ANNUAL SURVEY OF

TEXAS INSURANCE LAW

2012

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I. INTRODUCTION

This year's survey reviews more than three hundred insurance cases decided by Texas state and federal courts. As always, a large number of opinions dealt with whether insurers had a duty to defend their insureds. The Fifth Circuit reversed lower courts that departed from the "eight corners" rule to consider extrinsic evidence. Even though the Fifth Circuit has recognized an exception when coverage facts do not overlap liability facts, the court did not find the exception applied.

The courts continue to be concerned with determining the scope and effect of appraisal clauses, and deciding the extent to which appraisal is binding on the insurer. Familiar fact patterns remain, for example, as a court decided coverage for property damage from thieves stealing copper tubing. Other courts dealt with the common issue of liability for hurricane damage, and even whether an insured's intoxication negated coverage.

Post-*Ruttiger,* the Fifth Circuit considered whether a worker's compensation insured stated a viable claim for misrepresentation, and found it did not. And the Fifth Circuit issued a detailed opinion discussing whether and how an insurer may be found liable for bad faith when it relies on expert opinions.

Many cases reviewed insurers' efforts to remove cases to federal court claiming non-diverse parties were improperly joined, and the insured's efforts to get the cases remanded. A new wrinkle was the number of cases decided by federal courts to determine the adequacy of the plaintiff's pleadings, under the *Iqbal/Twombly* standards. The Fifth Circuit also issued a couple of decisions on choice of law, concluding that Texas law applied to accidents that occurred in other states.

The courts revisited familiar themes in many of the liability cases, such as what constitutes "use" of a vehicle, whether an insurer was primary or excess, and the rights of insurers to get money from each other after settlements. And courts continue to deal with late notice in both first party and third party coverage, and whether and how the insurer must show prejudice.

A new issue the Fifth Circuit considered was when there is a conflict requiring a liability insurer to pay for independent counsel for its insured. A few other decisions also addressed this issue.

Finally, Texas courts continue to review whether an insurer is entitled to severance and separate trials of bad faith and contract claims, particularly in cases involving uninsured motorist coverage.

II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile

A person was injured while helping his neighbor unload a deer stand off a trailer at his residence. The injured party sued his neighbor and his own UM/UIM carrier. The UM/UIM policy required that the injury "arise out of" use of the trailer. The court held that the process of using a trailer includes not only the immediate action of loading and unloading materials from the trailer but also moving them to their destination point. Therefore, coverage was allowed. *Farmers Ins. Exch. v. Rodriguez*, 366 S.W.3d 216 (Tex. App.–Houston [14th Dist.] 2012, no pet.).

In a suit arising from a drunk driver crashing into the insured's home, the court held that the insured's UM/UIM policy, which limited coverage to an automobile and property inside the automobile, did not cover damage to the insured's home. *Ibarra v. Progressive Co. Mut. Ins. Co.*, No. 02-10-00312-CV, 2012 WL 117955 (Tex. App.–Fort Worth Jan. 12, 2012, no pet.) (mem. op.).

An insurer's payment to the United States Army for medical services rendered was proper. *Warmbrod v. USAA County Mut. Ins. Co.*, 367 S.W.3d 778 (Tex. App.–El Paso 2012, no pet. h.). An insured sued her insurer to recover the full amount of her policy's underinsured motorist coverage after the insurer paid part of that amount to the Army for care she received at an Army hospital after her car accident. The court analyzed the Army's right to the proceeds and the property of the insurer's payment under various laws. The Army did not have a right to first party insurance proceeds under the Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-53. However, the Army had a valid reimbursement claim under 10 U.S.C. § 1095, which gives the federal government the "right to collect reasonable medical expenses for the care it provided at government expense from third-party payers," which includes automobile insurers. Because the Army had a right to recover from the insurer under section 1095, the insurer's payment to it was proper.

An insured's damages were not covered by her policy's uninsured motor vehicle coverage when she was injured in an accident caused by a city employee in the course and scope of his employment. *Malham v. Gov't Employees Ins. Co.*, No. 03-11-00006-CV, 2012 WL 413969 (Tex. App.–Austin Feb. 8, 2012, pet. denied) (mem. op.). At issue was whether the city vehicle was an "uninsured motor vehicle" under the policy. The policy definition excluded government-owned vehicles unless the operator was uninsured and "there is no statute imposing liability for damage because of bodily injury … on the governmental body for an amount not less than the limit of liability for this coverage." The city was party to an agreement with other political subdivisions to create a fund meant to provide "coverages against risks which are inherent in operating a political subdivision." The agreement insured the city and its employees acting in the scope of their duties, for up to $2,000,000. The court concluded that the agreement was a liability policy within the meaning of the insured's policy and, accordingly, the operator of the city-owned vehicle was not uninsured. Therefore, the vehicle was not an "uninsured motor vehicle."

The vacancy clause functioned as an exclusion because it suspended certain coverage while other coverage under the policy remained in effect.

B. Homeowners

A vacancy clause excluded coverage in *Farmers Insurance Exchange v. Greene*, 376 S.W.3d 278 (Tex. App.–Dallas 2012, pet. filed), where an insured's property was damaged by fire four months after she moved to a retirement community and placed her home on the market. The insurer denied coverage in reliance on the policy's vacancy provision, which suspended coverage for damage to the dwelling sixty days after it became vacant. The insured argued the insurer could not deny coverage on that basis without showing that it suffered prejudice under section 862.054 of the Insurance Code, which says that a breach of a policy condition does not render a policy void or serve as a defense to a suit for loss unless that breach contributed to the cause of the destruction of the property. The court held that the vacancy clause functioned as an exclusion because it suspended certain coverage while other coverage under the policy remained in effect. As such, section 862.054 did not apply. Because the vacancy provision was an exclusion, and not a condition, it did not matter that it did not contribute to the cause of the fire damage. The court distinguished this case from *Puckett v. U.S. Fire Ins. Co.*, 678 S.W.2d

936 (Tex. 1984), finding that *Puckett* involved a breach of a warranty or condition, whereas this case did not, and that the policy exclusion here was material and not a "technicality."

C. Commercial Property

A policy sublimit applied to both stolen property and resulting building damage. *SA-OMAX 2007, L.P. v. Certain Underwriters at Lloyd's London*, 374 S.W.3d 594 (Tex. App.–Dallas 2012, no pet.). An insured's building was damaged when thieves stole copper pipes and coils from the HVAC units on the roof. The building was further damaged by the resulting holes in the roof. The insurer denied the insured's claim to the extent it exceeded the $25,000 sublimit for theft. The insured argued that the theft sublimit applied only to the value of the items stolen and did not limit coverage for damage caused by the thieves during commission of the theft. The court disagreed. The policy provided coverage for "direct physical loss or damage to Covered Property … caused by or resulting from any covered Cause of Loss." The building was the covered property, and the covered cause of loss was theft. The policy further stated that the most the insurer would pay was the applicable limit shown in the declarations, which states that the limit for theft was $25,000. The court concluded that the sublimit applied to both the items stolen and the damage caused during the theft.

An excess property coverage policy required the insurer to elect and use the same valuation method to determine the amount of loss, in aggregate, for all of the properties damaged in a single occurrence. *Lynd Co. v. RSUI Indem. Co.*, No. 01-11-00193-CV, 2012 WL 1030342 (Tex. App.–San Antonio Mar. 28, 2012, no pet.). Several of the insured's apartment complexes were damaged by a hurricane in an amount exceeding its primary property insurance coverage. The amount of the loss was determined by an independent adjuster retained by both the primary and excess insurers. Rather than pay the amount in excess of the primary policy, the excess insurer had the adjuster recalculate the loss amount based on its interpretation of a "Scheduled Limit of Liability" endorsement contained in the excess policy. The endorsement stated that the insurer would pay "the least" of three different amounts "in any one 'occurrence.'" The term "occurrence" was defined as "any one loss [or] disaster … arising from one event." When the adjuster made the recalculation, he selected one of the three amounts for each damaged apartment building, rather than selecting one option and applying it to all of the apartments in aggregate. This recalculation resulted in a significantly lower amount owed by the excess insurer. The court held that it was improper for the insurer to mix and match the valuation options. The damage to all of the apartments was from a single occurrence. Although one valuation option was linked to the individual values of each scheduled property, the others were not, and the "mere presence of a Statement of Values does not transform an entire policy into a scheduled coverage policy."

An insured's line pipe was damaged during drilling, and the insurer stated that the damage was specifically excluded under the policy as it was caused by faulty construction. The court held that "construction" is an ambiguous term that could have multiple reasonable meanings in the policy. Therefore, the court found in favor of the insured. The court went on to state that the insurer's reading of the policy would effectively undermine the insured's reasoning for buying insurance in the first place. Which was to provide coverage for the insured's property. *RLI Ins. Co. v. Willbros Constr.*, No. H-10-4634, 2011 WL 4729866 (S.D. Tex. Oct. 5, 2011).

D. Life insurance

An ex-wife designated as beneficiary before her divorce was not entitled to recover life insurance proceeds. *Provident Life & Acc. Ins. Co. v. Cleveland*, 460 Fed. App'x 359 (5th Cir. 2012) (per curiam). The court found that a pre-divorce designation of a spouse as beneficiary is ineffective unless (1) the divorce decree designates the former spouse as beneficiary, (2) the insured redesignates the former spouse as beneficiary after the decree, or (3) the former spouse is designated as beneficiary in trust for the benefits of a child or dependent. Tex. Fam. Code § 9.301. None of these exceptions applied. The court declined to create another exception based on the ex-husband designating as beneficiary his "ex-spouse." The court rejected the ex-wife's argument that this designation showed her ex-husband either thought he was already divorced or intended to satisfy the redesignation requirement.

The alcohol exclusion in an accidental death policy barred coverage for a man who died from a heart attack he suffered after falling down while extremely drunk. *Likens v. Hartford Life & Acc. Ins. Co.*, 688 F.3d 197 (5th Cir. 2012). The policy excluded coverage for "any loss resulting from … [i]njury sustained as a result of being legally intoxicated from the use of alcohol." The court rejected the beneficiary's argument that "legal intoxication" meant that the insured had to be both drunk and engaged in some prohibited activity. The court concluded that a reasonable interpretation of "legal intoxication" simply focused on the level of intoxication, not the activities the person engaged in. Because the insured had blood alcohol three times the legal limit, the court found the insured met the definition of legal intoxication, so that the exclusion applied.

The *Likens* court rejected the argument that the fall could have been caused by the insured's clumsiness. There was medical evidence that his intoxication contributed to his fall, and witnesses observed him being extremely intoxicated and falling. The court reasoned that, even if he were clumsy, his high level of intoxication made falling far more likely, and there was no evidence that any clumsiness was actually the dominant factor in the fall.

In *Massachusetts Mutual Insurance Co. v. Mitchell*, No. H-11-3811, 2012 WL 1681653 (W.D. Tex. May 14, 2012), an insurer sought a declaration that it had no obligation to pay life insurance proceeds to the beneficiary until it obtained proof that the deceased was the insured. The beneficiary moved to dismiss, and the court denied the motion, holding that the insurer sufficiently alleged that the designated beneficiary did not have an insurable interest in the policies due to inconsistencies in the application process that lead it to question whether the insured applied for or consented to the policies at issue. The court also held that the incontestability provision did not bar the insurer from seeking rescission, as the Texas Insurance Code explicitly allows insurers to rescind life insurance policies even after two years if the insurer proves material, intentional misrepresentations were made in obtaining the policy.

A court granted summary judgment in favor of the insurer in a case where the daughter of the deceased's insured sued for the benefits of her father's accidental death policy. Her father died from misuse of prescription medications combined with alcohol use. The court held that the cause of death did not result from an accident independent of medical treatment. Additionally, the court held that the prescription drug exclusion barred coverage. *Arredondo v. Hartford Life & Accident Ins. Co.*, No. M-11-84, 2012 WL 948979 (S.D. Tex. March 20, 2012).

E. Other policies

An insured's ship was damaged during a hurricane. The insured did not notify the insurer of the damage until forty-six days after the alleged damage was sustained. Several of the damaged items had already been removed from the ship by the time the insurer was notified. The court held that the insurer was

not promptly notified of the claim as required under the policy. *S&J Diving Inc. v. Procentury Ins. Co.*, No. G-10-368, 2012 WL 1999633 (S.D. Tex. June 4, 2012).

Certain costs associated with a pollution incident at an offshore oil well were covered, while others were not. An insured's well was damaged by Hurricane Katrina, which caused a "sudden and accidental pollution incident" whereby hydrocarbons were released into the Gulf of Mexico. The policy covered clean-up efforts, including testing, monitoring, removing, containing, treating, and detoxifying pollutants. However, costs for pollution prevention, repairing flowlines, and removing wreckage and debris were not covered. Accordingly, the insured's costs to test for and locate leaking flowlines and to cap them to contain the escaping hydrocarbons were covered. Costs to identify leaks from vessels and equipment were also covered. However, equipment that was not leaking did not require pollution work and was therefore not covered. Pollution resulting from cutting non-leaking flowlines was not covered because it did not result from the sudden and accidental pollution incident. Costs of removing structural components that blocked access to leaking equipment were covered if they had to be removed only to abate the leak, but if they had to be removed anyway, and removal simply made pollution abatement more convenient, then the removal was not covered. *Cox Operating, L.L.C. v. St. Paul Surplus Lines Ins. Co.*, No. H-07-2724, 2012 WL 290027 (S.D. Tex. Jan. 31, 2012).

F. Worker's Compensation

In *Effinger v. Cambridge Integrated Services. Group*, No. 10-20630, 2011 WL 8201842 (5th Cir. Dec. 22, 2011), the court considered whether an injured worker stated a claim for misrepresentation and concluded he did not. The worker contended that the insurer misrepresented the scope of coverage by representing that it would complicate a compensable injury. The court concluded that any policy promise to promptly compensate did not become a misrepresentation merely because the insurance carrier disputed whether an injury was compensable and delayed payment. The court also held that an insurer's statement to the insured that coverage was denied did not amount to an actual misrepresentation merely because it was later determined that coverage was appropriate. The court concluded that an actual misrepresentation required the insurer to represent a "specific circumstance" would be covered and to subsequently deny coverage.

III. FIRST PARTY THEORIES OF LIABILITY

A. Unfair Insurance Practices, Deceptive Trade Practices & Unconscionable Conduct & Duty of Good Faith and Fair Dealing

The Fifth Circuit examined whether there was evidence that a worker's compensation insurer acted in bad faith by initially denying an employee's claim and then later paying the claim after the contested hearing. *Thompson v. Zurich Am. Ins. Co.*, 664 F.3d 62 (5th Cir. 2011). The issue was whether the insurer had reasonably relied on expert opinions from a doctor. The court reviewed Texas law and held that conflicting expert opinions do not, by themselves, establish that the insurer acted unreasonably in relying on its own expert. The court stated that the party alleging bad faith must bring evidence showing that the insurer's expert's opinion was questionable and the insurer knew or should have known that the opinion was questionable. The court found that the insurer's expert had well-documented credentials and a reasonable medical basis for his opinion. There was no evidence that the doctor's opinion was unreasonable or that there was any knowing omission in his investigation of such magnitude as to cast doubt on the insurer's basis for denial.

The Fifth Circuit distinguished other Texas cases where evidence showed that the expert was biased and the insurer knew it. In this case, the court held that there was nothing showing that the doctor gave opinions predominately in favor of insurers or that the insurer had knowledge of such a predisposition.

The *Thompson* court did acknowledge that under Texas law an insurer may breach its duty of good faith and fair dealing by failing to reasonably investigate a claim and that insurers have a continuing duty to investigate. The court stated that under Texas law "an insurer does have at least some continuing duty to the insured even after an initial reasonable denial." *Id*. at 70. However, in this case after the initial denial, the insurer participated in the administrative review proceedings and then paid the claim, so there was no breach based on any failure to investigate.

Although the *Thompson* case involved bad faith and common law bad faith in the context of a worker's compensation insurer, the analysis of the court would apply in a claim for statutory unfair insurance practices, because the Texas Supreme Court equated the statutory common law standards in *Universal Life Ins. Co. v. Giles*, 950 S.W.2d 48 (Tex. 1997).

The Fifth Circuit considered whether a beneficiary under a life insurance policy had standing to sue the insurer for fraud, negligence, unfair insurance practices, and deceptive trade practices in *Kocurek v. CUNA Mut. Ins. Soc'y*, 459 Fed. App'x. 371 (5th Cir. Jan. 24, 2012). Kocurek's husband bought an accidental death policy from CUNA in 2004. After paying premiums on that policy for four months, he received a mailing from CUNA offering him additional accidental death coverage, so he purchased a second policy in 2005. The first policy named Kocurek as the beneficiary, while the second policy named their children as primary beneficiaries. The husband paid premiums on both policies until his accidental death in 2006. CUNA refused to pay benefits under the 2004 policy, based on provisions in both policies stating that only one policy could be enforced.

Kocurek argued that CUNA behaved in a misleading manner by selling a second policy without disclosing that the second policy would void the first. The district court dismissed all her claims for lack of standing or for failure to state a claim. The Fifth Circuit reversed.

As to her fraud and negligence claims, the Fifth Circuit concluded that the petition showed Kocurek had suffered an injury, based on CUNA's failure to pay the claim under the 2004 policy of which she was the beneficiary. Further, she had standing to sue under the Texas Insurance Code because she alleged she suffered damages, and there was no requirement that she be a consumer.

However, the Fifth Circuit concluded that her claims under the DTPA were correctly dismissed. The court reasoned that only a "consumer" may sue under the DTPA and, since her husband actually purchased the policy, Kocurek did not qualify as a consumer. Relying on *Transportation Insurance Co. v. Faircloth*, 898 S.W.2d 269, 274 (Tex. 1995), the court held that if a person's only relationship to an insurance policy is as a beneficiary seeking proceeds then she is not a consumer.

On this latter point, the Fifth Circuit was wrong. The DTPA recognizes that a consumer is anyone who seeks or acquires goods or services. In *Kennedy v. Sale*, 689 S.W.2d 890 (Tex. 1985), the supreme court addressed the situation where an employee acquired insurance purchased by his employer. There, the Texas Supreme Court concluded that the insured employee was a consumer, because he acquired the policy, even though the employer actually purchased it. Similarly, in *Birchfield v. Texarkana Memorial Hospital*, 747 S.W.2d 361, 368 (Tex. 1987), the court held that a minor was a consumer of medical services because she "acquired them," even though they were purchased by her par-

ents. The supreme court held that a plaintiff establishes standing as a consumer in terms of her relationship to a transaction, not by a contractual relationship with the defendant. Therefore, the fact that Kocurek's husband bought the policy does not prevent her being a consumer, where she acquired the benefit by being named as beneficiary.

The court erred in its reading of *Faircloth*. The policy in *Faircloth* was a liability policy. In that context, the court held that a third party negotiating a settlement with an insured does not seek to purchase or lease any services of the insurer, and seeking the proceeds of the policy did not make the third party a consumer. This reasoning does not extend to a person named as a beneficiary under the life insurance policy, who clearly acquires the benefits of that policy. Fortunately, the court's error should not matter in most cases. Any representation or nondisclosure that would be actionable under the DTPA is actionable under the Texas Insurance Code. The only relevant cause of action unique to the DTPA is a claim for unconscionable conduct.

A mortgagor purchased a home and obtained homeowner's insurance as required by the mortgagee. The mortgagor let the homeowner's insurance policy lapse, and the mortgagee purchased a lender-placed policy to protect its interest. After a hurricane, the property was severely damaged. The mortgagor sued the insurer for failing to adequately compensate him, and against the mortgagee for violating the duty of good faith and fair dealing. The court held that the policy itself did not provide any direct benefit to the mortgagor, and the mortgagee's procurement of the policy did not create any duty for it to ensure that the mortgagor received proceeds under the policy. *Garcia v. Bank of Am. Corp.*, 375 S.W.3d 322 (Tex. App.–Houston [14th Dist.] 2012, no pet.).

An insurer breached its duty of good faith and fair dealing by wrongfully terminating coverage in *Hudspeth v. Enterprise Life Ins. Co.*, 358 S.W.3d 373 (Tex. App.–Houston [1st Dist.] 2011, no pet.). An insured purchased a disability insurance policy to cover her car payments in the event of her disability. After the insured was unable to work due to cancer, she notified the insurer of her disability and submitted her claim. The insurer paid for the first month's car payment. However, when the insured was unable to provide a doctor's certification while she was changing healthcare providers, the insurer stopped making payments. When the insured was finally able to provide the certification, the insurer again denied her claim, stating that coverage was cancelled. The court held that summary judgment for the insurer on the insured's bad faith claim was improper. The policy provided that proof of continuing disability be furnished "as soon as reasonably possible," and the insurer invited the insured to do just that when it first denied her claim. The insured submitted proof as soon as she was able, but the insurer then said it had cancelled her policy, even though none of the policy conditions for termination had occurred.

An insurer was not liable for misrepresenting coverage provided by a title insurance policy. *Fidelity Nat'l Title Ins. Co. v. Doubletree Partners, L.P.*, No. 4:08-CV-00243, 2011 WL 4715174 (E.D. Tex. Oct. 5, 2011). The insured filed a counterclaim against its title insurer for violations of the Texas Insurance Code. The court held that the title commitments did not have misrepresentations in them. The court held that it was not possible that the insured could have relied on the insurance documents to assume that the flowage easement would be covered by the policy, because it was clear after review that each document clearly excepted the flowage easement.

The court also held that because there was no breach of the insurance contract, there could not be a breach of the duty of good faith and fair dealing. *Fidelity Nat'l Title Ins. Co. v. Doubletree Partners, L.P.*, No. 4:08-CV-00243, 2011 WL 4715174 (E.D. Tex. Oct. 5, 2011).

A moving company's insurer owed no duty to the moving company's customer. *Lasewicz v. Joyce Van Lines, Inc.*, 830 F. Supp. 2d 286 (S.D. Tex. 2011). An individual hired a moving company to move her belongings and signed a bill of lading selecting full replacement value. The bill of lading specifically said it was not insurance. The individual sued the moving company and its insurer after items were damaged and lost during the move. The court found there was no insurance contract between the individual and the insurer, and held that where the injured party is not a party to the insurance policy, there is a long-standing prohibition against allowing the injured party to sue the insurance company.

An insured sued its insurer for unfair settlement practices relating to property damage in a hurricane. The insurer moved to dismiss the extra-contractual claims for failure to comply with the federal pleading requirement. The court held the insured failed to properly plead facts indicating that the insurer's communications were misrepresentations, rather than merely inaccurate evaluations of the true value of the damage. Therefore, the extra-contractual claims were dismissed. *Atascocita Realty, Inc. v. W. Heritage Ins. Co.*, No. 4:10-CV-4519, 2012 WL 4052914 (S.D. Tex. Sept. 13, 2012).

Extra-contractual claims for violations of the Texas Insurance Code are barred in suits filed pursuant to a Standard Flood Insurance Policy. *Davenport v. Fidelity Nat'l Prop. & Cas. Ins. Co.*, No. 1:10-CV-695, 2012 WL 929610 (E.D. Tex. Feb. 27, 2012).

An insured's building was damaged by a hurricane, and the insurer disputed the amount of damage incurred due to the hurricane. The court held that because there was a dispute as to the claim, the insured's prompt payment claim should not be dismissed. However, the court dismissed the insured's claims for breach of the duty of good faith and fair dealing and unfair settlement practices under ch. 541 because the summary judgment evidence showed no more than a bona fide dispute between the parties that did not rise to the level to support a claim for breach of the duty of good faith and fair dealing. The insured also did not identify any facts that the insurer allegedly misrepresented. *Harrison v. Int'l Catastrophe Ins. Managers*, No. 1:10-CV-683, 2012 WL 1231071 (E.D. Tex. March 22, 2012).

Insureds sued their insurer after their home was damaged. The insureds hired a contractor who took the insurer's payments but failed to pay the subcontractors. The insurer asked to do an

audit to determine how much money the contractor misappropriated. However, the insurer's audit was done to build a case based on trouble with the contractor as a reason to deny any additional payments to the insureds. The insured alleged that the insurer's acts violated the Texas Insurance Code and the duty of good faith and fair dealing. The court dismissed the claims, because the insured did not suffer any damages beyond the damages claimed for the breach of the insurance policy. The court noted that the insureds did not mention any item of damage independently related to any of their extra-contractual claims. The court did not allow the insureds to amend, because the insureds knew of the deficiencies in their amended complaint and had not filed a motion for leave to amend or suggested any allegations that they would make if permitted to amend again. *Tracy v. Chubb Lloyds Ins. Co.*, No. 4:12-CV-174-A, 2012 WL 2477706 (N.D. Tex. June 28, 2012).

The district court erred in its conclusion. The Texas Supreme Court has made it quite clear that policy benefits are damages and in fact may be damages as a matter of law, in *Vail v. Tex. Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 136 (Tex. 1988). In *Vail* the insurer made the same argument – that the insureds' only damages were under the contract and these were damages for breach of contract and were not actual damages for unfair settlement practices. The supreme court expressly rejected this argument, saying "We hold that an insurer's refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld." Thus, not only is it absurd to say policy benefits aren't damages for unfair settlement practices, such a conclusion is it directly contrary to controlling supreme court authority.

A mortgage lender did not owe a duty of good faith and fair dealing to an insured homeowner. *Picard v. Chase Home Fin., L.L.C.*, No. 3:11-CV-439-L, 2011 WL 5333060 (N.D. Tex. Nov. 3, 2011). After an insured's home was damaged during a storm and he sued his insurer, which eventually settled and paid $65,000 to the insured and his mortgage lender. The lender refused to release the full amount to the insured, insisting it would pay the insured in increments as the work was completed. The insured sued his lender for breach of contract along with breach of the duty of good faith and fair dealing. The court granted lender's motion to dismiss, because it could not locate any case that applied this duty in the context of a contract between a mortgagor and mortgagee with regard to settlement proceeds. The *Picard* court's decision is supported by *English v. Fischer*, 660 S.W.2d 521 (Tex. 1983), where on very similar facts, the Texas Supreme Court refused to imply a covenant of good faith and fair dealing.

An insured sued its insurer for violating the duty of good faith and fair dealing, following property damage after a hurricane. The court found sufficient evidence to support the claim, as the evidence showed that the insurer's expert reports were not prepared objectively. *Beaumont Preservation Partners, L.L.C. v. Int'l Catastrophe Ins. Managers, L.L.C.*, No. 1:10-CV-548, 2011 WL 6707287 (E.D. Tex. Oct. 6, 2011).

A lessor sued its lessee's insurer for breach of the duty of good faith and fair dealing after damage was sustained to the leased property as a result of a hurricane and the insurer failed to pay. The court held that being named on the certificate of insurance, as the lessor was, did not create insurance coverage when such coverage was precluded by the terms of the policy. The court also held that the lessor failed to prove it was an intended third party beneficiary, and it was not an implied third party beneficiary, because the lease did not require that the lessee procure a policy issued in the lessor's name. Therefore, summary judgment was granted in favor of the insurer. *Bender Square Partners v. Factory Mut. Ins. Co.*, No. 4:10-CV-4295, 2012 WL 208347 (S.D. Tex. Jan. 24, 2012).

B. ERISA

The Fifth Circuit held that ERISA did not preempt the claims of a third party medical device supplier suing the health insurer for promissory estoppel, negligent misrepresentation, and violations of the Insurance Code, where the insurer's representatives made statements that reasonably led the provider to believe its services would be covered. The court reasoned that liability for these representations did not depend on whether the services were actually covered by the plan, but instead depended on what the insurer said. The court also found that granting a cause of action did not affect the relations between the insured patients and the insurer, because the issue concerned the duties owed to the third party provider. The court held, however, that the provider's claims for quantum meruit and unjust enrichment would be preempted, because they depended on whether the claims were covered by the terms of the plan. *Access Mediquip, LLC v. Unitedhealthcare Ins. Co.*, 662 F.3d 376 (5th Cir. 2011, aff'd en banc, No. 10-20868, 2012 WL 474260 (5th Cir. Oct. 5, 2012)).

Not only is it absurd to say policy benefits aren't damages for unfair settlement practices, such a conclusion is it directly contrary to controlling supreme court authority.

An insurer denied a claim under the illegal acts exclusion where there was evidence that the insured was drunk at the time of the auto collision and his intoxication contributed to his injuries, even though the wreck was also caused by the conduct of two oncoming drivers who were racing. *Jimenez v. SunLife Ass. Co. of Canada*, No. 11-30872, 2012 WL 3495259 (5th Cir. Aug. 15, 2012) (not published). In reaching this conclusion, the court first had to decide whether to apply the law of Louisiana or Texas. This issue is discussed below.

Denial of a former NFL player's claim for greater disability benefits was not an abuse of discretion, where there were conflicting medical opinions as to whether he was totally and permanently disabled and, if so, whether that disability arose from football. The court held that delay in reaching a decision and the use of an arbitrator to break a deadlock in the initial decision were not errors that justified a less deferential standard of review. *Atkins v. Bert Bell/Pete Rozelle NFL Player Retirement Plan*, No. 11-51202, 2012 WL 3931010 (5th Cir. Sept. 11, 2012).

A district court held that a self-interested administrator applied a legally incorrect interpretation and therefore abused its discretion by denying the accidental death claim of an insured who died in a single-car crash when driving while intoxicated. As the policy contained no definition of "accident," the court found it was not a fair reading of the policy for the insurer to adopt a per se rule that death from drunk driving is never an accident because it is always foreseeable. The insured's beneficiary was therefore entitled to recover the policy benefits. The Fifth Circuit liked the opinion of the district court so much that it adopted and attached the opinion as an appendix. *Firman v. Life Ins. Co. of N. Am.*, 684 F.3d 533 (5th Cir. 2012).

An ex-wife sued to recover the insurance proceeds of her ex-husband's policy when he died six months after their divorce, and she was still designated as his beneficiary at the time of his death. Adhering to the plan documents, requirement of a writ-

ten request to change a beneficiary, the court concluded that the ex-wife should receive the proceeds. However, the court sustained the estate's breach of contract claim, holding that the ex-wife breached the divorce decree by claiming the benefits of the life insurance policies, since the decree divested her of other benefits existing by reason of the husband's past, present, and future employment. *Flesner v. Flesner*, 845 F. Supp. 2d 791 (S.D. Tex. 2012).

An insured employee who was injured on the job sued for violations of the Texas Insurance Code. The court held that the employee welfare benefits plan was governed by ERISA, which expressly preempts state law claims relating to a qualifying employee benefit plan. The court held that because the claims for violations of the Texas Insurance Code arose from the insurer's alleged denial of benefits under the plan, they were subject to conflict preemption and were dismissed. *Jones v. Aetna Ins. Co.*, No. 1:11-CV-266, 2011 WL 6963165 (E.D. Tex. Dec. 15, 2011).

IV. AGENTS, AGENCY & VICARIOUS LIABILITY

A. Individual liability of agents, adjusters, and others

Two companies sued their insurance agent, asserting that he sold them insurance from a non-admitted carrier without the license and training to do so, that the insurer became financially unstable, and that the agent's failure to disclose the lack of stability harmed them when the insurer failed to contribute towards settlement of a suit against them. The companies sought the full $5 million limits of the policy from the agent. The court of appeals held that there was no evidence that the agent's conduct caused damage to the insureds. *Guidry v. Envtl. Procedures, Inc.*, No. 14-11-00090-CV, 2012 WL 4017984 (Tex. App.–Houston [14th Dist.] Sep. 13, 2012, no pet.). Although the insurer did not initially contribute towards settlement, it ultimately contributed $500,000. There was no evidence that an admitted insurer would have contributed more. There also was no evidence that the insurer's financial condition caused it to contribute less than it might otherwise have or that it was financially unable to pay its covered claims. There also was no evidence that the insureds would have received a larger settlement contribution if their insurance had been procured by a licensed agent.

V. THIRD PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile liability insurance

The Fifth Circuit held that an adult son was not insured under his parents' personal liability umbrella policy because his "permanent residence" was his apartment, not his parents' house. *State Farm Fire Ins. Co. v. Lange*, No. 11-20396, 2012 WL 2547105 (5th Cir. July 3, 2012) (per curiam). The policy provided coverage to the insured's relatives "whose primary residence is your household." The court construed "primary" to mean one's chief, principle, and most important residence.

Motorists injured in a car accident with an uninsured truck sued an insurer that had given the trucking company insurance quotes, even though the trucking company did not purchase insurance. However, the insurance company did help the trucking company get state registration for the truck. The court found these facts did not show that the insurer had any duty to warn motorist of dangers relating to the trucking company's operations. *Salazar v. Ramos*, 361 S.W.3d 739 (Tex. App.–El Paso 2012, pet. denied).

A driver ran a red light, striking another vehicle. The driver's insurer denied coverage, so the injured party's insurer filed a subrogation suit against the driver to recover the insurance proceeds it paid to the injured party. The injured party's insurer obtained a default judgment against the driver, and the court signed a turnover order assigning to the insurer all of the driver's causes of action against its insurer. The court held that the driver's insurer had properly denied coverage, because the owned-vehicle exclusion applied. The negligent driver owned the vehicle he was driving at the time of the accident, but had failed to tell his insurer. *Nat'l Fire Ins. Co. of Hartford v. State & Co. Mut. Fire Ins. Co.*, No. 01-11-00176-CV, 2012 WL 3776422 (Tex. App.–Houston [1st Dist.] Aug. 30, 2012, no pet. h.) (mem. op.).

An injured motorist did not have standing to sue an insured's automobile liability insurer. The motorist claimed to have had an oral settlement agreement with the insurer that the insurer breached. However, because there was no evidence showing that the insured had entered into a settlement agreement with the motorist and the insurer as to her liability or that the motorist had a judgment against the insured, the court concluded that the motorist did not have standing. *Haygood v. Hawkeye Ins. Services., Inc.*, No. 12-11-00262, 2012 WL 1883811 (Tex. App.–Tyler May 23, 2012, no pet.) (mem. op.).

B. Comprehensive general liability insurance

In *Salcedo v. Evanston Ins. Co.*, 462 Fed. App'x 487 (5th Cir. 2012) (per curiam), the court held that a worker's burn injuries, caused by hot asphalt when a hose from a plant's asphalt reservoir to an oil truck ruptured, were excluded as arising out of the "use" of the truck. The court found that the injury occurred while the oil truck was being used as it was intended for uploading oil. The accident occurred within the truck's natural territorial limits before the actual use terminated. Finally, the truck produced the injury. Salcedo could not have been injured the way he was without the use of the oil truck, and the accident did not merely happen near the truck. The court rejected Salcedo's argument that the exclusion applied only if the injuries arose from the insured's use of the truck. Nothing in the policy language limited the exclusion this way.

A contractor hired a subcontractor to pour concrete for a city construction project. The concrete was improperly poured, and the contractor, subcontractor, and city reached an agreement as to the damages and how the problem would be fixed. Five months after the settlement was reached and the damage repaired, the contractor, who was listed as an additional insured under the subcontractor's insurance policy, filed suit against the subcontractor's insurer. The insurer required in its contract that the insured cooperate with the insurer to settle the claim. The court held that the insurer's right to participate in the settlement process was an essential prerequisite to its obligation to pay a settlement, and depriving the insurer of its contractual right constituted a material breach, or prejudice. Therefore, the court affirmed summary judgment for the insurer. *Allen Butler Constr., Inc. v. Am. Econ. Ins. Co.*, No. 07-10-0490-CV, 2011 WL 6183575 (Tex. App.–Amarillo Dec. 13, 2011, no pet.) (mem. op.).

A subcontractor's insurer had no duty to defend or indemnify the contractor as an additional insured. *Cont'l Cas. Co. v. Am. Safety Cas. Ins. Co.*, 365 S.W.3d 165 (Tex. App.–Houston [14th Dist.] 2012, pet. filed.). After settling with an injured employee of a subcontractor, the contractor's insurer sued the subcontractor's insurer to recover the settlement payment on grounds that the contractor was an additional insured on the subcontractor's policy. The court held that the subcontractor's insurer owed no duty to defend or indemnify under the terms of the additional insured endorsement. The endorsement provided defense coverage to the contractor only in the event that it was alleged to be vicariously liable for the sole negligence of the subcontractor. But the

underlying suit alleged separate negligence claims against both the contractor and subcontractor. Because the underlying suit was based on the contractor's own negligence and not vicarious liability, the subcontractor's insurer had no duty to defend the contractor. Further, the jury in the underlying case did not find that the injuries arose from the sole negligence of the subcontractor, and that the responsibility was shared by the contractor, the subcontractor's employee, and the underlying plaintiff. Therefore, the subcontractor's insurer had no duty to indemnify the contractor.

A refinery owner was an additional insured under a policy issued to the employer of a repair crew. *Pasadena Refining Sys., Inc. v. McCraven*, No. 14-10-00860-CV, 2012 WL 1693697 (Tex. App.–Houston [14th Dist.] May 15, 2012, pet. dism'd) (mem. op.). The refinery owner hired the employer to make certain repairs to the refinery. During repairs, a member of the repair crew was severely injured. The crew member successfully sued the refinery owner for negligence. The refinery owner sued the employer's insurer, seeking a declaration of its additional insured status under the policy. The court concluded that the owner was an additional insured under the policy. The policy described an additional insured as "Any person or organization … for whom the named insured … has specifically agreed by written contract to procure bodily injury … insurance …." The contract between the refinery owner and the employer required that the owner be added as an additional insured. The court of appeals looked to the unambiguous language of the policy, which did not limit coverage to indemnity under the contract between the owner and employer, and concluded that the owner was an additional insured under the policy.

An employer sought coverage as an additional insured under an oil company's policy for an arbitration award entered against it arising from injury to its employees who were working on the oil company's drilling operation. *Offshore Recruiting Servs., Inc. v. New Hampshire Ins. Co.*, No. 01-10-00946-CV, 2011 WL 6938531 (Tex. App.–Houston [1st Dist.] Dec. 29, 2011, no pet.) (mem. op.). Relying on an indemnity agreement between it and the oil company, the employer sued the oil company's insurer, which denied coverage on grounds that the policy was excess and the employer had already been fully indemnified for the arbitration award by its own insurer. The court held that the insurer did not owe indemnity to the employer as an additional insured for the amounts that the employer's own insurer had already paid. The policy stated that any coverage potentially available to the employer as an additional insured was limited to amounts in excess of insurance the employer was obligated to obtain under the terms of its contract with the oil company.

C. Professional liability insurance – Errors & omissions

The court of appeals reversed the district court's decision that an insurer was required to pay for claims against a doctor for medical malpractice. The court held that the unambiguous language of the policy stated that the policy only covered claims that were first made against the insured and reported to the insurer while the policy was in force. The court also held that an insurer need not demonstrate prejudice to deny coverage when an insured does not give notice of a claim within the policy's specified time period. Because the record showed that no claim was made against the doctor under the policy and no claim was reported within the policy period to the insurer, the insurer was not required to show prejudice to deny coverage. *Oceanus Ins. Co. v. White*, 372 S.W.3d 700 (Tex. App.–El Paso 2012, no pet.).

The court's holding on prejudice is in direct conflict with the supreme court's holding in *Prodigy Communications Corp. v. Agricultural Access & Surplus Ins. Co.*, 288 S.W.3d 374, 377 (Tex. 2009), where the court held under a claims-made policy that the insurer had to show prejudice. However, it appears the court reached the right conclusion if no claim was made against the insured during the policy period.

A doctor left his practice group, which purchased prior-acts professional-liability insurance for him. The practice group paid the premiums for that policy. *Coterill-Jenkins v. Tex. Med. Assoc. Health Care Liab. Claim Trust*, No. 14-11-00697-CV, 2012 WL 3524985 (Tex. App.–Houston [14th Dist.] Aug. 16, 2012, no pet.). Shortly after the doctor left, he passed away. The insurer paid the premiums back to his practice group, but the executrix of his estate sued the insurer and practice group stating those premiums should be paid to the estate. The court held that because the doctor never paid the premium on the policy, there was no payment to return to his estate.

VI. DUTIES OF LIABILITY INSURERS

A. Duty to defend

A liability insurer did not have a duty to defend an organ donation charity sued for representing that tissues would be distributed on a non-profit basis but that instead were sold for a profit. A daughter sued when she learned that the defendant was transferring her mother's organs to the for-profit companies. The Texas Supreme Court held that the definition of "personal injury," which was defined as "bodily injury, sickness, or disease, including death resulting therefrom sustained by any person," did not apply to claims for mental anguish, absent any physical injury. The court reasoned that because "bodily" modifies injury, sickness, and disease, a physical manifestation was required for sickness or disease to be covered. *Evanston Ins. Co. v. Legacy of Life, Inc.*, 370 S.W.3d 377, 382 (Tex. 2012).

The supreme court also held that the petition did not state a claim for "property damage" based on plaintiff's loss of use of her deceased mother's tissues, organs, bones, and body parts. The court recognized that the next of kin have certain rights regarding the deceased's body, which the court has recognized as a quasi-property right. However, the court concluded that the rights of the next of kin do not mean that tissues have attained the status of property of the next of kin. Further, because the deceased's estate has even fewer rights, the tissues were not the property of the estate. Therefore, there was no claim for property damage. *Id.* at 382-87.

Based on these holdings by the Texas Supreme Court, the Fifth Circuit held the insurer had no duty to defend. *Evanston Ins. Co. v. Legacy of Life, Inc.*, No. 10-50267, 2012 WL 3641641 (5th Cir. Aug. 24, 2012) (per curiam).

The Fifth Circuit rejected a district court's ruling that the "eight corners" rule did not apply to determine the duty to defend. *Guideone Specialty Mut. Ins. Co. v. Missionary Church of Disciples of Jesus Christi*, 687 F.3d 676 (5th Cir. 2012). A church employee and church member drove the employee's van to San Antonio where they proceeded to clean a church building. The employee loaned the van to the member, who ran a red light and collided with the plaintiff's vehicle, causing serious injuries. The plaintiff sued the church, the employee, and the member, alleging that the church and employee negligently entrusted the van to the member.

The church was insured under a policy that covered "non-owned autos," which were defined to include autos owned by employees, but only while used in the church's business or personal affairs.

Instead of applying the eight corners rule and comparing the petition to the insurance policy to determine whether there was a duty to defend, the district court instead considered extrinsic

evidence to determine whether the van was being used in connection with the church's business to support a conclusion that the church would be legally obligated to pay damages. Finding there was no evidence, the court held there was no coverage for the claim and therefore no duty to indemnify.

The district court justified its departure from the eight corners rule based on the language of the policy, which stated that the insurer had "no duty to defend the insured against any 'suit' seeking damages for 'bodily injury' or 'property damage' to which this insurance does not apply." The district court reasoned that this language made the duty to defend and duty to indemnify co-extensive so that it was proper to first consider whether there was coverage for the claim before deciding whether there was a duty to defend. The Fifth Circuit rejected this analysis and held that the district court erred by not applying the eight corners rule. The Fifth Circuit concluded that the language of the policy did not justify departure from the eight corners rule. The Fifth Circuit then applied the eight corners rule and concluded that the insurer had a duty to defend, since the petition alleged that the van was being used in connection with the church's business.

The court rejected the insurer's argument that the indemnity agreement was unenforceable and therefore did not assume tort liability of another party, and was not an insured contract.

The Fifth Circuit also rejected the insurer's argument that the court should apply an exception to the eight corners rule, which the Fifth Circuit has recognized "when it is initially impossible to determine whether the coverage is potentially implicated and when the extrinsic evidence goes solely to a fundamental issue of coverage which does not overlap with the merits of or engage the truth or falsity of any facts alleged in the underlying case." In this case, the court concluded that the questions regarding coverage overlapped with the questions regarding the plaintiff's negligent entrustment claim.

Another district court erred in relying on extrinsic evidence to find a liability insurer had no duty to defend in *Colony Nat'l Ins. Co. v. Unique Indus. Prod. Co.*, No. 11-20355, 2012 WL 3641523 (5th Cir. Aug. 24, 2012). The insurer offered affidavits and the insurance application to show that the plumbing product supplier knew of problems with its product before the policy was issued, thus invoking the "known loss" exclusion. The Fifth Circuit noted that even though it has recognized a narrow exception to the eight corners rule allowing consideration of extrinsic evidence that relates to an independent and discrete coverage issue but does not touch on the merits of the underlying claim, the Texas Supreme Court has not recognized such an exception. Moreover, the exception would not apply in this case, because the timing of when the insured became aware of the prior defects was relevant and prejudicial in the underlying case.

The *Colony National* court also rejected the insurer's argument that the insured violated the "consent to settle" clause by allegedly agreeing to take responsibility for existing and future claims related to the product defect. The majority opined that it was not clear that the alleged agreement constituted the type of settlement referenced in the clause, and the court could not determine that the entirety of the complaints against the insureds sought to recover "payment of a settlement." In addition, the court declined to find that the clause was a "condition precedent."

A liability insurer had a duty to defend a general contractor as an additional insured where the contract with the employer required that the employer add the contractor as an additional insured, in *Gilbane Building Co. v. Admiral Ins. Co.*, 664 F.3d 589 (5th Cir. 2011). The worker, Parr, sustained injuries when he was climbing down a ladder. He sued the general contractor, Gilbane, which was operating the construction project. He did not sue his employer, Empire Steel. The court first held that the contract requiring Empire to indemnify Gilbane and provide insurance was an "insured contract" within the meaning of the policy, so that Gilbane was an additional insured. The policy defined "insured contract" to mean a contract "under which you assume the tort liability of another party to pay for bodily injury." The court rejected the insurer's argument that the indemnity agreement was unenforceable and therefore did not assume tort liability of another party, and was not an insured contract. The court reasoned that whether Gilbane was an additional insured because of an "insured contract" turned not on enforceability of the contract but on whether the insured agreed to assume the tort liability of another.

The next question the court considered was whether there was a duty to defend based on the allegations in the pleadings. The additional insured provision provided coverage only with respect to liability bodily injury caused in whole or in part by Empire's acts or omissions or the acts or omissions of those acting on Empire's behalf. Thus, the insurer owed a duty to defend only if the underlying pleadings alleged that Empire or someone acting on its behalf, including Parr himself, caused Parr's injuries.

The court found no pleading of negligence by Parr and no pleading of negligence by Empire. Thus, there was no duty to defend. The insurer argued that the court should make an exception and should infer negligence by Parr, because an injured worker is unlikely to plead his own negligence. The insurer also argued that the court should assume that Empire, the employer was negligent and that Parr failed to allege such negligence to avoid worker's compensation issues. The court rejected both arguments because they would require it to read theories into the pleadings that were not there or would require consideration of extrinsic evidence.

The Fifth Circuit found there was not an "insured contract" in *Colony National Ins. Co. v. Manitex*, 461 Fed. App'x 401 (5th Cir. 2012) (per curiam). There, JLG manufactured cranes, which it sold to Powerscreen under an agreement by which Powerscreen assumed JLG's liabilities. Powerscreen sold the cranes to Manitex, under an agreement by which Manitex assumed Powerscreen's liabilities. Colony issued a policy to Manitex that covered liability for bodily injury. When Manitex was sued by two persons injured when a crane malfunctioned, it sought coverage from Colony. Colony declined, contending that the contractual liability exclusion denied coverage for bodily injury for which the insured is obligated to pay damages by the reason of the assumption of the liability in a contract. Manitex relied on an exception to the exclusion, which provided coverage for an "insured contract." The policy defined "insured contract" to mean: "that part of any other contract or agreement pertaining to your business … under which you assume the tort liability of another party to pay for 'bodily injury[.]' … tort liability means a liability that would be imposed by law in the absence of any contract or agreement." The court held that the agreement obligated Manitex to assume the liabilities of Powerscreen, and Powerscreen's liabilities were only contractual, not tort. Therefore, the insurer had no duty to defend or indemnify.

In reaching its conclusion, the Fifth Circuit reversed the district court's finding that the language was ambiguous and could be reasonably read to cover the contract because Manitex assumed the tort liability of JLG. It is hard to see why the district court's analysis is not correct. It does seem clear that Manitex assumed Powerscreen's liability, and Powerscreen's liability included JLG's

tort liabilities. Thus, it seems reasonable to construe the policy to provide coverage, because by contract Manitex did in fact assume the tort liabilities of JLG.

Two liability insurers both had duties to defend their insured ambulance company for injuries suffered by a patient when she was loaded into the ambulance. *Nat'l Cas. Co. v. W. World Ins. Co.*, 669 F.3d 608 (5th Cir. 2012). Preferred Ambulance was insured by National under a business auto coverage policy and by Western under a commercial general liability policy. Preferred was sued after a patient died from injuries sustained while emergency medical technicians loaded her into an ambulance. Both insurers denied any duty to defend. National's policy covered injuries resulting from the "use of an automobile." The court held the key factor was not whether the vehicle merely contributed to cause a condition that produced injury, but whether the vehicle itself produced the injury. The court noted that Texas law broadly interprets "use" in automobile insurance policies and concluded that allegations that the patient was injured while being loaded into the ambulance fell within that coverage.

The Fifth Circuit also concluded that the professional services exclusion did not negate the duty to defend. The court reasoned that part of the alleged conduct did constitute professional services, but other allegations did not. For example, the petition alleged that Preferred was negligent in failing to provide sufficient, competent personnel to safely transport the patient. This was an administrative task, not a professional one, so the exclusion did not negate all coverage.

Western argued that because the injuries related to "use" of the ambulance, they fit within the exclusion in its CGL policy for injuries arising out of the use of any auto, including loading and unloading. The court rejected this argument. Even though some allegations did relate to the use of the ambulance, other allegations, like failing to secure the patient to the gurney, happened apart from any use of the ambulance. Because some of the allegations were not within the exclusion, Western had a duty to defend.

The court also rejected Western's argument that its "other insurance" clause made its coverage excess, not primary. The court reasoned that "other insurance" provisions limit an already triggered duty to defend only when all of the allegations in the underlying lawsuit that fall under the policy's coverage provision also fall under policy's "other insurance" provision. In this case, none of the allegations that triggered Western's policy were covered by National's policy, so both Western's and National's coverage remained primary.

Defective construction of man-made lakes causing them to leak and thereby diminishing the value of the plaintiffs' lakeside properties stated a claim for "property damage" sufficient to trigger the insurer's duty to defend. *Mid-Continent Cas. Co. v. Academy Dev. Co.*, No. 11-20219, 2012 WL 1382459 (5th Cir. April 20, 2012). Even though the plaintiffs' petition was uncertain about whether the leaky lakes caused damage to their homes, the allegations about damage to the lakes themselves alleged property damage. Further, nothing in the insurance policy supported the insurer's argument that the property damage had to occur to property that the plaintiffs owned. Even though the plaintiffs did not own the lakes, they suffered diminution of value of their own properties caused by damage to the lakes.

The court also rejected the insurer's contention that the duty to defend should be apportioned pro rata over five policy years, some of which had higher deductibles. The petition alleged that the property damage occurred throughout the five-year period. The court concluded that the defendants were entitled to choose which year's policy to be defended under, and the insurer's pro rata method was improper. The court reasoned that when an insurer's policy is triggered, "the insurer's duty is to provide its insured with a complete defense, because the contract obligates the insurer to *defend* its insured, not to provide a pro rata defense."

An insured filed for bankruptcy and thus failed to pay the required $250,000 self-insured retention necessary before its liability insurer was obliged to defend. However, other insurers spent millions of dollars on the defense of the insured. The Fifth Circuit concluded that the self-insured retention was satisfied by the other insurers and did not have to be paid by the insured; therefore, the insurer's duty to defend was triggered. *Cont'l Cas. Co. v. N. Am. Capacity Ins. Co.*, 683 F.3d 79 (5th Cir. 2012).

The Fifth Circuit held that an insurer was not required to pay for independent counsel for its insured because no conflict of interest arose. The facts to be adjudicated in the underlying case were not the same as the facts upon which coverage depended. The court rejected the insured's argument that a conflict arises requiring independent counsel whenever the facts to be developed in the underlying case may be the same as the facts upon which coverage depends. *Downhole Navigator, Inc. v. Nautilus Ins. Co.*, 686 F.3d 325 (5th Cir. 2012). The insured was sued for negligently executing a plan to relocate an oil well. The court concluded that the facts to be adjudicated in determining whether the insured was negligent were not the same facts that would be determined in deciding the exclusions listed in the insurer's reservation of rights.

The court was careful to point out that the attorney hired by the insurer to represent the insured is duty-bound to defend the interest of the insured. If the lawyer hired by the insured did, at the insurer's direction, improperly advance an insurer's interest at the expense of the insured's interest, the insurer would breach its duty to defend the insured, and such breach would allow the insured to reject the counsel provided by the insurer. (It seems under Texas law that the consequences of disloyalty by the lawyer paid for by the insurer are more substantial than just replacing the lawyer. Under the *Tilley* doctrine, if the lawyer hired by the insurer develops facts adverse to the insured on coverage, the insurer is estopped to deny coverage. *Employers Cas. Co. v. Tilley*, 496 S.W.2d 552 (Tex. 1973)).

Another insured was not entitled to independent counsel, even though the insurer's offer to defend the insured was subject to a reservation of rights. *Partain v. Mid-Continent Specialty Ins. Servs., Inc.*, 838 F. Supp. 2d 547 (S.D. Tex. 2012). An insured business and individual employee were both sued for copyright infringement. The individual requested that the insurer engage a particular law firm to represent him. The insurer refused, stating that it had retained a different firm to represent both the business and the individual insureds. The individual argued that the insurer's reservation of rights created a conflict that allowed him to select his own independent counsel. The court determined that the insurer fulfilled its duty to defend by offering a defense provided by its selected counsel. There were no facts upon which coverage depended that would be adjudicated in the underlying suit. For instance, the policy provided coverage only for copyright infringement in advertisements. Although the underlying petition alleged that the infringements were in advertisements, the jury would not have an opportunity to specifically determine whether the infringements were in advertisements or elsewhere, since the jury question on infringement would ask simply whether the insured "infringed the copyrights."

In another case, an insured law firm that was sued for malpractice sought declaratory judgment that its insurer had a conflict of interest and should not be allowed to select counsel for the insured. The court held that the possibility that the insurer might reserve its rights for fraud claims did not create a conflict of interest because the insurer specifically stated it had not and would not

ever reserve its right to deny coverage for any claim based on the policy's dishonesty exclusion. The court also held the fact that the policy covered compensatory damages but not fee disgorgement did not create a conflict of interest, and the insurer's reservation of rights with respect to costs arising from declaratory relief did not create conflict of interest. *Coats, Rose, Yale, Ryman & Lee, P.C. v. Navigators Specialty Ins. Co.*, 830 F. Supp. 2d 216 (N.D. Tex. 2011).

Allegations against the insured were sufficient to state a claim that was potentially within coverage even though a specific date was not stated. The court held that nothing in the pleadings negated the possibility that injury occurred during the year the insurance policy was in place, and given that the underlying suit related to asbestos-related diseases, the court noted that it could take years of exposure to produce those diseases. This was an allegation of a potential occurrence within the policy's coverage period. *Geico Gen. Ins. Co. v. Austin Power, Inc.*, 357 S.W.3d 821 (Tex. App.–Houston [14th Dist.] 2012, pet. denied).

A suit filed in the policy period was not considered a claim within the policy period because the suit was "interrelated" with one filed in an earlier year before coverage commenced. *Reeves County v. Houston Cas. Co.*, 356 S.W.3d 664 (Tex. App.–El Paso 2011, no pet.). An insured county and sheriff sought a defense and indemnity from the county's liability insurer after they were sued. The plaintiff in the underlying suit had previously sued the county and sheriff four years before, and that first suit had been settled. The policy was a claims-made policy and, even though the second suit was filed within the policy period, the insurer denied coverage under the "Interrelated Acts" condition in the policy, stating that the current suit was part of the same claim as the first suit, which occurred before the policy period. The court agreed, holding that the suits were interrelated wrongful acts because they "both presented alleged facts as to [the sheriff's] retaliatory actions," and involved the same parties and "the same or similar alleged wrongful actions taken by [the sheriff.]" Because the suits constituted a single claim under the policy, the second suit was considered to be a claim in the year of the first suit and therefore took place outside of the policy period.

An insurer had no duty to defend its insured for claims arising from alleged sexual assault of a minor. The conduct alleged was intentional, and the policy excluded sexual-abuse. *GuideOne Ins. Co. v. House of Yahweh*, 828 F. Supp. 2d 859 (N.D. Tex. 2011).

An insured sold his car to a person who failed to sign the title certificate, file it with the state or get insurance. The purchaser's son got into a wreck in the car and was sued. The court held the previous owners' insurer had no duty to defend the buyer, as the buyer is treated as the owner when he has possession and the right of control over the vehicle. *State Farm Mut. Auto. Ins. Co. v. Scott*, No. H-10-2601, 2012 WL 1098364 (S.D. Tex. March 30, 2012).

An employee was injured while working and sued his employer. The insurer argued that the policy excluded employer's liability and workers' compensation claims. However, the petition did not allege a workers' compensation claim. Therefore, the insurer owed a duty to defend. *Mount Vernon Fire Ins. Co. v. Xpress Water, L.L.C.*, No. G-11-312, 2012 WL 1327806 (S.D. Tex. April 17, 2012).

Another court held that it would not look outside the eight-corners to examine extrinsic evidence – i.e. the certificate of insurance – when determining the insurer's duty to defend. Therefore, based on the underlying petition and policy, there was no coverage for the death of an insured's employee while on the job, and the insurer had no duty to defend. *Nautilus Ins. Co. v. S. Vanguard Ins. Co.*, Civ. No. 3:10-CV-1975-L, 2012 WL 3730945 (N.D. Tex. Aug. 29, 2012).

A law firm sued its liability insurer after the insurer denied coverage for an underlying suit in which the law firm was sued for breaching a referral agreement. *Shore Chan Bragalone Depumpo LLP v. Greenwich Ins. Co.*, No. 3:11-CV-0891-B, 2012 WL 1205159 (N.D. Tex. Apr. 11, 2012). The insurer argued that the suit was not covered because it did not "arise out of professional services." The insured argued that, under a liberal interpretation, the insurer must provide coverage because the damages sought resulted from the professional services that the firm provided to the referred clients. The court found this interpretation reasonable. The underlying petition alleged that the firm had "entered into numerous settlements and license to receive payments," the proceeds of which must be shared under the referral agreement. These actions related to the firm's performance as attorneys. In reaching settlements and licensing agreements for the referred clients, the firm was performing legal services when the damages alleged in the underlying petition arose. Therefore, the damages alleged arose out of professional services.

An insurer did not have a duty to defend its insured in *Materials Evaluation & Tech. Corp. v. Mid-Continent Cas. Co.*, No. 1:10-CV-740, 2011 WL 7052801 (E.D. Tex. Dec. 14, 2011). The insurer and insured disputed whether an earlier version of a policy or a renewal policy applied. The insurer argued that an employer's liability exclusion in the renewal policy barred coverage. The court found that the renewal policy applied, because it was in force at the time the plaintiffs in the underlying suit sustained their injuries from exposure to dangerous chemicals while working for the insured. The changes to the original policy were indicated on the renewal policy, and the insured was presumed to have agreed to those changes. The renewal policy contained an endorsement that excluded employer's liability and barred coverage for the plaintiffs' lawsuit.

A liability insurer had neither a duty to defend nor a duty to indemnify its insured for a suit against it for misrepresentations. *Nat'l Fire Ins. of Hartford v. C. Hodges & Assocs., PLLC*, 825 F. Supp. 2d 792 (W.D. Tex. 2011). The insured, a property developer, was sued by its tenants for making misrepresentations about the anticipated retailers in a shopping center. The misrepresentations alleged by the tenants were not "bodily injury" or "property damage" caused by an "occurrence" within the meaning of the policy. The court determined that negligent misrepresentations do not constitute an "occurrence." Further, the tenants' damages for lost revenue were not caused by physical injury or loss of use and therefore were not covered by the policy.

Two insurance companies each owed a duty to defend an insured property manager and apartment complex owner who were sued after one tenant was sexually assaulted by another tenant, the property manager's nephew, who was a known sex offender. *James River Ins. Co. v. Affordable Housing of Kingsville II, Ltd.*, No. H-11-2937, 2012 WL 1551529 (S.D. Tex. Apr. 27, 2012). The policy named as additional insureds "employees" and "any person … acting as your real estate manager." The pleading in the underlying suit alleged that the property manager was the manager of the apartment complex and was "employed" by the property owner. An exclusion for independent contractors did not apply, because the underlying pleading did not allege that the property manager was an independent contractor.

The second insurer argued that it did not owe a duty to defend, because its coverage period began after the sexual assault took place. However, the court disagreed, because the underlying pleading said that the assault took place "on or about" a certain date, which was "sufficiently indefinite and yet close enough in time to raise potential coverage for the claims." *Id*

An insured was involved in two lawsuits leading to a third one. In the first, the insured was sued by residents of property it managed. The insured had liability policies with three insurers. Two insurers refused to defend the insured. Following settlement of that suit, the one defending insurer sued the insured. The two others provided defense costs in the second suit. Afterwards, the two insurers sought reimbursement from some of the funds that had been set aside to settle the first suit. The third suit sought to determine the extent the insured had to contribute to the insurers' costs of defense in the second suit. The court found that the insurer's defense costs were "claim expenses" within the meaning of the policy and thus fell within the costs that the insured had to pay up to the deductible amount. Because the insured had not met the deductible amount, the insurer was entitled to some of the funds previously set aside. *Trammell Crow Residential Co. v. Am. Protection Ins. Co.*, No. 3:10-CV-2163-B, 2012 WL 4174898 (N.D. Tex. Sep. 20, 2012). Subsequently, the court concluded that, while the insurer's defense costs in the second suit were recoverable from the insured as "Allocated Loss Adjustment Expenses" up to the deductible amount, there remained fact issues as to whether the insured had met its deductible and whether either party had sustained any damages. *Trammell Crow Residential Co. v. Am. Protection Ins. Co.*, No. 3:10-CV-2163-B, 2012 WL 4364616 (N.D. Tex. Sep. 25, 2012).

B. Duty to indemnify

Shoddy workmanship could be an accident and thus an "occurrence" triggering a liability insurer's duty to indemnify a builder, even though the jury in the underlying case found the builder engaged in deceptive trade practices that were a producing cause of damages to the plaintiff, engaged in unconscionable conduct that caused damages, and did so knowingly and intentionally. *Mid-Continent Cas. Co. v. Brock*, 451 Fed. App'x. 335 (5th Cir. Oct. 11, 2011). The insurer argued that the jury's findings established that the builder's conduct was not caused by an occurrence because it was not an accident. The Fifth Circuit rejected this argument. The court reasoned that the focus of the inquiry as to intent or expectation of the insured is whether the harm was intended or expected, not whether the conduct itself was intended or expected. The jury's verdict did not demonstrate that the plaintiff's damages were highly probable or were the natural and expected result of the builder's actions. Further, the findings that the defendant acted knowingly and intentionally established that the builder intended to engage in the conduct and intended for the plaintiff to act in detrimental reliance, but did not establish that the builder intended the injuries.

Although the court in *Gilbane Building Co. v. Admiral Ins. Co.*, 664 F.3d 589 (5th Cir. 2011), found no duty to defend, the court nevertheless found the insurer had a duty to indemnify. To trigger a duty to defend, the court reasoned that the pleadings had to allege negligence by the employee or his employer. This was discussed *supra*. The court found no such pleadings and therefore found no duty to defend.

However, after the general contractor, whom the court found was an additional insured, settled, the court held that the district court properly found evidence that the employee was negligent or that a reasonable jury would have found the employee was negligent, so that the actual facts established coverage.

The term "penalties" within the phrase "fines, penalties, or taxes" is limited to payments made to the government. Therefore, an insurer was obligated to indemnify its insured that was sued in a class action and found liable for statutory damages for failing to provide required notices of default. *Flagship Credit Corp. v. Indian Harbor Ins. Co.*, No. 11-20408, 2012 WL 2299484 (5th Cir. June 15, 2012).

Lost earnings were not covered under an employment practices liability policy. *Pinnacle Anesthesia Consultants v. St. Paul Mercury Ins. Co.*, 359 S.W.3d 389 (Tex. App.–Dallas 2012, pet. filed). The policy excluded coverage for "that part of the Loss that constitutes … amounts owed under a written contract or agreement[.]" The court held that the exclusion excluded the award for lost earnings because those amounts represented the damages the employee was owed under the employment contract. The insured's interpretation of "that part of the Loss" assumed that some damages from breach of a written contract would not be excluded, but the court disagreed because the loss could include damages for breach of an oral contract, quantum meruit, or tort, none of which would be excluded. The court also rejected the insured's argument that lost earnings were not owed "under the contract" because they were consequential damages. The court instead held that the employee's damages for fees he would have earned under the employment contract were direct damages, and not consequential. The court also disagreed with the insured's narrow interpretation of "amounts owed under a written contract" as limited to money owed the employee for fees earned but not paid before termination. The employment contract gave the employee the right to earn fees, which he was wrongfully prevented from earning under the contract when he was fired. Therefore, the lost earnings were amounts the insured owed under a written contract. One justice dissented, however, concluding instead that the exclusion was ambiguous and that the insured's interpretation was reasonable: the lost earnings damages arose from the termination, and not the operation, of the employment contract, and could not be considered amounts owed "under the contract."

An insured had a contract to maintain vegetation at a railway crossing and was sued for failing to do so, which resulted in a fatal collision. The policy had an exclusion for "completed operations." The railroad, which had hired the insured, sought indemnity as an additional insured. The question of the insurer's duty to indemnify was previously considered by the supreme court, which held that it was error to decide whether an insurer had a duty to indemnify, without considering extrinsic evidence, because the duty to indemnify is determined by the facts actually established. The court of appeals reconsidered the question of the insurer's duty to indemnify. The evidence showed, among other things, that the insured had a vegetation control contract

with the railroad that had not expired at the time of the accident, the insured had an obligation to perform vegetation control to the railroad's satisfaction, the contract called for the insured to control vegetation for thirty feet on either side of the railroad track, and that the vegetation at issue was located 35-40 feet from the track. This evidence raised fact questions. *Burlington N. & Santa Fe Ry. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, No. 08-06-00022-CV, 2012 WL 3728176 (Tex. App.–El Paso Aug. 29, 2012, no pet. h.).

The petition in an underlying suit need not allege, nor the insured prove with expert testimony, the exact date physical damage occurred to trigger an insurer's duties to defend and indemnify. *Vines-Herrin Custom Homes, LLC v. Great Am. Lloyds Ins. Co.*, 357 S.W.3d 166 (Tex. App.–Dallas 2011, pet. filed). An insured homebuilder was sued by a buyer whose home developed a series of problems. During the construction and the subsequent years when problems became apparent, the homebuilder was insured. The insurer argued that the homebuilder could not prove coverage because it did not offer expert testimony to show precisely when the physical damage to the home actually occurred. The court disagreed. The petition in the underlying suit sufficiently alleged that actual damage occurred sometime during the policy periods, even though it was phrased in terms of when the plaintiff noticed the damage, because the petition alleged the date of construction, and the insured had continuous coverage from that time through the plaintiff's discovery of the problems.

The insurer in *Vines-Herrin* also had a duty to indemnify. The cause of damages was found to be defective framing, which occurred after the insured began construction and after the insurance was in place. The damage manifested while coverage was still in place. The actual damages must have occurred between the beginning of construction and the manifestation of damage, throughout which time there was coverage. The insured did not need to establish the exact date of injury by expert testimony to trigger the duty to indemnify.

An insured was sued by a landowner for damaging the landowner's property. The insurer had no duty to defend, because the allegations related to actions before the policy period. However, the court denied summary judgment on the duty to indemnify. Because the underlying lawsuit had been settled, there was an inadequate record to determine whether the insured's liability was based on facts that would give rise to a duty to indemnify. *Mount Vernon Fire Ins. Co. v. Boyd*, No. H-11-3785, 2012 WL 1610745 (S.D. Tex. May 8, 2012).

A jury found that an employer of a nanny willfully violated the Fair Standard Labor Act, but did not award damages for the nanny's emotional distress claim. The employer's insurer moved for summary judgment on duty to defend and indemnify following the jury verdict. The nanny asserted that the claim was covered under the policy as "personal injury," which included "false arrest, detention or imprisonment, or malicious prosecution or humiliation," and that the jury award showed humiliation occurred. The court did not agree, finding the jury did not award damages for "humiliation," because the nanny did not assert such a claim. *Safeco Ins. Co. v. Kamat*, 846 F. Supp. 2d 755 (S.D. Tex. 2012).

An excess insurer did not breach its contract and did not have a duty to indemnify its insured in *D.R. Horton, Inc. v. Am. Guar. & Liab. & Ins. Co.*, No 4:11-CV-039-A, 2012 WL 1893977 (N.D. Tex. May 22, 2012). An insured homebuilder sought coverage from its second-level excess insurer for losses it suffered from lawsuits alleging construction defects in residences. The policy provided coverage for "property damage," meaning "physical injury to tangible property." There was no coverage for the lawsuits, because the complaints concerned the insured's defective work and the damages sought were to correct those construction defects and prevent future damage to the property. An expert affidavit that attempted to convert the underlying settlement agreement's damage allocations from construction defects into physical injury was not persuasive. The homebuilder also failed to submit evidence that the primary and first-level excess policies had been exhausted.

An insurer did not owe a duty to defend or indemnify its insureds under the terms of its CGL policy because the insured's liability was not the result of an "accident." The insureds were sued in two lawsuits. In the first, the jury found the insured liable for either gross negligence or willful misconduct without specifying which. There was no finding that the insured was liable as the result of an "accident," and without an accident there was no "occurrence" within the meaning of the policy. A second lawsuit against the insured alleged that it had fraudulently transferred property to avoid paying the judgment in the first lawsuit. There was no coverage for this suit because an intentional act was not an "occurrence." *Jamestown Ins. Co., v. COG Mgmt. LLC*, No. 4:11-CV-01112, 2012 WL 1114073 (S.D. Tex. Apr. 2, 2012).

VII. SUITS BY INSURERS

A. Indemnity & contribution

Homeowners sued their contractor for negligently constructing their home. The insurers for the contractor agreed to defend him against the homeowners' claims. About a year into the lawsuit, one insurer withdrew its agreement to contribute to the defense costs, stating that the damage was outside its policy period. The other insurers settled the suit, and then sued the insurer for contribution and reimbursement of defense and settlement costs. The court held that, when facts alleged in a petition are not sufficient to show clearly that there was no coverage, the insurer had a duty to defend. *Great Am. Lloyds Ins. Co. v. Audubon Ins.Co.*, No. 05-11-00021-CV, 2012 WL 3156571 (Tex. App.–Dallas Aug. 6, 2012, pet. granted).

A trial court dismissed an insurer's claim for reimbursement from another insurer. *Great Am. Assurance Co. v. Wills*, No. SA-10-CV-353-XR, 2012 WL 3962037 (W.D. Tex. Sep. 10, 2012). The insurers had an opportunity to settle a claim against their mutual insured, but one refused to tender its pro rata share of the settlement demand. The subsequent judgment against the insured forced both insurers to exhaust their policy limits. The insurer that wanted to settle sued the other under Tex. Ins. Code § 542.003(b)(4) for reimbursement of the amount it had to pay in excess of its pro rata share of the settlement demand. The court dismissed the claim, finding that section 542.003 does not support a private cause of action and that only the Texas Department of Insurance could bring a claim under that section. Even if a private cause of action existed, it would not be available to the insurer as a third party claimant with no direct relationship with the other insurer.

B. Subrogation

A liability insurer that provided a defense for its insured when three other primary insurers wrongly failed to defend was entitled under the terms of the subrogation clause in its policy to reimbursement from the other insurers who should have borne the cost that it paid. *Cont'l Cas. Co. v. N. Am. Capacity Ins. Co.*, 683 F.3d 79, 86-87 (5th Cir. 2012).

An insurer paid injured parties for damages from the drunk driving of an insured minor. The insured minor died in the accident. The insured minor's father brought a lawsuit against the parents who provided alcohol to the minor, and the insurer intervened asserting a claim for equitable subrogation. The insurer

was asking to stand in the shoes of the injured parties. Under the policy, payment was owed to the injured parties by the insurer based on the fault of its insured. The court held that the insurer could not assert a claim for equitable subrogation to the extent payments exceeded amounts in proportion to fault of insured because such payments would have been voluntary by the insurer. *Allstate Ins. Co. v. Spellings*, No. 01-11-01065, 2012 WL 2452051 (Tex. App.–Houston [1st Dist.] June 28, 2012, pet. granted).

A subcontractor's workers' compensation insurer did not waive its rights of subrogation entitling it to recoup payments it made on behalf of its insured. *Approach Operating, LLC v. Resolution Oversight Corp.*, No. 03-11-00688-CV, 2012 WL 2742304 (Tex. App.–Austin July 3, 2012, no pet.) (mem. op.). The court held that both the insurance policy and the agreement obligating a party to purchase insurance must waive subrogation rights. Although the policy in question contained an endorsement waiving subrogation, the master service agreement between the general contractor and the subcontractor contained no explicit requirement that the insurer waive its subrogation rights.

Invoking equitable subrogation, an excess insurer sought indemnity from a primary insurer arising out of settlement of the underlying suit against the insured, which had filed for bankruptcy. *Admiral Ins. Co. v. Arrowood Indem. Co.*, 471 B.R. 687 (N.D. Tex. 2012). During settlement discussions, the bankruptcy trustee inaccurately told the excess carrier that the primary carrier had settled for policy limits but attorney's fees and outstanding invoices remained that were the responsibility of the excess insurer. Unbeknownst to the excess insurer, the trustee had transferred certain other claims to the primary insurer as part of their settlement. Recognizing the risk of litigation against its insured, the excess insurer settled with the Trustee. After learning of the terms of the settlement between the primary insurer and the Trustee, the excess carrier sued the primary carrier. The court found that the excess insurer had a claim for equitable subrogation because the primary carrier "superficially exhausted its limits by receiving unsecured bankruptcy claims" in exchange for purporting to tender its policy limits. Under these circumstances, the excess insurer could sue for the primary insurer's remaining policy limits. The excess insurer could recover the value of the claims transferred to the primary insurer, since that was the amount by which the primary insurer failed to exhaust its policy limits. The excess carrier was not entitled to attorney's fees under a theory of equitable subrogation.

C. Other causes of action

A fact question precluded summary judgment on whether attorney's fees awarded to an insured law firm as a sanction should go to its malpractice liability insurer under a theory of assumpsit for money had and received. The cause of action for money had and received is not based on contract or promise but on whether a defendant holds money that in equity and good conscience belongs to the plaintiff. The insured could not prove as a matter of law that this was not the case. *MGA Ins. Co. v. Charles R. Chesnutt, P.C.*, 358 S.W.3d 808 (Tex. App.–Dallas 2012, no pet.).

An insurer was not entitled to reimbursement from its insured oil company on theories of equitable restitution and equitable unjust enrichment after it paid for damages resulting from a well blowout. *Warren E & P, Inc. v. Gotham Ins. Co.*, 368 S.W.3d 633 (Tex. App.–El Paso 2012, pet. filed.). The court held that the insurer could not recover because, under *Excess Underwriters at Lloyd's London v. Frank's Casing Crew & Rental Tools, Inc.*, 246 S.W.3d 42 (Tex. 2008), an insurer has no right to equitable reimbursement. Here, the policy provided no right to reimbursement for payment of non-covered claims.

Similarly, the insurer could not recover under its theory of unjust enrichment. Again relying on *Frank's Casing,* the court explained, "equity cannot give [the insurer] rights of recovery that the parties did not agree to in their contract." One justice dissented, arguing instead that the law of the case prohibited the court's holding, because an earlier appeal of the instant case, decided before *Frank's Casing* came out, had determined that the insurer was entitled to restitution.

When "other insurance" clauses of excess policies are mutually repugnant, coverage is prorated among the insurers. *U.S. Fid. & Guar. Co. v. Coastal Refining & Mktg., Inc.*, 369 S.W.3d 559 (Tex. App.–Houston [14th Dist.] 2012, no pet.).

VIII. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Policy benefits

An insurer's liability for breach of contract was restricted to the remaining policy limits. *Hudspeth v. Enter. Life Ins. Co.*, 358 S.W.3d 373 (Tex. App.–Houston [1st Dist.] 2011, no pet.). An insured purchased a disability insurance policy to cover her car payments in the event of her disability. The value of the policy declined with each car payment that the insured made, and the policy terms required the insured to provide written proof of her continuing total disability every month. After the insured was unable to work due to cancer, she notified the insurer of her disability and submitted her claim. The insurer paid for the first month's car payment. However, when the insurer was unable to provide a doctor's certification while she was changing healthcare providers, the insurer stopped making the payments. The court held that the insured's damages for the insurer's breach of contract were measured by the remaining coverage under the policy, accounting for the insured's monthly payments, and not the value of her repossessed car.

B. Attorney's fees

In a suit for declaratory judgment, a court held that when the other insurance clauses of excess policies are mutually repugnant, coverage is prorated among the insurers. The court also held that the insurer that brought the suit was responsible for the other insurer's attorney's fees. *U.S. Fid. & Guar. Co. v. Coastal Refining & Mktg., Inc.*, 369 S.W.3d 559 (Tex. App.–Houston [14th Dist.] 2012, no pet.).

IX. DEFENSES & COUNTERCLAIMS

A. Arson

Evidence was found sufficient to support a conviction for arson for burning an insured vehicle in *Merritt v. State*, 368 S.W.3d 516 (Tex. Crim. App. 2012). Although the burdens of proof are different, the criminal court's analysis would be relevant in a civil case. The insured did not dispute that the vehicle fire had an incendiary origin. The question was whether the state established that it was the defendant who set the vehicle on fire. The court found the following evidence supported the conviction:

- Defendant had a motive to burn the vehicle because it was insured and the proceeds would ease his financial problems. His financial problems included a bankruptcy, an outstanding judgment for $35,000 based on another vehicle loan, and debts for substantial amounts of money for the SUV and the rims and tires he purchased for it.
- Defendant had both sets of keys, and there was no damage to the vehicle consistent with someone moving it without a key.
- There was testimony that the car could not be

moved without a key, unless it was towed, and there was no evidence that the SUV had been towed.

- Although there was testimony that an individual at a car wash had the keys for a short period of time, there was other testimony that it would have been extremely difficult for another person to obtain a duplicate key.
- Before the fire, the more expensive rims and tires were replaced by smaller, cheaper ones, indicating preplanning.
- Replacing the more expensive wheels with cheaper ones was inconsistent with a normal car theft, where the more expensive wheels are normally just removed, and the replacement with smaller wheels would have allowed the defendant to drive the vehicle.
- Although a door was damaged, the damage was not enough to allow access to the vehicle without a key. Interior items had been removed before the fire was set inside the SUV.
- Defendant gave a sworn statement saying that vehicle documents were left in the SUV, but those documents were found in his garage.
- Defendant gave inconsistent versions of the evening's events and could provide no corroborating evidence.
- Defendant never called "On Star," which could immediately locate the lost vehicle. Instead, the police took several hours to find the vehicle.
- Of "crucial importance" was testimony that this was the fifth time the Defendant had reported a stolen car, even though he initially said he had not experienced a vehicle theft before.

B. Limitations

The Fifth Circuit held that the four-year statute of limitations for breach of contract would apply to a claim for denial of benefits under ERISA. The court affirmed the holding that the claim for disability benefits was time-barred. The claim had been denied in 2001. Even though the insurer instituted a reassessment, that only tolled limitations during the reassessment: it did not restart limitations. Thus, once the reassessment decision was made in 2006, the insured had only two months left but did not file suit within that period. *King v. Unum Life Ins. Co. of Am.*, 447 Fed. App'x. 619 (5th Cir. 2011).

An insureds' breach of contract and other claims against an insurer and adjuster were barred by limitations. *Williams v. Allstate Fire & Cas. Ins. Co.*, No. H-11-530, 2012 WL 1098424 (S.D. Tex. Mar. 30, 2012). Although the insureds brought their claims within four years, the policy contained a provision shortening the limitations period to two years plus one day. The insureds never received a denial letter from the insurer or adjuster, at which point causes of action typically accrue. Instead, the court determined that the causes of action accrued after the insurer closed the insureds' claim file. The discovery rule did not apply because the injury was not inherently undiscoverable.

C. Mutual Mistake

In an unusual case involving a duty to defend and application of the "eight corners" rule, the Fifth Circuit had to first decide what the four corners of the contract included and whether there was a "mutual mistake." *Tech. Automation Servs. Corp. v. Liberty Surplus Ins. Corp.*, 673 F.3d 399 (5th Cir. 2012). A worker was injured by a chlorine leak and sued Technical. Technical was insured by Liberty, from 2003 to 2004, under a CGL policy that contained a form numbered "ES 344 EG/RH" and entitled "Exclusion–Professional Liability." Technical renewed its coverage with Liberty from 2004 to 2005. The policy schedule and forms of endorsements identified Endorsement 19 as form number "ES 344" and titled "Exclusion–Professional Liability," which would have made the terms of the new policy identical to the prior policy. However, the actual Endorsement 19 that was included was not an exclusion but instead was an endorsement providing errors and omissions coverage.

If the policy were supposed to include an exclusion, then there would be no coverage for the injury, because it occurred three days after the policy term ended. On the other hand, if the E&O endorsement applied, there could be coverage for the injury because that provided coverage for errors and omissions committed during the policy period.

Liberty refused to defend, contending that the policy was supposed to be the same as the prior year and that the E&O endorsement was included as a result of mutual mistake.

It is proper to consider parol evidence to determine whether there was a mutual mistake, even if the contract is otherwise unambiguous or fully integrated.

The district court applied the eight corners rule and rejected this argument, because it would require consideration of extrinsic evidence. The Fifth Circuit reversed, holding that when mutual mistake is alleged the first task of the court is to address whether the disputed provision resulted from an agreement between the parties. The court further held that it is proper to consider parol evidence to determine whether there was a mutual mistake, even if the contract is otherwise unambiguous or fully integrated. The court reasoned that a mutual mistake would rarely be readily apparent based on the terms of the contract itself. Thus, the district court should have first resolved the factual issue of whether there was a mutual mistake before deciding whether there was a duty to defend under the agreement between the parties.

D. Lack of Notice

The Fifth Circuit found a fact issue on whether an excess insurer was prejudiced and thus able to avoid coverage where the insurer did not get notice of the claim until after the jury verdict. *Berkley Regional Ins. Co. v. Philadelphia Indem. Ins. Co.*, 690 F.3d 342 (5th Cir. 2012).

The plaintiff suffered severe injuries from a slip and fall. The property owner had primary coverage with Nautilus and excess coverage with Philadelphia. Nautilus provided a defense. Philadelphia did not receive notice. The case went to trial after settlement efforts reached an impasse with the plaintiff's lowest demand at $215,000 and Nautilus's highest offer at $150,000. The jury awarded plaintiff $1.6 million. The insured then demanded that Philadelphia pay the amount in excess of the primary coverage. Philadelphia contended this was the first time it had notice of the suit or claim and therefore denied coverage. Nautilus paid its share and then sought to recoup the balance from Philadelphia.

The district court granted summary judgment for Nautilus, finding no evidence that Philadelphia was prejudiced by the late notice. The Fifth Circuit reversed. After an extensive discussion of Texas law on prejudice and late notice, the Fifth Circuit found that Philadelphia was prejudiced by the late notice because it was notified after all material aspects of the trial process had concluded and an adverse jury verdict was entered. Philadelphia lost the ability to investigate and conduct its own analysis of the case as

well as the ability to join in the primary insurer's evaluation of the case. The court held, "Most importantly, however, Philadelphia lost a seat at the mediation table." The court pointed out that Philadelphia could have influenced that process by convincing the plaintiff to come down further, or even by paying the difference between the demand and offer. "All of these rights were lost, leaving Philadelphia holding the bag for more than $700,000 in excess liability if Berkley prevails."

X. PRACTICE & PROCEDURE

A. Choice of law

In *Jimenez v. SunLife Assur. Co. of Canada*, No. 11-30872, 2012 WL 3495259 (5th Cir. Aug. 15, 2012) (not published), the Fifth Circuit had to determine whether to apply the law of Texas or Louisiana to a disability claim arising under ERISA with respect to an auto collision. The ERISA plan provided that Texas law would apply. However, Louisiana was where the accident occurred and where the insured lived and worked. The insurer denied the claim, based on the illegal acts exclusion, because there was evidence that the insured was drunk at the time of the collision. Under Texas law, this would be a sufficient basis to deny the claim. Under Louisiana law, a statute provides that the illegal acts exclusion applies only to felonies, and this was a misdemeanor. The court found that the insured presented no reason to override the parties' selection of Texas law in the contract. Even though Louisiana law was different, the insured failed to show that enforcing the policy's choice of law provision would be unreasonable, fundamentally unfair, or contrary to a fundamental policy of Louisiana.

Texas law also applied to deny a liability insurer's contribution claim for settlement of claims relating to a helicopter crash in Hawaii. The court found that Texas had the most significant relationship. Contacts with Hawaii included that the crash occurred there and some of the alleged negligence and failure to warn the defendant occurred there. However, the helicopter company was based in Texas and the failure to warn could have occurred here. In addition, the parties' businesses had significant contacts with France, Texas, and Nevada, as well as Hawaii. The court found that the parties' relationship was centered in Texas because their agreement contained a choice of law clause pointing to Texas. The clause did not require the application of Texas law, but it showed a decision by the parties to center their relationship in Texas for choice of law purposes. Finally, the court found that the Texas rule against allowing a settling defendant to have contribution rights was an important policy that would be frustrated if the law of Hawaii applied. On the other hand, Hawaii had no interest in allowing the contribution claim, because the settling crash victims were compensated at the expense of a non-Hawaii entity. *Nat'l Union Fire Ins. Co. of Pittsburg, PA v. Am. Eurocopter Corp.*, No. 11-10798, 2012 WL 3642264 (5th Cir. Aug. 27, 2012).

B. Jurisdiction

An insurer had sufficient contacts with Texas to establish jurisdiction. An automobile accident occurred in Oklahoma where the insured was located. A person injured in the accident was treated at a hospital in Texas. The insured was at fault in the accident, and its insurer paid settlement proceeds to the injured party. However, the insurer failed to pay a hospital lien owed in Texas. The hospital sued the insurer in Texas. The court held that the insurer maintained a license to do business in Texas and systematically conducted business in Texas with Texas insurance companies. Therefore, the court concluded that the insurer's contacts with Texas were such that it could reasonably foresee being haled into Texas court. Additionally, the court held there was no question that Texas has an interest in the enforcement of statutes enacted to secure payment for healthcare services provided within its borders. *Shelter Mut. Ins. Co. v. Dallas Co. Hosp. Dist.*, 366 S.W.3d 858 (Tex. App.–Dallas 2012, pet. denied).

An insurer sought for declaratory judgment that it had no duty to defend or indemnify regarding an underlying environmental cleanup claim. The trial court granted the insured's plea to the jurisdiction. However, the appellate court reversed, holding that the trial court had subject-matter jurisdiction over the case and that the carrier's request for a determination of whether the insurer owed a defense to the insured in the Indiana suit presented a justiciable issue. *Transp. Ins. Co. v. WH Cleaners, Inc.*, 372 S.W.3d 223 (Tex. App.–Dallas 2012, no pet.).

A person was injured while helping his neighbor unload a deer stand off a trailer at his residence. The injured party sued his neighbor and neighbor's homeowner's insurer. Prior to trial, the court granted summary judgment for the injured party finding that the homeowner's insurer had a duty to indemnify the neighbor insured. The jury awarded the injured party damages and found that the damages were covered by both the homeowner's policy and injured party's car insurer. The appeals court held that when the trial court granted the injured party summary judgment against the homeowner's insurer, the neighbor's obligations to pay damages to the injured party had not yet been established by final judgment or agreement. Therefore, the injured party's claim against the homeowner's insurer was not ripe. The appeals court held the proper remedy was to reverse the trial court's judgment as to the claims against the homeowner's insurer and render judgment dismissing these claims for lack of subject matter jurisdiction. *Farmers Ins. Exch. v. Rodriguez*, 366 S.W.3d 216 (Tex. App.–Houston [14th Dist.] 2012, no pet.).

Jurisdiction was proper in federal court where the policy was subject to ERISA. An affidavit submitted by the employer stating that it assisted in collection and remittance of premiums through payroll deductions, advised employees with regard to benefits, and assisted beneficiaries with collection of proceeds, indicated that the employer established and maintained the plans with the intent to provide insurance benefits to its employees, qualifying it as an ERISA policy. *Flesner v. Flesner*, 845 F. Supp. 2d 791 (S.D. Tex. 2012).

C. Removal & Remand

Insurance companies continue to remove cases to federal court on the basis of diversity jurisdiction, alleging that nondiverse parties, such as agents or adjusters, have been fraudulently joined. More often than not, courts have granted the insured's motion to remand. *See, e.g., McGowan v. Allstate Tex. Lloyd's*, No. H-11-CV-02590, 2011 WL 5325245 (S.D. Tex. Nov. 1, 2011); *Cal Dive Internat'l, Inc. v. Chartis Claims, Inc.*, No. 1:11-CV-347, 2011 WL 5372268 (E.D. Tex. Nov. 7, 2011); *Cano v. Scottsdale Ins. Co.*, No. H-10-3530, 2011 WL 5416320 (S.D. Tex. Nov. 7, 2011); *Durable Specialties, Inc. v. Liberty Ins. Co.*, No. 3:11-CV-739-L, 2011 WL 6937377 (N.D. Tex. Dec. 30, 2011); *Stevenson v. Allstate Tex. Lloyd's*, No. 11-CV-3308, 2012 WL 360089 (S.D. Tex. Feb. 1, 2012); *Nichols v. Allstate Tex. Lloyd's*, No. 4:12-CV-01524, 2012 WL 3780308 (S.D. Tex. Aug. 31, 2012); *Benton v. Lexington Ins. Co.*, No. 4:12-CV-01546, 2012 WL 3780312 (S.D. Tex. Aug. 31, 2012); *Anderson v. Geovera Specialty Ins. Co.*, No. C-12-243, 2012 WL 4461272 (S.D. Tex. Sep. 25, 2012).

This is appropriate. Since the removal statute is construed in favor of remand, the court must evaluate the factual allegations in the light most favorable to the plaintiff and engage in a Rule 12(b)(6)-type analysis, and the burden of proof to demonstrate jurisdiction and fraudulent joinder is on the defendant.

But in some cases, the courts have denied the insured's motion to remand and have dismissed claims against the nondiverse parties. *See, e.g., Adey/Vandling, Ltd. v. Am. First Ins. Co.*, No. A-11-CV-1007-LY, 2012 WL 534838 (W.D. Tex. Feb. 17, 2012); *Novelli v. Allstate Tex. Lloyd's*, No. H-11-2690, 2012 WL 949675 (S.D. Tex. Mar. 19, 2012); *Keen v. Wausau Bus. Ins. Co.*, No. H-11-1415, 2012 WL 949141 (S.D. Tex. Mar. 20, 2012); *Tracy v. Chubb Lloyds Ins. Co. of Tex.*, No. 4:12-CV-174-A, 2012 WL 1109489 (N.D. Tex. Mar. 30, 2012).

In these cases, the courts generally denied remand because the factual allegations against the nondiverse parties were not specific and individualized. For example, in *Novelli*, the court found that the allegations against the nondiverse adjuster were "in essence, allegations of wrongful conduct committed by [the insurer] through [the adjuster.]" In *Novelli*, the court found that the worker's complaint against his employers workers' compensation insurer and adjuster made only a general allegation against both defendants and failed to set forth specific and individualized factual allegations against the adjuster. Similarly, in *Tracy*, the court found that the allegations against the adjuster were conclusory. However, *Adey/Vandling*, was analyzed differently, under section 1447(e). In that case, the court denied remand because the insured did not sue nondiverse parties until after removal, which the court considered "strong evidence of the Plaintiff's true motive being to force the remand of the case," even while acknowledging that the insured would have to pursue the nondiverse defendants in a separate suit and forum and risk conflicting results and additional financial burden.

A court denied a medical care provider's motion to remand, concluding that the court had federal question jurisdiction. *Foundation Ancillary Servcs., L.L.C. v. United Healthcare Ins. Co.*, No. H-10-1374, 2011 WL 4944040 (S.D. Tex. Oct. 17, 2011). The medical care provider sued an insurer for underpayment of medical services in state court, alleging state law claims for violations of the Texas Insurance Code, DTPA, negligence, negligent misrepresentation, promissory estoppel, and quantum meruit. The provider did not have a provider agreement with the insurer but secured assignments of ERISA benefits from patients. The insurer removed on grounds that the provider's claims were completely preempted by ERISA. The court agreed that ERISA preempted the provider's state law claims because it accepted assignments from its patients to receive payments directly from the insurer and could thus assert a claim as assignee under section 502(a) of ERISA. Further, because the provider did not have an agreement with the insurer, it did not have an independent basis for recovery, and resolution of the dispute required reference to and interpretation of the patients' ERISA plans and the amount of coverage each patient enjoyed under the plan. Because the provider's right to payment derived entirely from the patients' ERISA plans, its claims were preempted by ERISA, giving the court federal removal jurisdiction.

As an unincorporated association, an insurer was considered a citizen of each state where its customers were citizens for diversity purposes. *Farmers Ins. Exch. v. MTD Products, Inc.*, No. 3:11-CV-2405-L, 2011 WL 5877025 (N.D. Tex. Nov. 22, 2011). Farmers, as subrogee, sued a products manufacturer in state court. The manufacturer removed the case, and Farmers then moved to remand, arguing that, because it was a reciprocal insurance exchange, it should be considered an unincorporated association for purposes of diversity jurisdiction and its policy holders considered members whose citizenship must be considered in determining the insurer's citizenship as an unincorporated association. The manufacturer contended that Farmers was not, in fact, an insurance exchange, arguing that its insureds pay nothing but premiums to join, have no liability other than premiums, and membership in the exchange terminates upon cancellation of the policy. The court determined that Farmers was an insurance exchange. The policy defined Farmer's members as its policy holders or insureds, which is consistent with the Texas Insurance Code's definition of a subscriber as including individuals who enter into reciprocal contracts. Further, the Texas Insurance Code allows insurance exchanges to limit the liability of its subscribers to the amount of the premium paid, and nothing prohibited cancellation of membership upon termination of an insurance policy. Farmers was therefore a reciprocal insurance exchange, its policyholders were members for diversity purposes, and, as such, there was no diversity between the parties.

D. Standing

An insured did not lose standing to bring her bad faith claims against her automobile insurer by settling her breach of contract claims. Standing is determined when suit is filed. Because the insured had standing when she filed suit, that standing was unaffected by the subsequent settlement of certain claims. *In re Safeco Lloyds Ins. Co.*, No. 12-12-00054-CV, 2012 WL 426608 (Tex. App.–Tyler Feb. 8, 2012, no pet.) (mem. op.).

A mortgagor qualified as a third-party beneficiary under a force-placed insurance policy and thus had standing to sue. *Alvarado v. Lexington Ins. Co.*, Nos. 01-10-00740-CV & 01-10-01150-CV, 2012 WL 5194057 (Tex. App.–Houston [1st Dist.] Oct. 18, 2012, no pet. h.).

E. Venue

Claims against a broker were properly dismissed in light of a forum selection clause in the policy. *Oliver v. Prime Ins. Co.*, No. 09-11-00636-CV, 2012 WL 3860637 (Tex. App.–Beaumont Sep. 6, 2012, no pet.) (mem. op.). Although the broker was not a party to the policy, the broker still had standing to enforce the forum selection clause because a policy receipt form sent by the broker contained the forum selection clause, and was signed by the broker, sent by the broker, and addressed to the broker. Further, the insured alleged in his petition that the broker and insurer were collectively liable for all causes of action asserted, which made the insured's claims against the broker fall within the scope of the policy's forum selection clause.

F. Pleadings

Federal courts addressed numerous motions to dismiss filed by insurers and their agents. In *Tiras v. Encompass Home & Auto Ins. Co.*, the court granted an insurer's motion to dismiss the insureds' non-contractual causes of action because their complaint recited elements and did not provide factual allegations to support those elements. No. 4:10-CV-03266, 2011 WL 5827298 (S.D. Tex. Nov. 17, 2011). In particular, the insureds' fraud claim had to meet the stricter pleading standards of Fed. R. Civ. P. 9(b), which requires allegations of the "time, place, and contents of the false representations, as well as the identity of the person making the misrepresentation and what he obtained thereby." The insured's complaint failed to meet this standard because it neither explained what the representations were, nor when and where the representations were made. Other claims under the Insurance Code were inadequately pled because they did not provide facts to support their "conclusory allegations."

Insureds sued their property insurer and adjuster for fraud and conspiracy to commit fraud. The defendants moved to dismiss these claims, and the court granted the motion, finding that the claims were not pled with the specificity required by Rule 9(b). *Williams v. Allstate Fire & Cas. Ins. Co.*, No. H-11-530, 2012 WL 1098424 (S.D. Tex. Mar. 30, 2012). In particular, the insureds failed to describe the content of the alleged misrepresentations

or identify their speaker, or state when and where the misrepresentations were made or why they were fraudulent. However, the court granted the insureds leave to amend.

In another case, the court again applied different pleading standards to different claims asserted by insureds, depending on whether the claim was "in essence" one of fraud. *Khan v. Allstate Fire and Cas. Ins. Co.*, No. H-11-2693, 2012 WL 1601302 (S.D. Tex. May 7, 2012). An insurer sought to dismiss insureds' claims arising out of the insurer's denial of their claim for hurricane damage to their home. The court found that the insured's fraud allegations were insufficient to state a claim because the pleading did not provide any factual support for or detail of how the insureds acted in reliance on the insurer's misrepresentations, as required under Fed. R. Civ. P. 9(b). By contrast, however, the court applied the pleading standard of Fed. R. Civ. P. 8 to the claim of breach of the duty of good faith and fair dealing. The court used this standard instead because the claim is not, in essence, one of fraud. The pleading was sufficient under this standard. The insured alleged that the insurer breached the duty by conducting unreasonable investigations, engaging in a coordinated course of conduct to adjust a claim without regard for industry standards or the policy, and used a pricing scheme to purposefully undervalue claims. This claim did not depend on the insurer's misrepresentations or fraud, and the pleading was therefore adequate.

Turning to the insureds' claims for violations of the Texas Insurance Code, the *Khan* court found that some fell under the fraud standard of Rule 9(b), while others did not. The insureds' claim under section 541.060(a)(1) involved misrepresentations and was therefore substantively a claim of fraud that had to meet the heightened pleading standard, which it did not, because the pleading did not explain how the misrepresentations related to coverage. By contrast, the insureds' claims under section 541.060(a)(3) and (7) did not involve misrepresentations, were not substantively fraud claims, did not have to be pled with particularity, and were sufficiently pled. Although the insureds' claim under section 541.060(a)(4) did not have to meet the heightened pleading standard, the insureds still failed to state a claim, because they did not allege that the timeframe the insurer took to deny their claim was unreasonable.

The insureds' claims under the prompt payment statute were not claims of fraud and did not have to meet the heightened pleading standard. Nevertheless, two of these claims – sections 542.055 and 542.056 – were insufficiently pled because the insureds did not identify the applicable time constraints, the information the insurer should have requested, what information the insureds provided, and when they provided it.

In *One Beacon Ins. Co. v. T. Wade Welch & Assocs.*, No. H-11-3061, 2012 WL 1155739 & 2012 WL 2403500 (S.D. Tex. April 5, 2012 and June 25, 2012), the insured, a law firm, sought dismissal of the malpractice insurer's claim that the policy was void for misrepresentation. The insured argued that the claim should be dismissed because the insurer's complaint did not state a claim that the misrepresentation in the policy application was material and did not allege fraud with particularity under Fed. R. Civ. P. 9(b). The insurer sought to void the policy because the insured did not disclose a sanction of attorney's fees in a case preceding the policy application. The insured argued that this alleged misrepresentation was not material – it did not increase the insurer's risk, because the policy expressly excluded attorney's fees from coverage. The court disagreed, finding it "plausible" that the insurer would have refused coverage had it known of the sanction award. Regarding the particularity standard under Rule 9(b), the court found that the complaint's statement, "upon information and belief" that the insured knew of the false representations, was sufficient. Although a complaint had to set forth who, what, when, where, and how of fraud with particularity, scienter may be pled generally.

A motion to dismiss in *One Beacon* was also filed by the insurer. Although the court rejected the insurer's argument that the insured's suit should be dismissed under the no-action clause in the policy, the court granted the insurer's motion to dismiss claims on a policy from 2006 because no claims were alleged to have been made during the period covered by that policy. The court also granted the insurer's motion to dismiss the insured's *Stowers* claim as being unripe because there was no final judgment in the underlying case, as well as the insured's claim for breach of the duty of good faith and fair dealing because the insurer had no such duty with regard to third-party claims.

The court denied the insurer's motion to dismiss the insured's fraud claims, because the insured specifically alleged that the insurer made misrepresentations in a reservation of rights letter and stated who sent the letter, when it was sent, and what the alleged misrepresentation was. Regarding the insured's claims under section 541.060, the court granted the motion to dismiss to the extent the insured claimed that the insurer failed to timely affirm or deny its duty to indemnify, because there was no final judgment or settlement in the underlying case; however, the court denied the motion to the extent the insured claimed that the insurer failed to timely affirm or deny its duty to defend. 2012 WL 2403500.

The court denied the insurer's motion to dismiss the insured's fraud claims, because the insured specifically alleged that the insurer made misrepresentations in a reservation of rights letter and stated who sent the letter, when it was sent, and what the alleged misrepresentation was.

Another court had to decide three motions to dismiss in one case. First, the court considered a motion by a defendant broker to dismiss the negligence claim by the insured. The court found that the insured did not adequately plead facts sufficient to state a claim for relief under its negligence theory by failing to plead facts giving rise to a special relationship between it and the broker. Acting as no more than an insurance broker, the broker did not owe the insured a duty beyond using reasonable diligence in acquiring a policy and informing the insured if it was unable to do so, neither of which was at issue. However, the court allowed the insured to amend its pleading to allege facts giving rise to a duty. *N. Cypress Medical Ctr. Operating Co. Ltd. v. Gallagher Benefit Services, Inc.*, No. 4:11-CV-00685, 2011 WL 5110456 (S.D. Tex. Oct. 24, 2011).

The *North Cypress* court granted the insurer's motion to dismiss a third-party complaint brought against it by the broker. *N. Cypress Medical Ctr. Operating Co. Ltd. v. Gallagher Benefit Services, Inc.*, No. 4:11-CV-00685, 2012 WL 438869 (S.D. Tex. Feb. 9, 2012). The broker, who was sued by the insured after an insurer wrongfully cancelled the insured's policy, impled the insurer and sought contribution and indemnity on various theories. The court found that the broker's contractual theories against the insurer could not stand because the requested remedy of contribution was only available for torts, not breach of contract. The court also dismissed the broker's claims of fraud by nondisclosure and breach of fiduciary duty because the insurer did not owe a fi-

duciary duty to the insured. The court also dismissed the broker's promissory estoppel claim because the insurer's prior acceptance of two late payments by the insured did not amount to a promise in the view of the court. Finally, the court dismissed the broker's claims for tortious interference with contract and tortious interference with prospective business relations. The court faulted the broker for inconsistent allegations: stating that the broker had a valid contract with the insured while also stating that it had continuing business relations not formalized by contract. However, the court allowed the broker to amend its complaint as to the tortious interference with prospective business relations.

Finally, the *North Cypress* court considered the insurer's motion to dismiss the broker's amended claim for tortious interference with prospective business relations. The court denied the motion. The broker alleged a preexisting business relationship with the insured that was reasonably probable to continue in the future, independently tortious conduct by the insurer for breaching its duty of good faith and fair dealing and violating section 541.061(5) of the Insurance Code, and the insurer's knowledge that the insured "would terminate its relationship with [the broker] when it cancelled the Policy[.]" *N. Cypress Medical Ctr. Operating Co. Ltd. v. Gallagher Benefit Servs., Inc.*, No. 4:11-CV-00685, 2012 WL 2870639 (S.D. Tex. July 11, 2012).

The court granted the motion to dismiss of a company hired by a disability insurer to arrange a medical examination for the plaintiff insured. *Hashempour v. Ace Am. Ins. Co.*, No. H-12-0181, 2012 WL 3948426 (S.D. Tex. Sept. 10, 2012). The insured sued the company on various theories, asserting that the company failed to determine the examining doctor's qualifications and cherry-picked the information supplied to the doctor. The court dismissed the insured's claim for violating section 541.060 of the Insurance Code because the company, as an independent entity hired by an insurer to provide an independent medical exam, was not a person engaged in the business of insurance for purposes of the Texas Insurance Code. Likewise, the court dismissed the insured's claim for violation of the DTPA because the insured did not allege facts sufficient to establish that he was a consumer. The court also considered and granted the company's motion to dismiss the cross-claims for negligence and breach of contract asserted against it by the insurer. Regarding the negligence claim, the court found that the insurer's allegation that the company failed to find a qualified medical provider was not sufficient to state a claim for negligence without allegations showing that it owed a legal duty to do so. Regarding breach of contract, the court found the complaint failed to allege facts capable of establishing that an agreement was formed and that the insurer performed under the agreement. The court denied the insurer's request to amend its complaint because the insurer knew of the company's objections before the motion to dismiss was filed but failed to take actions to cure the defects.

G. Discovery

An employee was not entitled to discovery of a workers compensation insurer's operational reports containing information about the insurer's denial rate. The employee could not obtain them in relation to her claims of breach of the duty of good faith and fair dealing and violation of section 541.060 of the Insurance Code, because those claims were foreclosed by *Ruttiger*. She also could not obtain the reports in connection with her DTPA and section 541.061 claims, because they were not relevant to those claims. *In re American Zurich Ins. Co.*, No. 01-11-00816-CV, 2012 WL 2923200 (Tex. App.–Houston [1st Dist.] July 12, 2012, orig. proceeding) (mem. op.).

H. Experts

An insurer was not entitled to summary judgment on an insured's claims under the Insurance Code and for breach of the duty of good faith and fair dealing. *Shiva Worldwide v. Great Lakes Reinsurance (U.K.) PLC*, No. 10-CV-3867, 2011 WL 5325788 (S.D. Tex. Nov. 3, 2011). The insurer argued that the insured's failure to designate an expert witness was fatal to the insured's claims. The court disagreed, finding that expert testimony was not needed for the insured to prove its claims. Section 541.060 provides sufficient guidance to juries on whether an insurer has violated the Insurance Code. Expert testimony also was not necessary to establish the standard of an ordinary insurer to prove the insured's bad faith claim.

I. Class actions

Class issues did not predominate, so the Fifth Circuit reversed the certification in *Ahmad v. Old Republic Nat'l Ins. Co.*, 690 F.3d 698 (5th Cir. 2012). The issue was whether the title insurer had overcharged premiums for title insurance policies where the property was already insured by a prior policy within the preceding seven years. While the insurer agreed, and the court found, that anyone within that class was entitled to the discount, the court concluded that it would require an individualized determination of each insured's eligibility for the discount. In reaching this conclusion, the court relied on its prior decision to the same effect in *Benavides v. Chicago Title Ins. Co.*, 636 F.3d 699 (5th Cir. 2011).

J. Arbitration

An insured was sued for exposing the plaintiffs to pollution. The insurer and insured disagreed over whether this suit was covered. The policy stated that if there was a dispute over the coverage language that would be submitted to arbitration, which the parties did. After the arbitration award came back in favor of the insurer, the insured filed a motion to vacate the award, which was denied. The court granted the motion to confirm the award. The appeals court affirmed the trial court's decision stating the insured failed to raise or brief the issue of limitations in its appellate brief, and therefore, waived the issue, and held the insured failed to attack an independent ground that supported the judgment. *Cont'l Carbon Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, No. 14-11-00162-CV, 2012 WL 1345748 (Tex. App.–Houston [14th Dist.] April 17, 2012, no pet.) (mem. op.).

A school district sued its insurer alleging that the insurance policy it received and signed differed in material terms from the offer negotiated and accepted by the school board. The insurer moved to compel arbitration under the policy, which the trial court denied. The appellate court held that the evidence before the trial court included a written contract signed by the superintendent and the contract provided for arbitration of all disputes arising out of the contract, which supported a conclusion that the arbitration clause was valid and should be enforced. The court also held that the agent, even though a non-signatory to the contract, was bound by the arbitration clause because the school district was relying on the agreement in asserting claims against the agent. *Aetna Life Ins. Co. v. Weslaco Ind. School Dist.*, No. 13-11-00532-CV, 2012 WL 1964576 (Tex. App.–Corpus Christi May 31, 2012, no pet.) (mem. op.).

K. Appraisal

The Fifth Circuit held that where an insured invoked the appraisal process and the insurer then promptly paid the $1 million award, the insured had no claim for breach of contract or bad faith, even though the insurer originally estimated and paid the hurricane loss at $50,000 and $300,000. *Blums Furniture Co. v.*

An appraisal award, by itself, does not entitle an insured to recover against an insurer.

Certain Underwriters at Lloyds London, 459 Fed. App'x 366 (5th Cir. 2012) (per curiam). The court reasoned that under Texas law, when an insurer makes a timely payment of a binding and enforceable appraisal award and the insured accepts the payment, the insured is estopped by the appraisal award from maintaining a breach of contract claim. Further, the court held that in most cases an insured may not prevail in a bad faith claim without first showing that the insurer breached the contract. The court found the only recognized exceptions are if the insurer "commits some act, so extreme, that would cause injury independent of the policy claim," or fails "to timely investigate the insured's claim." The court found no evidence of either of these exceptions.

Whether the court's conclusion is correct with regard to this case, the court's language is overly broad. The Texas Insurance Code expressly provides a cause of action for failing to act in good faith to effectuate a prompt settlement once liability is reasonably clear. In cases where the insurer denies the claim, or unreasonably delays payment, after its liability is reasonably clear and that delay causes damages, an insured would clearly have a right to recover, even if the insurer belatedly complied with the contract by paying the claim.

An insured's apartment was damaged during a hurricane. The insured could not reach an agreement with the insurer about the price and items covered under the policy, and moved to compel appraisal. The appraisal provision in the policy allowed either party to demand appraisal of the loss if they could not agree, "on the actual cash value, or, if applicable, replacement cost of [the] damaged property to settle upon the amount of loss." The insured was asking for costs associated with hiring a superintendent for the project. The court held that this dispute was over whether an expense was covered. Because this dispute did not relate exclusively to the actual cash value of the loss or its replacement value, the appraisal clause was not implicated. *Sam v. Nat'l Lloyds Ins. Co.*, No. H-10-2521, 2011 WL 4860009 (S.D. Tex. Oct. 13, 2011).

An insured's home was damaged in a hurricane and the insured and insurer had different damage estimates. The insurer invoked the appraisal clause, to which the insured objected. The appraisal award was in favor of the insurer. The court denied the insurer's motion for summary judgment, holding that the insureds raised genuine issues of material fact as to whether the insurer had waived its right to invoke the appraisal process and whether the appraisal award was incomplete or the result of mistake or fraud. *Singletary v. Allstate Tex. Lloyds*, No. H-10-CV-03990, 2012 WL 4675314 (S.D. Tex. Sept. 28, 2012).

An appraisal award, by itself, does not entitle an insured to recover against an insurer. *Sec. Nat'l Ins. Co. v. Waloon Investment, Inc.*, No. 14-11-00130-CV, 2012 WL 4788114 (Tex. App.–Houston [14th Dist.] Oct. 9, 2012, no pet. h.). An insured hotel owner sued its insurer regarding coverage for losses allegedly resulting from Hurricane Ike. After receiving an appraisal award, the insured filed a motion asking the court to order the insurer to pay the amount of the appraisal award, which was granted. However, the motion was not a motion for summary judgment and did not seek to prove as a matter of law all elements of the insured's breach of contract claim. The court of appeals held that the court order awarding the appraisal amount was erroneous. Appraisals only determine the amount of loss, and not the insurer's liability under the policy. The appraisal clause in the policy did not entitle either party to judgment based on the appraisal award alone.

An insurer did not waive appraisal as a condition precedent to suit. *In re Cypress Tex. Lloyds*, No. 09-12-00077-CV, 2012 WL 1435739 (Tex. App.–Beaumont Apr. 26, 2012, orig. proceeding) (per curiam). The insurer sought abatement of the insureds' suit against it pending appraisal. Citing last year's decision in *In re Universal Underwriters of Tex. Ins. Co.*, 345 S.W.3d 404 (Tex. 2011), the court of appeals held that, despite the insurer engaging in discovery before filing its motion to compel appraisal, the insurer did not waive that right, because the insureds were not prejudiced by the delay. The costs the insureds incurred in discovery could have been avoided if they had demanded appraisal.

An insured could not avoid an appraisal award on the basis of mistake by the appraisers where the only evidence presented was that its appraiser disagreed with the umpire's methods. *KLM Resources, LLC v. Ohio Cas. Ins. Co.*, No. G-10-593, 2012 WL 1911801 (S.D. Tex. May 25, 2012).

An insured unsuccessfully sought to set aside an appraisal award regarding damage to its commercial property. *Stateside Enterprises, Inc. v. Hartford Steam Boiler Inspection & Ins. Co.*, No. H-10-4186, 2012 WL 1098415 (S.D. Tex. Mar. 30, 2012). The insured argued that the appraisal panel was not impartial due to a business referral relationship between employers of the umpire and the insurer's appraiser. However, the court concluded that the pre-existing relationship alone was not enough to support a finding of bias, and that there was no other evidence of bias. The insured also argued that the appraisal was not based on sound methodology, because the insurer's appraiser did not present any reports to support his estimates, which were adopted by the umpire, whereas the insured's appraiser did. The court disagreed because the insurer's appraiser's estimates were based on his experience and expertise and did not require additional expert reports. The insured further argued that the appraisal panel exceeded its authority by deciding causation and coverage issues. The court rejected this argument, concluding that the appraisers disagreed about the extent of damage, not the cause of the damage. For instance, while the insurer's appraiser considered whether the moisture in the roof was attributable to a hurricane or wear and tear, that determination involved only separating losses due to a covered event rather than a pre-existing condition and was properly addressed by the appraisers. Therefore, the appraisal was proper and could not be set aside.

L. Motions for summary judgment

Proofs of loss can be considered as summary judgment evi-

dence. *United States Fire Ins. Co. v. Lynd Co.*, No. 04-11-00347-CV, 2012 WL 3326344 (Tex. App.–San Antonio, Aug. 15, 2012, pet. granted.). Two apartment complexes owned by the insured were damaged by hail. However, there was a dispute about whether the damage was caused by one storm or two. The insurer argued that the damage was caused by one storm and that it had already paid its policy limits for that storm. The trial court granted the insured's motion for summary judgment on grounds that the damage to the apartments was caused by two storms, creating two insurable occurrences. The court of appeals reversed, finding a question of fact as to whether the apartments were damaged by the second storm, because the insured's proofs of loss attributed the damage to a single storm. The court considered the proof of loss as statements by the insured that were inconsistent with its present position and, thus, admissions. Also, the proofs of loss were sworn. While not conclusive, the statements in the proofs of loss were prima facia evidence of the facts recited. That the proofs of loss were controverted by an expert report was irrelevant; the question of whether hail fell on a particular location on a particular day and caused property damage is not a matter solely within the scope of an expert's knowledge and did not require expert testimony.

A liability insurer was not entitled to summary judgment in a coverage dispute with its insureds. Although the policy contained an exclusion for "liability resulting from any actual or alleged conduct of sexual nature," there was no evidence presented that the underlying suit concerned such liability. *Doe # 1 v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, No. 07-11-0251-CV, 2012 WL 1071204 (Tex. App.–Amarillo Mar. 30, 2012, no pet.) (mem. op.).

A district court denied an insurer's motion for summary judgment on the insured's breach of contract claim because there was a fact issue on whether the insured's roof, which was damaged by Hurricane Ike, was adequately repaired. *AmTex Bancshares, Inc. v. Bancinsure, Inc.*, No. 1:10-CV-573, 2012 WL 4506295 (E.D. Tex. Sep. 28, 2012).

M. Severance & separate trials

An insured was injured in an automobile accident and collected a settlement from the party who hit her. The insured then filed a claim for breach of contract and extra-contractual damages against her insurer for underinsured motorist coverage. The trial court denied the insurer's motion to sever the two claims and motion to abate the extra-contractual claims pending resolution of the breach of contract claim. The appeals court held that, because the insurer offered to settle in full the insured's contract claims and the resulting damages, severance was required to avoid unfair prejudice to the insurer. The appeals court also held that it would be unjust to require the insurer to defend against the insured's extra-contractual claims until the insurer's liability under the policy had been determined. *In re State Farm Mut. Auto. Ins. Co.*, No. 08-12-00176-CV, 2012 WL 4099081 (Tex. App.–El Paso Sept. 19, 2012, orig. proceeding).

The same court held that abatement of extra-contractual claims is required in most instances in which an insured asserts a claim to UIM benefits and a settlement offer is made; however, in a mandamus context, for a party to preserve its complaint that the trial court failed to abate extra-contractual claims, that party must have brought the issue to the trial court's attention by seeking the issuance of an abatement order from the trial court. An insurer failed to preserve its complaint by failing to seek an abatement order from the trial court on the grounds on which it now sought mandamus relief. Therefore, the relief was denied. *In re Farmers Tex. Co. Mut. Ins. Co.*, No. 07-11-00396-CV, 2011 WL 4916303 (Tex. App.–Amarillo Oct. 17, 2011, org. proceeding).

In another case where an insured sued for UIM benefits, the court held that when contract and extra-contractual claims are being pursued simultaneously, the extra-contractual claims must be severed and abated when the insurer has made a settlement offer on the contract claim. *In re Allstate Co. Mut. Ins. Co.*, No. 14-11-00746-CV, 352 S.W.3d 277 (Tex. App.–Houston [14th Dist.] 2011, no pet.); *see also In re St. Paul Surplus Lines Ins. Co.*, No. 14-12-00443-CV, 2012 WL 2015796 (Tex. App.–Houston [14th Dist.] June 1, 2012) (orig. proceeding) (mand. denied); *In re Old Am. County Mut. Fire Ins. Co.*, No. 13-11-00412-CV, 2012 WL 506570 (Tex. App.–Corpus Christi Feb. 16, 2012, org. proceeding); *In re Am. Nat'l County Mut. Ins. Co.*, No. 03-12-004650CV, 2012 WL 4477371 (Tex. App.–Austin Sept. 25, 2012, org. proceeding).

An insurer was entitled to mandamus relief after its motion for severance was denied. *In re Reynolds*, 369 S.W.3d 638 (Tex. App.–Tyler 2012, orig. proceeding). An injured motorist brought a personal injury action against a truck driver and his employer, and also asserted a claim against his insurer for underinsured motorist benefits. The truck driver and his employer moved to sever the claims against them from those against the insurer. The trial court denied the motion, but the court of appeals granted mandamus relief, finding that the motorist's claims against the various defendants were not interwoven and were thus properly severable. The issues of whether the motorist had UIM coverage and whether the truck driver had adequate insurance were unrelated to the facts pertaining to the negligence claim. Furthermore, the truck driver and his employer would have been prejudiced by having the negligence claim tried along with the insurance claim, because it would interject insurance into the case by presenting evidence that the truck driver and his employer were or were not insured against liability, in violation of Tex. R. Evid. 411.

The motorist's claims against the various defendants were not interwoven and were thus properly severable.

An insurer sought, and was granted, mandamus relief to allow severance of an insured's extracontractual claims from his contractual claim against the insurer. *In re Texas Farm Bureau Underwriters*, 374 S.W.3d 651 (Tex. App.–Tyler 2012, orig. proceeding). After the insured was sued for killing a man by the victim's family, the insurer denied his defense. The insured then sued the insurer for breach of contract and breach of the duty of good faith and fair dealing. The trial court denied the insurer's motion to sever the claims. The court of appeals granted mandamus because evidence of the insurer's settlement offer would be admissible in the bad faith trial but inadmissible in the breach of contract trial.

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