Annual Survey of Texas Insurance Law 2010

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Insurance litigation continued to thrive this year.

I. INTRODUCTION

Insurance litigation continued to thrive this year, with over 100 reported decisions. Courts revisited recurring issues and decided several cases of first impression. For example, in *State Farm Lloyds v. Page*, the Texas Supreme Court revisited coverage for mold damage caused by plumbing leaks and concluded that dwelling damage isn't covered, but personal property is. Courts dealt with a number of claims arising from theft of copper for air conditioning units, and several decisions dealt with appraisal of claims related to Hurricane Ike, waiver of appraisal, and the effect of appraisal on the insurer's liability. Insurers also continued to try, unsuccessfully, to remove cases to federal court by arguing that adjusters can't be sued, so they aren't proper parties.

The Texas Supreme Court also decided several other significant cases. In *Gilbert Texas Construction, L.P. v. Underwriters at Lloyds, London*, the court held that a liability insurer could require its insured to assert defenses that will negate coverage, at least in the circumstances of that case. The court also continued to clarify when a declaratory judgment on the duty to indemnify is proper before liability is decided, finding in *D.R. Horton-Texas, Ltd. v. Markel International Insurance Co.*, that the answer is – only when the facts alleged negate any possibility of coverage. In *Metro Allied Insurance Agency, Inc. v. Lin*, the supreme court departed from several earlier decisions to hold that an insured complaining about a failure to get promised coverage has to prove that coverage was available.

Not all of this year's decisions clarified or settled the law. For example, the courts continued to muddy the waters on issues related to when an insurer can be liable for unfair insurance practices. In *Great American Insurance Co. v. AFS/IBEX Financial Services, Inc.*, the Fifth Circuit held that an insured who recovered under the insurance policy nevertheless had to show an "independent injury" to recover for unfair insurance practices. Of course, this holding ignored controlling Texas precedent that policy benefits alone are a sufficient injury to allow recovery under the statute.

Finally, a couple of federal court decisions held that punitive damages weren't insurable when that would shield the wrongdoer from punishment. Each of these decisions, and many more, are discussed below.

II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile

In *Laine v. Farmers Insurance Exchange*, No. 01-08-01010-CV, 2010 WL 375937 (Tex. App.–Houston [1st Dist.] Feb. 4, 2010, pet. filed), an insured sued her insurer for coverage under her umbrella policy for damages sustained in an accident with an uninsured drunk driver. The trial court awarded $175,000 in actual damages and $1,500,000 in exemplary damages against the drunk driver. The insurer had paid the policy limits of $250,000, but did not respond to the insured's request for additional payment under the umbrella policy. The court held that the umbrella policy did not cover exemplary damages against the third party uninsured drunk driver. The court stated it is against public policy to cover exemplary damages assessed against a third-party wrongdoer, because that would not punish the wrongdoer.

Another court held that an insured could not recover uninsured motorist benefits for damages resulting from an accident in which ice fell off a tractor trailer and hit the insured's vehicle. The policy defined an uninsured motor vehicle to mean a vehicle "which hits" the insured or his car. Because no part of the tractor trailer came in contact with the insured's car, the court concluded that the policy did not cover the accident. *Hernandez v. Allstate County Mut. Ins. Co.*, No. 04-09-00311-CV, 2010 WL 454949 (Tex. App.–San Antonio Feb. 10, 2010, pet. denied) (mem. op.).

Even though an employee and his wife were protected by liability insurance under the husband's employer's commercial auto policy, the policy did not include them as insureds for underinsured motorist coverage. The court concluded this was permissible and that the insurer was not required to extend UIM coverage merely because the policy covered them for liability. The court agreed that, because the employer could entirely waive UIM coverage, it could also have a policy that limited UIM coverage to only certain insureds. *Amanzoui v. Univ. Underwriters Ins. Co.*, No. 2:09-CV-65-TJW, 2010 WL 1945775 (E.D. Tex. May 12, 2010).

Finally, in an accident where the owner of a company was hit and killed by a car while riding her bike, the court found that the company's insurance policies for uninsured and underinsured motorist coverage did not cover her injuries. *Phila. Indem. Ins. Co. v. Creative Young Minds, Ltd.*, 679 F.Supp.2d 739, 743-44 (N.D. Tex. 2009). The named insured on the policy was the company. Therefore, the owner did not meet the definition of "insured," and coverage did not apply.

B. Homeowners

The Texas Supreme Court held that the former standard homeowner's policy–Form HO-B does not cover mold contamination resulting from plumbing leaks when the dwelling suffers damage, but it does cover damage to personal property. *State Farm Lloyds v. Page*, 315 S.W.3d 525 (Tex. 2010). The court revisited its prior decisions addressing mold coverage under the HO-B policy and found none were controlling. The policy provides an exclusion stating, "We do not cover loss caused by: … (2) rust, rot, mold, or other fungi. … We do cover ensuing loss caused by collapse of building or any part of the building, water damage or breakage of glass which is part of the building if the loss would otherwise be covered under this policy." The court reasoned that this exception to the mold exclusion did not allow coverage for damage to the dwelling caused by mold resulting from a plumbing leak. The court held that the plain language of the exclusion applied to mold damage to the dwelling; otherwise, the exclusion would have no meaning if it was rendered inapplicable every time there was a plumbing leak. In contrast, the policy stated that for personal property there was coverage for damage resulting from plumbing leaks and expressly stated that this exclusion did not apply to a loss to personal property caused by such a peril. Therefore, the homeowners were entitled to coverage for damage to their personal property.

Insureds whose home was underinsured when it burned appealed a trial court judgment in favor of the insurer. *Bryce v. Unitrin Preferred Ins. Co.,* No. 03-08-00670-CV, 2010 WL 1253479, *6 (Tex. App.–Austin April 1, 2010, no pet.) (mem. op.). The court affirmed the trial court's judgment holding that the insurer and the insurance agency did not know the insureds' home was underinsured and therefore did not incur a duty to notify the insureds that their home was insured for less than the actual replacement cost. The court also found that the insurer did not undertake any duty to calculate, set, or maintain the replacement cost coverage limits on the insureds' home when it performed inspections on the home.

C. Commercial Property

Insured commercial property owners sued their insurer for policy benefits to cover damage caused to their building when someone climbed onto the roof, opened up the HVAC units, and removed copper pipes and electrical wiring. The policy covered "vandalism," defined as "willful and malicious damage to, or

destruction of, the described property," but excluded damage caused by "theft." "Theft" was not defined by the policy. The person who climbed on the roof was arrested for theft, but pled guilty to and was convicted of felony criminal mischief. He did not take any of the pipes and wiring away from the building before his arrest. The insurer argued that the theft exclusion applied to bar coverage. On appeal, the court determined that "theft" should be given the same meaning in an insurance policy that it has under criminal law. To show theft under criminal law, the insurer had to show that the culpable party exercised control over the insured's personal property with the intention of depriving them of possession, enjoyment, or use. The insurer did not need to prove that the property was removed from the premises, only that it was removed from its customary location. In this case, the element of removal was proved as a matter of law. Additionally, even though the pipes were initially affixed to the building, they were personal property once they were separated from the building. Thus, the element of personal property was established. However, on the element of intent, the court held that an issue of fact existed. The parties did not stipulate to intent, and the culpable party confessed only that he intentionally damaged and destroyed property. *Nautilus Ins. Co. v. Steinberg*, 316 S.W.3d 752 (Tex. App.–Dallas 2010, pet. filed).

The court found the flood insurance provision to be ambiguous and adopted the construction most favorable to the insured.

The court in *Essex Insurance Co. v. Eldridge Land, L.L.C.*, No, 14-09-00619-CV, 2010 WL 1992833, *7 (Tex. App.–Houston [14th Dist.] May 20, 2010, pet. denied), held that a policy with a theft exclusion would not cover damage done by intruders. The court stated that the removal of pipe and wiring by the intruders did not fall under the damage caused by the "breaking in" exception, as the damage was not done to gain entry to the building, but rather was done once the intruders were inside the building.

An insured filed a claim for wind damage to its property from Hurricane Ike. The wind and hail policy contained a provision titled "Flood Warranty" that required the insured to procure flood insurance if the property was located in a floodplain. While investigating the insured's claim, the insurer learned that the property was located in a floodplain but that the insured did not have separate flood insurance, prompting the insurer to seek a declaration that there was no coverage under the policy. The court denied the insurer's motion for summary judgment, concluding that the "Flood Warranty" was not a warranty, for several reasons. The substance of that provision did not contain any warranty language, and instead described itself both as a "condition" and an "exclusion." It also did not state that the policy was void if the warranty was untrue. Another portion of the policy expressly identified circumstances under which the policy would be void, but did not include any mention of failing to provide flood insurance. Under these circumstances, the court found the flood insurance provision to be ambiguous and adopted the construction most favorable to the insured by characterizing it as an exclusion instead of a warranty. Because the provision was an exclusion, the insurer had to establish that the insured's failure to procure separate flood insurance was a material breach. *Underwriters at Lloyds, Syndicate 242 v. Turtle Creek P'ship, Ltd.*, No. 4:08-CV-3044, 2010 WL 2326046 (S.D. Tex. Jan. 14, 2010).

A thunderstorm caused a power outage at an insured's recycling facility. As a result, the furnace stopped working, causing molten metals inside to cool, solidify, and damage the furnace's brick lining. Two days later, the insured restarted the furnace and reheated the metal. Six days later, the reheating caused further damage to other parts of the furnace. The insured replaced the brick lining in the furnace and, several days later, heated the furnace to cure the bricks. The curing process revealed further damage from the prior reheating that rendered the furnace unsafe and unusable. The insurer tendered the per occurrence limit on the policy for all of the damage. The insured argued there had been three separate occurrences: the power outage, the reheating, and the brick curing. The policy defined an occurrence as "all loss or damage attributable directly or indirectly to one (1) cause or series of similar causes." On summary judgment, the court concluded that the facts presented only one occurrence. The power outage was at least an indirect cause of the reheating damage and curing damage. *All Metals, Inc. v. Liberty Mut. Fire Ins. Co.*, No. 3-09-CV-0846-BD, 2010 WL 3027045 (N.D. Tex. Jul. 29, 2010).

D. Life insurance

In *Irwin v. Irwin*, 307 S.W.3d 383, 385-86 (Tex. App.–San Antonio 2009, pet. denied), the court reversed the trial court's ruling in favor of the deceased's estate receiving the insurance proceeds rather than his ex-wife. The deceased had failed to change the designation of his life insurance beneficiaries to exclude his ex-wife, even though the divorce decree specifically stated that his ex-wife was divested of all rights to his life insurance proceeds. The appeals court held that the estate did not have standing to pursue the case against the ex-wife. Instead, his sons from a previous marriage, who were also listed as beneficiaries of the deceased's life insurance policy, were the proper plaintiffs.

A life insurer denied benefits under an ERISA group policy to the beneficiary of an undocumented migrant worker. The district court found that the life insurer, which was also the plan administrator, did not abuse its discretion. Even though the policy did not expressly require the employee to be a legal employee or resident of the United States, the insurer's imposition of such a requirement was found to be fair and reasonable, and the insurer had consistently applied that requirement for several years. Also, the legal status of the worker was found to be material to the insurer's risk because there was an "industry-recognized" underwriting risk associated with the legal status of the applicant, the worker would not have obtained the job or the insurance had he not misrepresented his status to his employer, and undocumented workers are less likely to seek medical treatment. Accordingly, the insurer did not wrongfully deny the benefits or rescind the contract. *Garcia v. Am. United Life Ins. Co.*, No. 5:07CV63, 2009 WL 6327459 (E.D. Tex. Dec. 9, 2009).

A plane crash resulted in the deaths of several persons. The pilot had a life insurance policy. His estate and the estates of the other decedents claimed the proceeds. The decedents argued that the pilot's estate was not entitled to the proceeds, because the life insurance policy contained an exclusion for bodily injury to the insured. The court concluded that the policy was intended to insure damages for which he would be liable to third parties, and that the pilot's estate was not entitled to the proceeds. The proceeds were apportioned according to agreement of the decedents. *U.S. Specialty Ins. Co. v. Estate of Schurrer*, No. 4:09CV353, 2010 WL 2598269 (E.D. Tex. June 24, 2010).

An employer had no insurable interest in its employee,

but received life insurance proceeds after the employee died. The employee's family sued the employer, as well the insurer and the insurance agent. The family argued that the insurer and agent had breached their contract and their duty of good faith and fair dealing. The court granted the insurer's and agent's motion to dismiss, finding that, the family was not a beneficiary of the policy nor was it privy to the insurance contract between the insurer and the employer. The family's only remedy was to seek a constructive trust against the employer for the money it had been paid. *Lewis v. Hays Group, Inc.*, No. H-08-215, 2010 WL 1404448 (S.D. Tex. Mar. 31, 2010).

E. Other policies

A crime protection policy covered a loss suffered by an insurance agency when the owner's son endorsed checks and deposited the funds into his own personal bank account. The court concluded that these acts constituted "forgery" within the policy definition. *Great Am. Ins. Co. v. AFS/IBEX Fin. Servs., Inc.*, 612 F.3d 800 (5th Cir. 2010). The policy covered loss resulting from "forgery" and defined the term to mean the signing of the name of another person or organization with the intent to deceive and did not include a signature that consists in whole or in part of one's own name signed with or without authority. The court rejected the argument that the loss was not a forgery because the son signed the name "Charles McMahon Insurance Agency" and his name was "Charles McMahon, Jr." The court rejected the argument that the endorsement was part of "one's own name." The court also rejected the insurer's argument that the term "forgery" should be construed as it would be under the Uniform Commercial Code, which would hold that when one is authorized to sign another's name but deposits the check into his own account that is not forgery. The court reasoned that the definition in the policy controlled, so there was no need to refer to the UCC definition.

III. FIRST PARTY THEORIES OF LIABILITY

A. Breach of Contract

An insured's group life plan stipulated that it would cease providing coverage for her husband on the date she retired. However, for over two years after the insured's retirement, the insurer continued to bill and accept premiums for both her and her husband's coverage. When the insurer learned that it had billed the insured for her husband's coverage after the insured's retirement, the insurer cancelled the husband's coverage retroactively but initially refused to refund premiums. The insured and her husband sued, alleging breach of contract and promissory estoppel. The insured offered two theories for the breach of contract claim. First, the insured argued that the insurer waived its termination of her husband's coverage under the certificate of insurance when it accepted premiums for two years and represented in writing that he had coverage. The court of appeals, following *Ulico Casualty Co. v. Allied Pilots Association,* 262 S.W.3d 773 (Tex. 2008), held that this theory was not viable because the coverage under the original contract could not be expanded or rewritten through waiver or estoppel. The insured's second theory was that the parties formed a new, separate agreement regarding the husband's coverage. As to this theory, the court held there was a genuine issue of fact. A meeting of the minds could be inferred from the insured's statement that she wanted to retain the coverage, the insurer's representation that the coverage would not lapse, the insured's premium payments, and the insurer's report confirming coverage. The court also concluded that, if a jury did not find a new contract had been formed and breached concerning the husband's coverage, there was enough evidence to conclude that promissory estoppel might apply to the insurer's representation of coverage. *Rice v. Metro. Life Ins. Co.*, No. 2-09-248-CV, 2010 WL 3433058 (Tex. App.–Fort Worth Aug. 31, 2010, no pet.).

After an insured was injured in a motor vehicle accident, she filed a claim for breach of contract against her insurer seeking uninsured/underinsured benefits. At trial, the insured did not introduce a copy of her policy into evidence but alleged that the policy introduced by her insurer was not her policy at the time. The policy introduced by the insurer showed a limit of $20,000. The jury awarded the insured an amount in excess of that policy limit, and the trial court rendered judgment for that amount. The court of appeals held that the trial court erred in awarding a judgment for breach of contract in excess of the $20,000 policy limits. The insured had the burden of proving she was protected by uninsured motorist coverage, and that the tortfeasor was at fault, was underinsured, and caused damages in excess of the amount recoverable from the tortfeasor. The insured failed to meet her burden of proof. She did not introduce a copy of her policy. She also did not introduce evidence of her settlement with the tortfeasor or the limits of the torteasor's insurance to show that the tortfeasor was an uninsured motorist. But because the insurer did not contest the coverage and provided evidence that the policy provided $20,000 in coverage, the insured was entitled to the $20,000 limit. *Mid-Century Ins. Co. of Tex. v. McLain*, No. 11-08-00097-CV, 2010 WL 851407 (Tex. App.–Eastland March 11, 2010, no pet.) (mem. op.).

A named insured drove a car that was owned by another person. The named insured and the owner were both listed on the automobile insurance declarations page as drivers who regularly operated any vehicles in their household. However, the owner lived with her mother, who was not a named insured and was not listed as a driver on the declarations page. The mother was in an accident involving her own car (not the insured car) but submitted an underinsured motorist claim to the insurer of the named insured and the owner. When the insurer denied coverage, the mother sued alleging she was a "covered person" under the policy. The policy defined "covered person" to include "you or any family member" and "any other person occupying your covered auto." The policy also defined "you" to mean the named insured and a resident spouse of the named insured. "Family member" meant a person who lived in the same household and was related to the named insured. The court held that the mother was not a covered person. She was not a named insured, she was not related to the named insured, and she was not occupying the covered car at the time of the accident. The fact that the insurer's agent knew that the owner owned the car and mistakenly listed the named insured instead did not matter in determining if a breach of contract occurred. There were no ambiguities in the policy, and the court was limited to ascertaining the parties' intent as reflected in the terms of the policy itself. The mother only brought a claim for breach of contract, and the evidence showed that the insurer did not breach the contract. *Williams v. State Farm Mut. Auto. Ins. Co.*, No. 06-09-00084-CV, 2010 WL 415408 (Tex. App.–Texarkana Feb. 5, 2010, no pet.) (mem. op.).

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

To recover for an insurance agency's negligence or DTPA violation for failure to procure a liability policy, a plaintiff must prove there was an available insurance policy that would have covered his liability for breach of contract. *Metro Allied Ins. Agency, Inc. v. Lin*, 304 S.W.3d 830 (Tex. 2009). Lin, an electrical engineer, needed a liability policy and performance bond to work on a government project, so he contacted Metro to obtain the coverage. He obtained a quote from Metro, which he contended would have provided coverage for the breach of contract claim

later asserted against him. The agency, Metro, acknowledged that it failed to procure a liability policy and that this failure was negligent, but Metro argued that the failure did not cause Lin any damages, because he failed to show there was any policy that could have covered his damages. The supreme court agreed. The court distinguished its prior decisions under the DTPA when the statute required proof that the consumer was "adversely affected." Those cases held that the consumer did not have to prove there was another policy that would have covered the loss. *See Parkins v. Tex. Farmers Ins. Co.*, 645 S.W.2d 775 (Tex. 1983). The court noted that the proof requirement changed and now a consumer must show that a deceptive practice is a "producing cause" of damages. Similarly, negligence requires proof that the conduct was a "proximate cause" of damages. Both causation standards require proof that the defendant's act be "a substantial factor in bringing about the injury and without which the harm would not have occurred." The court reasoned that, within this context, harm would have occurred only if the liability policy Metro agreed to procure would have actually covered the injury by suffered Lin.

The *Lin* court then examined the record to determine if there was any such evidence. The court found there was not. Lin testified that Metro's agent told him the liability policy the agent believed was issued would cover the claims. However, the court pointed to other evidence that the policy would include "standard CGL coverages," which would not cover breach of contract claims.

The court's analysis is flawed. According to the court, Lin testified that the agent told him the policy would cover the claim. The court cannot disregard that evidence in favor of contrary evidence by the agent. Based on Lin's testimony he was promised a policy that would cover the claim that later ensued. Further, it is well-settled that a plaintiff suing for breach of contract has a right to damages based on his expectation interest as measured by "the loss and the value to him of the other party's performance caused by its failure or deficiency[.]" *Restatement (2nd) of Contracts* § 347 (1981). As the Restatement explains: "Contract damages are ordinarily based on the injured party's expectation interest and are intended to give them the benefit of his bargain by awarding him a sum of money that will, to the extent possible, put him in as good a position as he would have been in had the contract been performed." *Comment* a. Texas recognizes these well-established measures of damages and has applied them in DTPA cases. *Formosa Plastics Corp. USA v. Presidio Eng'rs & Contractors, Inc.*, 960 S.W.2d 41, 49 (Tex. 1998); *Leyendecker & Assocs., Inc. v. Wechter*, 683 S.W.2d 369, 373 (Tex. 1984). Thus, when a defendant makes a misrepresentation, the plaintiff is entitled to recover damages based on what was lost because the statement was not true. In other words, Lin was entitled to recover the value of the policy Metro promised, even if no such policy existed. The fact that a defendant promises something it cannot deliver is no defense – it is a basis for liability. Given there was some evidence that Metro promised a liability policy that would cover Lin's loss, the court got it wrong.

Harm would have occurred only if the liability policy Metro agreed to procure would have actually covered the injury by suffered Lin.

Ironically, the court cited its prior decision in *Hearst v. Sears, Roebuck & Co.*, 647 S.W.2d 249 (Tex. 1983), in this discussion of causation. The court overlooked the holding in *Hearst* that impossibility of performance is no defense when a defendant promises to do something that cannot be done. *See Hearst*, 647 S.W.2d at 251. By that same reasoning, an insurance agency should be liable for promising to deliver a policy it cannot deliver.

In *State Farm Lloyds v. Page*, 315 S.W.3d 525 (Tex. 2010), the court held that the homeowners' policy did not cover mold damage to the dwelling but did cover mold damage to personal property, caused by a plumbing leak. After reaching this conclusion, the court held that, "When the issue of coverage is resolved in the insurer's favor, extracontractual claims do not survive. … There can be no liability under either Article 21.55 or Article 21.21 of the Insurance Code if there is no coverage under the policy." The court then concluded that the homeowners had no extracontractual claims with respect to their claim for damage to the dwelling, because there was no coverage, but remanded for consideration of their extracontractual claims with respect to the claim for personal property, because there was coverage. The court added, "Accordingly, to the extent Page's extracontractual claims are based on State Farm's denial of coverage for mold damage to her dwelling, they cannot survive."

The court's statement that there can be no liability under article 21.21 (now chapter 541) of the Insurance Code if there is no coverage is overly-broad. In the context of this case, as narrowed by the court's later statement, the statement is correct. If the extracontractual claim was based on the insurer denying the claim, once the court found the insurer properly denied the claim because there was no coverage, there could not be an unfair insurance practice claim based on the denial. However, the court has repeatedly held that an insurer may be liable under article 21.21 (now chapter 541) for a misrepresentation of coverage, precisely because there is no coverage under the policy. *See Royal Globe Ins. Co. v. Bar Consultants*, 577 S.W.3d 688 (Tex. 1979). The court's statement cannot be taken out of context, or it would be incorrect.

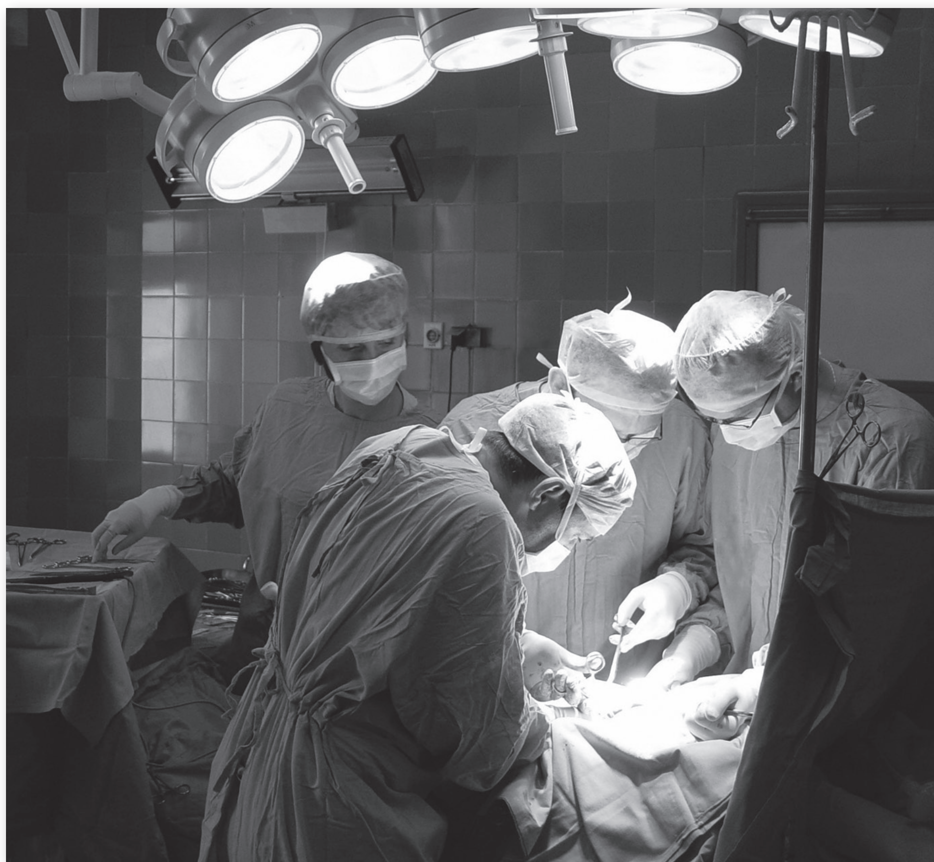
After finding that an insurer improperly denied a claim for damages caused by "forgery," the Fifth Circuit held that the trial court nevertheless properly dismissed the insured's extracontractual claims for "bad faith and violations of the Texas Insurance Code." *Great Am. Ins. Co. v. AFS/IBEX Fin. Servs., Inc.*, 612 F.3d 800 (5th Cir. 2010). The Fifth Circuit agreed with the district court's conclusion that the insurer was entitled to judgment as a matter of law on the insured's extracontractual claims "solely because [the insured] failed to plead and prove injuries separate from those that flowed from [the insurer's] breach of contract." The Fifth Circuit rejected the insured's argument that it did not need to prove a separate injury to maintain its extracontractual claims and that the denial of insurance proceeds, standing alone, entitled it to recover on its extracontractual claims. The court held this assertion did not comport with the prior decision in *Parkans Int'l, L.L.C. v. Zurich Ins. Co.,* 299 F.3d 514, 519 (5th Cir. 2002). In *Parkans* the Fifth Circuit held that "[t]here can be no recovery for extracontractual damages from mishandling claims unless the complained of actions or omissions caused injury independent of those that would have resulted from wrongful denial of policy benefits." Oddly, the Fifth Circuit rejected the insured's argument that it was entitled to attorney's fees incurred in separate litigation as damages, but held those attorney's fees "*may* provide the separate injury necessary to support AFS's claim that it is entitled to extracontractual damages for GAIC's alleged bad faith in violation of the Texas Insurance Code." The court then remanded to the district court to determine whether there was a basis for the extracontractual claim.

It is hard to follow the *AFS/IBX* court's reasoning that

the attorney's fees damages were not recoverable yet could be the separate injury. What is more troubling, and clearly incorrect, is the court's conclusion that a separate injury is required for an insured to recover for unfair insurance practices. The court correctly quoted its prior holding in *Parkans*, but misapplied it.

A number of cases have stated that there must be a separate injury for an insured to recover for unfair claims handling. This statement can be true when the insurer *does not* owe the claim. For example, in *Republic Ins. Co. v. Stoker*, 903 S.W.2d 338 (Tex. 1995), the supreme court found no coverage for the claim and held that the lack of coverage precluded liability based on allegations the insurer improperly failed to pay policy benefits. That holding makes perfect sense. If the insurer does not owe the claim, it cannot be liable for unreasonably failing to pay the claim. However, the *Stoker* court recognized that even when the insurer does not owe the claim, it could be liable, if in the course of handling the claim, the insurer committed an extreme act that caused "independent injury." *See also First Tex. Sav. Ass'n v. Reliance Ins. Co.*, 950 F.2d 1171 (5th Cir. 1992).

The statement that an independent injury is required is correct in that context, where the insurer *does not* owe the claim.



The policy benefits cannot be damages, because the policy benefits are not owed. Thus, if there is no independent injury then there is no basis for extracontractual liability.

The Fifth Circuit's decision in *Parkans* was another example of this principle properly applied. In *Parkans*, the court first found there was no coverage for the claim and then found there could be no extracontractual recovery for bad faith, because there were no injuries independent of the contract damages. Of course, since those contract damages were not recoverable, they could not serve as damages for the unfair insurance practices.

The *Parkans* court relied on the Texas Supreme Court's decision in *Provident American Insurance Co. v. Casteneda*, 980 S.W.2d 189, 198-99 (Tex. 1998). In *Provident*, the supreme court did state that there was no evidence of an independent injury, but it did so after concluding that the insurer was not liable for unfair settlement practices. In *Provident*, the insureds did not sue for breach of contract, so the court was not considering whether they could or could not recover contract damages. What the court did consider was that the insurer had a reasonable basis to deny the claim, even if it is was wrong. Obviously, a reasonable denial of the claim could not cause any damages. The court found no evidence to support the claim for loss of credit reputation, and then concluded that there was no other independent injury. This statement regarding an independent injury made some sense in *Provident*. The policy benefits could not be damages for an unfair claim denial, when the court found there was no unfair claim denial. In other words, the insurer was not liable because it had not committed a violation – according to the court – not because the benefits wouldn't be damages if the insurer had committed a violation.

Where the *Great American Insurance Co. v. AFS/IBEX* court got it wrong was to apply the independent injury requirement to a case where the insured *does* recover policy benefits. Under Texas law it is absolutely clear that when an insurer wrongfully withholds policy benefits, those benefits may be contract damages and may also be damages for the unfair insurance practice. The Texas Supreme Court expressly addressed this issue in the leading case of *Vail v. Texas Farm Bureau Mutual Ins. Co.*, 754 S.W.2d 129, 136 (Tex. 1988), rejecting the insurer's argument that damages for an unfair settlement practice had to be something more than the amount due under the policy. The supreme court held that damages for a wrongful refusal to pay are at least equal to the policy benefits, as a matter of law.

This language in *Vail* was bolstered by *Waite Hill Services, Inc. v. World Class Metal Works, Inc.*, 959 S.W.2d 182, 184-85 (Tex. 1998) (per curiam), where the court stated that the same damages under the contact were also tort damages.

The most common damages under the unfair insurance practices statute are the policy benefits. One of the more common causes of action is for failing to act in good faith to effectuate a prompt, fair, and equitable settlement once liability is reasonably clear. Further, the statute is to be liberally construed and allows recovery of "actual damages." It would be exceedingly odd for the legislature to create a cause of action that says recovery of "actual damages" is allowed for failing to settle once liability is reasonably clear, but to hold that the most common damages – policy benefits – were not recoverable and the insured had to establish some other bizarre "independent injury." The legislature could have done that, but the language it chose certainly does not disclose that it did. The supreme court's analysis and holding in *Vail* do not allow such a conclusion.

A trial court properly granted summary judgment on bad faith claims for an insurer denying a hail damage claim, where the insurer relied on the reports of two adjusters that there was little damage. *JM Walker, L.L.C. v. Acadia Ins. Co.*, 356 F.App'x 744 (5th Cir. 2009). Other appraisers later determined that five roofs were damaged, four roofs needed to be replaced, and the

total amount owed was $423,000. However, that was not proof that the insurer was unreasonable in relying on the earlier reports by the adjusters, absent evidence that the insurer was unreasonable to rely on those reports or that the experts were biased in favor of the insurer.

An insured's group life plan stipulated that it would cease providing coverage for her husband on the date she retired. However, for over two years after the insured's retirement, the insurer continued to bill and accept premium payments for both her and her husband's coverage. When the insurer learned that it had billed the insured for her husband's coverage after the insured's retirement, the insurer cancelled the husband's coverage retroactively and initially refused to refund premiums. The insured and her husband sued the insurer, alleging various claims including DTPA claims of false, misleading, or deceptive acts, and unconscionability. The court of appeals reversed summary judgment for the insurer. The court held that the insurer's prolonged acceptance of premiums created a fact issue regarding whether the insurer engaged in false, misleading or deceptive acts because it misrepresented that all of the terms of the insured's original policy, including her husband's coverage, would be continued if she elected to do so. Similarly, the court held that a fact issue existed to support the unconscionability claim because the evidence showed the following: the insurer represented that the husband had coverage when the insured did not know he did not have such coverage; the insurer accepted premiums for over two years and did not refund them until the insured filed a motion for new trial; the insurer never sent written notice of termination of the husband's coverage when it said it would; the insurer told the insured that an agent would contact her about purchasing a personal policy for the husband and failed to do so; and the insurer left the insured without an opportunity to obtain coverage for her husband. *Rice v. Metro. Life Ins. Co.*, No. 2-09-248-CV, 2010 WL 3433058 (Tex. App.–Fort Worth Aug. 31, 2010, no pet.).

A steel processor, Port Metal, stored a customer's steel in its warehouse. The warehouse burned down, and the customer, Omni, lost all of its steel. Port Metal's insurer denied coverage for damages to Omni's steel, invoking an exclusion in the bailee policy for goods stored at Port Metal for over sixty days, for which Port Metal received a storage fee. The denial was contrary to assurances from the agent that Omni's steel would be insured under Port Metal's policy. Omni sued the insurer and Port Metal's insurance agent for negligent misrepresentation and violations of the DTPA and former article 21.21. *Brown & Brown of Tex., Inc. v. Omni Metals, Inc.*, 317 S.W.3d 361 (Tex. App.–Houston [1st Dist.] 2010, pet. filed). The court held that the evidence was legally and factually sufficient to sustain the jury's findings that the insurer and agent had misrepresented the policy's coverage and violated the DTPA and article 21.21. The agent knew of the storage fee exclusion and the fact that Port Metal was receiving a storage fee from Omni, and yet did not disclose the exclusion to either Port Metal or Omni. Instead, the agent told Port Metal's president that the exclusion did not apply to the steel stored at Port Metal, and Port Metal's president conveyed this information to Omni. The agent also created a false impression of coverage by disclosing in a certificate of insurance only that Port Metal had an "all risk" bailee policy. The agent did so even though he knew that Omni was relying on the representation of coverage by providing the certificate of insurance to its lender as evidence that its steel was insured. The agent did nothing to inform Port Metal or Omni of the exclusion. The court also held that, as a customer of an insured, Omni had no legal duty to read Port Metal's insurance policy or to verify its terms in order to maintain its suit for misrepresentation and violations of the DTPA and under article 21.21 of the Insurance Code.

A court of appeals granted an insurer's petition for writ of mandamus, holding that the trial court abused its discretion by denying the insurer's motion to abate an insured's suit for violations of the DTPA and the Insurance Code where the insured's notice letter failed to provide specific factual allegations supporting his causes of action and failed to specify the damages sought. *In re Liberty Mut. Fire Ins. Co.*, No. 14-09-00876-CV, 2010 WL 1655492 (Tex. App.–Houston [14th Dist.] Apr. 27, 2010, orig. proc.) (mem. op.).

The court held in *Cool Partners, Inc. v. Admiral Ins. Co.*, No. 02-30446-HDH-7, 2010 WL 1779668 (N.D. Tex. April 30, 2010), that an excess insurer did not have the right to sue the primary insurer for violations of the Texas Insurance Code. The court noted that it was reluctant to expand the right to sue based on misrepresentations regarding an insurance policy to those beyond individuals in privity of contract with the insurer or those with a direct relationship to the insurance company, such as health care providers. The court stated that Texas courts generally do not recognize direct duties owed by a primary to an excess carrier. Therefore, the court held that the direct claims asserted against the primary carrier were not available to the excess carrier.

Texas courts generally do not recognize direct duties owed by a primary to an excess carrier.

An insurer had a reasonable basis to suspect the insureds were involved in the theft and burning of their vehicle, so summary judgment on the claims for common law bad faith and statutory unfair settlement practices was justified. *Nunn v. State Farm Mut. Auto Ins. Co.*, No. 3:08-CV-1486-D, WL 2573213 (N.D. Tex. June 23, 2010). Although the insureds claimed the vehicle had been stolen, the court found the insurer had a reasonable basis for suspicion because the vehicle could not be moved without keys that were in the possession of the insureds, there was no sign of forced entry, the vehicle had not been stripped, and the insureds delayed giving statements to the insurer.

The *Nunn* court also rendered summary judgment on claims for failing to conduct a reasonable investigation, finding the evidence showed that the insurer had conducted a reasonable investigation. The insurer did not have a duty to "leave no stone unturned," and could reasonably have not investigated other suspicious people because there was no evidence of forced entry, the insured's ex-husband who might be suspicious lived in Virginia at the time of the alleged theft, and the insured told the investigator that she had no enemies and knew of no suspects.

The insured also argued that the insurer should be liable for denying the claim without a reasonable basis and for misrepresentations based on the insurer's insistence that the driver submit to an examination under oath. The insured argued that the driver, his daughter, was not "a person seeking coverage" in the policy and thus was not required to give an EUO. The court reasoned that even if the insured's position was correct, the insurer's position was not unreasonable. Further, the insured himself was required to give an examination under oath, but had refused to do so for sixteen months.

C. Prompt Payment of Claims

A court properly awarded penalties after a life insurer failed to pay benefits within sixty days, where the beneficiary recovered benefits, even though the insured's breach of contract

claim was dismissed. *Federated Life Ins. Co. v. Jafreh*, No. 09-20859, 2010 WL 3278362 (5th Cir. Aug. 18, 2010). The insurer filed a declaratory judgment suit seeking to void a life insurance policy based on an argument that the insured misrepresented his condition. The beneficiary counterclaimed for breach of contract and bad faith, but the district court dismissed these claims because the beneficiary was not the personal representative or executor of the estate and did not have capacity to bring those claims. The district court later awarded the policy benefits to the insured and penalties under Tex. Ins. Code section 542.060(a).

The insurer argued that there should be no penalty because "this contingent penalty exists as part and parcel of a claim for breach of contract and springs from the carrier's ultimate liability under the policy." The court rejected this argument because the insurer failed to raise it in the district court. However, the court went on to note "that the statutory language seems to require just a 'breach' of the statutory obligation, regardless of whether there is a cause of action for breach of the policy."

Even though the court's decision arises in the context of an insurer owing the policy benefits, the court's language clearly notes that liability under the statute is independent of liability for breach of contract. This supports the argument that an insurer that violates the prompt payment statute may owe the claim, even if it would not owe the claim under the contract. *See generally* Mark L. Kincaid & Christopher W. Martin, *Texas Practice Guide: Insurance Litigation,* 17:43 (West 2010).

The court held that acting in good faith is not a defense to violations of the prompt payment of claims statute.

The court in *Great American Ins. Co. v. AFS/IBEX Financial Servs., Inc.*, 612 F.3d 800 (5th Cir. 2010), held that the statutory penalty continues to accrue only until the date of judgment, relying on the supreme court's decision in *Republic Underwriters Ins. Co. v. Mex-Tex, Inc.*, 150 S.W.3d 423 (Tex. 2004). It is true that is what the supreme court said in *Mex-Tex*, but the statement was dicta and should not be the law. The issue in *Mex-Tex* was the amount of the "claim" subject to the penalty. The court's holding was that when an insurer unconditionally tenders partial payment, the penalty accrues on the remaining unpaid part of the "claim." The court reasoned that, "This encourages insurers to pay the undisputed portion of a claim early, consistent with the statute's purpose 'to obtain prompt payment of claims made pursuant to policies of insurance.'" 150 S.W.3d at 426. The court later concluded that the penalty should accrue from the date the insurer tendered partial payment "to the date of judgment." *Id.* at 427-28. However, the statement that the penalty accrued until the date of judgment was not in response to any point raised by either party as to when the penalty should end. The supreme court simply put the date of judgment as the end date, because that had been the end date used by the parties and the courts below. No party disputed that end date.

In a case where the issue is raised, the court should conclude, for the same reasons set forth in *Mex-Tex*, that the penalty continues to accrue until the judgment is *paid*. In *Mex-Tex*, the court ended the penalty on the portion that the insurer paid, to "encourage[] insurers to pay the undisputed portion of a claim early, consistent with the statute's purpose 'to obtain prompt payment of claims made pursuant to policies of insurance.'" This same purpose is served by allowing the penalty to continue to accrue when the adjudicated portion of the claim remains unpaid – that is, until the claim is paid, not merely until the date of judgment. If an insurer must pay the penalty when it is disputing the claim, which it must, then certainly the insurer should have to pay the penalty once its position has been rejected and the claim reduced to judgment. Given that the purpose of the statute is to encourage payment of the claim, continuing to accrue the penalty serves that purpose.

A court found a fact question regarding whether an insurer reasonably believed it would need the insured's statement to investigate an alleged auto theft, where the insurer failed to request that statement within the initial fifteen-day deadline after receiving the claim. The insurer asked for other information by the deadline, but failed to request the insured's statement. The court reasoned that the insurer could request additional information after the deadline if it did not believe prior to the deadline that it reasonably needed the statement. *Nunn v. State Farm Mut. Auto Ins. Co.*, No. 3:08-CV-1486-D, 2010 WL 2573213 (N.D. Tex. June 23, 2010).

The *Nunn* court also found a fact question whether the insurer violated the statute by denying the claim more than thirty days after receiving all evidence necessary to secure proof of loss. The insured argued that the insurer had everything it needed by the time it had concluded the car was not in fact stolen. The insurer argued that it did not have all the required information until after it got a statement from the insured some eighteen months later, or after it received certain bank records.

An insured property management company reported a loss to its insurer on five properties that were damaged by Hurricane Ike. The insurer did not dispute that it was liable for at least a portion of the claims. However, the insured sued the insurer because it did not pay the claims until after the expiration of the statutory deadlines under the Texas Insurance Code. The insurer argued that it acted in good faith to process the claim and keep the insured informed. The court held that acting in good faith is not a defense to violations of the prompt payment of claims statute, and found that the insurer was liable for statutory interest and attorney fees. *Phila. Indem. Ins. Co. v. C.R.E.S. Mgmt., L.L.C.*, No. H-09-1032, 2009 WL 5061805 (S.D. Tex. Dec. 15, 2009).

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

The San Antonio Court of Appeals found no evidence that a worker's compensation insurer acted in bad faith in *Durst v. Tex. Mut. Ins. Co.*, No. 04-09-00430-CV, 2010 WL 3332198 (Tex. App.–San Antonio Aug. 25, 2010, no pet.) (mem. op.). An employee obtained worker's compensation benefits and then sued the insurer for bad faith handling of his claims, asserting that the insurer did not have a reasonable basis to dispute his claim of an aggravation of a pre-existing back condition. The employee sought to have a back surgery recommended by his doctor. However, the insurer determined the surgery was unrelated to the workplace accident and denied coverage, based in part upon the medical opinion of another doctor who had reviewed the employee's medical records. The insurer argued that its denial of benefits was reasonable because the evidence demonstrated that there was a bona fide coverage dispute. In support of its position, the insurer presented evidence of conflicting medical opinions, as well as evidence that the opinions on which it relied were "not so outside the medical norm as to be a sham." The employee argued that the opinions relied upon were biased and not medically reasonable, and presented evidence that the doctor the insurer relied upon had received monetary payments from the insurer, had a general

professional view that the surgery sought was not appropriate for the employee's condition, was generally conservative regarding treatment, and had previously denied requests for the surgery.

In affirming summary judgment for the insurer, the court of appeals noted that of the seven doctors evaluating the employee's injury, three supported the employee's position, and four supported the insurer's. The conflicting medical evidence showed a genuine factual dispute regarding the extent of the employee's injury, constituting a bona fide dispute of coverage to negate bad faith. Because of the conflicting medical opinions on each side, the only way the employee could avoid summary judgment was to present evidence to raise a fact issue as to whether the insurer's denial was based on a non-objective, sham expert opinion. The court held that the employee failed to do so. The five independent doctors reviewing the file stated that the insurer's doctor's opinion was medically reasonable and within medical norms. The employee's doctor never stated that the insurer's doctor's opinion was not medically reasonable, only that he disagreed with it. Accordingly, the insurer could rely on those opinions in good faith.

E. ERISA

An insurer did not abuse its discretion in denying a claim for accidental death benefits for a person killed while operating a motorcycle with a blood alcohol level three and one-half to four and one-half times the legal limit, where the policy defined "covered accident" as a "sudden, unforeseeable, external event." The court found the insurer's interpretation of "unforeseeable" was consistent with the term's plain meaning, in concluding that a serious accident was a foreseeable consequence of riding a motorcycle while the driver was that intoxicated. *Davis v. Life Ins. Co. of N. Am.*, No. 09-50853, 2010 WL 2102040 (5th Cir. May 26, 2010).

Determination of an insured's benefits was an abuse of discretion even though the insurer relied on opinions of four doctors, where those opinions were inconsistent and unsupported by any concrete evidence. *Scheuermann v. Unum Life Ins. Co. of Am.*, No. 08-51106, 2010 WL 2725408 (5th Cir. July 6, 2010). The employee's doctors had performed six surgeries on his back, but he continued to have severe pain. His doctors found that he was disabled and was unable to perform the duties of any gainful occupation for which he was reasonably fitted by education, training, or experience. The district court found the insurer had not abused its discretion, but the Fifth Circuit reversed that holding and rendered judgment for the employee. One doctor relied on by the insurer merely stated that he disagreed with the employee's treating physician, but never expressed the opinion that the employee was not disabled under the policy definition. The second doctor relied on by the insurer had changed his opinion, even though he lacked information he said was necessary and even though there was no factual basis for him to change his opinion. That doctor's initial opinion was that the employee was disabled and might qualify for light duty work after rehabilitation and pain management, which never occurred. The third doctor's report had clear errors in his description of the employee's condition and also did not state that the employee was disabled. The fourth doctor relied on the mistaken facts asserted by the third doctor and added his own wrong fact that the employee had three surgeries, instead of six. The court concluded that the insurer's decision was not "based on evidence, even if disputable, that clearly supports the basis for its denial."

An administrator did not abuse its discretion by finding an employee was no longer totally disabled, where a doctor and vocational specialist both concluded that she was able to perform certain jobs, despite her chronic back pain, and where she had in fact returned to work part time. *Cooper v. Hewlett-Packard Co.*, 592 F.3d 645 (5th Cir. 2009). The court held the worker was not denied meaningful review by the administrator changing the basis for its denial. The administrator originally denied the claim because she could work and later denied the claim because she was working. The majority concluded these were different facets of the same reason, not a change in the basis for denial. One judge dissented from this holding.

An insurer did not abuse its discretion by finding that an insured's death while engaged in autoerotic asphyxiation was excluded as an "intentionally self-inflicted injury." The plan documents gave the insurer discretionary authority, and the court found no abuse of discretion, based on circumstantial evidence that the insured intentionally engaged in a high risk activity. The court also found that the trial court erred by excluding from the record a doctor's report relied on by the insurer, even though the insurer did not disclose it as required by the plan, where the insured's beneficiary got the record as part of litigation and could not have appealed the denial administratively after learning of the doctor's report. *Thompson v. Sun Life Assurance Co.*, 354 F.App'x. 183 (5th Cir. 2009).

In *Harwood v. Unicare Life & Health Ins. Co.*, No. SA-09-CV-0845-OG-NN, 2010 WL 1641273, *2-3 (W.D. Tex. April 19, 2010), the court held that a husband, who paid for his former wife's medical treatment because her health care provider had denied coverage, was entitled to bring a claim under ERISA for repayment, because his former wife had assigned her claim to him.

F. Other Theories

The estates of passengers killed in an automobile accident sued State Farm for negligence and strict products liability. Prior to the accident State Farm had owned the vehicle the passengers were travelling in and sold it for salvage at an auto auction. A repair shop purchased the vehicle at the auction, restored

it, and sold it. The passengers' estates argued that State Farm failed to inspect and warn subsequent passengers of the salvage-titled car and its safety, and suitability for repair. The court found that State Farm complied with the regulatory requirements associated with selling salvage-titled cars and had no further duty to inspect or warn subsequent purchasers of the dangers associated with those types of cars. *Leal v. State Farm Mut. Auto. Ins. Co.*, No. 04-09-00308-CV, 2010 WL 962286 (Tex. App.–San Antonio March 17, 2010, no pet.)(mem. op.).

IV. AGENTS, AGENCY, AND VICARIOUS LIABILITY

A. Individual liability of agents, adjusters, and others

An insured purchased insurance through its agent, who obtained coverage using a surplus lines insurance agency. The surplus lines insurance agency used a broker that obtained insurance for the insured through Lloyds. When the insured suffered a loss that was not covered under the policy, it sued the agent, who then sued the broker and surplus lines agency. The court held that the agent provided sufficient facts to state a claim under Texas Insurance Code section 541.060(a)(1) since he had alleged that the broker represented that a "blanket policy" was issued to the insured, when in actuality the policy was not a "blanket policy." Because the agent provided sufficient allegations to suggest an entitlement to relief, the court denied the motion to dismiss. *Lake Texoma Highport, L.L.C. v. Certain Underwriters at Lloyd's of London*, No. 4:08-CV-285, 2010 WL 1416683 (E.D. Tex. March 4, 2010).

The court granted the motion to dismiss as to the agent's DTPA claim, finding that the agent did not qualify as a "consumer," because he did not purchase or lease any goods or services from the broker and was not covered by the policy. The court also granted the motion as to violations of sections 541.060(a)(2)-(5) of the Insurance Code, because the plain language of those subsections focus on the duties or acts of an insurer, and the agent did not allege that the broker was an insurer. The court also granted the motion as to the breach of contract claim. The agent argued that he was a third party beneficiary of a contract between the broker defendant and another broker. The court determined that the agent did not allege the existence of a contract between those entities and, even assuming a contract, the agent failed to plead sufficient facts to show he had third party beneficiary status.

An out-of-state plaintiff bought property insurance from an agent. After her property was damaged by a storm, she hired a contractor to make repairs. She had worked with the contractor previously and had given him a key to the building. When the plaintiff later came to inspect the building, she found that it had been vandalized and her personal property had been stolen. The insurer paid the storm damage, but denied the plaintiff's claim as to the theft and vandalism, citing an exclusion for such coverage if the building had been vacant for more than sixty days. The plaintiff sued her agent for misrepresenting the policy to her and for negligence in selecting it, since the agent knew the building would be vacant. The agent argued he had no liability because the insurer could have denied the plaintiff's theft and vandalism claim under a different exclusion for dishonesty, rendering any negligence harmless. The district court agreed with the agent. The dishonesty exclusion barred coverage for dishonest or criminal acts "by anyone to whom [the insured] entrusted the property for any purpose." The court found this exclusion would apply because the plaintiff believed that the contractor had vandalized the building and stolen her personal property and because the plaintiff had entrusted the contractor with the property by giving him the key. Because this exclusion would have applied in addition to the vacancy exclusion, any negligence by the agent with regard to the vacancy exclusion did not cause the plaintiff's harm. *Wagner v. Edemnify, L.L.C.*, No. 4:08-CV-299, 2009 WL 5062058 (E.D. Tex. Dec. 16, 2009).

B. Other

The insurance company in *Farmers Insurance Exchange v. Hudson*, No. 09-09-00297-CV, 2010 WL 1806660 (Tex. App.–Beaumont May 6, 2010, no pet.) (mem. op.), fired an agent for "switching" – the act of replacing one company's policy with another company's policy while the first policy remains in force and remains eligible to be written by the first insurance company. The agent sued the insurance company for wrongful termination, stating that underwriting had become stricter at Farmers, which was why he was screening more carefully the applicants that he put with Farmers. He was also unaware that this particular insured was currently insured with Farmers at the time he rewrote the policy. The court held that the insurance company breached the agency agreement when it terminated the agency.

V. THIRD PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile liability insurance

In *Amerisure Insurance Co. v. Navigators Insurance Co.*, 611 F.3d 299 (5th Cir. 2010), the court considered whether several exclusions applied under a commercial automobile-liability insurance policy. Satterfield and Clanton, both of whom were employees of Texas Crewboats, were severely injured when the driver, Sylvester, fell asleep and caused the vehicle to veer off the road and flip over. Sylvester had been driving the two to the location of their employer's boat.

Amerisure had the primary policy, and Navigators had the excess policy. They settled the injured workers' claims, with Amerisure paying $1 million and Navigators paying $1.35 million. Amerisure contended that it did not owe coverage and sought to recover from Navigators the $1 million, claiming contractual subrogation. The Fifth Circuit held that Amerisure could pursue its claim (this holding is discussed elsewhere) and then considered whether Amerisure established there was no coverage

under its policy. The first exclusion was for any obligation that the insured or insured's insurer may have under a worker's compensation or similar law. The court concluded this exclusion did not apply, because suit was brought against Texas Crewboats under the Jones Act, which the court concluded was not a law that was similar to worker's compensation. The exclusion would not apply to Sylvester, either, because he was not the worker's employer.

The exclusion next asserted was for "employee indemnification and employer's liability," and it excluded coverage for bodily injury to an employee of an insured arising out of and in the course of employment, but the exclusion did not apply to bodily injury to domestic employees. The court found this exclusion would preclude coverage for Texas Crewboats, as employer of the two workers, but would not preclude coverage for Sylvester, because he was not their employer. Navigators argued that an exception to the exclusion applied, for "domestic employees," and argued this meant employees who work in the United States, not just "butlers and chambermaids." The court rejected this interpretation and found the exception to the exclusion did not restore coverage.

Finally, the court considered the "fellow employee" exclusion, which barred coverage for bodily injury to any fellow employee of the insured arising out of and in the course of the fellow employee's employment. The court held this exclusion would not apply to Texas Crewboats because it was the workers' employer, not their fellow employee.

With respect to Sylvester, the court considered two more issues. First the court held that the injuries did arise in the course of the employees' employment, concluding that when Texas Crewboats hired someone to pick up its workers and pay for their transportation, and paid for their time while in transit to get them to the location of its vessel, that was within the course of their employment with respect to that vessel. The second question was whether Sylvester was the workers' "fellow employee." The court found conflicting evidence on whether Sylvester was an employee of Texas Crewboats or was an independent contractor, so the court remanded for determination of that issue.

B. Commercial general liability insurance

A contractor's liability policy did not cover its contractual liability for flooding an adjoining property, where the contractor was otherwise immune from liability because of governmental immunity. *Gilbert Tex. Constr., L.P. v. Underwriters at Lloyds, London*, 53 Tex. Sup. Ct. J. 780, (Tex. June 4, 2010). Gilbert Construction contracted with the Dallas Area Rapid Transit Authority to construct a light rail system. An adjoining property owner sued after its building was flooded, contending that was caused by Gilbert's work. Gilbert successfully moved for summary judgment on all liability theories, except breach of contract, because it was working for a governmental entity and it was therefore protected by governmental immunity. The breach of contract theory was based on Gilbert's agreement with DART that it would protect adjacent property from damage. The adjacent property owner contended that it was a third party beneficiary of that contract.

After Gilbert settled the claim for $6 million, Underwriters denied coverage. The supreme court upheld the denial based on an exclusion in the policy for contractual liability, which excluded liability for damages "by reason of the assumption of liability in a contract or agreement." The court rejected Gilbert's argument that this exclusion only applied to contracts assuming liability of third parties. The court found the plain language would not support this meaning.

The court also found that an exception to the exclusion did not apply. The policy contained an exception to the contractual liability exclusion if the insured would otherwise be liable. The court reasoned that because Gilbert avoided liability on every theory except breach of contract, it was not "otherwise liable" and therefore the exception did not apply.

The pollution exclusion barred coverage for an insured who allegedly loaded waste paper into a trailer contaminated with fertilizer, resulting in injuries to persons who later unloaded the contaminated paper. *Standard Waste Systems, Ltd. v. Mid-Continent Cas. Co.*, 612 F.3d 394 (5th Cir. 2010). The court reasoned that the insured, which was alleged to have loaded the scrap paper into a trailer already contaminated with fertilizer, was alleged to be the source of the pollution, which barred coverage under an exclusion for damages arising out of the release or escape of "pollutants," including waste materials.

A liability insurer had no duty to defend or indemnify an insured that manufactured defective plastic chambers to be used in water heaters, where the insured intentionally under-heated the plastic and the resulting damage was highly probable. In an exhaustive opinion detailing numerous Texas authorities on what is and is not an "accident," the court concluded there was no covered "occurrence," because the acts were not an accident. *Nat'l Union Fire Ins. v. Puget Plastics Corp.*, No. B-05-050, 2010 WL 3362117 (S.D. Tex. Aug. 25, 2010).

Where an insured performed work at a refinery to repair a reactor, damage caused by the insured was excluded as "your work" but was not excluded as "your product." *Am. Home Assur. Co. v. Cat Tech, L.L.C.*, 717 F.Supp.2d 672 (S.D. Tex. 2010). The court found that the exclusion for "your work" included materials, parts, and equipment furnished in connection with such work. An arbitration panel found the insured caused damage to the parts of the reactor on which it performed its faulty work. This fit within the exclusion for damage to the insured's work.

However, the court found the exclusion for "your product" did not apply. That exclusion excluded coverage for property damage to "your product" arising out of it or any part of it. The policy further provided that "your product" is defined as "any goods or products other than real property, manufactured, sold, *handled*, distributed or disposed of by … you[.] (Emphasis added). The insurers argued that the insured "handled" the parts of the reactor that were damaged. The court rejected this argument, finding under the doctrine of *noscitur a sociis* that the word "handled" had to mean something similar to "manufactured, sold, distributed, or disposed of." Thus the word "handled" did not mean to touch, but meant "to deal or trade in." It was undisputed that the insured did not deal or trade in the parts that were damaged.

A subcontractor built a roof on a Home Depot, which two years later was determined to be defective. *N. Am. Roofing Servs. v. Nat'l Trust Ins. Co.*, No. G-08-038, 2010 WL 723781, *4 (S.D. Tex. Feb. 25, 2010). The subcontractor was supposed to maintain a CGL policy and name the contractor as an additional insured. After Home Depot sued, the contractor settled and looked to the subcontractor's insurer for indemnity. However, the court held the subcontractor's insurer was not liable because, under the policy, the contractor ceased to be an additional insured under the policy once the work was completed.

In *Markel Ins. Co. v. S.T.C.G.*, No. 4:08-CV-758-Y, 2010 WL 3283051, *7 (N.D. Tex. Aug. 19, 2010), the court held that the insurer of a gymnastics facility did not owe the insured a duty to defend or indemnify in a suit for injuries sustained by one of the employees at the facility. The court found the claim arose under Texas workers' compensation law, and that the policy specifically excluded any such obligation. There was also an exclusion for any expenses for bodily injury to a person hired to do work for the insured.

The court in *David Lewis Builders, Inc. v. Mid-Continent*

Casualty Co., No. 4:09-CV-218-A, 2010 WL 1286544, *8 (N.D. Tex. April 1, 2010), held that a builder was not entitled to coverage for a claim brought by a homeowner for foundation damage. An exclusion stated that the insurance did not apply to "property damage to that particular part of real property on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if the property damage arises out of those operations." The construction problem the homeowners complained of was specifically excluded under this provision.

A policy did not cover "defective installation" of air conditioning duct work that required the ducts be replaced. The policy covered "property damage" caused by "an occurrence." While there was a fact question regarding whether the damage arose from an "occurrence," the court determined that the damages were not covered as "property damage" within the meaning of the policy, because there was no allegation or evidence that the ducts caused damage to the building, only that the ducts themselves were defective. Even if damage fell within coverage, an exclusion for "property damage to 'your product'" applied. That exclusion barred coverage for damage to "any goods or products . . . sold [or] handled" by the insured, which was the case here. *Building Specialties, Inc. v. Liberty Mut. Fire Ins. Co.*, 712 F.Supp.2d 628 (S.D. Tex. 2010).

C. Directors & officers liability insurance

The Fifth Circuit held, in an appeal arising from the Stanford "Ponzi" scheme, that the directors' and officers' liability insurers were required to advance defense costs until there was a judicial determination that the executives were "in fact" guilty of conduct within the broad policy definition of "money laundering." *Pendergest-Holt v. Certain Underwriters at Lloyds of London*, 600 F.3d 562 (5th Cir. 2010). The court found the definition of "money laundering" was broad enough to include taking money as part of a Ponzi scheme. The exclusion was subject to an exception that provided that the insurers would pay defense costs "until such time that it is determined that the alleged act or alleged acts did in fact occur." Once there was such a determination, the executives would be required to reimburse the insurer for defense costs that were advanced.

The insurers argued that they got to make the determination that money laundering had in fact occurred, and they had made such a determination based on a guilty plea by a co-conspirator, a Securities and Exchange Commission investigation, an audit by a forensic accountant, and other evidence. The executives argued that the determination had to be made judicially, not unilaterally by the insurer. The court ruled for the executives.

The court then considered whether the determination had to be made in the criminal proceeding against the executives or whether the determination could be made in a parallel civil proceeding by the insurers. The court contrasted the fraud exclusion, which would deny coverage only after a "final adjudication" of fraud. The court found that language required the determination be made in the same civil or criminal proceeding where the allegations were made against the insureds. In contrast, the court concluded that the language of the money laundering exclusion, allowed for a parallel coverage action by the insurers to seek a determination that money laundering had "in fact" occurred.

The court also considered what standard the district court would apply in making such a determination. The executives had argued that the court should apply the "eight corners" rule and base the determination solely on the allegations in the complaint and in the language of the policy, without regard to extrinsic evidence. They relied on duty to defend cases. The court noted that the insurers had no duty to defend, only a duty to advance defense costs. The court did not have to decide whether the eight corners rule would apply in such cases, because here the policy language as construed by the court expressly required a determination "in fact," which necessarily required consideration of extrinsic evidence.

The court further concluded that any determination of coverage would remain subject to reconsideration if the criminal proceeding determined that the executives were not guilty. Thus, the trial court in the coverage suit could determine that money laundering in fact did occur, so there was no coverage, and then that decision would be displaced if the other court trying the criminal case reached the opposite conclusion. The court remanded the case for such a coverage determination by a different judge than the one who would decide the criminal case.

D. Employers' liability insurance

Negligence claims against an employer that did not subscribe to worker's compensation were not excluded as obligations of the insured under any worker's compensation or similar law. *Am. Int'l Specialty Lines Ins. Co. v. Rentech Steel, L.L.C.*, 620 F.3d 558 (5th Cir. 2010). The employer's liability policy contained a "various laws" exclusion that excluded coverage for any "obligation of the Insured under … any workers' compensation, disability benefits, or unemployment compensation law, or any similar law." The insurer argued, unsuccessfully, that the negligence claims against the nonsubscribing employer nevertheless were obligations under the Texas worker's compensation law. The court rejected this argument, based on the plain language of the statute, which does not create an obligation for a nonsubscribing employer, but merely defines and limits certain defenses. The court found this conclusion was also supported by other decisions of the Texas Supreme Court on related issues. In *Kroger Co. v. Keng*, 23 S.W.3d 347 (Tex. 2000), the Texas Supreme Court stated in dicta that a negligence claim against a nonsubscriber is modified by the Worker's Compensation Act but remains a claim in common law. In *Fairfield Ins. Co. v. Stephens Martin Paving, L.P.*, 246 S.W.3d 653 (Tex. 2008), the court held that the same employer's liability policy exclusion did not exclude claims for gross negligence for nonsubscribers. The Fifth Circuit also found its conclusion was supported by other decisions, and overruled the contrary decision in *Illinois National Ins. Co. v. Hagendorf Construction Co.*, 337 F.Supp.2d 902 (W.D. Tex. 2004).

Negligence claims against an employer that did not subscribe to worker's compensation were not excluded.

In contrast, the court of appeals reached the opposite conclusion in *Robertson v. Home State County Mutual Insurance Co.*, No. 2-08-280-CV, 2010 WL 2813488 (Tex. App.–Fort Worth, July 15, 2010, no pet.).

E. Executive & Organization liability insurance

An insurer was not obliged to pay as a "loss" severance benefits that an executive had to return to the bankrupt company as a fraudulent transfer. *Trans Tex. Gas Corp. v. US Bank Nat'l Ass'n*, 597 F.3d 298 (5th Cir. 2010). The court held that the return of funds due to a fraudulent transfer is in the nature of restitution and is not a "loss." The court agreed that "a 'loss' within the meaning of an insurance contract does not include the restoration of an ill-gotten gain."

F. Excess insurance

Where a primary liability policy excluded coverage for "loss of hole" – that is, loss of gas reserves because a well was improperly plugged – the excess policy also would not provide coverage. *Delta Seaboard Well Servs., Inc. v. Am. Int'l Specialty Lines Ins. Co.*, 602 F.3d 340 (5th Cir. 2010). The court rejected as unreasonable the insured's argument that the excess policy applied because it contained a more general description of a primary policy. The court found that the policy unambiguously referred to the actual primary policy, which contained the exclusion. The excess policy had a "follow form" endorsement that made the exclusion applicable to the excess coverage also. Even though the excess policy had a "sunrise" endorsement that extended the potential dates for occurrences, that did not expand coverage beyond the "loss of hole" exclusion.

G. Additional insureds

An indemnity agreement between a landlord and tenant was void under the "express negligence" doctrine because it did not give fair notice. However, the court held that the provision requiring the tenant to provide liability insurance for the landlord's negligence was a separate obligation and was valid to make the landlord an additional insured under the tenant's policy. *Travelers Lloyds Ins. Co. v. Pac. Employers Ins. Co.*, 602 F.3d 677 (5th Cir. 2010). As a result, the tenant's insurer was obligated to share a portion of the defense and settlement costs for a claim brought by a person injured on the property.

VI. DUTIES OF LIABILITY INSURERS

A. Duty to defend

A liability insurer had a duty to defend a suit alleging that a contractor was liable for approving drilling plans (which might be excluded as a professional service) and for failing to use ordinary care in drilling (which would be liability apart from any professional services), despite an exclusion for liability "arising out of" professional services. *Willbros RPI, Inc. v. Continental Cas. Co.*, 601 F.3d 306 (5th Cir. 2010). The court noted that the contractor could be liable for its drilling work, even if there was no liability for professional services related to the plan. Thus, the claims were separate and independent, so that the professional services exclusion did not negate the duty to defend.

In contrast, in *Admiral Insurance Co. v. Ford*, 607 F.3d 420 (5th Cir. 2010), the court found the professional services exclusion encompassed all of the insured's conduct so that the insurer had no duty to defend. The court reasoned that the insured was hired as an "oil and gas consultant" to create a drilling print plan for an oil well and then consult and assist in the drilling of the well. After the well had a blowout and the insured was sued for his failure to perform an adequate and competent drilling operation, the court concluded that all of these allegations fit within the professional services exclusion, even though certain aspects of the services might involve menial tasks.

Before deciding that the insurer had a duty to defend, the *Ford* court had to determine the scope of the exclusion. The insurer provided $50,000 worth of coverage for the insured's professional liability and $1 million for the insured's general liability. The CGL policy had an exclusion for property damage "due to the rendering or failure to render any professional service." The exclusion contained as the description of professional services "all operations of the insured." The insured argued that the exclusion for professional services was so broad that it would encompass all of the insured's operations, making the general liability coverage illusory, and therefore making the exclusion void. While the district court agreed, the court of appeals disagreed. The appellate court held that under Texas law the *description* of "professional services" does not necessarily determine the *definition* of "professional services." The court held that "[t]o qualify as a professional service, the task must arise out of acts particular to the individual's specialized vocation, [and] … it must be necessary for the professional to use his specialized knowledge or training." Thus, the exclusion would only apply to some of the insured's activities. The court found the insured's broad reading of the exclusion, which would negate coverage, was unreasonable.

A liability insurer had a duty to defend a property owner who was sued for negligence based on renovations she made to a home she sold to the plaintiffs. *Essex Ins. Co. v. Hines*, 358 F.App'x 596 (5th Cir. 2010). The court found the policy language potentially covered such a claim for renovations, in particular noting a "renovated property endorsement," which said the policy covered a renovation project and covered the usable existing structure that predated the renovation project.

The *Hines* court further held that two exclusions did not apply. First, the allegations of negligent work did not fit within the exclusion for property damage "expected or intended from the view point of the insured." Second, the exclusion for "property damage to … that particular part of any property that must be restored, repaired, or replaced because 'your work' was incorrectly performed on it," did not apply. The plaintiffs alleged damage to parts of the property other than the specific portions the insured replaced or renovated.

[Note: The Fifth Circuit's opinion in *Essex v. Hines* states that determining the duty to defend should be a "seemingly simple task" and "when in doubt, defend." The court's decision is an excellent restatement of the principles of Texas law that apply when determining the duty to defend.]

A liability insurer had a duty to defend a masonry contractor sued for defective masonry work, where the petition was broad enough to allege different types of damage, and not just damage within an exclusion for damage related to work on the exterior which included an EIFS or exterior cladding or finish system. *Trinity Universal Ins. Co. v. Employers Mut. Cas. Co.*, 592 F.3d 687 (5th Cir. 2010). Having decided that EMC owed its insured a defense, in a case of first impression, the court further held that the other four insurers who had provided a defense were entitled to contribution for EMC's one-fifth share of the defense costs. The Fifth Circuit distinguished the holding in *Mid-Continent Ins. Co. v. Liberty Mutual Insurance Co.*, 236 S.W.3d 765 (Tex. 2007), where the Texas Supreme Court held that, when multiple liability policies contain pro rata or "other insurance" clauses, an insurer that overpays does not have a right of contribution from another insurer that underpays. The Fifth Circuit reasoned that the *Mid-Continent* case held there was no right of contribution because the pro rata clauses required each insurer to only pay its pro rata share of indemnity and thus the insurers did not share a common burden, which was a necessary element for a contribution claim. In contrast, the pro rata "other insurance" clause did not apply to the duty to defend, so each insurer did have a common and full obligation to defend the insured. Therefore, those who defended the insured had a right of contribution against an insurer that had a duty to defend but failed to do so. The Fifth Circuit reasoned that the "other insurance" provision spoke only to the insured's "loss," which the court construed to mean the duty to indemnify the insured, not the duty to defend.

A liability insurer had no duty to defend an insured accused of removing too much oil well casing so that the well was too shallow and inoperable. The delay in reworking the well to the proper depth was not "loss of use of tangible property" within the definition of "property damage." The use of a shallow well was not lost, because it was unusable. The delay while the well was drilled to the right depth was not loss of use of tangible property,

because that well did not exist until it was completed. The court further held that the same reasons that negated the insurer's duty to defend also negated the insurer's duty to indemnify. *Cook v. Admiral Ins. Co.*, No. 2:09-CV-0109-J, 2010 WL 2605256 (N.D. Tex., June 29, 2010).

An insurer did not have a duty to defend its insured in a claim for injuries sustained by a passenger in a trucking accident where the driver was killed. Both men in the truck were working for the insured. The court explained that the employee exclusion in a standard Texas commercial auto policy excludes from coverage injuries sustained by a truck driver while operating a covered vehicle, regardless whether the driver was an independent contractor or an employee. This exclusion relieved the insured of any duty to defend; and where there is no duty to defend, there is also no duty to indemnify. *Canal Indem. Ins. Co. v. Texcom Transp., L.L.C.*, No. 3:09-CV-1430-BD, 2010 WL 2301007 (N.D. Tex., June 4, 2010).

The court in *Atlantic Casualty Insurance Co. v. PV Roofing Corp.*, No. H-08-3583, 2010 WL 2035586, *3 (S.D. Tex. May 20, 2010), held that the insurer of a roofing company was not required to defend the insured roofing company in a suit brought by an injured employee. The employee exclusion excluded coverage for all persons providing services on behalf of the insured.

In *Canal Indemnity Co. v. Williams Logging & Trees Services*, No. H-09-3333, 2010 WL 2131641 (S.D. Tex. April 21, 2010), the court held that the insurer had no duty to defend or indemnify the insured for a claim brought against its insured in a motor vehicle accident. The car that the insured was driving was not listed on the surplus liability coverage policy, and did not fall under a catch-all public liability endorsement that interstate motor carriers are required to have, because the truck did not meet the definition of a commercial motor vehicle.

In *Associated Automotive, Inc. v. Acceptance Indemnity Ins. Co.*, 705 F.Supp.2d 714, 727 (S.D. Tex. 2010), the court held that, in the absence of a policy provision to the contrary, an isurer who has a duty to defend also has the duty to appeal a case it lost, where there are reasonable grounds for the appeal. Therefore, a factual issue existed as to whether there were reasonable grounds for the insurer to appeal the underlying state court judgment against the insured.

While a carrier was delivering goods for Shell, an explosion occurred at the delivery site, due to the product being delivered. The delivery carrier listed Shell as an additional insured on its insurance policy. The court held that the insurer had a duty to defend Shell under the CGL policy, as the allegations in the underlying suit potentially stated a claim for property damage caused by an "occurrence" as defined in the policy. *Shell Chemical L.P. v. Discovery Prop. & Cas. Ins. Co.*, No. H-09-2583, 2010 WL 1338068 (S.D. Tex. March 29, 2010).

A general contractor sued his subcontractor and subcontractor's liability insurer for failing to defend him in a suit brought by his subcontractor's employee for injuries sustained at construction site when the employee fell from a ladder. The court held that the insurer had a duty to defend the general contractor because he was an additional insured under the policy and that the additional insured policy provision was triggered by the underlying petition. This was an issue of first impression for the court where an additional insured sought coverage under the new additional insured endorsement in a "third-party over" action[1] because of possible contributory negligence on the part of the injured employee. To trigger the duty to defend, the policy required that the injury be caused in whole or in part by the insured contractor or those acting on his behalf. The court found that it could not say that the injured employee (who was acting on behalf of the insured) was not possibly a contributing cause of his injuries. Therefore, a duty to defend existed under the new additional insured policy provision, because someone acting on behalf of the insured potentially caused the injury. The court stated that the additional insured can still have coverage, even if no allegations are made directly against the insured, when it appears from the petition that the injured person acting on behalf of the insured may have been at fault. *Gilbane Bldg. Co. v. Empire Steel Erectors, L.P.*, 691 F.Supp. 712 (S.D. Tex. 2010).

An insurer did not have to defend its insured when the insured contractor was sued for damage to property it was working on. The damage was excluded under an exclusion that stated, "no coverage is afforded for any liability or claim that arise[s] out of, is related to, or connected with the following: TORCH DOWN ROOFING." The damage caused to the property was connected with the insured's torch down roofing job. *Gemini Ins. Co. v. Trident Roofing Co., L.L.C.*, No. 3:09-CV-704-M, 2010 WL 335314 (N.D. Tex. Jan. 22, 2010).

In *Endurance American Specialty Insurance Co. v. Brown, Miclette & Britt, Inc.*, No. H-09-2307, 2010 WL 55988 (S.D. Tex. Jan. 4, 2010), insureds turned to their insurer to defend them in claims brought by victims of the alleged Stanford investment Ponzi scheme. The court held that the securities fraud exclusion in the policy applied. However, the victims also alleged common law negligence claims, to which the exclusion did not apply. If one claim is potentially covered and not excluded, the duty to defend extends to all claims in the underlying litigation. Therefore, the court held that the insurer had a duty to defend.

If one claim is potentially covered and not excluded, the duty to defend extends to all claims in the underlying litigation.

A general contractor's insurer, Amerisure, sued the insurers of several subcontractors, seeking a declaration that the subcontractor's insurers (Beacon, Travelers, and Western Heritage) had a duty to defend the general contractor in an underlying suit brought against him relating to work performed by the subcontractors. *Amerisure Mut. Ins. Co. v. Travelers Lloyds Ins. Co.*, No. H-090-662, 2010 WL 1068087 (S.D. Tex. Mar. 22, 2010). The parties filed cross-motions for summary judgment. As to Beacon and Western Heritage, the court concluded that they did not have a duty to defend the general contractor. Applying the standard for occurrence-based policies set forth in *Don's Building Supply, Inc. v. OneBeacon Insurance Co.,* 533 F.3d 901 (5th Cir. 2008), the court found that the eight-corners rule was not satisfied as to either of these insurers because the underlying complaint did not allege that the harm occurred during the term of those policies. However, the Traveler's policy was in effect when the alleged harm occurred. Traveler's had agreed to defend the general contractor as to certain claims but sought to limit its duty. The issues, therefore, were not whether Travelers owed a duty to defend but whether it had a duty to defend on all claims alleged and whether it or Amerisure was the primary insurer rather than the excess insurer. The court concluded that Traveler's had a duty to defend the general contractor on all alleged claims. The court also found that Traveler's and Amerisure's policies both made them excess to each other. Consequently, the court ignored the conflicting provisions and determined that Traveler's and Amerisure shared the duty to defend the general contractor pro

rata relative to the limits of their policies.

The El Paso Court of Appeals held that an insurer did not owe a duty to defend a railroad company in a case brought by the family of a victim of a fatal railroad crossing accident. The plaintiffs alleged that the accident was due to the negligence of a weed control company hired by the railroad. The weed control company was supposed to name the railroad as an additional insured on its liability policy. Following *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008), the court of appeals found that the railroad company was an additional insured and that the attribution of fault between the railroad and the weed control company did not matter. The court stated that the insurer "breached its duty to defend." But the court then went on to hold that an exclusion negated the insurer's duty to defend. The exclusion barred coverage for product or work completed by the weed control company, but did not exclude work that was not complete or was abandoned. The court found this exclusion applied because the plaintiffs' petition phrased its allegations about the weed control company in the past tense (*e.g.*, "There *was* excessive vegetation at the crossing"), despite the fact that the petition would necessarily describe the event in the past tense, since it happened in the past. The court concluded that the insurer did not have a duty to defend the railroad. *Burlington N. & Santa Fe Ry. Co. v. Nat'l Union Fire Ins. Co.*, No. 08-06-00022-CV, 2009 WL 4653406 (Tex. App.–El Paso Dec. 9, 2009, pet. filed).

A construction company converted from a corporation to a limited partnership. After the conversion, it was sued for negligence and sought coverage from its liability insurer. The insurer denied coverage and sought summary judgment on grounds that the construction company was not a named insured. The district court agreed. The court found that an exception to the eight-corners rule existed in this situation to allow it to consider extrinsic evidence as to whether the new entity succeeded to the insurance coverage of the old entity, because the facts relevant to whether the construction company was insured were readily ascertainable, did not contradict any allegations in the pleadings in the underlying suit, and controlled the question of coverage. The extrinsic evidence showed that the company converted from the corporation named in the policy to the limited partnership (the names were identical except for the entity notation "L.P." instead of "Inc."). The company argued that the policy should cover the new entity because a statute treats new and old entities as "legal equals." The court disagreed, finding no case law discussing that statute in the context of insurance contracts. Instead, the court determined that the company could not "substitute a new party" to the policy without the insurer's knowledge or approval or giving it the opportunity to evaluate the new entity. The company also did not request any coverage for the converted entity. Thus, the court concluded that the insurer had no duty to defend the new company. *VRV Dev., L.O. v. Mid-Continent Cas. Co.*, No. 3:09-CV-1382, 2010 WL 375499 (N.D. Tex., Feb. 3, 2010).

A plaintiff sued a radiology lab for damages she sustained from an unauthorized vaginal exam. The lab had three policies from three insurers. The district court determined that two insurers had no duty to defend, but the third did. The first insurer had no duty to defend, because its policy had exclusions for injury arising out of medical or diagnostic procedures, and for injuries arising out of services furnished by health care providers. Interpreting the phrase "arising out of" broadly, the court found that these exclusions applied because the plaintiff alleged she was subjected to conduct tantamount to a "sexual assault" during an ultrasound and, had that procedure not taken place, the assault would not have occurred.

The second insurer had no duty to defend, because its umbrella policy had an exclusion for injury arising out of the rendering or failure to render medical treatment or the application of a medical appliance. The court found that this exclusion applied because the performance of the ultrasound involved the application of a medical appliance.

The third insurer had a professional liability policy that covered damages resulting from professional services. Although the policy contained exclusions for sexual misconduct, violations of the law, and intentional acts, the court concluded that none of these exclusions barred coverage. Although the plaintiff's petition characterized the vaginal exam as tantamount to a sexual assault, the actual description in the pleading "did not necessarily frame it as being a sexual act." The plaintiff also clearly sued the radiology lab for negligence in performance of the exam and in performing a vaginal exam that was unauthorized. It was not clear from the pleadings that the vaginal exam was a sexual act, intentional tort, or a crime, as defined by the policy. Construing the facts liberally in favor of coverage, the court found the third insurer had a duty to defend the lab. *National Fire Ins. Co. of Hartford v. Radiology Assocs., L.L.P.*, 694 F.Supp.2d 658 (S.D. Tex. 2010).

An insured maker of natural gas equipment had a policy that excluded products manufactured in one particular factory. The insured was sued after a piece of its casing ruptured. The insurer argued that the casing failure was not an occurrence, because it was highly probable the casing would fail due to the known defective manufacturing process at the factory. The court disagreed, because the evidence showed that the casing at issue did not come from the problematic factory. Because the insured neither knew nor should have known the casing would fail, the accident was an occurrence and fell within coverage. *Lexington Ins. Co. v. N. Am. Interpipe, Inc.*, No. H-08-3589, 2010 WL 1558609 (S.D. Tex. Apr. 19, 2010).

A liability insurer had a duty to defend an insured that allegedly failed to properly wash and rinse a disposal trough so that material was ignited by welding. The policy covered operations described as "above ground water line installation/ service" and classified the insured's business as "water mains or connections construction." The suit alleged negligence by the insured in performing service work on a salt water disposal trough. The court found that "water" could include salt water, and "construction" could include welding repairs. *Essex Ins. Co. v. McFadden*, No. 6:09-CV-193, 2010 WL 2246293 (E.D. Tex. June 3, 2010).

The *McFadden* court also held that the professional services exclusion did not apply, because neither welding nor cleaning out a trough were the types of services "that required specialized knowledge or training."

B. Duty to settle

An insurer waived conditions precedent in its policy by tendering policy limits before it was legally obligated to do so. Having tendered its policy limits, the insurer had no duty to participate in or fund a third-party settlement that took place after the insurer's payment. *Mid-Continent Cas. Co. v. Eland Energy, Inc.*, No. 3:06-CV-1576-D, 2010 WL 610713 (N.D. Tex. Feb. 22, 2010).

C. Duty to indemnify

A liability insurer may have a duty to indemnify, even though it has no duty to defend. *D.R. Horton-Texas, Ltd. v. Markel Int'l Ins. Co.*, 300 S.W.3d 740 (Tex. 2009). Homeowners sued their builder for defects in the home. The builder was named as an additional insured under a subcontractor's policy for claims arising from the subcontractor's work. The homeowners'

petition did not allege anything about the subcontractor. Thus, based on the eight corners of the petition and the insurance policy, the insurer had no duty to defend, because no covered claim for the subcontractor's work was alleged. However, the supreme court recognized that the duty to defend is based on the allegations in the petition, while the duty to indemnify depends on the facts actually established. Even though the insurer did not have a duty to defend, it might have a duty to pay, if the evidence established that the defects were caused by the subcontractor.

In *D.R. Horton,* the court clarified its holding in *Farmers Texas County Mutual Insurance Co. v. Griffin*, 955 S.W.2d 81 (Tex. 1997), where the same facts that negated the duty to defend also negated the duty to indemnify. In *Griffin*, the underlying tort suit alleged a drive by shooting. The court reasoned there was no way that facts could develop that would transform the drive by shooting into a covered "auto accident"; therefore, there was no duty to defend and could be no duty to indemnify. In the present case, unlike *Griffin*, the builder presented evidence showing that the subcontractor was responsible for the defects, which raised the possibility of a duty to indemnify.

The Fifth Circuit held that a trial court correctly determined the duty to indemnify was not justiciable before the underlying lawsuit was resolved. The defendant was sued for its approval of certain drilling plans (which could be excluded as a professional service) and for its failure to exercise ordinary care in conducting drilling (which would not be excluded). The Fifth Circuit held that the district court correctly applied the general rule that indemnity issues must await resolution of the underlying suit. The defendant might be liable for covered acts for mistakes in drilling, for excluded acts for approving the plans, or for nothing at all. The court concluded, "in such a case, facts necessary to determine whether a duty to indemnify arises cannot be known until after liability is determined. Thus, because different theories of liability are alleged in the underlying suit that might or might not exclude coverage, the district court was correct to hold the indemnity issues were non-justiciable." *Willbros RPI, Inc. v. Continental Cas. Co.*, 601 F.3d 306 (5th Cir. 2010).

The court in *Zurich American Insurance Co. v. Meinen*, No. H-08-3005, 2009 WL 4667226 (S.D. Tex. Dec. 1, 2009), held that the insurer had no duty to indemnify the insured for the sums awarded against him in an arbitration, because the governing contract is the policy itself and not the certificate of insurance. When a certificate of insurance contains language stating that the certificate does not amend, extend, or alter the terms of any insurance policy mentioned in the certificate, the terms of the certificate are subordinate to the terms of the insurance policy.

Passengers contracted tuberculosis after riding on a tour bus with a driver who had tuberculosis. The passengers sued the tour bus company and its driver. The bus company and driver sued their insurer seeking coverage, and the passengers intervened. The trial court granted summary judgment, finding that the insurer had a duty to indemnify the driver and bus company for the judgment. On appeal, the insurer argued that the summary judgment in favor of the passengers was defective because it did not include a finding on the insurer's duty to defend and because the passengers' pleadings did not support such a finding. The court rejected this argument, noting that an insurer's duty to indemnify is separate and distinct from its duty to defend. The trial court did not err in looking to the policy and the facts actually established at trial. It did not need to look at the underlying pleadings. *Lancer Ins. Co. v. Perez*, 308 S.W.3d 35 (Tex. App.–San Antonio 2009, pet. filed).

The insurer also argued that there was a fact issue regarding whether the tuberculosis was caused by the "use" of the bus. The court disagreed with the insurer's assertion that there could never be coverage under the policy when passengers were infected by the bus driver's airborne disease. For damages to be caused by "use" of a vehicle, the vehicle must be more than merely the site of the injury and cannot merely contribute to the condition producing the injury. An integral part of the vehicle must have produced the injury. In this case, there was evidence that the bus produced the infections. The bus contained an air conditioning system that recirculated the air inside the bus, causing the passengers to breathe the same air as the driver. However, there was also evidence that the infections were unrelated to the bus. Some passengers were exposed to the bus driver while standing outside the bus, and outside air could be introduced by a "fresh air button" on the bus although no witness testified as to whether that button was pressed during the trip. Given the conflicting evidence, the court concluded that summary judgment for either party was inappropriate and remanded for trial.

A home builder was sued for claims covered by his liability insurance policy. After the plaintiff obtained a judgment against the builder, his insurer entered into a settlement with the plaintiff and paid her for a full release of the builder. The builder sued the insurer, arguing that the insurer should have paid him the amount of the judgment. The court granted the insurer's motion for summary judgment, finding that by paying for the settlement and obtaining the release the insurer had fulfilled its duty to indemnify and was not obligated to pay any other sum to the builder. *Rotella v. Mid-Continent Cas. Co.*, No. 3:08-CV-0486-G, 2010 WL 1330449 (N.D. Tex. Apr. 5, 2010).

VII. THIRD PARTY THEORIES OF LIABILITY

A. *Stowers* duty & negligent failure to settle

The First Court of Appeals addressed the issue of "whether a settlement offer triggers an insurer's duty to settle when the plaintiffs' settlement terms require funding from multiple insurers, and no single insurer can fund the settlement within the limits that apply under its particular policy." *AFTCO Enterprises, Inc. v. Acceptance Indem. Ins. Co.*, 321 S.W.3d 65 (Tex. App.–Houston [1st Dist.] 2010, pet. denied). The court held that it did not.

The underlying suit was for personal injuries resulting from a motor vehicle accident caused by a tractor-trailer. The plaintiffs made a global settlement offer to the various carriers involved for an amount that exceeded the individual limits of each policy but was within the combined total of all the policy limits. The insurers tendered their policy limits, but failed to do so until several months after the demand was made. Following judgment in the underlying suit, the insureds brought *Stowers* actions against their primary and excess liability insurers seeking attorney fees and compensation for damage to their business reputations resulting from the delay in settling. The trial court granted summary judgment, finding that there was no evidence that any *Stowers* obligations

***Stowers* duties were not triggered, because the demand was directed toward multiple policies and insurers, and did not offer to release claims against a particular insured under a specific policy for the limits available under that policy.**

were triggered as to either the primary or excess insurers. The court of appeals affirmed. As to the primary insurer, the court held that its *Stowers* duties were not triggered, despite language in the settlement demand that the claims against all defendants would be released in exchange for "a tender of the policy limits available under the insurance policies," because the demand was directed toward multiple policies and insurers, and did not offer to release claims against a particular insured under a specific policy for the limits available under that policy. The court also noted that the settlement demand referred to an aggregate sum in excess of the primary insurer's policy. In support of its conclusion, the court cited *Mid-Continent Insurance Co. v. Liberty Mutual Ins. Co.*, 236 S.W.3d 765 (Tex. 2007), for the proposition that "in a claim involving multiple policies, a settlement demand does not activate one primary insurer's *Stowers* duty unless the demand falls within the applicable limits available under that single policy." As to the excess insurer, the court held that its *Stowers* duties were not triggered because the primary insurer had not tendered its policy limits. Citing *Keck, Mahin & Cate v. Nat'l Union Fire Ins. Co.*, 20 S.W.3d 692 (Tex. 2000), the court explained that an excess carrier's *Stowers* duty does not arise until the primary carrier receives a settlement demand within its limits and tenders its policy limits.

B. Unfair insurance practices

In a case where an employer was late paying its workers' compensation premium due to a miscommunication with the insurance agent, the court held it was the employer's burden to establish that coverage was reasonably clear as part of its case under the Insurance Code and DTPA when seeking to obtain coverage for an injured employee. *Tex. Mut. Ins. Co. v. Sara Care Child Care Center*, No. 08-08-00192-CV, 2010 WL 3567094, *11-12 (Tex. App.–El Paso Sept. 15, 2010, no pet.). The court found that the employer did not establish coverage was reasonably clear.

VIII. SUITS BY INSURERS

A. Declaratory relief

An employee of an insured tree trimming company was injured on the job. The employee first sued the insurer in state court. The insurer, in turn, filed a third party claim against the insured. The insurer claimed that the employee and the insured were colluding, and asked the state court for a declaration that the employee was not a policy beneficiary and that the insured was not covered under the policy. After the employee directly sued the insured in state court, the insurer filed this suit in federal court, arguing that it had no duty to the insured or the employee and that its insured breached the policy's cooperation clause. The insured moved to dismiss under federal abstention doctrine and under Rule 12(b)(6) for failure to state a claim. The court granted both motions. The court found that Texas law does not recognize a breach of contract action for breach of a cooperation clause. Having done so, the court's abstention consideration was limited to whether it should abstain from deciding the insurer's request for declaratory judgment. The court found that abstention on that issue was proper because the questions in controversy could be settled in the state court suit, which was filed first, involved state law issues, and in which all the parties were involved. *Evanston Ins. Co. v. Tonmar, L.P.*, 669 F.Supp.2d 725 (N.D. Tex. 2009).

B. Subrogation

A trial court could not ignore a health insurer's subrogation interest by allocating all the settlement proceeds to a widow and orphans and none to the decedent's estate. The supreme court held that it was an abuse of discretion for a trial court to rely on the "made whole" doctrine to conclude that a health insurer would not suffer from being awarded no part of the settlement, and the widow and orphans would, so that the trial court allocated all of the $800,000 settlement to them, and none to the insurer, despite its subrogation claim for $337,000 in medical expenses. *Texas Health Ins. Risk Pool v. Sigmundik*, 315 S.W.3d 12 (Tex. 2010). The court relied on its prior opinion in *Fortis Benefits v. Cantu*, 234 S.W.3d 642 (Tex. 2007), which held that the equitable "made whole" doctrine does not apply when the parties have a contractual provision providing a clear and specific right of subrogation for the health insurer. While the *Sigmundik* court held the trial court abused its discretion by awarding the health insurer nothing, "the trial court was free to exercise some discretion in dividing the settlement funds[.]"

Texas law now provides three possibilities for subrogation by health insurer. If there is no contractual provision providing for subrogation, then the insurer's subrogation right is subject to the equitable principle that the insured must first be "made whole." *Ortiz v. Great S. Fire & Cas. Ins. Co.*, 597 S.W.2d 342, 343-44 (Tex. 1980). If the insurer has a subrogation clause in the contract, then its right is not subject to the made whole doctrine, as provided in *Fortis* and *Sigmundik*. If that subrogation clause gives the insurer the right to be paid without regard to whether the insured is made whole, then that contract provision will be enforced. If, as in *Sigmundik*, the contract provides a right of subrogation but does not specify that the insurer gets paid first, the trial court still has some degree of discretion to allocate funds between the insurer and the insured or other claimants. The *Sigmundik* court does not explain how that allocation is to be made, but presumably a trial court could consider the proportionate amount of each party's claim.

In a case of first impression, the Fifth Circuit held that a primary insurer that pays to settle a claim it does not cover may have a right of contractual subrogation against an excess insurer, even though the insureds have been fully indemnified. *Amerisure Ins. Co. v. Navigators Ins. Co.*, 611 F.3d 299 (5th Cir. 2010). The Fifth Circuit distinguished the decision in *Mid-Continent Insurance Co. v. Liberty Mutual Insurance Co.*¸ 236 S.W.3d 765 (Tex. 2007), where the Texas Supreme Court held that an overpaying primary insurer had no right of subrogation against an underpaying primary insurer, where both provided coverage and the insured was fully indemnified. The Fifth Circuit agreed with lower courts that have limited *Mid-Continent* to its particular facts. The Fifth Circuit held that *Mid-Continent* does not bar contractual subrogation simply because the insured is fully indemnified. In this case, the primary insurer disputed that it owed coverage but settled to protect the insured's interests and expressly reserved its subrogation rights. Because the court found a fact question on whether the primary insurer's policy provided coverage, the court remanded, holding that if the primary insurer did not actually have coverage, then it would be entitled to subrogation against the excess insurer for the amount it had paid.

In *Munters Eurofoam GMBH v. American National Power, Inc.*, No. 03-05-00493-CV, 2009 WL 5150033, *2 (Tex. App.–Austin Dec. 31, 2009, pet. dism'd) (mem. op.), a subcontractor contended that a project owners' insurer had no claim for subrogation for payment of a fire claim that occurred during installation of the evaporative cooling system. The subcontractor argued that the project owners had waived their claims against it and, therefore, the insurer had no claims to which they could be subrogated. However, the court held that the right to subrogation belongs to the insurer and that it is not the owner's or the contractor's right to waive.

IX. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Exemplary damages

The Fifth Circuit held it is against public policy to insure punitive damages awarded against a repeat offender drunk driver of an eighteen wheeler who knew he was a danger to others and had been convicted of DWI twice before. *Minter v. Great Am. Ins. Co. of NY*, No. 09-10734, 2010 WL 3377639 (5th Cir. Aug. 27, 2010). The court found it unnecessary to consider whether public policy always bars insuring exemplary damages awarded against an individual, finding that the facts of this case voided coverage.

B. Attorney's fees

An insured that suffered forgery losses that were covered by the policy, but which the insurer wrongfully denied, was not entitled to recover as damages the attorney's fees it incurred in suing the forger. The court relied on the general rule that attorney's fees may not be recovered unless provided for by a statute or contract. The court recognized that a plaintiff may recover attorney's fees incurred in litigation with a third party as damages when they are the natural and proximate consequence of the defendant's conduct, but found these were not such damages in this case. The court reasoned that the insured did not have to file suit against the other party and could have simply sued the insurance company for denying the claim. *Great Am. Ins. Co. v. AFS/IBEX Fin. Servs., Inc.*, 612 F.3d 800 (5th Cir. 2010).

In *Underwriters at Lloyds of London v. Harris*, No. 11-09-00221-CV, 2010 WL 2219674, *2 (Tex. App.–Eastland June 3, 2010, no pet.), a tow truck company sued a tractor-trailer's insurer when it refused to pay the tow truck company the full bill for towing, storage, and cleanup costs of its insured's trailer. The court held that the insurer was liable for all actual damages incurred by the tow truck company, but not for attorney's fees, because the Vehicle Storage Facility Act only allowed recovery of attorney's fees when the attorney general prevailed under the Act, not a private litigant.

In a coverage dispute arising from two similar and related underlying lawsuits, a district court had held that a liability insurer had a duty to defend its insured in one of the lawsuits, and also had held that the Texas Prompt Payment Statute applied to the insurer's failure to timely pay for the defense in the covered lawsuit. As a result, the insured was entitled to its attorney's fees in the coverage litigation. The court had to determine what percentage of the attorney's fees were attributed to the covered suit. In other words, if only the covered suit were involved, what percentage of the total fees in the coverage litigation would have been incurred? The insured argued that 95% of its fees would have been incurred even without the uncovered suit. The insurer objected, arguing that the similarity of the cases meant that the insured's attorney's fees would have been evenly split between the two cases. The court disagreed. The similarity of the cases is what justified a finding that a high percentage of the overall fee would have been incurred in litigating coverage even without the unsuccessful claim. The legal issues involved in both cases were the same. The court analyzed the various pleadings and motions and concluded that the insured was entitled to recover 90% of its attorney fees. *Nautilus Ins. Co. v. Int'l House of Pancakes, Inc.*, No. H-03-2182, 2009 WL 5061767 (S.D. Tex. Dec. 15, 2009).

X. DEFENSES & COUNTERCLAIMS

A. Misrepresentation or fraud by insured

A driver was involved in an accident with an unlicensed, seventeen-year-old motorist. The motorist was not a named insured on her parents' policy even though she resided with them. In the application for the policy, her father warranted that he and his wife were the only drivers in the household and denied that there were any residents in his household over fifteen who were not listed in the application. When the parents' insurer learned during its investigation of the accident that the daughter resided with the parents, it rescinded the policy, refunded the parents' premiums, and filed suit for a declaratory judgment that it had no duty to defend or indemnify the motorist or her parents. The court concluded that judgment for the insurer was proper. The insurer offered the father's deemed admission that he intentionally failed to disclose his daughter's residence and unlicensed status to deceive the insurer and avoid paying a higher premium. The insurer also offered proof that it would not have accepted the risk of insuring the father's car if he had disclosed that his unlicensed daughter would be driving it. *Perez v. Old Am. Co. Mut. Fire Ins. Co.*, No. 14-09-00456-CV, 2010 WL 3168389 (Tex. App.–Houston [14th Dist.] Aug. 12, 2010, pet. filed) (mem. op.).

An insured applied for a term life policy and named his father as beneficiary. The insured represented in the application that he had not been treated for drug or substance abuse. The insured died less than two years after the policy was put in place, and the father sought death benefits. When the insurer investigated the claim, it learned that the insured had been treated for substance abuse, and it rescinded the policy, refunded the premium, and sought a declaratory judgment that it did not owe benefits to the father. The court granted the insurer's motion for summary judgment, finding that the insured had made a misrepresentation of material fact with intent to deceive upon which the insurer had relied. The insured represented in the application that he had not received substance abuse treatment, and stated the same in a telephone interview and questionnaire. The insurer did not know that the insured had previously been treated for substance abuse. The insured's intent to deceive was shown by the fact that the insured made the misrepresentation three separate times and by the fact that he knew from language in the application that he would not qualify for coverage if he had received substance abuse treatment. The court also accepted as evidence of the insured's intent the fact that his father, the beneficiary, had sold the insured his policy, paid for the policy, and received a commission of 130% of the policy's premium. Finally, even though substance abuse did not contribute to the event that caused the insured's death, the court found that the element of materiality was satisfied by the fact that the insurer would not have accepted the risk if the true facts had been disclosed. *United of Omaha Life Ins. Co. v. Halsell*, No. SA-08-CV-1007-XR, 2010 WL 376428 (W.D. Tex. Jan. 25, 2010).

B. Collateral estoppel

An insurer was collaterally estopped to relitigate the issue of whether another insurer had standing to assert a subrogation claim, where that issue was fully and fairly litigated by the insured, with the first insurer controlling the defense in the underlying litigation. *Mid-Continent Cas. Co. v. Bay Rock Operating Co.*, 614 F.3d 105 (5th Cir. 2010).

C. Lack of Notice

In *Hudson v. City of Houston*, No. 01-07-00939-CV, 2010 WL 3212137, *8 (Tex. App.–Houston [1st Dist.] Aug. 12, 2010, no pet.), an insured failed to notify its insurer of a claim against her and failed to request a defense, resulting in a default judgment of $3.5 million. The court held that the insurer was prejudiced by the lack of notice as it deprived the insurer of its ability to answer and defend against the injured party's claims, to conduct discovery, and to fully litigate the merits of the claim. Moreover, actual notice of the claim, absent compliance with the policy's notice provision, did not trigger the duty to defend.

Washington Mutual Bank loaned money to borrowers to refinance their mortgage. In connection with the loan, Commonwealth issued Washington Mutual a mortgagee title insurance policy that insured it for loss due to a defect in title. Shortly after, the borrowers filed for bankruptcy. Because the deed of trust lien was recorded less than ninety days before the bankruptcy, the bankruptcy trustee filed an adversary proceeding against Washington Mutual, alleging that recording the lien was a preferential transfer. The trustee filed a motion for summary judgment, which Washington Mutual did not oppose. Instead, the trustee and Washington Mutual entered into an agreed judgment by which Washington Mutual surrendered its rights in the property and transferred them to the bankruptcy estate, leaving Washington Mutual with an unsecured claim against the estate that was ultimately worth substantially less than the amount loaned. Four months after the entry of the agreed judgment, Washington Mutual filed a claim with Commonwealth, which was denied on grounds that Washington Mutual failed to timely notify Commonwealth of the adversary proceeding, in contravention of the policy. Washington Mutual sued Commonwealth, but Commonwealth prevailed. The court of appeals affirmed, concluding that Commonwealth was prejudiced by Washington Mutual's failure to notify it of the adversary proceeding. Washington Mutual did not attempt to defend against the trustee's claims, and Commonwealth was denied the opportunity to do so. Because Washington Mutual failed to comply with a condition of the policy that was prejudicial to Commonwealth, Washington Mutual was not entitled to coverage. *Washington Mut. Bank v. Commonwealth Land Title Ins. Co.*, No. 13-08-00256, 2010 WL 135685 (Tex. App.–Corpus Christi Jan. 14, 2010, no pet.) (mem. op.).

An insured was sued for damages from an accident allegedly caused by a motorcycle it produced. The insured notified its insurer two months after it answered the suit and twenty-seven days after the expiration of the policy. The insurer sought to avoid coverage on grounds that the insured did not give notice "as soon as practicable" as the policy required. The insured filed a motion to dismiss the insurer's suit for declaratory judgment, because the insurer failed to allege that it was prejudiced by the lack of timely notice. The court found no prejudice. The insurer did not allege that it was unable to investigate the suit, that it was unable to defend the claims, that it closed its books on the policy, that there was no notice whatsoever, or that a default judgment had been filed. While the insurer argued that it was not able to close its books and that it issued a new inaccurately priced policy to the insured, the insurer did not allege this in its pleadings. Under the circumstances, the insurer did not allege sufficient prejudice, so the insured's motion to dismiss was granted. *Evanston Ins. Co. v. Keeway America, L.L.C.*, No. 3:09-CV-1115-M, 2010 WL 2652330 (N.D. Tex. June 29, 2010).

D. Insurer's waiver of, or estoppel to assert, defenses

In *Gilbert Texas Construction, L.P. v. Underwriters at Lloyds, London*, 53 Tex. Sup. Ct. J. 780, (Tex. June 4, 2010), the insured contractor had no coverage after it avoided liability on every theory except breach of contract. The policy contained an exclusion for liability assumed under a contract, but provided an exception if the insured would otherwise be liable. The insured successfully moved for summary judgment on all other liability theories, based on the defense of governmental immunity. The supreme court held that the contractual liability exclusion applied, and that the exception did not apply, because the insured was not "otherwise liable," having won on all other liability theories. The insured then argued that the insurer was estopped to assert this exclusion, because the insurer forced it to assert the governmental immunity defense, which effectively forced it out of coverage. The supreme court rejected this argument.

Gilbert argued that the insurer should be estopped to deny coverage, because Underwriters threatened to deny coverage based on a failure to cooperate, if Gilbert did not file a motion for summary judgment asserting the governmental immunity defense. Gilbert's defense lawyer testified that he was pressured by Underwriters and believed that if he did not move forward with the motion the insurer would invoke the cooperation clause to deny coverage. Gilbert argued that the insurer had taken control of the defense and had prejudiced Gilbert by this conduct.

The supreme court noted that the insurer had the right to associate itself in the defense and also noted that the insurer "had the right to stand on the cooperation clause in its policy." The court found significant that Gilbert was represented by a counsel independent from the insurer and had the right to refuse to assert governmental immunity and afterwards to seek recovery from Underwriters. "Underwriters' disclosure of its intent to stand on contractual rights in its policy does not equate with asserting actual control over Gilbert's defense," the court concluded. The court also found it significant that Gilbert's attorney had asserted the governmental immunity defense without consultation with Underwriters.

The court rejected the argument that the insurer's conduct violated the principles in *Employers Casualty Co. v. Tilley*, 496 S.W.2d 552 (Tex. 1973). In that case, the defense lawyer hired by the insurer developed facts that supported the insurer's coverage defense. The *Tilley* court concluded that was a breach of the lawyer's duty of loyalty, which estopped the insurer to deny coverage. The court found this case was not similar, because the insurer did not have a duty to defend Gilbert and did not retain an assigned defense lawyer. The court also found no prejudice, because an attorney for Gilbert's parent company acknowledged that it likely would not have mattered whether Gilbert raised the issue of governmental immunity, because the trial court ruled that governmental immunity extended to all the contractors in the case.

The court may have reached the right conclusion, but the circumstances of this case are very troubling for insureds and their defense lawyers. The court said that the insurer was entitled to assert the insured's duty to cooperate, but did not decide whether the insured's refusal to assert a defense that would negate coverage would have breached the duty to cooperate. Clearly, it would not. An insured cannot have a duty to cooperate with the insurer in asserting positions that will deny coverage. On that issue, the parties are adverse, and the insurer cannot have the right to dictate what the insured must do. However, it may make no difference in this case.

In a different context, the supreme court approved a holding that an insured did not have to sign a nonwaiver agreement as part of his duty to cooperate. The court approved this language: "The policy obligated the company to defend the suit, and, having entered upon the defense, it was in no position to require Long [the insured], without consideration, and without his full understanding, to waive himself out of court … When an insurance company contracts to defend against the insured it is bound in good faith to perform this obligation and has no right to insist upon the insured signing away his rights as a condition precedent to the performance of this duty." *Auto. Underwriters' Ins. Co. v. Long*, 63 S.W.2d 356, 359 (Tex. Comm'n App. 1933, holding approved). Similarly, to the extent the insurer had the right to participate in the defense, the insurer could not insist as a condition that Gilbert plead himself out of coverage. In this case, the insured properly could have refused to assert the governmental immunity defense in the underlying suit. Then, when the insured sued the insurer for coverage, the insurer would be entitled to assert that there was no coverage because the insured was

protected by governmental immunity from every theory except breach of contract, and so the exclusion applied.

By refusing to raise the defense in the underlying suit, the insured would not avoid it, but would only delay it. Given the court's conclusion that there was no coverage, ultimately it seems to make little difference whether the insured has no coverage because the issue was resolved in the underlying suit, or whether the insured has no coverage because the issue is resolved in the coverage suit. The decision in this case creates a certain tension about the extent to which defense counsel and insureds must comply with demands of insurers. The insured should not lose for failing to cooperate, but would lose anyway because the claim was not covered.

E. "Other insurance" clauses

The Fifth Circuit held that two liability insurers' "other insurance" clauses were in conflict, so that each insurer was required to pay a pro rata share of defense costs, even though one policy reasonably could be read to be primary and the other policy reasonably could be read to be excess. The court nevertheless held that its conclusion was required by prior Fifth Circuit precedent. *Willbros RPI, Inc. v. Continental Cas. Co.*, 601 F.3d 306 (5th Cir. 2010). The *Willbros* panel did recommend that the Fifth Circuit reconsider en banc its prior decision in *Royal Insurance Co. of American v. Hartford Underwriters Insurance Co.*, 391 F.3d 639 (5th Cir. 2004).

The court reached a similar result in *Travelers Lloyds Ins. Co. v. Pacific Employers Ins. Co.*, 602 F.3d 677 (5th Cir. 2010), holding that under Texas law most "other insurance" clauses will be found to conflict so that each insurer owes a pro rata share, which the court found was the result in the case before it.

A corporation that already was fully compensated under its general liability policies for its pollution liability could not recover under its environmental impairment liability policy. *RSR Corp. v. Int'l Ins. Co.*, 612 F.3d 851 (5th Cir. 2010). RSR was covered under a number of general liability policies and several environmental impairment liability policies. RSR first obtained $76 million in settlements under its general liability policies and then sought additional recovery for pollution cleanup costs under its environmental policies. The court first held the liability policies were within the "other insurance" clause in the environmental policies. The court held that the clause only required that there be other insurance, and it did not matter whether recovery under the policies came by settlement or otherwise. The clause also required that the other policies provide overlapping coverage. The court found that RSR was judicially estoppped because it had taken the position in prior litigation, successfully, that the general liability policies and environmental policies did cover the same liability.

The court then turned to the issue of who had the burden of allocating the prior settlements to determine whether RSR had been fully compensated. The court reasoned that the Texas Supreme Court would conclude that the burden was on RSR, as the settling party, to allocate the prior settlements to different claims, because it would be unfair to make the environmental insurers, as nonsettling parties that lacked access to the information.

Two insurance companies disputed whose policy would cover the damage when an insured was driving a car owned by her brother. The court in *Safeco Lloyds Ins. Co. v. Allstate Insurance Co.*, 308 S.W.3d 49, 60 (Tex. App.–San Antonio 2009, no pet.), held that both shared liability on a pro rata basis, in proportion to the amount of insurance provided by their respective policies. The test used by the court to determine proper liability was to first determine if the insured had coverage from one of the two policies but not from the other. If the insured is covered by each policy, the court looks at whether each policy contains a provision that conflicts with a provision of the other insurance. These offending provisions must then be ignored.

In *Truck Insurance Exchange v. Mid-Continent Casualty Co.*, No. 03-08-00526-CV, 2010 WL 3370517 (Tex. App.–Austin Aug. 27, 2010, no pet.), one commercial general liability insurer sued another insurer seeking contribution for defense costs it had expended for the insured. The court held that the existence of an "other insurance" clause precluded a contribution claim for defense costs as a matter of law, explaining that the clause precludes a direct claim for contribution among insurers because the clause makes the contracts independent of each other.

F. Filed-rate doctrine

The filed-rate doctrine barred a claim by homeowners that they were charged artificially inflated rates as a result of a price-fixing scheme by title insurers. "The filed-rate doctrine prevents state-regulated entities from charging rates other than those mandated by the proper authority. … The doctrine also prohibits suits by customers against entities charging government-prescribed rates." Because title insurance rates are set by the Texas Department of Insurance, the claims for price-fixing in violation of the Sherman Act, and for violations of the DTPA and Texas Free Enterprise & Antitrust Act were barred. *Winn v. Alamo Title Ins. Co.*, 372 F.App'x 461 (5th Cir. 2010).

XI. PRACTICE & PROCEDURE

A. Presuit Notice

In *Corona v. Nationwide Prop. & Casualty Insurance Co.*, No. H-10-1651, 2010 WL 2636119 (S.D. Tex. June 29, 2010), the insureds sued their insurer for violations of the Texas Insurance Code. The court held that the insured's notice letter did not furnish the factual detail needed to meet the statutory requirement of a specific complaint. The insureds stated in their notice letter that the adjuster appeared uninterested in helping them resolve their claim or assess their damage, and that the adjuster failed to include all of their damages, which resulted in the insureds being underpaid. The court held this did not meet the requirement that the insurer be advised with reasonable specificity of what the shortcoming was in the claims process. Therefore, the court granted the insurer's plea in abatement and stayed the case until sixty days after insureds provided the insurer with proper written notice.

B. Standing

A steel processor stored a customer's steel in its warehouse. The warehouse burned down, and the customer lost all of its steel. After the processor's insurer denied coverage, the customer sued the insurer and the processor's insurance agent for negligent misrepresentation and violations of the DTPA and former article 21.21 of the Texas Insurance Code. *Brown & Brown of Tex., Inc. v. Omni Metals, Inc.*, 317 S.W.3d 361 (Tex. App.–Houston [1st Dist.] 2010, pet. filed). The insurer and agent argued that the customer lacked standing to bring its claims. The insurer and agent argued that the customer was not a consumer under the DTPA and therefore lacked standing to assert claims under section 17.46(b). The court held that the customer had standing to bring all of its DTPA claims. As to the claim under section 17.46(b)(12), the customer did not need to be a consumer under the terms of the statute. As to the other DTPA claims asserted, the court applied the rule of the case, noting that an earlier court of appeals decision had already settled that issue in favor of the customer because the DTPA does not require the plaintiff to be the actual purchaser of the insurance to be classified as a consumer. As to the claim under former article 21.21 of the Insurance Code, the insurer and agent argued that the customer was not a "person"

entitled to bring the claim because the customer was neither an insured nor third party beneficiary of the policy. Again, the court disagreed, holding that contractual privity or third party beneficiary status is not required for standing to assert claims against insurers for negligent misrepresentation and claims under the DTPA and Insurance Code. The court observed that privity is unnecessary for these types of claims because the plaintiff is not suing on a policy or for wrongful denial of benefits, but for the damages it suffered by relying on the representations of coverage made by the defendants. Therefore, the customer had standing to assert all of its claims.

C. Pleadings

The court in *In re Park Mem'l Condo. Ass'n, Inc.*, 322 S.W.3d 447 (Tex. App.–Houston [14th Dist.] 2010, orig. proc.), held that a condominium association that had collected insurance money from the insurer of the property was not required to distribute the insurance proceeds to the homeowners. The court ordered the trial court to set aside its distribution orders as the homeowners had not specifically asked for that relief in their pleadings. The court noted that, "[a] trial court cannot grant relief to a party in the absence of pleadings supporting that relief, unless the issue has been tried by consent." The attorney for the association had specifically noted in the hearing that he could not agree to an order that the proceeds be distributed, as that was not a part of the pleadings in the case.

D. Experts

A federal court held that noted legal scholar, Chris Martin, could not properly give expert opinions on contract interpretation, because there was no need for expert testimony to explain the meaning of the insurance policies. In contrast, the court noted that expert testimony is admissible when the contract language is ambiguous or involves a specialized term of art, science, or trade. *Am. Home Assur. Co. v. Cat Tech, L.L.C.*, No. H-08-3692, 2010 WL 2331395 (S.D. Tex. June 9, 2010).

However, the court did hold that, to the extent Chris Martin's testimony explained claims handling and what generally constitutes bad faith within the insurance industry, it was admissible. The court reasoned such testimony could be helpful to a trier of fact called on to decide claims for bad faith in violation of the Texas Insurance Code.

The *Cat Tech* court also allowed testimony from a chemical engineer explaining the meaning of technical terms used in the documents in describing the work that the insured had performed and the technical processes involved in carrying out that work. That expert's expertise in that technical area was helpful in explaining the work the insured undertook. It explained what parts of the reactor were damaged. Therefore, the testimony was admissible to that extent, but the court did not rely on the technical expert's report to interpret the policy or reach any conclusions that were inconsistent with the arbitration award rendered against the insured.

E. Arbitration

A court determined that an arbitration clause covered third party claims made by an insurance agent against an insurance broker, and compelled arbitration of those claims. The agent and the third party broker had entered into a brokerage agreement containing an arbitration clause that broadly encompassed all disputes or claims "arising out of or in any way related" to the brokerage agreement. Because the agent's claims related to the procurement of insurance for the agent's client, the claims were subject to the arbitration agreement. *Lake Texoma Highport, L.L.C. v. Certain Underwriters at Lloyd's of London*, No. 4:08-CV-285, 2010 WL 302786 (E.D. Tex. Jan. 20, 2010).

F. Appraisal

An appraisal award for hail damage to several roofs was not subject to being set aside based on "mistake," where the insured argued that the umpire used the wrong measurements for one roof. An award can be set aside for a mistake only when the award does not reflect the intent of the umpire, not when the umpire chose between competing numbers. *JM Walker, LLC v. Acadia Ins. Co.*, 356 F.App'x 744 (5th Cir. 2009).

The appraisal award also was not subject to being set aside based on fraud. The court found the insured provided no evidence of a material misrepresentation, and a discrepancy among measurements alone did not create a fact issue as to whether one

set of measurements was false. Further, the court noted that the insured's appraiser disagreed with the dollar amounts awarded but not the measurement.

Finally, the court held that the insurer did not waive its right to invoke the appraisal clause by sending a letter denying the claim where, once the insured disputed the denial, the insurer immediately invoked the appraisal clause.

An insured submitted a claim on damage to her home following Hurricane Ike. The insurer adjusted the claim, and paid the amount to the insured. Several months later the insured filed suit against the insurer for breach of contract and violations of the Texas Insurance Code. The insurer invoked the appraisal clause of its policy, while the insured said the right to invoke appraisal under the policy had been waived. There was an order regarding appraisal requests that stated that a standing pre-trial order for Ike cases cannot be opted out of as a response to a request for appraisal, unless all parties agreed to participate in the appraisal process and opt out of the standing order. The court held that the insurer should have raised its complaint regarding the appraisal order to the trial court, which then could have modified the order to satisfy the insurer's concerns. Therefore, the insurer's request for mandamus relief was denied. *In re Capitol County Mut. Fire Ins. Co.*, No. 14-09-00904-CV, 2010 WL 1655461 (Tex. App.–Houston [14th Dist.] April 27, 2010)(mem. op.).

An insurer did not waive its right to appraisal and was

entitled to an abatement of the suit against it. *In re Slavonic Mnt. Fire Ins. Ass'n*, 308 S.W.3d 556 (Tex. App.–Houston [14th Dist.] 2010, orig. proc.). Insureds filed a claim for property damage, including roof damage, following Hurricane Ike. The insurer had an adjuster inspect the property. When the insureds were dissatisfied with the value assigned for the loss, the insurer ordered a second inspection and added additional reimbursement. However, the insurer refused to cover replacement of the entire roof, as the insureds requested. Four months later, the insureds sued. The insurer invoked its right to an appraisal six days after receiving the suit and demand letter. The insureds argued that the insurer waived its right to appraisal because it waited an unreasonable amount of time to demand it – seven months after it first learned that the insureds disagreed with the adjustment of the loss. The court disagreed, however, finding that the date of disagreement or impasse between the parties was on the date the insureds sent their demand letter, and that the insurer filed suit only six days afterwards.

The court did not explain why the date of disagreement was the date of the demand letter rather than the date the insureds complained of the adjustment. But the court noted that the policy included an "anti-waiver" clause and that the insurer had sent a reservation of rights letter, both of which evidenced the insurer's intention not to waive its right to appraisal. Because the insurer did not waive its right to appraisal, abatement was appropriate. The court also rejected the insured's argument that the insurer violated the Insurance Code's prompt payment provisions by delaying invoking appraisal.

The Fourteenth Court of Appeals granted a commercial property insurer's writ of mandamus to compel the trial court to grant the insurer's motion to compel appraisal. *In re Security Nat'l Ins. Co.*, No. 14-10-00009-CV, 2010 WL 1609247 (Tex. App.–Houston [14th Dist.], April 22, 2010, orig. proc.) (mem. op.). After the insured's property was damaged by Hurricane Ike, the insured submitted a proof of loss to the insurer and invoked the policy's appraisal provisions. Subsequently, the insured told the insurer it was no longer pursuing appraisal. Meanwhile, the contractor hired to repair the property sued the insured for failing to endorse insurance drafts the insurer issued for repairs. The insurer intervened in the suit and participated in mediation. After mediation failed, the insurer moved to compel appraisal, but the trial court denied the motion.

In the mandamus proceeding, the insured argued that the insurer had waived its right to appraisal because it did not object to the insured's withdrawal from the appraisal process, it sought a declaratory judgment as to coverage, and it participated in the mediation. The court of appeals disagreed. The insurer's request for a declaratory judgment was not a denial of coverage and was thus not a waiver of its right to appraisal: "Appraisal is limited to determining the amounts of loss, and not determining whether the insurer should pay." Furthermore, the court concluded that, rather than being inconsistent with appraisal, the insurer's conduct showed that it was endeavoring to ascertain the amount of damage. Although the court did not directly address the insurer's failure to object to the insured's withdrawal from appraisal, it seemed to find that the insurer's silence was inadequate to support a finding of waiver in light of the insurer's initial willingness to participate in appraisal and to work with the insured in the mediation process. In sum, the court concluded that the record did not show that the insurer engaged in conduct that established a denial of liability or would otherwise lead the insured to believe compliance with the policy terms was not desired.

Another insurer did waive its right to an appraisal by delaying nearly a year before making a demand. After an insured's home was damaged by Hurricane Ike, the insurer had the home inspected and found that the damage was less than the deductible. The insured called the adjuster and complained about the adjustment right away, informing her that he disagreed. Six months later, the insured filed suit. The insurer abated the case because it hadn't received notice before the suit. Then the insurer abated the case to mediate it. One month after the unsuccessful mediation and nearly a year after the insured's phone call, the insurer for the first time invoked the appraisal clause. The court found that the point of impasse was the telephone call because at that point the insurer knew there was disagreement on the amount of damage and was on notice that it had the right to invoke the appraisal clause. During the six months between the phone call and the suit, the insurer made no inquiry or attempt to settle the claim. The court concluded that the insurer's delay waived its right to an appraisal. *Sanchez v. Prop. & Cas. Ins. Co. of Hartford*, No. H-09-1736, 2010 WL 413687 (S.D. Tex. Jan 27, 2010).

Lightning struck the roof of insureds' home and damaged some of their electronics. Their insurer did not dispute that the damage caused by lightning was covered by the policy, but the insureds protested about the qualifications of the insurer's adjusters. The insurer invoked the appraisal clause. Both parties appointed appraisers, but the insurer's appraiser ultimately had to withdraw. The insurer attempted to find a new appraiser, but before it could, the insureds presented their appraiser's estimate of the loss. The insurer refused to pay, and the insureds filed suit. The insurer moved to compel appraisal and stay the proceedings. The insured argued that the appraisal process was completed when their appraiser submitted his estimate. Alternatively, the insureds argued that the insurer refused to participate in appraisal or waived its right to appraisal. Finally, the insureds argued that the insurer was estopped from compelling appraisal because the policy did not allow appointment of a replacement appraiser. The court rejected each of these arguments. The appraisal process was not completed, because no umpire was ever chosen and because two appraisers needed to set the amount of loss, which did not occur. The insurer did not waive its right to appraisal by allowing its appraiser to withdraw. The insurer had initially invoked appraisal, and after its appraiser withdrew the insurer attempted to appoint a replacement. The insurer's actions showed that it actively participated in the process and did not manifest an intention to relinquish its rights. Finally, the insurer was not estopped from appointing a replacement. The policy was silent on appointing replacement appraisers, so the court inferred a reasonable term, namely that the parties were allowed to select replacement appraisers within a reasonable time of the withdrawal. Accordingly, the court granted the insurer's motion to compel appraisal. *Woodward v. Liberty Mut. Ins. Co.*, No. 3:09-CV-0228-G, 2010 WL 1186323 (N.D. Tex. Mar. 26, 2010).

G. Motions for summary judgment

A driver injured in a car accident sued her insurers for failing to pay underinsured motorist benefits. After the driver's counsel withdrew, the insurers served the driver with requests for admissions to an improper address, and the driver did not receive them. The insurers moved for and were granted summary judgment based on the deemed admissions. The court of appeals reversed. First, the court determined that the driver did not waive her right to complain of the deemed admissions on appeal, because nothing in the record suggested that she knew she needed to move to withdraw the deemed admissions or to file a response to the motions for summary judgment. Then the court held that the deemed admissions were legally insufficient to sustain summary judgment. The deemed admissions would have defeated

the prerequisite to an uninsured motorist claim – namely that the plaintiff be damaged by the other driver's negligence. But because they did so, they denied the driver's due process rights. When a non-movant has not engaged in flagrant bad faith or callous disregard for the rules, summary judgment is improper if the only evidence is merits-preclusive deemed admissions. This is because such deemed admissions are tantamount to merits-preclusive discovery sanctions. Because the deemed admissions here were on the fundamental issue to be tried, the trial court erred in granting summary judgment. *Petree v. S. Farm Bureau Cas. Ins. Co.*, 315 S.W.3d 254 (Tex. App.–Corpus Christi 2010, no pet.).

H. Severance & separate trials

An insured involved in a car accident sued his employer's insurer for underinsured motorist benefits. The claims made were for underinsured motorist benefits and extra-contractual bad faith claims. The court reversed the trial court's ruling in favor of bifurcation, and instead granted the insurer's motion to sever, holding that the insurer was under no contractual duty to pay UIM benefits until the insured established liability and the underinsured status of the other driver. *In re United Fire Lloyds*, No. 04-10-00094-CV, 2010 WL 2770257, *4 (Tex. App.–San Antonio July 14, 2010, orig. proc.).

I. Removal and Remand

The court in *King v. Provident Life & Accident Insurance Co.*, No. 1:09-CV-983, 2010 WL 2730890, *8 (E.D. Tex. June 4, 2010), held that it lacked subject-matter jurisdiction, as complete diversity did not exist because the adjuster, an in-state defendant, was properly joined in the lawsuit. The adjuster stated he had taken on the role of investigator and information gatherer for the insurer in his capacity as the insurer's employee. The court concluded that the insurer did not demonstrate that there was no possibility that the adjuster was not a "person" engaged in the business of insurance subject to liability under the Texas Insurance Code.

Another federal district court remanded a case that was removed to federal court on the basis of fraudulent joinder of a nondiverse insurance adjuster. *Rankin Road, Inc. v. Underwriters at Lloyds of London*, No. 10-CV-2226, 2010 WL 4007619 (S.D. Tex. Oct. 12, 2010). The insurer argued that the adjusting service and individual adjusters were improperly joined because they were not "persons" subject to being sued under the Texas Insurance Code. The court rejected this argument, because the Texas Supreme Court, Fifth Circuit, plain language of the statute, and numerous prior decisions all recognize that insurance adjusters are "persons" within the meaning of Chapter 541. In fact, the statute specifically includes "adjuster" as a "person" subject to being sued.

The court also rejected the adjusters' argument that they were merely engaged in "ministerial duties" and not acting as adjusters. The court pointed to various correspondence from the adjusting company saying they were acting as adjusters and would be investigating the claim. Further, the adjusting company admitted that it supervised the handling of the claim, and that is specifically defined by the Texas Insurance Code as part of the definition of an adjuster.

The court further held that the adjusting company could be vicariously liable for the conduct of the individual adjusters, because the adjusting company allowed letters to be sent out claiming they were adjusters, which created apparent authority sufficient to make the company vicariously liable.

Finally, the court rejected the argument that the pleading was not sufficiently specific to state a claim against the adjusters. Texas procedure only requires "fair notice" and not detailed allegations. Nevertheless, the pleading did state in some detail the specific acts committed by the adjusters that the plaintiffs contended violated the statute.

In *Galveston Bay Biodiesel, L.P. v. Ace American Insurance Co.*, No. G-10-132, 2010 WL 2485995, *4-5 (S.D. Tex. June 11, 2010), the court also remanded the case to state court because diversity jurisdiction did not exist since the insurance adjustment firm employed by the insurers and an employee of the firm were both residents of Texas, and the claims made against them were proper.

The court in *Wells Fargo Bank, N.A. v. American General Life Insurance Co.*, 670 F.Supp.2d 555 (N.D. Tex. 2009), held that a plaintiff brokerage firm suing for brokerage commissions would be ignored for purposes of assessing whether diversity jurisdiction existed, because it was not licensed by the Texas Department of Insurance, and therefore, did not have a viable claim. An unlicensed partnership in Texas cannot accept from any person a commission for services performed as an agent in Texas. Because both a defendant and a plaintiff in the case were citizens of Texas, the court found that there was no diversity jurisdiction.

J. Jury Argument

A court ordered a new trial because the insured's lawyer engaged in improper jury argument by repeatedly alluding to bad faith conduct by the insurance company after the bad faith claims had been severed into a separate case. *Mid-Century Ins. Co. of Tex. v. McLain*, No. 11-08-00097-CV, 2010 WL 851407 (Tex. App.–Eastland March 11, 2010, no pet.) (mem. op.).

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1 A third party over action occurs in worker compensation law when an injured worker is paid medical and lost wage benefits by his employer or insurer, and the injury is caused by some person other than the employer who is paying benefits. The injured worker has a right of "action over" against the third party. The injured worker is barred from suing his employer, but can sue a third party.