not submitted within ninety or 120 days after the accident. The insured had filed separate actions to keep the amount in controversy below the $75,000 that would allow removal of his suit to federal court. The court of appeals reasoned that it was an abuse of discretion to sever a cause of action that was so interwoven with the remaining actions as to involve the same facts and issues.

Interestingly, the insured presumably achieved his goal, if the consolidation and mandamus proceedings delayed the litigation at least one year. *See* 28 U.S.C. § 1446(b) (case pending one year or more is not removable based on diversity of citizenship).

G. Evidence

A trial court committed reversible error in a fire loss case by allowing the insured to offer evidence that he was not indicted

for arson. The court held that a grand jury's decision not to indict is not authoritative in a civil suit because there may be reasons other than lack of guilt for the nonindictment. *Munoz v. State Farm Lloyds*, 522 F.3d 568 (5th Cir. 2008).

A trial court did not abuse its discretion by refusing to allow into evidence discounts in the plaintiff's medical expenses, despite the "paid or incurred" statute. The statute, Tex. Civ. Prac. & Rem. Code section 41.0105 limits recovery of medical or healthcare expenses "to the amount actually paid or incurred by or on behalf of the claimant." In an automobile accident case, two of the medical bills offered by the plaintiff had been discounted substantially. The defendant argued that it should be entitled to present evidence of those discounts to the jury. The trial court rejected this argument and agreed to consider the effect of the discounts "post verdict and prejudgment." Because the jury awarded less than the amount of damages shown by the plaintiff, the trial declined to impose any offset. The defendant's only argument on appeal was that the evidence should have gone to the jury. The court of appeals rejected this argument, because the statute does not expressly state that evidence must be allowed in front of the jury and admission of such evidence regarding discount caused by the plaintiff's health insurance would be a significant departure from existing trial practice. The court of appeals it is not an abuse of discretion for a trial court to decline to allow such evidence, without a more explicit statutory provision. *Gore v. Faye*, 253 S.W.3d 785 (Tex. App.–Amarillo 2008, no pet.)

Finally, the court considered the insurer's complaint about improper jury argument by the defendant. The defendant argued that this was really a suit by an insurance company that was trying to make a profit by seeking more in damages than it paid on the insurance claim, and that the insureds themselves thought the defendant did nothing wrong. The court noted that the insurer's attorney first raised insurance in its closing argument and did in fact ask for $1.5 million in damages, when the insurer had only paid $900,000 on the claim. Thus, those two arguments were invited. The court agreed that the argument referring to the views of the joint venturer was incorrect, because they were not competent to express an opinion, but in light of other evidence the error was harmless.

The insurer in *Richmond Condominiums v. Skipworth Commercial Plumbing, Inc.*, 245 S.W.3d 646 (Tex. App.–Fort Worth 2008, pet denied), complained that the defendants' cross-examination of the joint venturer forced it to inject insurance into the case. Specifically, the insurer complained that questions and cross-examination of the joint venturer required it to introduce the proof of loss relating to the insurance claim. However, after examining the record, the court found that the insurer offered the proof of loss first, and without any limitation.

H. Experts

A district court did not abuse its discretion by excluding an expert whose testimony was disclosed nineteen days after the scheduling order deadline. The court noted that reasons for the late disclosure were not presented to the trial court, and the plaintiffs did not seek reconsideration when the trial was postponed. The court found it is very important to enforce the deadlines to avoid increasing the cost of litigation. *Garza v. Allstate Texas Lloyd's Co.*, 284 F. App'x 110 (5th Cir. Feb. 6, 2008).

In a suit to allocate settlement funds between covered and noncovered claims, the Fifth Circuit held that the district court should not have considered testimony from the insurer's expert witness regarding the reasonable settlement value of the actual damage claim. However, the court found the error harmless because the district court awarded more in damages than the expert opined was reasonable. *American Int'l Spec. Lines Ins. Co. v. ResCare, Inc.*, 529 F.3d 649 (5th Cir. 2008).

In ruling that a primary liability insurer offered no evidence to support its argument for equitable reformation of the policy, a court held the insured's affidavit from its expert was no evidence. The expert relied on several documents to opine that the insurer and insured intended that a nonstacking endorsement be included, which then was not. The court held this evidence was not probative on its face because it was conclusary and speculative. Therefore, summary judgment against the insurer was proper. *U.S. Fire Ins. Co. v. Scottsdale Ins. Co.*, 264 S.W.3d 160 (Tex. App.–Dallas 2008, pet. denied).

I. Court's Charge

In *Insurance Network of Texas v. Kloesel*, No. 13-05-680-CV, 2008 WL 907479 (Tex. App.–Corpus Christi April 3, 2008, pet filed.), the court held that the trial court did not err in refusing the agency's proposed jury instruction that would have told the jury, "A party to a contract is obligated to protect itself by reading what it signs and its failure to do so is not excuse by mere confidence and integrity of the other party." The court found this instruction could be misleading because it did not include the exceptions the court found under applicable law.

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1 This year's survey covers the period from October 2007 through November 2008.
2 It comes as no surprise that the court would be so insightful in its analysis, considering that the author, Hon. Catharine Haynes, was an expert in insurance law as an attorney before she became a judge.