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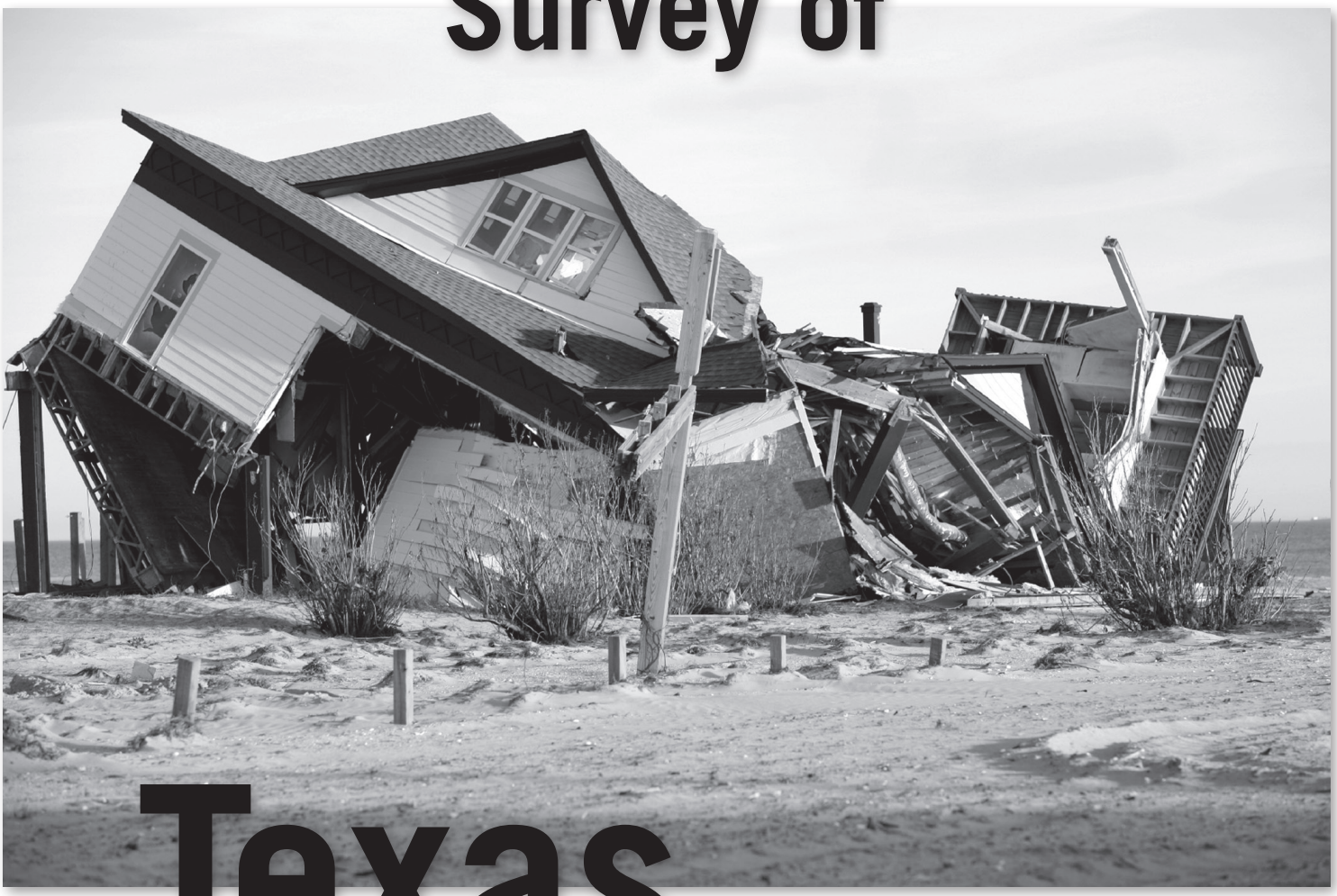

Texas Insurance Law 2009

Mark L. Kincaid,
Suzette E. Selden,
& Elizabeth von Kreisler*

I. INTRODUCTION

This insurance survey period presented an unprecedented amount of activity, with two hundred Texas insurance cases decided since November 2008, almost double the norm.

A number of decisions favored insureds. For example, in *Pine Oak Builders, Inc. v. Great American Lloyds Insurance Co.*, 279 S.W.3d 650 (Tex. 2009), the Texas Supreme Court reinforced its recent holding that a liability insurer must show prejudice before late notice will provide a defense, with respect to a claims-made policy. The Fifth Circuit echoed this holding and elaborated on what is necessary to establish prejudice but found no prejudice from late notice in *Trumble Steel Erectors, Inc. v. Moss*, 304 F. App'x 236 (5th Cir. 2008) (per curiam).

The supreme court relied on its recent precedent to again decline to allow extrinsic evidence to determine the duty to defend, in *Pine Oak Builders, Inc. v. Great American Lloyds Insurance Co.* In contrast, the Fifth Circuit relied on the same precedent as an invitation to embrace extrinsic evidence to deny a duty to defend, in *Ooida Risk Retention Group, Inc. v. Williams*, 579 F.3d 469 (5th Cir. 2009), where the extrinsic facts related to coverage and did not overlap the underlying allegations.

The supreme court narrowly construed an "intentional" act exclusion in an automobile policy to avoid rendering coverage "illusory" in many instances, in *Tanner v. Nationwide Mutual Fire Insurance Co.*, 282 S.W.2d 828 (Tex. 2009). But the court was at odds with itself over how to treat an ambiguity when multiple documents may be construed as one policy or two. In *Progressive County Mutual Insurance Co. v. Kelley*, 284 S.W.3d 805 (Tex. 2009) (per curiam), the court treated this as a fact question to be decided by the fact finder. In contrast, a unanimous court held in *Balderama v. Western Casualty Life Insurance Co.*, 825 S.W.3d 432 (Tex. 1991), that such an ambiguity was construed in favor of the insured.

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In *State Farm Lloyds v. Johnson*, 290 S.W.3d 886 (Tex. 2009), the supreme court expounded in detail on the issues that are proper for appraisal and those that are not, rejecting the insurer's plea to stay out of appraisal over roof damage. And, in a remarkable case, two justices of the Fifth Circuit held that no reasonable person could read policy language the way it was read by a retired United States Supreme Court justice who was assigned to the panel. *Certain Underwriters at Lloyds London v. Law*, 570 F.3d 574 (5th Cir. 2009).

As you would expect, number of hurricane cases worked their way through the appellate system. There also were the usual number of ERISA cases, but with the key difference that several claimants actually won in the face of the federal preemption/deferential review juggernaut. In a few cases, the Fifth Circuit reversed findings against claimants, finding insurers had abused their discretion.

Finally, in a sure sign that the digital age is here to stay, one avant-garde court used the on-line resource, www.dictionary.com, to find plain meaning definitions, in *Markel Insurance Co. v. Muzyka*, 293 S.W.3d 380 (Tex. App.–Fort Worth 2009, no pet.).

II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile

The supreme court considered whether two documents constituted a single auto policy or two separate policies in *Progressive County Mutual Insurance Co. v. Kelley*, 284 S.W.3d 805 (Tex. 2009) (per curiam). Kelley was injured in a collision and suffered injuries alleged to exceed $1 million. Her family had one policy with a limit of $500,000, insuring four vehicles. Another policy with the same limit and a separate policy number, insured a fifth vehicle. The insurer argued these were just one policy and, even if they were separate, the "two or more auto policies" provision in each allowed for only a single policy limit. The insurer pointed to evidence that its computer system would only allow four vehicles, so a second document was generated when there was a fifth vehicle. The insurer also pointed to the fact that the fifth vehicle got a multicar discount.

The supreme court found there was a latent ambiguity in the second document. The court noted Kelley's evidence that the insurer's own policy guide referred to a "second policy" when there was a fifth vehicle, and giving a multicar discount could be a reward for insuring an additional vehicle, whether it was a single policy or a separate policy.

The court recognized the principle that ambiguities are construed in favor of the insured but stated: "Here, we are not interpreting a particular exclusion or provision within an insurance policy …; rather, we are determining whether two policies amount to a single or separate policies." Based on this distinction, the court remanded for a determination by the factfinder whether there was a single policy or two separate policies. The court did not reach the question whether the "anti-stacking" provision nevertheless would limit recovery to one policy limit.

The distinction the court made in remanding the ambiguity for the factfinder to decide is in conflict with *Balderama v.*

Western Casualty Life Insurance Co., 825 S.W.2d 432 (Tex. 1991), where the court was faced with a similar question of whether several documents constituted a single policy. Justice Hecht, for unanimous court, wrote: "At best, whether Western's documents constitute a single policy is an ambiguity, which in these circumstances, must as a matter of law be resolved against Western, and in favor of coverage." *Id.* at 434.

An insured was not "occupying" his car at the time of the accident, when he had exited the car, closed the door, and walked around the front towards a retaining wall before another car hit his vehicle. Coverage applied to injuries while "occupying" a covered vehicle and defined the term as "in, upon, getting in, on, out, or off." The insured argued that he was occupying the vehicle because after the collision he ended up being "upon" it. The court found the plain meaning of the word "occupying" could not apply to this situation. *U.S. Fid. & Guar. Co. v. Goudeau*, 272 S.W.3d 603 (Tex. 2008).

Where an insured's renewal had to be received by May 9th, but was postmarked May 11th, the policy did not renew and did not cover an accident on May 9th. Further, when the insurer renewed the policy effective May 12th, it did not extend the original offer to renew effective May 9th. The insurer did not violate administrative code provisions that require a policy to be in force at least twelve months. The insurer offered twelve months of coverage, but the insured failed to pay in time. In addition, the insurer was not required to give thirty days notice of its intent to decline to renew, because it intended to renew. *Hartland v. Prog. Co. Mut. Ins. Co.*, 290 S.W.3d 318 (Tex. App.–Houston [14th Dist.] 2009, no pet.).

An injured driver sued his insurer under his uninsured motorist coverage. At trial, the evidence showed the drivers who hit the injured party were actually insured. The appeals court reversed the jury's award for the insured driver. The court also held the insurer should have been allowed to amend its pleading to assert offset since the other drivers were insured. *Allstate Prop. & Cas. Ins. Co. v. Gutierrez*, 281 S.W.3d 535, 539 (Tex. App.–El Paso 2008, no pet.).

An insured was prohibited by the family-use exception from recovering underinsured motorist benefits where the insured's sister, a co-insured under the policy, was driving at the time of the accident. The court also held that the family-use exception did not violate public policy. *Hunter v. State Farm Co. Mut. Ins. Co.*, No. 2-07-463-CV, 2008 WL 5265189 (Tex. App.–Fort Worth Dec. 18, 2008, no pet.) (mem. op.).

An insurer was not liable to pay an uninsured motorist claim where the insureds were unable to establish that the uninsured vehicle made "actual physical contact" with the insured's vehicle. Also, because the insureds lacked proof of damages, they could not prevail on their unreasonable investigation claim. *Y Ngoc Mai v. Farmers Tex. Co. Mut. Ins. Co.*, No. 14-07-00958-CV, 2009 WL 1311848 (Tex. App.–Houston [14th Dist.], pet. filed) (mem. op.).

An insured purchased a truck trailer and had it insured by Underwriters at Lloyd's of London. After the trailer was damaged, an adjuster for Underwriters declared the trailer totaled and placed it up for salvage bids. Underwriters sent the insured payment in full under the policy, conditioned on execution of a power of attorney that would allow the adjuster to transfer title to the trailer. The insured did not execute the power of attorney, nor did he attempt to negotiate the Underwriters' check. Despite the insured's refusal to grant the power of attorney to transfer the title, the adjuster ultimately assigned the trailer to the highest bidder. The insured sued Underwriters and the adjuster on various theories. On appeal, the court addressed whether the Underwriters were permitted to dispose of the property under a title theory or if it was prohibited from doing so until it received the power of attorney signed by the insured. The Underwriters argued that policy language allowing it to "take all or any part of the property at the agreed or appraised value" entitled it to dispose of the property upon tendering payment. The court disagreed because the plain language of the policy did not put the insured on notice that he would lose all rights to his property once the Underwriters tendered a check. Another reasonable interpretation of the language was that the right does not attach until the insured negotiated the check and executed a power of attorney to assign title. Thus, Underwriters did not acquire title to the trailer merely by tendering payment. *Bruton v. Underwriters at Lloyd's, London*, 283 S.W.3d 502 (Tex. App.–Fort Worth 2009, rehearing overruled).

An insurer issued a personal auto policy to a divorced husband and wife, naming both as insureds. *Verhoev v. Progressive County Mutual Ins. Co.*, No. 2-08-055-CV, 2009 WL 2357004 (Tex. App.–Fort Worth July 30, 2009, no pet.) (publication forthcoming). After the wife was severely injured while a passenger in her ex-husband's car, the insurer sought a declaration that it owed no UM benefits and that the liability coverage for the husband as to the wife's claim was limited to $20,000 by the policy's family-member exclusion. In analyzing the policy language, the court held that the liability coverage was limited to $20,000 because of the family-member exclusion, but that the wife was entitled to full UM benefits. Regarding the liability coverage, the court found that the family-member exclusion capped coverage not because the wife was a family member but because she was an insured. The policy language excluded coverage "for you … for bodily injury to you." The court agreed with the insurer that the only reasonable way to interpret that provision, in this circumstance, was that the policy did not provide coverage "for the husband … for bodily injury to the wife." Accordingly, the liability coverage was capped. Regarding the UM benefits, the court found that the policy was ambiguous and adopted the wife's interpretation. Under that interpretation, the wife was entitled to UM coverage as a named insured, and the family member exclusion did not apply because the car driven by her husband at the time of the accident

was underinsured and was not owned by her. Therefore, although the husband's liability coverage was capped, the wife was entitled to the full UM benefits as a named insured.

An injured driver sued her insurer for uninsured motorist coverage. The court held that an insurer's contractual duty to pay a UM claim is not triggered until liability and damages are determined. The court dismissed the insured's claim for breach of contract, and abated the other claims pending the determination of the other driver's liability and underinsured status. *Stoyer v. State Farm Mut. Ins. Co.*, No. 3-08-CV-1376-K, 2009 WL 464971 (N.D. Tex. Feb. 24, 2009).

B. Homeowners

Homeowners sued their insurer for failure to pay for mold and water damage to their home. The insurer's liability was limited in the policy to the amount "actually and necessarily" spent to repair the home. Because the evidence showed the repairs to the water damage were not complete, the appeals court held it would be impossible to determine the amount actually spent. Therefore, it was improper for the district court to grant summary judgment in favor of the insurer for breach of contract and breach of the duty of good faith and fair dealing relating to water damage. *Garcia v. State Farm Lloyds*, 287 S.W.3d 809, 822 (Tex. App.–Corpus Christi 2009, pet. filed).

C. Commercial Property

A divided panel of the Fifth Circuit held that damages caused by thieves stealing copper tubing from air conditioning units was not covered by a policy that provided coverage for vandalism, but not theft, but did cover damage from breaking and entering. *Certain Underwriters at Lloyds London v. Law*, 570 F.3d 574 (5th Cir. 2009). Thieves broke into seventeen air conditioning units and stole $2,000 worth of copper tubing, causing $200,000 worth of damage. The policy covered "vandalism, meaning willful and malicious damage to or destruction of damage to, or destruction of, the described property." The policy also had the following exclusion: "We will not pay for loss or damage caused by or resulting from theft, except for building damage caused by the breaking in or exiting of burglars." The trial court found coverage and rendered judgment for the insureds. The court of appeals reversed. The majority found the policy language was unambiguous. The majority first held that "vandalism" only means damage for the sake of damage, and could not include damage in furtherance of a theft. The majority rejected as unreasonable the argument that damage that was excessive and unnecessary could be considered vandalism. The majority therefore concluded that the theft exclusion applied.

The majority rejected the argument that the "ingress/egress" exception applied. The district court had determined that the air conditioners were part of the insured building because they were fixtures, and the policy specifically defined "building" to include fixtures. The insureds argued that the thieves broke into the air conditioning housings in order to steal the copper tubing and therefore the exception should apply. The majority, however, found no ambiguity and found the policy had to be construed to define "building" to include only the building itself, despite the definition that included fixtures. In fairly strident terms, the majority held that the dissenting justice's interpretation would be "illogical," and the plain language of the policy "ineluctably" required breaking through a building's exterior. The majority found "no room in the ordinary understanding of the phrase" for extending it to include breaking in to the roof-mounted air conditioners.

The dissenting justice reasoned simply that the policy could reasonably be read to include the air conditioning units as part of the "building," because it specifically defined the term to include fixtures. Further, the majority conceded that the thieves had broken into the air conditioning units; therefore, it was reasonable to apply the "ingress/egress" exception to cover the damage. The thieves broke in to a part of the building to steal the copper tubing. The dissenting justice relied on the rules requiring construction of ambiguities in favor of coverage, and requiring that exceptions to coverage be read narrowly. There was nothing in the policy to preclude construing the policy so that it covered breaking into a fixture.

This case is a particularly pointed example of the arrogance that too often attends judicial constructions that adamantly state no reasonable person could construe the language otherwise. In this case, the trial judge was Hon. David Hittner, widely-regarded as a very intelligent judge. He found the policy could reasonably be read to provide coverage. The majority concludes that no reasonable person could think as he did.

Even worse, the dissenting justice was none other than retired supreme court Justice Sandra O'Connor, sitting by designation. This is the same Justice O'Connor who graduated third from her class at Stanford, who was the first woman ever appointed to the United States Supreme Court, and whose swing vote in numerous 5/4 decisions over two decades dictated what the law has been in the United States on many vital issues. Nevertheless, the two intermediate court judges are adamant that the policy language cannot reasonably be read as she reads it and that their interpretation is the only possible one.

While not conclusive, the fact that other judges have reached conflicting conclusions should be considered some evidence that perhaps the language is subject to more than one reasonable interpretation – unless the majority justices are willing to declare that no reasonable person could think what their colleagues think. See 2 Eric M. Holmes and Mark S. Rhodes, *Holmes's Appleman on Insurance 2d* § 6.1, p. 178 & n. 127 (1996). One would think that having an express policy definition in your favor, a smart federal trial judge agreeing with you, and an esteemed retired supreme court justice also agreeing with you would be enough to suggest that perhaps the insured's interpretation might possibly be reasonable. Apparently not.

An insurer could not rely on the vacancy clause to deny liability, when it could not show how long the property was vacant before the theft occurred. The court rejected the argument that "occur" should mean when the loss was discovered, at which time the property had been vacant more than sixty days. The court concluded that the plain meaning of "occur" is when the theft took place, not when it was discovered. Alternatively, the

court reasoned that "occur" was ambiguous and would be construed against the insurer. *Cen. Mut. Ins. Co. v. KPE Firstplace Land, LLC*, 271 S.W.3d 454 (Tex. App.–Tyler 2008, no pet.).

A church's land was excluded from the definition of "covered property" within a commercial insurance policy, but the court found that the land was covered under a specific provision for pollutant cleanup and removal. Therefore, the insurer's motion for summary judgment was denied to the extent it sought to avoid liability for expenses incurred in extracting pollutants from the church's land. *First Baptist Church v. GuideOne Mut. Ins. Co.*, No. 1-07-CV-988, 2009 WL 415482 (E.D. Tex. Feb. 17, 2009).

D. Life insurance

An insured under a life insurance policy sued the insurer, claiming he was told that his $300,000 premium was a one-time payment for a $5.5 million policy. The contract stated that the policy required a $300,000 annual premium. The appeals court held that the insured cannot complain that he relied on a prior oral representation directly contradicting the terms of the written agreement, unless he was tricked into accepting the terms of the policy. The court affirmed summary judgment in favor of the insurer. *Wuertz v. Nationwide Life Ins. Co.*, No. 01-07-00272-CV, 2009 WL 1331860 (Tex. App.–Houston [1st Dist.] May 14, 2009, no pet.).

Where an insured's check bounced before the policy was issued and he died in a car wreck before the subsequent payment was attempted, there was no coverage. *Cantu v. Jackson Nat'l Life Ins. Co.*, 579 F.3d 343 (5th Cir. 2009). The court found no evidence to support the beneficiary's argument that the insurer had agreed to delay depositing the check. There was no evidence that if the deposit had been postponed there would have been enough money in the account, and there was no evidence that the bank would have allowed the insured to cover the shortfall.

Wal-Mart took out a life insurance policy on its employee, who later died. The employee's estate sued Wal-Mart for obtaining a life insurance policy on an individual in whom it had no insurable interest. The district court dismissed the claim as time-barred, holding that it was a tort action for conversion and was subject to a one-year statute of limitations. The Fifth Circuit reversed, holding that the correct statute of limitations was ten years, because the case was more analogous to an action for unjust enrichment since it alleged Wal-Mart took possession of benefits properly belonging to the employee's estate. *Richard v. Wal-Mart Stores, Inc.*, 559 F.3d 341 (5th Cir. 2009).

A trial court found that the named beneficiary of a life insurance policy was entitled to the proceeds even though he was a suspect in the insured's murder. The insurer had deposited the money in the registry of the court because it did not know who to pay. However, the insured's family failed to file a statement as to why the beneficiary should not receive the proceeds, so the court gave the proceeds to the named beneficiary. *Primerica Life Ins. Co. v. Baccus*, No. 3-07-CV-264-O, 2009 WL 1138729 (N.D. Tex. April 27, 2009).

E. Disability insurance

In *Garza-Trevino v. New England Financial*, an insured sued for breach of contract, fraud, and bad faith after the insurer denied her disability benefits. 320 F. App'x 203 (5th Cir. 2009) (per curiam). The Fifth Circuit affirmed a no-evidence summary judgment against the insured. Regarding breach of contract, the court determined that the insured failed to offer any evidence that she was totally disabled as defined by the policy. Regarding fraud, the court found the insured failed to offer any evidence of a material false representation. Instead, the court found the policy made no representations on certain points alleged by the insured and clearly set forth other details the insured claimed were undisclosed. Regarding bad faith, the court found that the statute of limitations barred the insured's claim because she brought her claim more than two years after the denial of her claim became final.

An insured filed suit against his disability insurer when it refused to pay his claim for benefits after he developed emphysema. The doctor's reports concluded that the insured was not able to walk frequently or for long amounts of time. His policy was an "own occupation" policy, and his job included walking frequently. The district court found for the insurer, but the Fifth Circuit reversed, holding that there was no evidence in the record to support the insurer's finding that the insured was capable of performing one of the essential duties of his occupation – i.e., frequent walking. *Burtch v. Hartford Life & Acc. Ins. Co.*, 314 F. App'x 750 (5th Cir. 2009).

F. Other policies

An insurer was allowed to apply a 1% deductible "per occurrence" to each item damaged by tenants so that none of the claims exceeded the deductible, where the court found the term "occurrence" was not ambiguous. The court rejected the insured's argument that the term was ambiguous because the insurer had applied a 1% deductible in another case to all items as a group. The court held that parole evidence could not create an ambiguity. The court also rejected the argument that the definition of "occurrence" in the liability section of the policy applied to the property coverage portion of the policy. The court found the insured's interpretation of "occurrence" to apply to all damage as a group was not reasonable. *Mitchell v. State Farm Lloyds*, No. 05-08-00184-CV, 2009 WL 596611 (Tex. App.–Dallas, March 10, 2009, no pet.).

While the court may have correctly concluded that the definition of "occurrence" in the liability section only applied to that section, that does not mean that when applying the ordinary definition of the term a similar definition could not apply.

The court's analysis is flawed. While parole evidence may not be admissible to create an ambiguity, the fact that the insurer had applied the deductible to the claims as a group in another case supports the insured's argument that such an interpretation is reasonable – otherwise, why would the insurer have applied such an interpretation?

Further, while the court may have correctly concluded that the definition of "occurrence" in the liability section only applied to that section, that does not mean that when applying the ordinary definition of the term a similar definition could not apply. Just because the policy defines the terms specifically in one section does not mean that definition is not applicable to another section; it simply leaves the definition subject to debate. While the court rejected the insured's interpretation, it did not ever state what definition it applied. It seems reasonable to treat all the damage caused by tenants as an "occurrence," considering that the liability section defined a single occurrence to include repeated exposure to the same condition. Viewed another way, it would be unreasonable to consider each damaged item to be a separate occurrence; otherwise, when there was a fire – normally viewed as a single occurrence – each damaged item would be considered an occurrence.

In ruling on coverage under a federal flood insurance policy for a claim arising from hurricane Katrina, the Fifth Circuit declined to adopt the "constructive total loss doctrine," which treats a building as a total loss when the building, although still standing, is damaged to an extent that ordinances prohibit rebuilding, so the building had to be demolished. The court reasoned that under the federal flood insurance program, Congress has allocated a certain amount of coverage for repairs required by ordinances, which precludes further expansion. *Monistere v. State Farm Fire & Cas. Co.*, 559 F.3d 390 (5th Cir. 2009). The court also found insufficient evidence to justify a higher payment than the insurance company had paid. Although the insureds submitted higher estimates, they did not sufficiently justify the increases and included repairs above the level of the flood.

G. Title insurance

A title insurance company had no duty to disclose to its insured that the property purchased by the insured was unplatted. *Solano v. Land America Commonwealth Title of Fort Worth, Inc.*, No. 2-07-015-CV, 2008 WL 5115294 (Tex. App.–Fort Worth Dec. 4, 2008, no pet.) (mem. op.). The issuance of a title policy is not a representation of the property's title status but an agreement to indemnify for certain risks. Therefore, the title company's discovery of the property's unplatted status was relevant only to its decision to insure the property.

III. FIRST PARTY THEORIES OF LIABILITY

A. Breach of Contract

An insured sued for breach of contract after the insurer cancelled the policy. The policy previously had been cancelled and reinstated. The insurer cancelled the policy a second time because the insured failed to return a refunded, unearned premium that had been paid for the prior cancellation. The insured argued that the money did not need to be paid during the policy term because the policy provided that premiums would be paid at the beginning and end of the term, not during the term. The court disagreed. When the insurer reversed the prior cancellation and retroactively reinstated the policy, the initial premium was reinstated as if no cancellation had occurred. This left outstanding the premium amount that had been refunded. Because the insured failed to repay the refunded amount, the insurer's cancellation was within the insurer's rights under the policy. *Sembera Security Sys., Inc. v. Texas Mut. Ins. Co.*, No. 01-07-00310-CV, 2009 WL 214573 (Tex. App.–Houston [1st Dist.] Jan. 29, 2009, rehearing denied) (mem. op.).

A mutual insurance company declared a distribution to policyholders of a membership credit. However, the insurer made the distribution contingent on a policyholder's policy renewal after the record date. One policyholder had a policy set to expire after the record date of the distribution but before its public declaration. The policyholder did not renew. When the mutual insurance company failed to pay a distribution share to the policyholder, the policyholder sued for breach of contract. The Fifth Circuit found that the insurance company breached its contract because the policyholder was a member in good standing on the distribution's record date. In reaching its decision, the court first determined that breach of contract – and not the business judgment rule – was the applicable standard by which to evaluate the insurance company's conduct. A policyholder's right to a distribution share is governed by contract law, whereas the timing, amount, and method of distribution is governed by the business judgment rule. Although the policy did not address the board's discretion over distributions of surplus, the court held that, as a mutual insurance policy, there was a settled expectation that excess surplus would be returned in distribution to the policyholders to preserve the mutual insurance function of "insurance at cost." By imposing a renewal condition on the settled expectation of distribution, the board breached its contract with the policyholder. All policyholders on the record date of distribution were entitled to a share of any announced surplus distribution in proportion to their prior contributions. *Kimberly-Clark Corp. v. Factory Mut. Ins. Co.*, 566 F.3d 541 (5th Cir. 2009).

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

Summary judgment was proper on the insured's claim that the insurer unfairly underpaid a claim for roof damage. Even though the parties had disagreed on the amount necessary for repairs, there was no judgment evidence showing that the insured's estimate was reasonable or that the insurer's estimates were unreasonable. The fact that the insurer reconsidered and paid additional amounts after inspection was evidence of good faith, not an evidence of bad faith. The summary judgment evidence showed nothing more than a bona fide dispute. *Spicewood Summit Office Condo. Ass'n v. Am. First Lloyd's Ins. Co.*, 287 S.W.3d 461 (Tex. App.–Austin 2009, pet filed).

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

A jury found that a worker's compensation insurer acted in bad faith and knowingly violated the Texas Insurance Code. The appeals court held that reasonable jurors could have concluded that the insurer failed to reasonably investigate the claim, and failed to attempt in good faith to settle the claim when its liability had become reasonably clear, instead undertaking a pretextual investigation designed to support denial of the claim. The insurer never spoke with the treating doctor or with the injured employee before denying the claim and failed to provide its medical expert with relevant medical records the insurer had in its possession. *Tex. Mut. Ins. Co. v. Morris*, 287 S.W.3d 401 (Tex. App.–Houston [1st Dist.] 2009, pet. filed).

D. ERISA

In a case of first impression, the Fifth Circuit held that a health care provider's complaints under the Texas Prompt Pay Act were not preempted by ERISA, where they related to the amount of payment due under the provider agreement and not whether the claim was covered under the employee benefit plan. *Lone Star OB/GYN Assoc. v. Aetna Health Inc.*, 579 F.3d 525 (5th Cir. 2009). The health care provider sued under Tex. Ins. Code section 843.342, which provides that a health care provider can collect the contracted rate plus penalties for payable claims that are not paid within a specified time. The insurer argued that these claims were preempted by ERISA because they related to an employee benefit

plan. The court found the insurer had a duty to pay under its agreement with the provider, which was independent of the terms of the ERISA plan. For claims where there was no dispute as to coverage, the health care provider could sue under state law to recover the amount of the claim and penalties. On the other hand, where the denial was based on a determination of coverage, those claims would be preempted. The Fifth Circuit remanded to the district court for a determination of which categories the disputed claims fell into.

In a case brought by a deceased pilot's beneficiaries for accidental death benefits under ERISA, the Fifth Circuit held that the administrator's conclusion that the pilot was intoxicated at the time of the crash was not arbitrary or capricious, since the evidence did show the decedent was under the influence of propoxyphene at the time of the crash and that he had recently used alcohol and cocaine. Moreover, the court found that the nature of the accident itself supported the conclusion that drugs contributed to it. *Dutka v. AIG Life Ins. Co.*, 573 F.3d 210 (5th Cir. 2009).

An administrator of an ERISA plan determined that the residential treatment a claimant received was not medically necessary, because outpatient treatment would have been sufficient. The Fifth Circuit affirmed, holding that ERISA does not require that the opinions of treating physicians be preferred over those of other physicians reviewing a file. ERISA merely requires that the opinions of treating physicians, as with all evidence submitted by the claimant, actually be taken into account in an administrator's determination. *Love v. Dell, Inc.*, 551 F.3d 333 (5th Cir. 2008).

A man injured in an accident received over $300,000 in medical coverage from an ERISA plan. He also received over $800,000 from a settlement with a third-party. The plan sought reimbursement from the settlement funds. The Fifth Circuit held that the funds were specifically identifiable due to the settlement; they belonged in good conscience to the plan (due to the unambiguous subrogation provision); and they were within the possession and control of the defendant beneficiary, as they were being held in trust by the injured's attorneys. *AT&T, Inc. v. Flores*, 322 F. App'x 391 (5th Cir. 2009).

The Fifth Circuit affirmed a decision denying benefits to an ERISA plan participant for neurofeedback therapy to manage constipation. The plan specifically excluded all neurofeedback therapy, which was always considered a nonmedical service under the plan. *White v. St. Luke's Episcopal Health Sys.*, 317 F. App'x 390 (5th Cir. 2009).

An ERISA plan participant sued after the administrator deducted payments for Social Security disability insurance benefits. *Sanders v. Unum Life Ins. Co. of America*, 553 F.3d 922 (5th Cir. 2008). Under the policy, a participant would receive a defined monthly payment with a deduction for other income benefits, which included SSDI benefits, provided that the other income benefits were payable as a result of the same disability. The policy did not define "same disability." Here, the participant claimed that the benefits were not for the same disability because, although they stemmed from same incident, the plan's payments were payable due to his physical disability, while the SSDI payments were payable due to his mental disability. The court found that this distinction did not accurately reflect the facts in the record. The administrator had found the participant disabled from both psychological and physical disorders, and its payments were based on both disabilities. Because the administrator had always paid based on both disabilities, even if SSDI benefits applied only to psychological problems, the payments arose out of the same disability.

A plan participant sued an ERISA plan administrator after it terminated her "own occupation" benefits. The participant initially received disability benefits because she was no longer able to perform her own occupation. The plan administrator later terminated those benefits based on the opinions of its consulting physicians. The physicians' opinions were based exclusively on a surveillance video. The Fifth Circuit held that that the plan administrator's decision to terminate the plan participant's benefits was an abuse of discretion. The video relied on by the consulting physicians was inconclusive, generally consistent with the plan participant's claimed limitations, and did not adequately address her ability to perform the duties of her own occupation. Accordingly, the opinions of the consulting physicians were not "substantial evidence" supporting the denial of benefits. Moreover, evidence from the plan participant's treating physicians established the existence of an objective condition that could cause her pain. Therefore, the denial of benefits was an abuse of discretion. *Bray v. Fort Dearborn Life Ins. Co.*, 312 F. App'x 714, 2009 WL 585615 (5th Cir. March 9, 2009) (per curiam).

Another plan participant successfully sued an ERISA plan administrator for denying her disability benefits in *Bernardo v. American Airlines, Inc.*, 297 F. App'x 342 (5th Cir. 2008) (per curiam). The plan participant initially suffered from a hematological disorder. The plan administrator granted her disability benefits for a period of time while she received treatment from that disorder. Unfortunately, the treatment caused the plan participant to develop a neurological disorder, even as she recovered from the hematological disorder. The plan administrator denied the participant further disability benefits because she had recovered from the hematological disorder, even though her treating physicians determined that she was totally disabled from the neurological disorder. The court held the denial of disability benefits was improper and unsupported by the evidence. Although the reviewing physicians' reports addressed the participant's hematological disorder, they did not even mention her neurological disorder and made no effort to explain why the severe symptoms identified by the treating physicians were not disabling. Because the only evidence on record showed that the plan participant was disabled by the neurological disorder, the plan administrator abused its discretion in denying disability benefits.

An insured who suffered from narcolepsy was denied short term disability benefits after the insurer concluded that neither her medical records nor the independent medical examination provided sufficient evidence that the insured was disabled. The insured appealed, providing her insurer with a sleep study performed by a neurologist that stated she had disabling narcolepsy. The insurer denied her appeal. The court held that the first denial was not an abuse of discretion, because the insured had not submitted objective evidence that showed her disease had recently worsened to where she was permanently disabled. However, the court held that the denial of the appeal was an abuse of discretion, as the sleep study was an objective test showing the insured had disabling narcolepsy. The court ordered a reconsideration of the insured's appeal. *Archer v. United Tech. Corp.*, No. 3-07-CV-1485-M, 2009 WL 561375 (N.D. Tex. March 3, 2009).

In reaching its conclusion, the court examined the particular structure of the exchange and determined that the structural relationship between the board and subscribers was nearly identical to that between the board of a corporation and its shareholders.

E. Other theories

The Fifth Circuit held that the board of directors of a reciprocal insurance exchange did not owe fiduciary duties to its subscribers. In reaching its conclusion, the court examined the particular structure of the exchange and determined that the structural relationship between the board and subscribers was nearly identical to that between the board of a corporation and its shareholders. Thus, the court analogized the exchange to a corporation in deciding whether a fiduciary duty existed. The court further determined that the exchange was a separate and distinct legal entity to which the board can owe a fiduciary duty. Applying corporate law, the court held that the directors owed a fiduciary duty only to the exchange, which represents the interests of subscribers as a whole, and not to individual subscribers. *True v. Robles*, 571 F.3d 412 (5th Cir. 2009).

IV. AGENTS, AGENCY, AND VICARIOUS LIABILITY

A. Individual liability of agents, adjusters, and others

A broker who was sued for failing to get coverage that would protect the insured when sued by a competitor for patent and trademark violations did not owe a fiduciary duty to the insured. A fiduciary duty did not arise from evidence that the broker selected and recommended insurers and coverages, prepared or processed the application, and procured policies and delivered them to the insured. The court relied on prior decisions holding that an insurance agent has no duty to procure additional coverage for a customer merely because the agent has knowledge of the need for such insurance, especially in the absence of evidence of prior dealings where the agent customarily has taken care of the customer's needs without consulting him. *Envtl. Procedures, Inc. v. Guidry*, 282 S.W.3d 302 (Tex. App.–Houston [14th Dist.] 2009, pet. denied). The court also found the evidence insufficient to establish an informal fiduciary relationship.

A boat owner sued an insurer for failing to procure or renew insurance. The appeals court reversed summary judgment in favor of the insurer, holding that evidence that the insurers' standard renewal procedures were not followed raised fact issues as to: (1) whether the insurer owed him a duty to keep him reasonably informed; and (2) whether it breached that duty. *Haye v. Elton Porter Marine Ins.*, No. 13-07-310-CV, 2009 WL 542486, *8 (Tex. App.–Corpus Christi March 5, 2009, no pet.). The court also held that a finding of no coverage does not, as a matter of law, defeat a property owner's complaint against an agent for an alleged misrepresentation as to insurance coverage.

After paying an insured's claim, Underwriters sued the insurance agency that submitted the insured's application because the application contained misrepresentations. *Underwriters at Lloyds v. Edmond, Deaton & Stephens Ins. Agency, Inc.*, No. 14-07-000325-CV, 2008 WL 5441225 (Tex. App.–Houston [14th Dist.] Dec. 30, 2008, no pet.) (mem. op.). A jury concluded that the underwriters were 65% comparatively responsible for causing the damages they suffered, and the trial court rendered judgment that they take nothing. On appeal, the Underwriters argued that the comparative responsibility statute was improperly applied. The court disagreed, finding that Chapter 33 of the Civil Practice and Remedies Code applied to the Underwriters' common-law tort claims, since the statute applies generally to common-law claims. The Underwriters also contended that the trial court erred in failing to grant a new trial on the issue of whether the insurance agency breached its fiduciary duty, which the Underwriters argued the agency owed as a matter of law. However, the court overruled this issue because the Underwriters did not object to the relevant jury questions to preserve error.

In *Horizon Offshore Contractors v. Aon Risk of Tex., Inc.*, 283 S.W.3d 53 (Tex. App.–Houston [14th Dist.] 2009, pet. denied), the court held that an insurance broker was not the insured's agent where the agreement stated that the broker was not the agent except with respect to confidential communications with the insured's legal counsel or insurance carriers. Therefore, there was no principal/agent relationship, so no fiduciary duty was owed to the insured.

V. THIRD PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile liability insurance

An auto policy that excluded liability for injuries caused "intentionally," including willful acts the result of which the insured knows or ought to know will follow from the insured's conduct," did not exclude liability for a collision caused by a high speed chase in which the insured fled from police. *Tanner v. Nationwide Mut. Fire Ins. Co.*, 282 S.W.3d 828 (Tex. 2009). The insured fled from the police at high speeds for quite some time, through urban and rural areas before colliding with the plaintiffs. Prior to the collision, the insured tried to stop but could not. A jury found the insured did not act "intentionally" under the policy language, but the trial court and court of appeals found his conduct fit within the exclusion.

The supreme court held that the exclusion did not conclusively apply. The evidence did not show that the insured actually intended to cause the injuries, as opposed to intending to engage in the conduct. Further, the policy excluded injuries that the insured ought to know "will follow" from his conduct, not that were likely to follow.

While the *Tanner* court found the insured's conduct was reprehensible, the injuries were not the necessary result of that conduct. The chase could have ended many other ways, including injuries to no one or injuries to the insured, not necessarily only resulting in injuries to a third party. The court expressed its concern that reading the exclusion broadly would render coverage "illusory" for many common risks. For example, a broad reading of the exclusion would deny liability for an insured who ran a red light but intended no harm, which would frustrate the purpose of requiring liability insurance to protect third parties.

The *Tanner* court construed a policy from Ohio, but noted that the standard Texas policy also excludes liability for intentionally causing bodily injury. The Texas exclusion does not refer to willful acts. The court further noted that the standard Texas policy has an exclusion under personal injury protection coverage for bodily injury sustained by a person while attempting to elude arrest, but does not have a similar language under the liability coverage. Thus, it appears that injuries caused during a high speed chase would not be excluded under a Texas policy.

B. Comprehensive general liability insurance

The "known falsity" exclusion applied where corporate vice-principals knew their defamatory statements were false, even though the definition of "insured" included the corporation but did not expressly include vice-principals. *Chrysler Ins. Co. v. Greenspoint Dodge of Houston, Inc.*, No. 08-0780, 2009 WL 3494981 (Tex. Oct. 30, 2009). Greenspoint was insured for defamation, with an exclusion for injuries "arising out of oral or written publication if done by or at the direction of the insured with knowledge of its falsity." The policy defined "insured" to include the organization, executive officers and directors, and stockholders. The court reasoned that, while this defined who was an insured, it did not define whose conduct counted as that of Greenspoint. Because Greenspoint was a corporation, its conduct included that of its vice-principals. In this case, the vice-principals were found to have knowingly defamed the employee, so the exclusion ap-

plied. The court rejected the argument that Greenspoint only included officers, directors, and shareholders. Under the "separation of insureds" provision, which provided coverage to each insured separately, the exclusion also had to apply separately to each insured. Having found no coverage, the court also found no basis for the awards of punitive and extracontractual damages against the insurer for denying the claim.

The supreme court revisited several recent holdings to conclude in *Pine Oak Builders, Inc. v. Great American Lloyds Insurance Co.*, 279 S.W.3d 650 (Tex. 2009), that:

> (1) a faulty workmanship claim against a builder alleged a claim for "property damage" caused by an "occurrence," *see Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1, 4-5, 16 (Tex. 2007);
>
> (2) liability is triggered under an occurrence-based liability policy when the damage occurs, not when the damage manifests, *see Don's Building Supply, Inc. v. OneBeacon Ins. Co.*, 267 S.W.3d 20 (Tex. 2008); and
>
> (3) extrinsic evidence may not be considered in determining the duty to defend, thus, precluding consideration of evidence that the builder's liability might actually be covered because the work was done by subcontractors, *see GuideOne Elite Ins. Co. v. Fielder Road Baptist Church*, 197 S.W.3d 305, 307 (Tex. 2006).

A girl's injuries sustained while playing "the helicopter game" were not within an exclusion for injuries occurring while participating in a "sporting or exercise activity." The game consisted of one person swinging a big rope while kids jumped over it. Unfortunately, the person swung too high and knocked the girl down. The court embraced dictionary definitions of "sport" and "exercise" to conclude that the words could not reasonably apply to a game that was just for fun with no intent to promote physical fitness or to engage in an athletic activity. The court rejected as unreasonable the insurer's argument that any form of exertion would qualify as "exercise." *Markel Ins. Co. v. Muzyka*, 293 S.W.3d 380 (Tex. App.–Fort Worth 2009, no pet.). In relying on dictionaries, as courts often do when construing insurance policy language, this court went on-line to find its definitions at dictionary.com.

A policy potentially covered a foundation repair company in a suit alleging negligent repairs that caused damage to the house when the foundation shifted; thus, the insurer had a duty to defend. *Wilshire Ins. Co. v. RJT Constr., L.L.C.*, 581 F.3d 222 (5th Cir. 2009). The court first held that the complaint alleged an occurrence within the policy. While the foundation work was originally done in 1999, the petition alleged that cracks appeared in the walls and ceilings in late 2005, which was within the insurer's policy period. The court held that the policy was triggered when the damage occurred, which was in 2005.

The *Wilshire* court also held that the "subsidence" exclusion did not apply. The exclusion disclaimed liability "caused by, resulting from, attributable or contributed to, or aggravated by the subsidence of land as a result of landside, mudflow, earth sinking, or shifting, resulting from your operations or your subcontractor's operations." In this case, the petition alleged that negligent repairs failed to protect the foundation from movement caused by subsidence, not that the work caused the subsidence. The *Wilshire* court held that the exclusion for "your work" did not preclude coverage for damage to the house, where the insured's work only included foundation repairs.

The Fifth Circuit held that a party was an additional insured under a liability policy, even though a separate agreement generally required that party to indemnify the insured for the party's own negligence. *Aubris Res., L.P. v. St. Paul Marine Ins. Co.*, 566 F.3d 483 (5th Cir. 2009). United hired J&R to service its oil field properties. The parties agreed that J&R's liability insurance would name United as an additional insured. The agreement also required United to indemnify J&R for causes of action arising from United's own negligence. After an explosion injured two J&R employees, United sought coverage and a defense from J&R's insurer. The insurer argued that United was not an additional insured. The Fifth Circuit relied on the recent supreme court decision in *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008), to hold that the liability policy clearly covered United as an additional insured, under language in the additional insured endorsement stating that coverage was extended if a "written contract for insurance specifically required such coverages[.]" The result was not changed by language in the contract between United and J&R that excluded coverage "with respect to any obligations for which United has specifically agreed to indemnify Contractor." The court agreed with United's argument that this provision did not extend to general indemnification for United's negligence but only to a specific agreement relating to the particular litigation. The court construed the service agreement between the parties as part of the insurance contract because it was incorporated by reference. The court therefore accepted United's reasonable interpretation of the agreement.

A worker injured on the job obtained a judgment against his employer, which had opted out of worker's compensation. The worker then sought to recover from the company's insurer as a third-party beneficiary under the employer's general liability policy. The Fifth Circuit affirmed summary judgment for the insurer, holding that the worker was an employee and was excluded under the policy. The court found that the worker did not fall within the "temporary worker" exception to the exclusion because the worker was not referred to the employer by a third party. *Parra v. Markel Int'l Ins. Co. Ltd.*, 300 F. App'x 317 (5th Cir. 2008).

A general contractor looked to its subcontractor's insurer after they both were sued by a swimming facility for faulty design and construction of a pool. The subcontractor's insurance policy covered certain "occurrences," which was defined as an accident that caused repeated exposure to the same general harmful conditions. However, the policy's contractual liability exclusion applied, and no tort claim triggered the exclusion's "insured contract" exception. *Century Sur. Co. v. Hardscape Constr. Specialties, Inc.*, 578 F.3d 262 (5th Cir. 2009).

C. Other policies

A commercial driver was not covered by an MCS-90 Endorsement contained in a commercial vehicle policy. The court construed the endorsement to extend coverage only for liability of the named insured, not to an employee of the named insured. The court reached its conclusion despite an earlier holding that, under the policy itself, the employee was an "insured" for purposes of determining the duty to defend. *Ooida Risk Retention Group, Inc. v. Williams*, 579 F.3d 469 (5th Cir. 2009).

D. Worker's compensation

The supreme court overruled its recent precedent to hold that a worker's compensation carrier does not waive the ability to contest compensability of an employee's injuries when it does not give notice of its refusal to pay within seven days of receiving notice of the injury. *Sw. Bell Tel. Co. v. Mitchell*, 276 S.W.3d 443

(Tex. 2008). The majority reasoned that the prior practice of the Texas Worker's Compensation Commission, the agency charged with enforcing the statute and subsequent amendments by the legislature, adopted the rule that a failure to give notice within seven days only incurred an administrative penalty, and that an insurer waived the right to contest compensability only if it delayed more than sixty days in giving notice. The court considered its prior decision to be an anomaly and thus overruled *Continental Casualty Co. v. Downs*, 81 S.W.3d 803 (Tex. 2002), which held the insurer waived the right to contest compensability by not giving notice within seven days. The majority concluded that the doctrine of *stare decisis* did not justify perpetuating a clear error.

The supreme court overruled its recent precedent to hold that a worker's compensation carrier does not waive the ability to contest compensability of an employee's injuries when it does not give notice of its refusal to pay within seven days

Chief Justice Jefferson wrote the dissent. Although he dissented in *Downs* and thought the case was wrongly decided, he and the other dissenters in this case felt *stare decisis* precluded changing the prior decision.

VI. DUTIES OF LIABILITY INSURERS

A. Duty to defend

The supreme court reaffirmed the rule that extrinsic evidence that overlaps liability allegations will not be allowed to establish or defeat an insurer's duty to defend, because only the eight corners of the coverage provided by the policy and allegations stated in the petition may be considered. *Pine Oak Builders, Inc. v. Great Am. Lloyds Ins. Co.*, 279 S.W.3d 650, 655 (Tex. 2009). The court relied on its recent decision in *GuideOne Elite Insurance Co. v. Fielder Road Baptist Church*, 197 S.W.3d 305, 307 (Tex. 2006). In *GuideOne,* the court refused to allow the insurer to introduce extrinsic evidence that contradicted allegations in the petition and would have undermined the duty to defend. In the present case, the court considered whether a builder that was sued for defective workmanship could offer extrinsic evidence to show the work was actually done by subcontractors, which would be covered under the policy, even though the petition against the builder contained no such allegations. The court held that extrinsic evidence that contradicts allegations in the petition will not be allowed to defeat or support the duty to defend. While the duty to defend extends to allegations that are true or false, it does not extend to allegations that have not been asserted, because this policy only requires the insurer to defend a "suit."

An insurer had no duty to defend an insured under its "disparagement" and "infringement of trade dress" coverage where the insured was accused of stealing and copying a competitor's design. *KLN Steel Prods. Co. Ltd. v. CNA Ins. Cos.*, 278 S.W.3d 429 (Tex. App.–San Antonio 2008, pet. denied). KLN was sued for obtaining confidential information about a competitor's product – a bed for the military – and then making its own version. KLN sought a defense under its insurance policies, which insured against claims of publication of disparaging material and trade dress infringement. The court ultimately found no duty to defend. First, the court held that when the petition alleged conduct after a certain date, policies for prior years were not triggered. However, when the petition alleged conduct in the "latter part of 2001," even though that was vague, it was sufficient to trigger coverage under a policy effective September 30, 2001.

The court then considered whether the petition alleged publication of disparaging material, and found that it did not. The court construed the word "disparage" as requiring some negative statement. KLN never said anything negative about the competitor's product.

The court also found no infringement of the competitor's "trade dress" – defining trade dress to mean the product's design, size, and shape. The court cited cases that distinguish between "trade dress" as the product's overall appearance that make it distinctive, and merely copying a product. The petition alleged that KLN had copied the product, but did not allege any distinctive design that constituted trade dress.

A commercial vehicle insurer had no duty to defend a driver sued for the death of the truck's owner/operator who was asleep in the cab. *Ooida Risk Retention Group, Inc. v. Williams*, 579 F.3d 469 (5th Cir. 2009). Williams was driving a truck ~~owed~~ owned by Moses, while Moses slept in the cab. Williams lost control of the truck, and Moses died in the ensuing wreck. The court first found that Williams was an "insured" under the policy, because he was using it with permission of the named insured. However, the court found that coverage was barred by the "fellow employee exclusion," which precludes coverage for injury to any fellow employee of the insured. The court relied on federal regulations defining "employee" to include an owner/operator like Moses. Thus, Moses was a fellow employee of Williams, even though Moses was also owner of the vehicle.

The court then considered whether Moses was acting as a tandem driver at the time of the accident. The court recognized that the eight corners of the policy and petition did not answer this question. However, the court decided it was appropriate to apply a narrow exception to the eight corners rule and allow extrinsic evidence in this case. The court justified an exception because the extrinsic evidence related to readily ascertainable facts, that were relevant to coverage, and did not overlap or engage the truth or falsity of the facts alleged in the underlying case. 579 F.3d at 475-76. The extrinsic evidence showed that Moses was tandem driving with Williams, which meant he was "operating" the vehicle, within the scope of the exclusion.

An insurer had a duty to defend, where the allegations in the petition indicated that water-related problems occurred within the policy period. The court noted that it required no speculation to recognize that the first instances of water infiltration and resulting property damage potentially occurred the first time it rained after the subcontractors started performing their work. Therefore, the subcontractors' insurers had a duty to defend the contractor, as the damage potentially occurred within the policy period, the damage arose from the subcontractors' work, and the claims did not come within any policy exclusions. *Thos. S. Byrne, Ltd. v. Trinity Universal Ins. Co.*, No. 05-07-01255-CV, 2008 WL 5095161 (Tex. App.–Dallas Dec. 4, 2008, no pet.). If property damage could have occurred during the policy period, those are potentially covered claims that require the insurer to defend the general contractor under the subcontractor's policy.

An employee was injured when a Continental baggage handler rear-ended an AccuFleet vehicle stopped on the tarmac. He sued both Continental and AccuFleet who looked to AccuFleet's insurer for a defense and indemnification. The court held the insurer did not have a duty to defend or indemnify Continental, because Continental was not an "insured" under the policy as there was no allegation in the lawsuit that the accident involved Continental's use of a covered automobile that was owned by AccuFleet. Instead, Continental's own vehicle contributed to the accident. However, the court did hold that the policy coverage for

bodily injury resulting from the use of a covered auto required the insurer to defend AccuFleet. *Accufleet, Inc. v. Hartford Fire Ins. Co.*, No. 01-08-00684-CV, 2009 WL 2961351, *5 (Tex. App.–Houston [1st Dist.] Sept. 17, 2009, no pet.).

The Fort Worth court of appeals held that an insurer has no duty to defend or indemnify unless and until the insured complies with the notice of suit conditions and demands a defense, even if the insurer has actual knowledge of the suit and defends other insureds in the same litigation. *Jenkins v. State & County Mut. Ins. Co.*, 287 S.W.3d 891 (Tex. App.–Fort Worth 2009, pet. denied). A judgment creditor sued a liability insurer to collect on a default judgment against the insured. In the underlying suit, the plaintiff was not able to personally serve the insured and instead served by publication and sent pleadings to the insurer. The insurer defended other individuals in the suit under the same policy. Thus, the insurer had actual knowledge of the claims against the insured. Nevertheless, the court held that the insurer was not liable under the policy for the default judgment because the insured never provided notice of the suit, which the policy required as a condition precedent to coverage. The court held that knowledge of the suit did not bar the insurer from showing prejudice and that entry of a final default judgment was prejudicial to insurer.

Other courts found a duty to defend in the following cases:

- An insurer owed a duty to defend because the lack of notice exclusion did not apply. The petition alleged a claim for bodily injury, which was covered, and the exclusion only applied to property loss claims. *Solvent Under. Subscribing to Energy Ins. Int'l v. Furmanite Am., Inc.*, 282 S.W.3d 661 (Tex. App.–Houston [14 Dist.] Feb. 5, 2009, pet. denied).
- An insurer was required to defend its insured against an injured subcontractor's claim. The appeals court held that the policy exclusion did not apply to the subcontractor individually, but only applied to both employees of the insured and employees of any subcontractor. *Republic-Vanguard Ins. Co. v. Mize*, 292 S.W.3d 214 (Tex. App.–Amarillo 2009, no pet.).

Courts found no duty to defend in these cases:

- An insurer did not have a duty to defend a parent company in an arbitration, when the insured under the policy was the subsidiary company of the parent company. *Am. Int'l Specialty Lines Ins. Co. v. LM Ericsson Telefon*, No. 05-07-01747-CV, 2008 WL 5235711 (Tex. App.–Dallas Dec. 17, 2008, pet. denied).
- An insurer had no duty to defend its insured under its commercial general liability coverage policy when the loss of use was purely an economic loss. The duty to defend was not triggered by factual allegations of misrepresentation that caused the loss of the plaintiff's investment and anticipated profits. *Daneshjou Daran, Inc. v. Truck Ins. Exch.*, No. 03-06-00206-CV, 2009 WL 2410932 (Tex. App.–Austin Aug. 5, 2009, no pet.).
- An insurer did not owe a duty to defend insured convenience store in a suit brought for selling alcohol to a minor, which resulted in death, because a liquor liability exclusion excluded liability by reason of contributing to the intoxication of any person or furnishing alcoholic beverages to a minor. *Certain Underwriters at Lloyd's of London v. Kutchins Enter., Inc.*, No. 4-08-CV-143-A, 2008 WL 5381244 (N.D. Tex.-Dec. 22, 2008).
- The Fifth Circuit found no duty to defend when an apartment complex was sued by the mother of a baby who was harmed by carbon monoxide while in utero when workers accidentally blocked the vent to a furnace. The court found that carbon monoxide was a pollutant, so the pollution exclusion applied. *Nautilus Ins. Co. v. Country Oaks Apartments, Ltd.*, 566 F.3d 452 (5th Cir. 2009).
- An excess liability insurer did not breach its duty to defend when the insured maintained both primary and excess policies, and the primary policy limits had not been exhausted until after mediation and settlement. The court also found that the insurer did not breach its duty to indemnify as the insured did not carry its burden of proof with respect to proving that the leaks from cracked parts constituted an "occurrence" under the policy. *Nat'l Union Fire Ins. Co. of Pittsburgh v. Puget Plastics Corp.*, No. B-05-050, 2009 WL 2485757 (S.D. Tex. Aug. 12, 2009).
- In *Essex Insurance Co. v. Davis*, No. 3-08-CV-1078, 2009 WL 2424088 (N.D. Tex Aug. 7, 2009), the court held that the insurer had no duty to defend an insured who built a leaky roof for a synagogue, as the policy only covered residential construction.

In *Mid-Continent Cas. Co. v. JHP Dev., Inc.*, 557 F.3d 207 (5th Cir. 2009), the insured contractor was sued by a development company it built condominiums for, after interior walls and ceilings started to leak. The insurer denied coverage, and a $1.5 million default judgment was rendered against the insured. The Fifth Circuit found that the insurer had a duty to defend. The "performing operations" exclusion did not apply because the insured was not actively engaged in the construction activities at the time the water intrusion occurred, as construction had been suspended pending the purchase of the condominium units. The "particular part" exclusion did not apply because it excluded coverage only for property damage to parts of the property that were themselves the subject of defective work by the insured. The exclusion did not bar coverage for damage to parts of a property that were the subject of only nondefective work by the insured and were damaged as a result of defective work by the insured on other parts of the property. The interior was not defective, but was damaged as a result of the defective work done on the exterior of the property. Therefore, the insured owed a duty to defend.

A court held that an insurer had a duty to defend its insured in a disability discrimination lawsuit brought by the Equal Rights Center for frustrating the pursuit of its overall mission of eliminating discrimination in housing. The policy covered claims for damages arising out of an "offense." The court found that "offense" included discrimination because of physical disability. The court found the insurer had a duty to defend even if the plaintiff did not suffer such discrimination, as it was enough that the damages arose out of discrimination due to physical disability. *Trammell Crow Residential Co. v. Va. Sur. Co.*, 643 F. Supp. 2d 844 (N.D. Tex. 2008). The court held that although proof of the insured's defense costs is necessary to calculate damages for which the insurer is liable, an insurer can still be held liable under the Prompt Payment of Claims Act before the insured has submitted statements of its defense costs to the insurer.

An insurer had a duty to defend its insured in an ac-

tion brought against it for failing to perform its obligations with respect to management and handling of a claim with the degree of skill customary for claims litigation administrators. The insurer attempted to apply an exclusion that would have been applicable if one analyzed it under the circumstances at the date the claim was made. The exclusion stated that the policy did not apply to any claim and claim expenses arising out of any professional services performed for any entity in which any insured is a principal, partner, officer, director, or a more than three-percent shareholder. However, the court held that in interpreting the exclusion, the court must look to the circumstances present at the time the accounting services were performed, which meant the exclusion did not bar coverage. *Philadelphia Indem. Ins. Co. v. Hallmark Claims Serv., Inc.*, No. 3-07-CV-1469-O, 2008 WL 5191910 (N.D. Tex. Dec. 10, 2008).

B. Duty to indemnify

A contractor sought defense and indemnity from its subcontractor's insurer, after some of the subcontractor's workers were killed on the job. The accident involved a pulley system that was attached to a "headache ball" on one end and a pick-up truck on the other. The workers had attached themselves to the headache ball which was raised up, but the rope broke and the men fell to their deaths. The appeals court held that the vehicle exclusion did not apply, because the workers' deaths did not arise out of the use of the motor vehicle, but rather occurred because of a defective rope. The court also held that the subcontractor's insurer could not avoid liability merely because the subcontract was not signed prior to the incident. Both parties consented to the terms, and there was no evidence of an intent to require signatures as a condition precedent. *Mid-Continent Cas. Co. v. Global Enercom Mgmt.*, 293 S.W.3d 322 (Tex. App.–Houston [14th Dist.] 2009, pet. filed).

A purchaser of a property at a foreclosure sale sued its title insurer seeking indemnification for its settlement of claims in a mechanic's lienholder's lawsuit. *GCI GP, LLC v. Stewart Title Guar. Co.*, 290 S.W.3d 287 (Tex. App.–Houston [1st Dist.] 2009, no pet.). The title insurer denied the claim on grounds that the mechanic's liens applied to "removable" items and were not liens "against the land." The policy gave coverage for a loss arising from a mechanic's lien "having its inception … on or before the date of the policy" and that had "priority over the lien of the insured mortgage." The court held that the insurer's interpretation, which would exclude coverage when a lien was on improvements and not against the land, would render the coverage provision meaningless. Under Texas law, the only circumstance in which a prior-in-time lien of the insured mortgage would lack priority over a mechanic's lien is when the mechanic's lien is on removable improvements. Because the insurer's interpretation was not reasonable, the court held that the insurer breached its duty to indemnify the insured.

Under Texas law, the only circumstance in which a prior-in-time lien of the insured mortgage would lack priority over a mechanic's lien is when the mechanic's lien is on removable improvements.

While street-racing in a repossessed vehicle, an employee of a repossession company was involved in an accident, which severely injured the persons in the other vehicle. The insurer of the repossession company sued the insurer of the repossessed vehicle alleging breach of its duty to indemnify in the action brought by the injured persons. *Empire Indem. Ins. Co. v. Allstate County Mut. Ins. Co.*, 319 F. App'x 336 (5th Cir. 2009) (per curiam). At issue was an exclusion for a person "using a vehicle without a reasonable belief that the person is entitled to do so." The court held the exclusion applied and the vehicle insurer had no duty to indemnify the other insurer. The vehicle was not used with a reasonable belief of entitlement to do so. At the time of the accident, the employee of the repossession company was driving to another city in search of a part for a different vehicle. Driving the repossessed car in this manner exceeded the limited purpose of preserving the collateral that is allowed by law during repossession. Furthermore, the employee who was driving pleaded guilty to aggravated assault with a deadly weapon stemming from the accident, which the court deemed irreconcilable with a reasonable belief that he was entitled to use the repossessed car in the manner he did.

VII. THIRD PARTY THEORIES OF LIABILITY

A. Breach of contract

An insurer failed to defend its insured at trial, which resulted in the insured putting on no defense and the claimant winning an excess judgment against the insured. The claimant looked to the insurer for payment, as the insurance policies provided that once liability was determined by a judgment, the claimant could recover under the policy up to the limits of coverage that applied. The insurer argued that because the insured did not present a defense, the judgment did not evidence liability of the insured decided by a trial. The court disagreed, holding that the insurer owed a duty to defend, which it breached, and therefore, the insurer could not insist on compliance with the "actual trial" requirement of the insurance policy once it breached its duty to defend. *Lamar Baptist Church of Arlington v. St. Paul Fire & Marine Ins. Co.*, No. 4-08-CV-370-A, 2009 WL 329885 (N.D. Tex. Feb. 10, 2009).

The Fifth Circuit also held that the insured was bound by the default judgment because it breached its duty to defend in *Mid-Continent Cas. Co. v. JHP Dev., Inc.*, 557 F.3d 207 (5th cir. 2009), noted *supra* regarding the duty to defend.

B. Unfair insurance practices

After the supreme court reversed a breach of contract award, finding no coverage for defamation when the insured knew of the falsity, the court also reversed the award of extracontractual damages for the insurer's unfair insurance practices. The court relied on the general rule that there can be no claim for bad faith when an insurer has promptly denied a claim that in fact is not covered. Because the insurer did not breach the insurance contract, there was no support for an award of extracontractual damages. *Chrysler Ins. Co. v. Greenspoint Dodge of Houston, Inc.*, No. 08-0780, 2009 WL 3494981 (Tex. Oct. 30, 2009).

In *East Tex. Med. Ctr. Reg'l Healthcare Sys. v. Lexington Ins. Co.*, the Fifth Circuit held that an insurer that received late notice of suit nevertheless had to show prejudice before it could avoid coverage for medical malpractice claim. 575 F.3d 520 (5th Cir. 2009). On remanding the case to decide the issue of prejudice, the court held that the insured could not state a claim for misrepresentation based on the insurer's letter denying the claim because of late notice. The insured argued that this letter was false because on other claims the insurer had accepted loss runs as notice, indicating that it did not require strict compliance. The insured argued that the insurer's stated reason for denying the claim was therefore a sham. The court rejected this argument, holding that a letter citing valid reasons for rejecting a claim is not a misrepresentation. Further, even if the insured prevailed because the insurer was not prejudiced, "mere breach of contract, without

more, does not constitute a 'false, misleading, or deceptive act.'"

A landlord filed a claim with its insurer after a tenant retrieved property from the premises after the landlord posted an eviction notice. The insurer denied the claim, and the landlord sued for unfair claim settlement practices. The court held that summary judgment for the insurer was proper, because the landlord failed to establish that it had an insurable interest in the tenant's property. *Imagination Realty Ltd. Co., L.L.C. v. Trinity Universal Ins. Co.*, No. 11-07-00135-CV, 2009 WL 92225 (Tex. App.–Eastland Jan. 15, 2009, no pet.) (mem. op.).

VIII. SUITS BY INSURERS

A. Interpleader

An insurer that issued an annuity contract to a husband, but then received notice of a divorce decree giving the ex-wife a half-interest, was faced with rival claims so that an interpleader was proper. However, the trial court erred in dismissing the husband's pre-interpleader claims for breach of contract, interest, breach of fiduciary duty, and other theories. These claims had to be decided on the merits. Further, while the insurer's two-year delay in tendering the funds after notice of the dispute did not preclude an interpleader, it did preclude an award of attorney's fees to the insurer. *Clayton v. Mony Life Ins. Co.*, 284 S.W3d 398 (Tex. App. –Beaumont 2009, no pet.).

B. Indemnity & contribution

A company that owned an oil and gas lease, Abraxas, hired another company, Pool, to perform work on the lease, both agreeing to indemnify the other for any claims for injuries or deaths suffered by their respective employees. Both companies obtained appropriate insurance, and later, an employee of Pool was killed on the job. Abraxas was sued, and its insurer provided a defense and then turned to Pool for indemnification. Pool's insurer became insolvent, leaving Pool to pay a portion of the settlement. Pool then looked to Abraxas's insurer for reimbursement. The court affirmed a take-nothing judgment in Pool's favor, holding that the evidence demonstrated that Pool had preserved the right to seek reimbursement for the settlement funds. *Northfield Ins. Co. v. Nabors Corp. Servs., Inc.*, No. 13-07-093-CV, 2009 WL 1546848, *6 (Tex. App.–Corpus Christi May 29, 2009, no pet.).

C. Subrogation

The Employees Retirement System of Texas has exclusive jurisdiction to decide claims for benefits, but it does not have exclusive jurisdiction to decide its own claim for subrogation. *Employees Retirement Sys. of Texas v. Duenez*, 288 S.W.3d 905 (Tex. 2009). ERS paid benefits to the Duenez family and then sued to assert its subrogation right to be repaid from their tort recovery. ERS then moved to dismiss its own suit, arguing that ERS itself had exclusive jurisdiction of the claim. The court rejected this argument, finding no basis in the statute to assume that the legislature intended for ERS to have exclusive jurisdiction of a subrogation claim. The court did hold that ERS had a right to include a subrogation provision in its plan, and that ERS might have exclusive jurisdiction if the defense to the subrogation claim challenged the amount of the charges.

A trial court did not abuse its discretion by allocating all of a settlement to a widow and the children of an insured so that the insured's estate recovered nothing, leaving the health insurer no money against which to assert its subrogation interest. The insurer did not properly preserve the point by failing to timely object. Further, the court of appeals found that the trial court did not abuse its discretion in allocating all of the money to the widow and children based on testimony regarding the mental anguish they suffered from the father's death and their financial concerns from losing the primary breadwinner. *Texas Health Ins. Risk Pool v. Sigmundik*, No. 03-05-00057-CV, 2009 WL 2341837 (Tex. App.–Austin, July 31, 2009, pet. filed).

An insurer that paid its insured's property loss could not assert by subrogation the insured's claims under the Deceptive Trade Practices Act against the product maker. The insurer could not acquire the insured's "consumer" status by assignment and itself had assets too large to qualify as a consumer. *Dewayne Rogers Logging, Inc. v. Propac Indus., Ltd.*, No. 12-08-00048-CV, 2009 WL 2712324 (Tex. App.–Tyler Aug. 31, 2009, no pet.).

Where an insurer served the pro se defendant at the wrong apartment number, its summary judgment on its subrogation claim would be reversed. *Ihonvbere v. State Farm Mut. Auto Ins. Co.*, No, 03-06-00118-CV, 2009 WL 1563525 (Tex. App.–Austin June 4, 2009, no pet.) (mem. op.).

An equipment lessor's liability insurers, as subrogees, brought an action against the lessee's commercial general liability insurer to recover a settlement they paid for the death of lessee's employees that occurred while they were in a trench box leased by the lessor. The lessor's liability insurers failed to give the lessee's insurer notice before settlement, as they lacked knowledge of their additional insured status until later. The lessee's insurer had knowledge of the suit but did not offer its additional insured a defense. The appeals court held that the lessee's insurer was prejudiced by lack of notice until after settlement, because the insurer was deprived of the ability to defend the lawsuit. Therefore, the court reversed the judgment for the lessor's liability insurers. *Maryland Cas. Co. v. Am. Home Assur. Co.*, 277 S.W.3d 107 (Tex. App.–Houston [1st Dist.] 2009, pet. filed).

An insurer sued a drilling company for subrogation after the insurer paid damages to its insured, the manager of the oil and gas contract area, caused by a well blowout. The court held that the insurer had a contractual subrogation right pursuant to its insurance policy with its insured and, therefore, only had to prove its negligence claim to the jury. *Bay Rock Operating Co. v. St. Paul Surplus Lines Ins.*, No. 04-08-00180-CV, 2009 WL 856040, *6-7 (Tex. App.–San Antonio Apr. 1, 2009, pet. filed). The court stated that St. Paul "stepped into the shoes" of its insured, and could bring the same claims against the drilling company that its insured could bring – i.e. negligence causing property damage. Therefore, prejudgment interest was proper. The appeals court also reversed the part of the trial court's judgment limiting the amount the drilling company paid to 51% of recoverable damages, instead finding that the drilling company was jointly and severally liable because it was assessed over 50% responsibility.

A contractor was hired to renovate a school, and while doing so the temporary roofing installed by a subcontractor leaked. The school's insurer paid for the damage and then sued the contractor for subrogation. The appeals court held that the insurance policy obtained by the school did not waive the insurer's subrogation rights against anyone, nor was it required to do so. The policy allowed the school to waive claims by specific written agreement under certain circumstances, which the school had not done. Therefore, the appeals court reversed the summary judgment in favor of the contractor. *Austin Indep. School Dist. v. H.C. Beck Partners, Ltd.*, No, 03-07-00228-CV, 2009 WL 638189 (Tex. App.–Austin Mar. 13, 2009, pet denied) (mem. op.).

A water line ruptured in a condominium, which caused water damage. The contractor and owner of the condominium had signed a waiver of subrogation clause. The insurer of the condominium, as the owner's subrogee, sued the subcontractor who installed the water line. The trial court awarded summary judgment for the subcontractor, but the appeals court reversed, holding that the waiver provided that the owner and contractor waived all rights against each other but that there was no waiver as

to the subcontractor. *Travelers Lloyds Ins. Co. v. Dyna Ten Corp.*, No. 2-08-502-CV, 2009 WL 2619232 (Tex. App.–Fort Worth Aug. 26, 2009, no pet.) (mem. op.).

In *Nautilus Ins. Co. v. Pac. Employers Ins. Co.*, 303 F. App'x 201 (5th Cir. 2008), EOG Resources contracted with J.R. Nichols to determine the surface and mineral estates of certain properties, and also contracted with Veritas to perform seismic dynamite blasting. Nichols and Veritas both obtained insurance policies listing EOG as an additional insured. As a result of the surveying and blasting, several homeowners sued EOG alleging that the seismic activity caused foundation damage to their homes. EOG's insurer and Nichols's insurer settled the lawsuit. However, Veritas's insurer refused to agree to settlement and proceeded to trial and won. Nautilus sued Pacific, claiming that Pacific paid more than its proportionate share since Pacific did not contribute to the settlement and did not pay anything in the state cases. The district court granted summary judgment in favor of the co-primary insurer, Pacific. The Fifth Circuit held that where the primary insurer paid the insured's entire claim, resulting in the insured being fully indemnified, the insured had no rights to enforce against a co-primary insurer, and therefore, the primary insurer had no right of subrogation against the co-primary insurer.

IX. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Attorney's fees

In a worker's compensation case, a fee of $160,000 was supported by affidavit testimony from the claimant's attorney, setting forth his qualifications, experience, familiarity with standards of practice, and opinion that the hourly rates were reasonable and customary. The attorney explained the basis for his opinions and testified that he took into account the contingent nature of the representation. The court approved hourly rates of $295, $385, and $395 for three different attorneys. *Texas Mut. Ins. Co. v. Durst*, No. 04-07-00862-CV, 2009 WL 490056 (Tex. App.–San Antonio, Feb. 25, 2009, no pet.) (mem. op.)

A worker's compensation claimant's attorney was entitled to a full one-third fee from the insurer's subrogation claim, where the claimant's attorney did all the work that led to the recovery, and the work done by the carrier's attorney was mainly aimed at enforcing the lien. The court entertained the idea that the claimant's attorney's portion of the fee might be reduced where he had tried to reduce the amount of the lien, but, because the attorney abandoned that position, the court did not reduce his fee. *Benchmark Ins. Co. v. Sullivan*, No. 12-07-00223-CV, 2009 WL 1153385 (Tex. App.–Tyler Apr. 30, 2009, no pet.) (mem. op.).

In an ERISA case, a court held that, where the unsuccessful claimant's position was not groundless or had "some merit," an award of attorney's fees to the insurer was not warranted. Because this was a close case with meritorious arguments on both sides and an award of fees in this case could discourage beneficiaries and participants from bringing claims on other important issues under ERISA, the court concluded that no attorney's fees would be awarded. *Estate of Thompson v. Sun Life Assur. Co.*, No. 4-07-CV-594-Y, 2009 WL 855649 (N.D. Tex. Mar. 31, 2009).

X. DEFENSES & COUNTERCLAIMS

A. Coinsurance

A court of appeals held that a coinsurance clause was not ambiguous and provided that the insurer would not be liable for a greater percentage of the insured's liability than the limit of the policy composed to the total value of the cargo at the time of loss. *RSI Int'l, Inc. v. CTC Transp., Inc.*, 291 S.W.3d 104, 105 (Tex. App.–Fort Worth 2009, no pet.).

B. Indemnification

A plaintiff's release of entities that were alleged to be responsible for negligent supervision of a school bus driver who sexually assaulted a minor were covered by the indemnification provision in the settlement agreement, so that they were released from any obligation to defend or indemnify the claim against the driver individually. The court held the indemnity language was broad enough to include the insurer in its capacities as insuring the entities and as insurer for the driver, there was no ambiguity, and the minor's mother had sufficient authority to enter into the settlement agreement and agree to such indemnity. While the release specifically preserved the claims against the driver, that did not preclude indemnifying his insurer. *Doe v. Texas Ass'n of School Bds., Inc.*, 283 S.W.3d 451 (Tex. App.–Fort Worth 2009, pet. denied).

C. Late Notice

The supreme court extended its holding in *PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 630 (Tex. 2008) to hold that even under a "claims-made" policy, late notice is not a defense unless the insurer shows prejudice. *Prodigy Commc'ns Corp. v. Agric. Excess & Surplus, Ins. Co.*, 288 S.W.3d 374 (Tex. 2009). In *PAJ*, the court dealt with an "occurrence" policy and held that late notice was no defense, absent a showing of prejudice to the insurer. In this case, the insurer argued that its "claims-made" policy was different because coverage only extends to claims first made within the policy period. The court first held that it made no difference whether the notice language was a condition precedent or a covenant. In this case, the notice provision stated that the insured was required to give notice "as soon as practicable" and that was a "condition precedent." The court then distinguished between notice of a claim against the insured, which is necessary to trigger coverage under the policy, and notice of the claim to the insurer. While the former has to occur within the policy period, the latter does not. The court reasoned that the question is whether the insurer was denied the benefit of the contract. In this case, the insurer received notice within the ninety-day extended reporting period and admitted that it was not prejudiced. The court held under these circumstances that late notice provided no defense.

The dissenting justices argued that the court

was ignoring the plain language of the contract between the parties. Of course, this is always true when a court decides whether prejudice is required. If some explicit provision of the contract were not breached, there would be no need to get to the issue of whether prejudice was required.

The supreme court addressed a similar question in *Financial Industries Corp. v. XL Speciality Ins. Co.*, 285 S.W.3d 877 (Tex. 2009). In *Prodigy*, the policy required notice "as soon as practicable" but not later than ninety days after the policy expired. In this case, the claims-made policy required notice as soon as practicable, without a clear reporting deadline. The insured gave the insurer notice of the claim within the policy period but not as soon as practicable. The supreme court concluded, based on *PAJ* and *Prodigy*, that the insurer could not deny payment without showing prejudice from the late notice.

The issue of late notice was also considered by the Fifth Circuit in. *Med. Ctr. Reg'l Healthcare Sys. v. Lexington Ins. Co.*, 575 F.3d 520 (5th Cir. 2009). A hospital was sued for medical malpractice, and the excess insurer refused to pay, claiming late notice. The court first held that loss runs were sufficient notice of the claims. While these computer-generated spreadsheets contained relatively scant information about multiple patients' claims, they were nevertheless sufficient, especially in light of evidence that the insurer on three other occasions had acknowledged loss runs as a "notice of claim."

The court (something to match the "first" in the previous paragraph) held that the insured had a separate obligation to give prompt notice of any lawsuit. Notice seven months after suit was filed was not timely, but the insurer would have to show prejudice from that late notice, and the court remanded the case for this purpose.

The court reversed the jury finding that the insurer waived the requirement that it receive the suit papers. Evidence that the insurer asked for other information did not waive its entitlement to this information.

The Fifth Circuit considered what was sufficient to show prejudice from late notice in *Trumble Steel Erectors, Inc. v. Moss*, 304 F. App'x. 236 (5th Cir. 2008) (per curiam). Trumble's crane hit a power line, resulting in the electrocution death of a worker. Trumble immediately gave notice to its insurance agent, but the agent did not forward the notice to the insurer for three months, waiting until after Trumble was sued. The insurer sued Trumble for declaratory relief, alleging that it was prejudiced by late notice of the accident because it could not immediately conduct its own investigation. Trumble sued the insurance agent for negligence and breach of contract in failing to forward notice to the insurer. The insurer and Trumble then settled, with the insurer having the right to assert Trumble's claims against the agent.

The Fifth Circuit panel reviewed Texas law regarding the requirement of prejudice, which it defined as loss of a valuable right or benefit. Prejudice requires an adverse change in position due to the delay. Further, the insurer need not show precisely what the outcome would have been if timely notice had been given, and the uncertainty from the insured's failure to comply should not be used as a weapon against the insurer. Uncertainty, however, does not relieve the insurer of the burden to show the "precise manner" in which its interest have suffered.

The court noted that prejudice has been found when an insured does not receive notice until trial is fast approaching, a default judgment has been entered, or after trial and entry of judgment. In this case, the court found no evidence that the insurer was prejudiced by not being able to conduct its own investigation immediately following the accident. The insurer argued that it had a special "shock loss" investigation whereby it would try to investigate in a manner that would shift liability from its insured and onto others. The court found the following facts dispositive to establish insufficient prejudice: (1) the insurer had access to extensive investigations performed by three other entities – the police department, the utility company, and OSHA; (2) the insurer identified no significant deficiencies in those investigations other than that they were presumably objective rather than aimed at decreasing liability; (3) the insurer received notice in a relatively short time of three months after the accident and had sufficient time to conduct discovery, settlement negations, and its own investigation; (4) the insurer's risk coordinator was unable to offer a clear indication of how their own investigation would have improved on the existing investigations or how the insurer was prejudiced; and (5) lost opportunities to engage in early settlement talks, to attempt to persuade others to accept responsibility, and to perform its own investigation immediately were "overly attenuated" from demonstrating actual prejudice.

D. Limitations

Renters' claims against a car rental company for coverage after they were injured in a collision were barred by limitations. The renters filed suit within two years against the rental agency to recover damages for their personal injuries but waited more than two years to amend the petition to sue for breach of contract and negligence, fraud, and statutory violations based on the rental agency's failure to provide coverage. The court rejected the argument that these later claims related back to the original suit, finding the original suit was based on the injuries, while the later claims were based on the rental transaction, so they did not arise from the same transaction. *Walker v. Presidium, Inc.*, No. 08-07-00113-CV, 2009 WL 1026600 (Tex. App.– El Paso, Apr. 16, 2009, no pet.).

The court seems to have gotten it wrong. It seems the only reason the rental agency would be liable for the injuries is because of the rental transaction by which it agreed to provide insurance. The rental agency did not cause the injuries; it simply agreed to be responsible for them. Thus, there was only one transaction between the renters and the agency, so later claims should have related back to the original petition and been timely.

An insurance contract provision requiring that suit be brought within two years and one day after the loss or damage occurred was void. The court relied on Tex. Civ. Prac. & Rem. section 16.070, which declares void any contract provision that provides less than two years to bring suit. Because suit cannot be brought until the claim accrues, and the claim does not accrue until there is a breach of contract, requiring suit within two years and one day of the loss violated the statute. *Spicewood Summit Office Condos. Ass'n v. Am. First Lloyd's Ins. Co.*, 287 S.W.3d 461 (Tex. App.–Austin 2009, pet. filed).

E. Misrepresentation or fraud by insured

An insurer was not entitled to summary judgment on its fraud defense based on evidence that an insured submitted a request for payment of additional living expenses that had not been paid by the insured. *Temcharoen v. United Fire Lloyds*, 293 S.W.3d 332 (Tex. App.–Eastland 2009, pet. filed). The court first held that the "anti-technicality" statute in Tex. Ins. Code section 705.003 applied and provides that a policy provision stating that the policy is void for misrepresentation has no effect unless the misrepresentation was fraudulently made, misrepresented a fact material to the insurer's liability, and misled the insurer and caused it to waive or lose a valid defense. The insured had faxed coversheets labeled "invoice" with attached "receipts" showing payment of room and board during the time the insureds were dislocated from their home as a result of a hurricane. The insureds had not yet paid $7,000 of the rent, because their practice

was to get the money from the insurance company, and deposit it into their account, and then the landlord would cash their check. The insurer persuaded the trial court that this voided the policy for fraud. The court of appeals held that the statute applied, even though the alleged misrepresentation was not in a formal proof of loss. Prior cases had read the statute broadly to include other statements made in support of a claim. Under the statute, the insurer offered no evidence of any fraudulent intent or any proof that it was harmed or had waived any defense. Moreover, the insured testified that she submitted the requests based on instructions from the insurer's representative.

The *Temcharoen* court also concluded the insurer failed to show common law fraud. The court relied on the element in *Mayes v. Mass Mut. Life Ins. Co.*, 608 S.W.2d 612, 616-17 (Tex. 1980), requiring a fraudulent statement with intent to deceive as a basis to void a policy based on a misrepresentation in the application. The court reasoned that the same rules apply to a misrepresentation in a claim for payment. The insurer did not conclusively establish intent to deceive, based on the insured's testimony.

Under maritime law and New York law, an insured violated the *uberrimae fidei* doctrine, or utmost good faith – by failing to disclose to the yacht insurer three prior insurance claims. The boat's captain admitted he intentionally left the answer blank. Moreover, the trial court found sufficient evidence to establish the elements of misrepresentations sufficient to void the policy. It was undisputed that a false representation was made. The insurer submitted sufficient evidence that it relied on the representation and that it was material. Finally, the court found that the captain's intentional failure to disclose the loss history, which was deceiving, was sufficient to show he intended to deceive the insurer and that his omission was not the result of mistake or inadvertence. *Great Lakes Reinsur. (UK) PLC v. S. Marine Concepts, Inc.*, No. G-07-276, 2008 WL 2523861 (S.D. Tex. Oct. 21, 2008).

F. Statute of frauds

A letter agreeing to issue surety bonds, upon receipt of an acceptable contract, was not an enforceable contract to provide surety bonds, because it was not sufficiently specific to comply with the statute of frauds. The letter lacked the necessary element of a writing manifesting a present intent to be bound. *Hartford Fire Ins. Co. v. C. Springs 300, Ltd.*, 287 S.W.3d 771 (Tex. App.–Houston [1st Dist.] 2009, pet. denied).

G. Waiver of, or estoppel to assert, defenses

An insurer was not equitably stopped to assert that the 1% deductible in a policy covering a rental home applied to each damaged item instead of all damaged items aggregated, despite evidence that the insurer had applied the deductible collectively on another claim. *Mitchell v. State Farm Lloyds*, No. 05-08-00184-CV, 2009 WL 596611 (Tex. App.–Dallas Mar. 10, 2009, no pet.). The court noted first that the insured offered summary judgment evidence of the insurer's conduct on another claim, but did not otherwise prove the elements of estoppel, which require a misrepresentation that is detrimentally relied on. Further, the court held that estoppel could not be used to expand insurance coverage.

While the court may be correct that the insured did not present evidence of equitable estoppel, its reliance on the general rule regarding estoppel may be incorrect. It is true that estoppel and waiver cannot be used to expand insurance coverage. However, the doctrines can be used to avoid a defense or other forfeiture. *See Ulico Cas. Co. v. Allied Pilots Ass'n*, 262 S.W.3d 773, 778-79 (Tex. 2008). Arguably, estopping the insurer to change how it applied the deductible would not expand coverage – the items were already covered – it would only bar the insurer's defense based on the deductible amount.

A worker's compensation insurer waived the right to contest the compensability of a worker's claim by failing to contest it within sixty days. *Fed. Ins. Co. v. Ruiz*, 281 S.W.3d 177 (Tex. App.–Dallas 2009, pet. denied).

H. Other defenses

An appeals court reversed a summary judgment dismissing a claim based on judicial estoppel. *Horizon Offshore Contractors v. Aon Risk Servs. of Tex., Inc.*, 283 S.W.3d 53 (Tex. App.–Houston [14th Dist.] 2009, pet. denied). The court held that none of the statements satisfied the requirements for judicial estoppel, because they either were not sworn statements or were not inconsistent with the insured's position.

XI. PRACTICE & PROCEDURE

A. Appraisal

The supreme court discussed in detail the scope of appraiser's authority to decide issues of liability, damage, and causation in *State Farm Lloyds v. Johnson*, 290 S.W.3d 886 (Tex. 2009). After hail damaged the insured's roof, State Farm inspected the roof and concluded that only the ridge line was damaged and estimated the repair cost at $500. The insured's roofing contractor concluded that the entire roof needed to be replaced at a cost of $13,000. The insured sought to invoke appraisal under the policy, and State Farm resisted. State Farm argued that the appraisers would have to determine causation and liability, which were beyond the scope of their authority to determine damages. The supreme court rejected this argument and concluded that, based on the record before it, it was not clear that the appraisers would exceed their authority, so State Farm could not avoid appraisal.

None of the statements satisfied the requirements for judicial estoppel, because they either were not sworn statements or were not inconsistent with the insured's position.

The court attempted to clarify the division between issues that are subject to appraisal and those that are not. At one end, questions on liability are not proper for appraisal and must be decided in court. At the other end, the amount of damage is subject to appraisal. In between, questions on causation may be decided by appraisers in determining the amount of the loss. The court rejected State Farm's argument that every issue of causation is beyond the scope of appraisal. For example, the court reasoned that determining the amount of the loss would require the appraisers to determine both the cost of shingles and how many needed to be replaced. The court also held that appraisers can properly allocate damages between covered and excluded perils. The court tried to clarify the boundaries by saying that the issues are for the courts, and not appraisal "when different causes are alleged for a single injury to property[.]" In contrast, "when different types of damage occur to different items of property, appraisers may have to decide the damage caused by each before the courts can decide liability." The court also reasoned that appraisers can decide causation in determining whether a loss is due to a covered event as distinguished from the property's preexisting condition.

The court did not decide the extent to which the ap-

praisal award would be binding, but found a challenge to the appraisal before it occurred was premature.

The district court denied the insurer's request to compel a non-binding appraisal and allowed trial to proceed, resulting in a win for homeowners whose insurer had denied insurance payments on their home damaged by Hurricane Katrina. The Fifth Circuit vacated the judgment and remanded with instructions to compel appraisal. The court also reversed the award for attorneys' fees granted under the Equal Access to Justice Act, and stated that the insurer could not be characterized as an "independent establishment" (meaning independent entity within the executive branch) or a "corporation in which the United States has a proprietary interest," and therefore, attorneys' fees were not appropriate in this context under the Act. *Dwyer v. Fidelity Nat'l Prop. & Cas. Ins. Co.*, 565 F.3d 284 (5th Cir. 2009).

B. Arbitration

A plaintiff suing for an employer's failure to pay life insurance benefits waived her right to arbitration by filing suit, litigating certain issues, and conducting discovery before moving to compel arbitration. *Nicholas v. KBR, Inc.*, 565 F.3d 904 (5th Cir. 2009). An employee's widow filed suit in state court, which was removed to federal court. She then filed a motion to remand, which was denied based on ERISA preemption, then she responded to discovery, and conducted a third party deposition, all before raising the issue of arbitration under the agreement with the employer. The Fifth Circuit held this evidence showed an invocation of the judicial process and that the employer would be prejudiced by compelling arbitration.

An annuity insurer was not bound by an arbitration award involving a structured settlement agreement as it was not named as a party or served with notice of the suit to confirm the arbitration award. *Transam. Occidental Life Ins. Co. v. Rapid Settlements, Ltd.*, 284 S.W.3d 385 (Tex. App.–Houston [1st Dist.] 2008, no pet.).

A plaintiff suing for an employer's failure to pay life insurance benefits waived her right to arbitration by filing suit, litigating certain issues, and conducting discovery before moving to compel arbitration.

An insurance agent and insurer sought to compel arbitration in a suit brought by an insured employer who had adopted an insurance benefits plan sold by the agent and offered by the insurer. However, neither the agent nor the insurer was a signatory to the contract with the plan administrator that contained the arbitration provision. They sought to compel arbitration by asserting that equitable estoppel applied and that they were third party beneficiaries to the contract. The court held that equitable estoppel did not apply. The agent and insurer each had separate contracts with the insured that lacked arbitration clauses. Allowing them to compel arbitration would allow them to rewrite their contracts. Also, the insured's claims did not rely on the contract with plan administrator. The court also held that the insurer and agent were not third party beneficiaries of the contract with plan administrator. The contract did not contain any language showing an intent to give them the right to sue to enforce the contract. Therefore, the insurer and agent could not compel arbitration. *Hartford Life Ins. Co. v. Forman*, No. 13-08-00547-CV, 2009 WL 1546924 (Tex. App.–Corpus Christi June 3, 2009, pet. denied) (mem. op.).

C. Jurisdiction

In *Foster v. Teacher Ret. Sys.*, the court of appeals held that sovereign immunity barred an insured's suit against TRS and the private insurer administering the TRS insurance plan. 273 S.W.3d 883 (Tex. App.–Austin 2008, no pet.). The court determined that the insured's declaratory action did not allow her to avoid sovereign immunity, because the "declaratory relief sought to control the State's action and was barred absent express legislative consent." Also, the court determined that the legislature did not waive TRS's immunity. Finally, the court held that the private insurer was shielded by sovereign immunity because it was functioning as an agent for TRS, which is a state agency. The court determined that the private insurer was a "fiduciary intermediary," as that term is used in federal cases concerning Eleventh Amendment immunity, because it had no financial stake in approving or denying claims and was acting as an agent in a fiduciary capacity for the state. Because the insurer was a fiduciary intermediary and because the insured did not allege that the insurer had exceeded the scope of its duty or committed fraud, TRS's sovereign immunity extended to the private insurer.

D. Choice of law

An injured party sued his employer along with the company who leased the equipment that caused his injury. The employer and lessor signed an agreement that provided the laws of Maryland would govern. The court held that Maryland law was appropriate to apply when determining an indemnity issue as parties can express in their agreement their choice that the law of a specified jurisdiction be applied to their contract. *CMA-CGM (Am.) Inc. v. Empire Truck Lines Inc.*, 285 S.W.3d 9 (Tex. App.–Houston [1st Dist.] 2008, no pet.).

Texas law properly applied to two life insurance policies with a combined value of $1 million, because they were a "qualified transaction" under Tex. Bus. & Com. Code section 271.001(1). *Cantu v. Jackson Nat'l Life Ins. Co.*, 579 F.3d 343 (5th Cir. 2009). The court held under the plain language of the statute that the two $500,000 policies were considered part of a single transaction. They were entered into contemporaneously and had at least one common party, because the insured who paid for them attempted to pay for them with a single check. The court further found a "reasonable relationship" to Texas, because the insurance agent who negotiated the policies lived in Texas. The court held that the agent was properly considered a party to the "transaction."

The fact that an insurer had substantial assets and connections to New York, including the presence of an agent for service, was a sufficient relationship to support a choice of law provision designating New York law. *Great Lakes Reinsurance (UK) PLC v. Southern Marine Concepts, Inc.*, No. G-07-276, 2008 WL 2523861 (S.D. Tex. Oct. 21, 2008).

E. Experts

In a mold case where the claimants sought to recover damages for loss of property and for bodily injury, the experts failed to test items concurrently with their presence in the actual apartment and failed to examine the claimants to make a clinical diagnosis regarding their health problems. Because toxic tort cases require proof of both general and specific causation, the court held that the opinion testimony of the experts did not raise a fact issue to defeat the insurer's summary judgment motion. *Plunkett v. Conn. Gen. Life Ins. Co.*, 285 S.W.3d 106 (Tex. App.–Dallas 2009, pet. filed).

F. Evidence

Where an insurer intervened to collect its subrogation interest and also appeared as a defendant to deny coverage, an admission that the claim was covered by the insurer's intervenor was not binding on the insurer as defendant. *United States Fid. & Guar. Co. v. Goudeau*, 272 S.W.3d 603 (Tex. 2008). The majority reasoned that the insurer was appearing in different capacities and an admission in one capacity did not bind it in the other. The dissenters relied on the general rule that no party can sue himself, and would treat the insurer as a single party for purposes of the admission.

A trial court did not err in excluding as hearsay two insurance trade publications that reported negative information about an insurance broker and insurer to show that a broker placing coverage should have been put on notice of problems. The court rejected the insured's argument that this evidence went to show notice by the insurer and was not offered for the truth. *Envtl. Procedures, Inc. v. Guidry*, 282 S.W.3d 302 (Tex. App.–Houston [14th Dist.] 2009, pet. denied).

XII. OTHER ISSUES

A. Excess & primary coverage

One court held that a parent company is not insured under a liability policy listing one of its subsidiaries as the named insured. The parent company was ordered to pay a claimant $43 million in damages. The trial court granted the parent company and subsidiary's summary judgment motion, declaring the parent company to be an insured under an excess policy. All parties agreed that the parent company would not be insured under the excess policy if the parent company was not insured under the primary policy. The appeals court held that *"you"* as defined in the primary policy was different from the word "you" in the application. The only place the primary policy promises to indemnify anyone is in the policy, and that promise extends to *"you"* – Ericsson Inc. (the subsidiary company), its subsidiaries, and employees. The excess insurer proved that the parent company was actually a parent company to Ericsson, which established that the parent company did not fall within the definition of *"you"* under the primary policy. Therefore, the parent company was not insured under the excess policy either. *Certain Under. at Lloyd's v. LM Ericsson Telefon*, 272 S.W.3d 691 (Tex. App.–Dallas 2008, pet. filed).

B. Subrogation

When an insurer paid an insured for the value of his vehicle after it was stolen, the court held that the insured was not entitled to recover the vehicle when it was found by the insurer. Title to the vehicle is transferred to the insurer by operation of the insurance contract, even if the release does not transfer title, as contractual subrogation is created by the agreement that grants the right in exchange for payment of a loss. *Ysasaga v. Nationwide Mut. Ins. Co.*, 279 S.W.3d 858, 867 (Tex. App.–Dallas 2009, pet. denied).

C. Other issues

An insurer was required to refund all unearned premiums to a premium finance company. In *Southern County Mut. Ins. Co. v. Surety Bank, N.A.*, 270 S.W.3d 684 (Tex. App.–Fort Worth 2008, no pet. h.), the court held that the finance company had proved all elements to entitle it to the full refund amount, even though a third party (and not the insured, in whose shoes the finance company stood) had paid the premiums. If a premium finance company proves the following elements, then it is entitled to the refund: (1) the policy provides for refund of unearned premiums upon cancellation; (2) the finance company is authorized to collect the refund; (3) the finance company gave timely notice of the finance agreement; (4) the insured defaulted on that finance agreement; and (5) the finance company gave the insurer notice of the default and cancelled the policy. Any payment of premiums to the insurer is a payment of premium between the insured and the insurer, no matter who makes the payment.[2]

* Mark L. Kincaid is a partner with Kincaid & Horton, L.L.P. in Austin. He graduated with honors from the University of Texas Law School and teaches Texas Insurance Litigation there as an adjunct professor. He is co-author of West's *Texas Practice Guide on Insurance Litigation*, and has written and spoken frequently on insurance and consumer issues.

Suzette E. Selden is an associate with Kincaid & Horton, L.L.P. She graduated with highest honors from Brigham Young University with a B.A. (2002), and with honors from the University of Houston Law Center (2006).

Elizabeth von Kreisler is an associate with Kincaid & Horton, L.L.P. She graduated from Reed College with a B.A. (2002), and with high honors from the Texas Tech University School of Law (2007).