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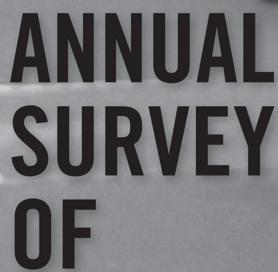

Texas Insurance Law 2013

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I. INTRODUCTION

This year's survey reviews more than 150 insurance cases decided by Texas state and federal courts. This crop of cases presents many of the same themes as in prior years.

As usual, a significant number of cases addressed whether insurers owed a duty to defend or indemnify their insureds. For instance, in one case the Fifth Circuit held that an insurer had a duty to defend a city whose city council members were sued. In another case, the Fifth Circuit held that an insurer had no duty to defend an insured in a suit claiming "property damage" where the facts alleged in the petition did not actually show any "property damage."

ERISA actions continue to be a concern in federal courts. For example, the Fifth Circuit reversed a district court's finding in favor of an ERISA claimant's disability claim, concluding that an insurer had no duty to investigate or consider the source of evidence in its determination of benefits.

Several cases reviewed familiar issues, such as when an insured driver is entitled to UM coverage, how late in the game an insurer may invoke appraisal, and when a life insurer is entitled to interpleader relief. Many property insurance cases stemming from Hurricane Ike continue to percolate through the courts.

Like last year, many cases concerned insurers' efforts to remove cases to federal court claiming that non-diverse parties were improperly joined, and the insureds' efforts to remand the cases.

A few *Stowers* cases were decided during the survey period. For instance, the Fifth Circuit held in one case that insurers did not breach their *Stowers* duties by paying policy limits to settle claims against one insured, thereby leaving no coverage remaining for another insured. In another case, a court of appeals applied *Gandy* to hold that a judgment that was not the result of a fully adversarial trial could not be evidence of damages in a *Stowers* suit against insurers that failed to settle.

In addition to retreading old ground, the courts considered some new issues of interest. For example, the United States Supreme Court held that an insurer could remove a case to federal court under the Class Action Fairness Act, despite the class representatives' stipulation that it would not seek damages in excess of the jurisdictional limit of $5 million, because the stipulation could not be binding on other class members prior to certification of the class. And, the Texas Supreme Court considered the issue of whether a liability policy provided coverage for a settlement agreement reached without the insurer's consent. The court concluded that it did, because the insurer could not show any prejudice.

The Fifth Circuit concluded that a new exclusion in a renewal policy was controlling and precluded coverage, rejecting the argument that all renewals should be on the same terms as the prior policy. And, in an issue of first impression, the court also decided whether late notice excused a liability insurer from its duty to defend where, even though judgment had been rendered against the insured, that judgment was later reversed. According to the court, the key factor is whether the insurer was prejudiced by the delay, and in this case it was.

Finally, in *Mid-Continent Cas. Co. v. Eland Energy, Inc.*, the Fifth Circuit addressed whether an insured had claims for unfair settlement practices or breach of the duty of good faith and fair dealing when an insurer made a secret settlement offer to one party that undermined the insured's defense of another lawsuit, and concluded that the insured had no actionable claims because he suffered no damages.

II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile

An insured sued her insurer for breach of contract and extra-contractual claims after she was hit by an uninsured driver. The trial court concluded that the diminished value of the car was not recoverable under the UM coverage. The appellate court reversed holding that UM coverage could allow an insured to recover for diminished value, in addition to the cost of repairs and loss of use. *Noteboom v. Farmers Tex. Co. Mut. Ins. Co.*, 406 S.W.3d 381 (Tex. App.—Fort Worth 2013, no pet. h.).

An insured sued her insurer after being injured in an accident, but the jury found no damages for past physical pain. The appeals court reversed, holding that the jury's finding was so against the great weight of the evidence as to be unjust, because experts for both sides conceded that part of the insured's pain was caused by the accident. *Schaffer v. Nationwide Mut. Ins. Co.*, No. 13-11-00503-CV, 2013 WL 2146833 (Tex. App.—Corpus Christi May 16, 2013, pet. denied) (mem. op.).

An uninsured motorist provision did not cover injuries sustained by an insured due to an assault committed by an uninsured passenger from another car after a rear-end collision. *Home State County Mut. Ins. Co. v. Binning*, 390 S.W.3d 696 (Tex. App.—Dallas 2012, no pet.). The insured was rear-ended and then attacked and beaten by a passenger in the car at fault. The police were unable to apprehend the attacker. The insured sued his insurer for uninsured motorist benefits, which the insurer denied. The policy stated that for coverage to apply, the damages "must arise out of the … use… of the uninsured motor vehicle." The insured argued that the damages arose from use of the vehicle because, but for the collision, he would not have exited the car to exchange information with the driver, which put him in position to be assaulted. The court disagreed, reasoning that at the time of the collision the insured was pulling into a parking space at a convenience store and would have exited the vehicle to enter the store, and thus "the assault involved the vehicle only incidentally." Further, the injuries were not caused by the vehicle itself but by the assailant striking the insured with a pistol. Because the assailant was not caught, the insured could not establish that the assault was an attempted carjacking, and no Texas law supported the theory that a carjacking constitutes a use of the uninsured vehicle.

A car dealership lost coverage under an auto policy when an excluded driver drove the insured's car. *Stadium Auto, Inc. v. Loya Ins. Co.*, No. 08-11-00301-CV, 2013 WL 3214618 (Tex. App.—El Paso Jun. 26, 2013, no pet.). An insured purchased a car from a car dealership, which also financed the purchase. The insurer is-

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sued a standard auto policy to the insured for the car. The policy included an exclusion of named driver endorsement and listed an individual as an excluded driver. That individual was operating the car without the insured's permission when it was involved in a collision. The insured stopped making payments to the dealership for the car, and she sought coverage under the policy for the car. The dealership made demand on the insurer under the loss payable clause of the policy, but the insurer refused to pay, based on the named driver exclusion. The dealership then sued the insurer for violations of section 541.060 of the Insurance Code and section 17.46(b) of the DTPA, arguing that the loss payable clause provided coverage to the loss payee (the dealership) despite the named driver exclusion.

The court found that the named driver exclusion unambiguously stated that no coverage applied when the excluded driver operated the vehicle and that the insured thus lost her coverage because an excluded driver was operating the car at the time of the accident. The court then examined the loss payable clause, which stated that coverage for the dealership would "not become invalid because of your fraudulent acts or omissions." According to the court, the loss payable clause protected the dealership only from the insured's fraudulent acts or omissions; it did not protect the dealership from any act or neglect of the insured. Here, the excluded driver took the insured's keys without her permission, but there was no evidence of any omission on the insured's part since she had no obligation under the policy to prohibit the excluded driver from driving the car. Under these circumstances, the dealership lost coverage to the same extent as the insured when the excluded driver drove the car.

B. Homeowners

A trial court granted summary judgment against an insured because he failed to give a sworn examination as part of the insurer's investigation after his home burned. The appellate court reversed, holding that failure to comply with such a provision only supports abatement, not summary judgment. *Shafighi v. Tex. Farmers Ins. Co.*, No. 14-12-00082-CV, 2013 WL 1803609 (Tex. App.—Houston [14th Dist.] April 30, 2013, no pet.).

Another court denied an insurer's motion for summary judgment related to an insured's claim for damage to her home, where the insured showed by her expert homebuilder's affidavit that there was evidence to support her statutory and bad faith claims. *Lundgren v. Empire Indem. Ins. Co.*, No. G-10-351, 2013 WL 2385236 (S.D. Tex. May 30, 2013).

An insured sued his insurer to pay for water damage. The court denied the insurer's motion for summary judgment on breach of contract claim, holding that when experts have different theories – one which would allow coverage and one which would not – the jury will be left to decide which it believes. However, summary judgment denying breach of the duty of good faith and fair dealing was granted, because the insurer articulated a reasonable basis for denying the claim. *Button v. Chubb Lloyds Ins. Co. of Tex.*, No. 4:11CV536, 2013 WL 394886 (E.D. Tex. Jan. 31, 2013).

Insureds lost their insurable interest in property following foreclosure. *Rhine v. Priority One Ins. Co.*, No. 06-13-000390CV, 2013 WL 4428930 (Tex. App.—Texarkana, Aug. 20, 2013, no pet.). After the insured's house was destroyed by fire, their insurer denied coverage, arguing that the insureds lost any insurable interest in the property following a foreclosure that took place before the fire. The court agreed. The policy limited coverage to the insureds' insurable interest. After the foreclosure, the insureds were merely tenants at sufferance. Also, the policy provided no coverage for property of "roomers or tenants," and therefore provided no coverage for the insureds' personal property.

In a suit concerning claims for damage to a home following Hurricane Ike, a federal court granted a flood insurer's motion for summary judgment and dismissed the case where the insurer had paid timely proofs of loss but not proofs submitted after the deadline. *Fiedler v. Fidelity Nat'l Property & Cas. Ins. Co.*, No. G-11-025, 2013 WL 5439543 (S.D. Tex. Sep. 27, 2013). No waiver of the deadline was granted by the Federal Insurance Administrator.

C. Commercial Property

An insured suffered a loss when a pipe froze and ruptured during a winter storm causing damage to his commercial building's two interior units. The pipe that froze was located in the attic above the vacant unit. The other unit was occupied and heated. The insurer denied the claim, arguing that neither exception to the exclusion for frozen plumbing applied. However, the appeals court held that one of the exceptions to the exclusion did apply, which was that the insured do their best to maintain heat in the building. The court stated that the insured met this obligation by providing the heat source necessary to heat the occupied unit during the ice storm. *Am. Nat'l Prop. & Cas. Co. v. Fredrich 2 Partners, Ltd.*, 408 S.W.3d 610 (Tex. App.—El Paso 2013, pet. filed).

A fire occurred in a commercial building that a tenant was leasing. The original lease required that the landlord be an additional insured under the policy, but the current lease did not include that requirement. The landlord sued the tenant and its insurer, as it was not listed as an additional insured on the policy. The insurer sought declaratory judgment that the landlord was not entitled to recover under the policy. The court concluded that the landlord was not a party to the policy and that the language of the policy did not demonstrate an intention by the tenant and insurer to contract for the direct benefit of the landlord. Therefore, the landlord lacked standing to sue as a third-party beneficiary. *Ostrovitz & Gwinn, L.L.C. v. First Specialty Ins. Co.*, 393 S.W.3d 379 (Tex. App.—Dallas 2012, no pet.).

In *XCoal Energy & Res. v. N.Y. Marine & Gen. Ins. Co.*, the insured coal company purchased coal but had it stored at the seller's facility. The seller went bankrupt, and the insured coal company never received delivery. The court denied the insured's motion for summary judgment asking the court to find that the coal was covered under the policy, stating that it is unclear whether the coal was actually stored or if it was still in the ground waiting to be mined. If no coal was stored, there were no "goods" insured

by the policy. No. H-11-0645, 2013 WL 1289998 (S.D. Tex. March 4, 2013).

An insured church suffered damage during a thunderstorm and disagreed with its insurer regarding the damage amount. Eventually an appraisal was conducted, but the insured filed suit against the insurer during that process. The insurer paid the appraisal award and moved for summary judgment on all of the insured's claims. The court denied the summary judgment motion, holding that a genuine dispute existed as to whether the parties contractually agreed to be bound by the appraisal award and whether the insured accepted the insurer's post-appraisal payments with the understanding that it was barred from pursuing claims regarding additional damages. The court also held that it could not say that the insured was precluded from asserting extra-contractual claims, because there had been no finding as to liability. *Church on the Rock North v. Church Mut. Ins. Co.*, No. 3:10-CV-0975-L, 2013 WL 497879 (N.D. Tex. Feb. 11, 2013).

Endorsements concerning increased costs for demolition as a result of an ordinance did not provide coverage for an insured's hurricane loss, even though the City of Galveston passed an ordinance requiring demolition of the insured's property. *Lexington Ins. Co. v. JAW The Point, LLC*, No. 14-11-00881-CV, 2013 WL 3968445 (Tex. App.—Houston [14th Dist.] Aug. 1, 2013, pet. filed). An insured had insurance for its apartment complex that provided coverage for wind damage, but not flood damage. The policy also contained two endorsements: one that provided coverage for demolition and increased building costs caused by ordinance (the ordinance endorsement), and another that provided coverage for demolition and increased cost of construction (the DICC endorsement).

After the apartment complex was damaged by Hurricane Ike, the insured sought coverage. During the claims processing, the City of Galveston passed an ordinance requiring demolition and rebuilding of structures when the damage was 50% of the value of the property, so that the structures would comply with new building codes. The city required demolition of the insured's complex. The insured thus sought coverage under the endorsements, but the insurer denied the claim.

The court of appeals held there was no coverage under the policy and neither endorsement applied. The court held that the endorsements had to be read in conjunction with a concurrent causation clause, which stated that a flood loss was not covered regardless of whether any other cause contributed to the loss. When read together, the court found that the terms provided that the insurer would pay for demolition and increased rebuilding costs that were caused by an ordinance when the loss resulted from a covered cause, but not a loss from an unsegregated combination of covered and uncovered causes. Because the insured did not present any evidence at trial allocating the damages caused by wind, flood, or a combination of wind and flood, neither the ordinance endorsement nor the DICC endorsement applied.

Another insured sought coverage for damage to its business personal property as a result of Hurricane Ike. The policy had a 10% limit for business personal property at newly acquired locations, with policy limits of $100,000. An endorsement increased the limit to $250,000. But the endorsement stated that a limit "shown elsewhere in the policy … applies in addition to" the endorsement limit. The question on appeal was how to interpret the "in addition to" language. The insured argued it should get the initial 10% limit (not to exceed $100,000) plus another $250,000, not subject to the 10% limit. The insurer argued that the endorsement merely increased the $100,000 limit to $250,000, but maintained the 10% limitation, meaning coverage was capped at $25,000. The court agreed with the insurer, concluding that the policy set up a two-tiered limit – i.e., a percentage limit and a dollar limit – and while the endorsement modified the dollar limit, it did not modify the percentage limit. Thus, the policy unambiguously limited coverage to 10% of business personal property, up to $250,000. *Shafaii Children's Trust v. W. Am. Ins. Co.*, No. 14-12-00447-CV, 2013 WL 5530824 (Tex. App.—Houston [14th Dist.] Oct. 8, 2013, no pet. h.).

A commercial property policy did not provide coverage for the theft of copper from the insured's storage facility. *United Nat'l Ins. Co. v. Mundell Terminal Svcs., Inc.*, 915 F. Supp. 2d 809 (W.D. Tex. 2012). The policy stated that it did not cover property covered under another policy. Another policy issued to the owner of the copper also provided coverage. The insured and the owner had a bailment relationship. A bailee is authorized to insure bailed goods in its own name and, in the case of loss, recover their entire value, holding the excess over its own interest in the goods for the benefit of the bailor. The insured's policy stated that its payment for loss of "personal property of others will only be for the account of the owner of the property." Relying on this language, the court found that the insured's policy provided coverage for the benefit of the owner of the property and covered the interests of the owner. Thus the insured's policy and the owner's policy insured the same interest – that of the owner. As such, the "other policy" exclusion applied.

D. Life insurance

The Supreme Court held that the Federal Employees' Group Life Insurance Statute providing that benefits be paid to the named beneficiary preempted a conflicting state law that would require payment of the proceeds to the insured's widow. *Hillman v. Maretta*, 133 S. Ct. 1943 (2013). Although the case involved a Virginia statute, it is relevant to Texas litigants. Texas has a similar statute that revokes a beneficiary designation when the insured divorces the beneficiary and does not re-designate them. *See* Tex. Fam. Code § 9.301(a). Presumably, the Texas statute would also be preempted.

A mother purchased a life insurance policy for her daughter in the amount of $50,000, and when the daughter became disabled, the mother sued the insurer for failing to pay her a disability benefit of $50,000. The insurer argued that the policy did not provide for a $50,000 payment in the event the purchaser of the policy became disabled, rather the premium payments are waived for a set time if the payor became disabled. The court upheld summary judgment in favor of the insurer. *Hopes-Fontenot v. Farmers New World Life Ins. Co.*, No. 01-12-00286-CV, 2013 WL 4399218 (Tex. App.—Houston [1st Dist.] Aug. 15, 2013, no pet. h.).

A woman with a mortgage applied for mortgage-decreasing accidental death insurance, after receiving solicitation letters regarding the product. She received a letter that her application was incomplete and more information was needed. She applied again for the insurance but this time applied jointly with her daughter. The first collection letter she received was for a different monthly premium than she had selected in the application, and was for an individual rather than joint. The woman made the payment, and later passed away. The insurance company argued that they were insuring her daughter but not her, and the daughter argued they were insuring her mother. The court held that it is possible that a reasonable finder of fact could conclude that the mother saw the letter stating a different monthly premium as a counter-offer and accepted it by tendering her first payment, and that it remained to be determined if there was actually a meeting of the minds. Therefore, it denied the plaintiff's and defendant's motions for summary judgment. *Hines v. Liberty Life Ins. Co.*, No. EP-11-CV-545-KC, 2013 WL 310320 (W.D. Tex. Jan. 25, 2013).

An insured changed the beneficiary of her life insurance pol-

icy from her partner to her brother. After her death, the brother asked for the proceeds. However, the insurer only gave him half of the proceeds, because Texas is a community property state. The partner proved he had a common law marriage with the insured, so he was entitled to the other half of the proceeds. *Genworth Life Ins. Co. v. Armendariz*, No. SA-12-CV-00328-DAE, 2013 WL 8700092 (W.D. Tex. March 7, 2013).

A life insurer was entitled to interpleader relief in light of demand letters written to it from a prior-named beneficiary. *Patterson v. American Gen. Life Ins. Co.*, No. 01-11-00528-CV, 2013 WL 1804494 (Tex. App.—Houston [1st Dist.] Apr. 30, 2013, no pet.). An insured named his father as beneficiary. He later designated his mother and sister as co-beneficiaries instead. After the insured died, all three filed claims. The insurer sought and received interpleader relief. The mother and sister appealed this decision, arguing there was no evidence of a "bona fide" rival claim. The court of appeals disagreed. Interpleader is within the trial court's discretion. Although there was no transcript of the hearing, the insurer argued it had received three demand letters from the father.

A life insurer had no obligation to pay proceeds where the person who applied for the policies was not the same as the alleged insured decedent. *Mass. Mut. Ins. Co. v. Mitchell*, No. H-11-3811, 2013 WL 1802861 (S.D. Tex. Mar. 4, 2013). A life insurer sued a beneficiary arguing that it had no obligation to pay the proceeds because its investigation revealed that the person who applied for the policies and presented for the medical examinations was not the same person as the decedent. The decedent was wheelchair bound and had an extensive medical history, and he could not have been "the healthy and ambulatory person" who appeared for medical examinations.

E. Flood insurance

Federal law did not preempt state law so as to preclude insureds from bringing suit against their flood insurer. *Spong v. Fidelity Nat'l Prop. & Cas. Ins. Co.*, No. G-10-228, 2013 WL 5563756 (S.D. Tex. Oct. 8, 2013). The insureds contracted to purchase a home that was within the John A. Chafee Coastal Barrier Resources System (CBRS). The insureds were unaware that the home was within the CBRS and was thus uninsurable under the National Flood Insurance Program. The insureds applied for flood insurance with an insurer that did know the home was within the CBRS. Nevertheless, it issued a policy. However, because the home was uninsurable under the NFIP, the policy was void when issued. FEMA notified the insurer that the policy was invalid because of the property location. The insurer repeatedly challenged the FEMA determination, but neither FEMA nor the insurer notified the insureds of this issue or their dispute about it.

The insureds' home was destroyed by Hurricane Ike. Only then did the insurer conclude that the property was within the CBRS, and on that basis denied the claim, cancelled the policy as void, and refunded the insureds' premiums. The insureds sued in state court for state law tort and statutory violations; the insurer removed the case and sought summary judgment on grounds that federal law preempted all of the insureds' claims. The district court was faced with conflicting authorities on the issue of FEMA preemption. In *Campo v. Allstate Ins. Co.*, 562 F.3d 751 (5th Cir. 2009), the Fifth Circuit held that FEMA did not preempt state law. However, FEMA issued a memorandum critical of *Campo* within months of its publication, and the FEMA memorandum expressly stated that it intended for its regulations to preempt state law claims related to policy formation. While observing that the FEMA memorandum might ultimately persuade the Fifth Circuit to reverse its prior determination, the court held that *Campo* was binding on its decision. The court therefore held that FEMA did not preempt state law and that the insureds' claims could proceed. The court further noted that, given the insurer's negligence and the substantial harm it caused the insureds, it could not condone the result the insurer requested.

An insured filed an untimely fourth proof of loss, which the flood insurer refused to pay. The court held that absent a waiver from FEMA, a timely proof of loss is a condition precedent to the filing of suit against a carrier for additional benefits. Because the fourth proof of loss was untimely, the insurer's motion for summary judgment was granted. *Jones v. Fidelity Nat'l Prop. & Cas. Ins. Co.*, No. G-10-289, 2013 WL 1572064 (S.D. Tex. April 12, 2013).

F. Other policies

A commercial crime insurance policy would cover a loss caused by two company officers who obtained loans and subsequently misappropriated funds, if they were acting within the scope of their apparent authority, even though they were not authorized to enter into the transactions. But the court concluded that apparent authority was a fact issue not resolved on summary judgment. *BJ Services S.R.L. v. Great American Ins. Co.*, ___ F. App'x ___, 2013 WL 4779701 (5th Cir. Sept. 6, 2013).

A claimant sought workers' compensation benefits after her husband died from a heart attack. The insurer argued that to be compensable the heart attack must occur during work hours. The appeals court held that to be compensable the heart attack must be identified as having occurred at a definite time and place, and caused by a specific event occurring in the course and scope of the employee's employment, and there was proof that both of these requirements were met. *New Hampshire Ins. Co. v. Allison*, No. 01-12-00505-CV, 2013 WL 3947822 (Tex. App.—Houston [1st Dist.] Aug. 1, 2013, no pet. h.).

A title insurer included in house closing documents notice of a third party mineral lien on the property. Five years later, the homeowners discovered the lien and sued the insurer for violations of the DTPA and Tex. Ins. Code. The court held that the injury arising from the third party lien was not inherently undiscoverable when the homeowners bought the home, and therefore, there was no tolling of the statute of limitations. The court granted the insurer's motion for summary judgment. *Palmer v. Chicago Title Ins. Co.*, No. H-12-0297, 2013 WL 3049343 (S.D. Tex. June 17, 2013).

III. FIRST PARTY THEORIES OF LIABILITY

A. Breach of Contract

Because insureds did not pay their homeowner's insurance premium before a fire damaged their rent house, the policy expired, and the insurer was not liable for breach of contract. *Texas Farm Bureau Underwriters v. Rasmussen*, No. 01-12-00992-CV, 2013 WL 3989145 (Tex. App.—Houston [1st Dist.] Jul 11, 2013, pet. filed). The insureds paid the first year's premium, but did not pay for the following year. The insurer sent renewal notices, but the insureds never received them, and their agent never told them that the policy was cancelled. Afterwards, a fire destroyed rental property owned by the insureds. The insurer denied the claim because the insureds had failed to pay the premium due six months before the fire occurred. The court of appeals agreed that there was no policy in place at the time of the fire. The policy only provided coverage during the policy period, and coverage was conditioned on receipt of the premium. Therefore, the policy expired by its own terms six months before the fire. The policy was not automatically renewed under section 551.105 of the Texas Insurance Code, because the insureds did not pay the premium, even though they did not receive timely notice of

nonrenewal. The court also held that the insurer was not liable for improperly cancelling the policy, because the policy expired when the insureds failed to pay the premium, so the insurer did not cancel the policy.

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

In *Texas Farm Bureau v. Rasmussen*, noted above, the insurer also was not liable for unfair settlement practices, because there were no covered claims. The insurer was not liable under section 541.061 because it did not misrepresent the terms or benefits of the policy, nor did it deny coverage that it previously represented would be covered.

An insured restaurant owner sued its agent for DTPA and Insurance Code violations for allegedly misrepresenting coverage for power outages in order to get the insured to switch from one carrier to another. The agent claimed the coverages were identical. Following Hurricane Rita, the old carrier provided coverage, but following Hurricane Ike, the new carrier denied coverage. The insured argued that the old carrier would have covered the loss. The court examined the old policy, which contained an exclusion for power losses caused by damage to overhead transmission lines. The court held that the evidence conclusively showed that this exclusion would have precluded coverage under the old policy, because the power failure was due to overhead transmission lines. Therefore, the old policy did not provide any more coverage than the new one. As such, the agent did not misrepresent the coverages as being the same. *Houstoun, Woodard, Eason, Gentle, Tomforde & Anderson, Inc. v. Escalante's Comida Fina, Inc.*, No. 01-11-00746-CV, 2013 WL 4680262 (Tex. App.—Houston [1st Dist.] Aug. 29, 2013, no pet.).

Following Hurricane Rita, the old carrier provided coverage, but following Hurricane Ike, the new carrier denied coverage. The insured argued that the old carrier would have covered the loss.

After denying summary judgment for the insurer on breach of contract, and granting it on bad faith, a district court also granted the insurer's motion for summary judgment on the DTPA violation, because the insured failed to show injury independent of the injury resulting from wrongful denial of policy benefits. *Button v. Chubb Lloyds Ins. Co. of Tex.*, No. 4:11CV536, 2013 WL 394886 (E.D. Tex. Jan. 31, 2013).

In this holding on the DTPA claim, the court erred by following an erroneous holding from the San Antonio court of appeals. That court has held that a plaintiff suing under the DTPA must show that "she was injured by the alleged statements in any way other than the injury that would always occur when an insured is not promptly paid its demand." *Walker v. Fed. Kemper Life Assur. Co.*, 828 S.W.2d 442, 454 (Tex. App.—San Antonio 1992, writ denied). This goes directly against the supreme court's holding that policy benefits are damages recoverable under the statutory cause of action and may even be damages as a matter of law. "We hold that an insurer's unfair 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." *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 136 (Tex. 1988).

C. Prompt Payment of Claims

Hospitals could not sue a health insurer for prompt payment penalties where they did not have a contract with the insurer but instead had contracted with another entity. *Christus Health Gulf Coast v. Aetna, Inc.*, 397 S.W.3d 651 (Tex. 2013). The court held this conclusion was mandated by the plain language of the statute. Tex. Ins. Code §§ 843.336-.334.

Neither the prompt payment of claims statute nor the unfair settlement practices provisions of the Insurance Code applied to an insurer's payment of a judgment against it. *Doss v. Warranty Underwriters Ins. Co.*, No. 04-11-00776, 2012 WL 5874316 (Tex. App.—San Antonio Nov. 21, 2012, no pet.). An insured obtained a judgment against his insurer, which paid the judgment in full sixty-seven days after it was entered. Subsequently, the insured sued the insurer for violating the prompt payment of claims and unfair settlement practices statutes. The court held that those provisions did not apply because: (1) they applied only to the insurer-insured relationship, not the judgment creditor-judgment debtor relationship; and (2) they applied only to "claims," and a claim reduced to final judgment is no longer a claim.

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

An owner of a condominium sued the condominium association insurer for breaching the duty of good faith and fair dealing. The court held that even if the condo owner paid premiums for and was entitled to liability coverage under the policy, she was still a third-party claimant, and the insurer did not owe her the duty of good faith and fair dealing, as that would mean the insurer owed conflicting duties to its tortfeasor insured – the condominium association – and to the condo owner. *Reule v. Colony Ins. Co.*, 407 S.W.3d 402 (Tex. App.—Houston [14th Dist.] 2013, no pet.).

An insured was injured in a car accident. Her UM/UIM insurer offered to settle for a certain amount, but the insured denied the offer, instead suing the insurer for breach of the duty of good faith and fair dealing. A jury awarded $18,000 more than what the insurer offered. The court granted the insurer's motion for summary judgment on the extra-contractual claim, holding that the jury's award showed the insurer was being reasonable and an impasse was reached in negotiations because the plaintiff was unreasonable in asking for $450,000 for mental anguish and physical pain. *Quintana v. State Farm Auto. Ins. Co.*, No. H-11-007-A, 2013 WL 5495827 (S.D. Tex. Oct. 2, 2013).

An insured was injured when he hit an abandoned car. He sued his insurer for his UM/UIM benefits, and the jury found in the insured's favor. Because the insurer identified evidence showing its reasonable basis for delaying payment of the insured's demand because of a reasonable disagreement about the extent of the injuries, and because the insured failed to identify evidence showing that the disputes were unreasonable, the court held that the insurer did not breach its duty of good faith and fair dealing by delaying payment. However, the court disagreed with the insurer's argument that just by reserving a decision on a bad faith claim, the insurer is immunized from liability. *Accardo v. Am. First Lloyds Ins. Co.*, No. H-11-0008, 2013 WL 4829252 (S.D. Tex. Sept. 10, 2013).

After he was injured by an uninsured motorist an insured brought suit against his UM/UIM insurer for breach of contract, breach of duty of good faith and fair dealing, and violations of the Tex. Ins. Code. The court granted summary judgment in favor of the insurer on all counts, holding: (1) the insurer's contractual duty did not arise until the insured obtained a judgment, so the contract was not breached; (2) the jury awarded basically the same amount the insurer offered, so there was no breach of the duty of good faith and fair dealing; and (3) the insurer's offer to settle by paying a certain amount, which was rejected by the insured, did not notify the insured that the insurer would pay that amount and therefore did not trigger the

Tex. Ins. Code five-day payment provision. *Terry v. Safeco Ins. Co. of Am.*, 930 F. Supp. 2d 702 (S.D. Tex. 2013); No. H-10-0340, 2013 WL 5214315 (S.D. Tex. Sept. 17, 2013).

The court in *Bean v. Tex. Mut. Ins. Co.*, No. 09-11-00123-CV, 2012 WL 5450826 (Tex. App.—Beaumont Nov. 8, 2012, no pet.) (mem. op.), held that a worker's compensation claimant has no cause of action against the compensation insurer under the Insurance Code for unfair settlement practices or for a breach of its duty of good faith and fair dealing. The Worker's Compensation Act provides the exclusive remedy for the claimant's compensation benefits, and a judicial remedy is not available for the statutory and common law claims.

The family of a deceased worker sued a worker's compensation insurer for fraud, negligent misrepresentation, breach of the duty of good faith, and violations of the DTPA and Insurance Code, contending that the insurer unreasonably delayed payment and made false representations that they weren't entitled to coverage. *Hopper v. Argonaut Ins. Co.*, No. 03-12-00734-CV, 2013 WL 5853747 (Tex. App.—Austin Oct. 18, 2013, no pet.). The court held that *Ruttiger* precluded all of the plaintiffs' claims. The court also held that section 541.061 of the Texas Insurance Code regarding misrepresentation of a policy was also precluded because there was no evidence that the insurer misrepresented the terms of the policy. The alleged misrepresentations concerned statements about whether the worker's death was due to compensable injury and whether the plaintiffs were beneficiaries, not the policy terms themselves. Although *Ruttiger* did not specifically involve common law claims of fraudulent and negligent misrepresentation or unconscionability, the court held that these claims were also barred by *Ruttiger* because they concerned delays in payment, claims handling, and entitlement to benefits.

E. Fraud

T. Boone Pickens, a supporter of Cowboy athletics at Oklahoma State University, bought $10 million life insurance policies on twenty-seven OSU alumni. The agents marketed the policies as an investment by claiming the ability to select individual insureds who were likely to die in a pattern that would beat the actuarial tables. When no one died soon enough, Pickens became dissatisfied with the investment and sued the insurers for fraud. The court held there was no evidence of misrepresentations. Under applicable Oklahoma law, representations about future events could not support claims of fraud, and the record established that the defendant's disclosures and the plaintiff's own due diligence apprised him of the inherent risk and assumptions underlying the investment program. *Lincoln Nat. Life Ins. Co. v. Management Compensation Group Lee, Inc.*, ___ F. App'x ___, 2013 WL 3227223 (5th Cir. March 18, 2013).

An insured did not present evidence of damages to support a fraud action. *Espinosa v. Allstate Ins. Co.*, No. 13-12-00509-CV, 2013 WL 593875 (Tex. App.—Corpus Christi Feb. 14, 2013, no pet.). The insured alleged that he bought two automobile policies he would not have otherwise purchased, because of the insurer's fraud regarding its claims-handling policies. But he produced no evidence of economic loss related to the policies or the insurer's claims-handling. No claims were made on one policy, and the claims made on the other were paid and resolved. The insured conceded that he received the benefit of coverage during the years he had the policies. Because the insured had no evidence of injury, the insurer was entitled to summary judgment.

F. ERISA

The Fifth Circuit reversed a district court's finding in favor of a disability claimant under ERISA in *Truitt v. Unum Life Ins. Co. of America*, 729 F.3d 497 (5th Cir. 2013). Truitt was an attorney whose practice required her to travel extensively and carry files. She was found to be disabled from that job in 2003. Unum continued to review her disability and took surveillance videos and had examinations that suggested her disability did not continue. Other evidence suggested that it did. In addition, an ex-companion of Truitt's provided to Unum extensive emails outlining much travel and many activities that were inconsistent with her claimed disability. However, there was evidence that the ex-companion had a questionable background, including admitting to assaulting Truitt.

Based on this record, the district court held that Unum had substantial evidence to support its finding that Truitt was not disabled; nevertheless, the district court held that denying benefits was an abuse of discretion because Unum acted arbitrarily by failing to further investigate and by failing to consider the questionable source of some of the evidence. The Fifth Circuit rejected both of these reasons. The appellate court held there was no duty to investigate further and there was no precedent for requiring the insurer to consider the source of the evidence. The Fifth Circuit found that the insurer reasonably considered all of the evidence and that supported its denial.

The court also held that Unum's decision was not undermined by the fact that it had a structural conflict of interest – being the decider and the payor – or by Unum's well-documented history of bad claims-handling. The court said that recent cases showed the Unum had improved.

The court reversed the district court's award of benefits and remanded so that the district court could reconsider Unum's fraud claim to recoup benefits already paid. The court of appeals held the district court erred by applying Texas fraud law, instead of federal common law under ERISA, to conclude Unum was not entitled to repayment.

A participant brought action under ERISA against the plan administrator and claims administrator challenging the calculation of her long-term disability benefits. The court held that the record showed a reasonable basis to support the calculation of her annual benefits compensation and held that the lump sum pension benefits elected by the participant and rolled over into an IRA constituted benefits received by the participant for purposes of an offset to the monthly long term disability amount. *Phillips v. Metro.Life Ins. Co.*, 405 S.W.3d 880 (Tex. App.—Dallas 2013, no pet.).

An ERISA claimant brought suit against his employer and the employee benefit plan for denial of benefits. The employer filed a motion to dismiss, arguing that the plan was the only appropriate defendant. The court disagreed, holding that when an employer has the ultimate decision-making authority as to whether the plaintiff is entitled to benefits under the plan the employer is a proper party. The motion to dismiss was denied because the claimant asserted that the plan was self-administered by his employer, and the employer sent the plan a letter stating the claimant was faking his injury, which constituted an act of control over plan administration. *Vazquez v. AMO Enter., Inc.*, No. EP-12-CV-29-KC, 2013 WL 593457 (W.D. Tex. Feb. 14, 2013).

A doctor was insured by two disability insurance policies. After becoming disabled, he made claims under both policies. The court held the first policy was not preempted by ERISA because it was purchased by the doctor, who was the owner of his business, and it benefitted only him and no other employees. Even though other benefits were provided to other employees, that fact did not make his policy part of an ERISA plan. The court held the second policy was preempted by ERISA, because it was originally purchased by an employer. The second policy lapsed but was later continued by the doctor when he went into private practice. The court said that because the second policy was continued and

allowed for the same discount that his previous employer had negotiated, it was still part of an ERISA plan. *Henderson v. Paul Revere Life Ins. Co.*, No. 3:11-CV-1992-D, 2013 WL 1875151 (N.D. Tex. May 6, 2013).

ERISA did not preempt claims against the broker of an employer's insurer. *Kersh v. United Healthcare Ins. Co.*, No. SA:13-CV-00052-DAE, 2013 WL 2286078 (W.D. Tex. May 23, 2013). An employee's widow sued a life insurer for denying her claim for supplemental life insurance. The widow's claims for breach of contract and wrongful denial of insurance benefits were "related to" an ERISA plan and were preempted. However, ERISA did not preempt the widow's claims for negligence and violations of the Texas Insurance Code against the broker of the employer's insurer. The widow argued that the broker breached its duty of care by giving incorrect or misleading information about how to request supplemental life insurance. The broker argued that the claims were preempted because they were intertwined with and implicated the ERISA plan. The court disagreed, and held that the negligence claim was not subject to preemption because it did not address an area of exclusive federal concern, such as the distribution of benefits under an ERISA plan, but sought compensatory damages based on the broker's failure to use reasonable diligence to procure the desired insurance. Moreover, the broker was not an ERISA entity. The widow's claims under the Insurance Code also were not preempted. While some claims brought under the Code are preempted by ERISA, preemption is not automatic. Here, the claims were not preempted because they were not premised on the right to recover benefits under the terms of the ERISA plan.

An ERISA plan participant was entitled to long-term disability benefits in *Mattson v. Aetna Life Ins. Co.*, 928 F. Supp. 2d 905 (S.D. Tex. 2013). A participant in a long-term disability plan brought an ERISA action against the claims administrator, challenging the termination of his benefits. The district court found that the participant should be awarded benefits under the plan because substantial evidence did not support the determination that there were reasonable occupations he could perform. Although the evidence supported the conclusion that the participant could perform sedentary occupations, there was no evidence about whether the jobs he could perform that would permit him to earn "an income of more than 80% of [his] adjusted pre-disability earnings," as the plan required. Consequently, the administrator abused its discretion in denying the participant's application for benefits. Under the circumstances, the participant was entitled to long-term disability benefits under the plan.

IV. AGENTS, AGENCY, AND VICARIOUS LIABILITY

A. Individual liability of agents, adjusters, and others

An insurance agent had to return its commissions to an insurer as unearned after the insurer was forced to return the premiums it received from an insured due to the agent's failure to exercise his duty of honesty, good faith, and fair dealing in the sale of the policy. The term "unearned commission" in the agency agreement was not ambiguous, and the agent breached the agency agreement by refusing to return the commissions received on the policy in question. *American Gen. Life Ins. Co. v. Mickelson*, No. H-11-3421, 2012 WL 6020339 (S.D. Tex. Dec. 3, 2012).

An agent who actually received commission checks and deposited them into an account over which he had control was liable to repay those commissions to the insurer when the policies were rescinded, even though he had an agreement assigning those commissions to another entity. The court held that *quasi estoppel* precluded the agent arguing that he was not liable, where he had asserted control over the money. *American General Life Ins. Co. v. Bryan*, ___ F. App'x ___, 2013 WL 4082874 (5th Cir. Aug. 14, 2013).

V. THIRD PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile liability insurance

A policy's "reasonable-belief-of-entitlement exclusion" barred coverage for the death of a passenger in the insured's car. *Sederberg v. IDS Prop. Cas. Ins. Co.*, No. 05-11-01275-CV, 2013 WL 1646398 (Tex. App.—Dallas Apr. 17, 2013, no pet.). The insured owner of a car allowed her daughter to drive the car. The daughter borrowed the car one night to attend a party with her friend. After the party, the friend drove the car and, while driving, drove off the side of the road. The daughter died as a result of her injuries from the accident. The insurer brought a declaratory judgment action against the daughter's estate, arguing that it did not have a duty to defend or indemnify under the policy because there was no coverage for the friend and there was no uninsured motorist coverage for the daughter.

The court of appeals affirmed the trial court's summary judgment in favor of the insurer. The policy excluded liability for persons "using a vehicle without a reasonable belief that that person is entitled to do so." According to the court, this type of exclusion requires permission or consent to the use of the vehicle at the time and place in question and in a manner authorized by the owner, expressly or impliedly, and that such permission may be inferred from a course of conduct or relationship between the parties. Here, although the insured gave her daughter permission to use the car, the summary judgment evidence showed that the friend did not have the same permission. The insured did not know the friend, had never met him, did not give him permission to drive the car on the occasion in question, did not know he was driving the car, and had no prior relationship with him from which he could have reasonably believed he was authorized to drive the car. The insured's affidavit statement that she "would have allowed him to drive" the car "since he was one of the coworkers" of the daughter was conclusory and subjective and insufficient to raise an issue of fact.

Failure to obtain a judgment against a driver does not make the driver an uninsured motorist. *State Farm Mut. Auto. Ins. Co. v. Bowen*, 406 S.W.3d 182 (Tex. App.—Eastland 2013, no pet.). An insured was involved in a collision with another driver, who had automobile insurance sufficient to cover his damages. However, the insured did not file suit against the other driver within the limitations period, so that case was dismissed. The insured then sued his automobile insurer for uninsured/underinsured motorist benefits. The policy language defined an uninsured motor vehicle to include a vehicle "to which a liability … policy applies at the time of the accident but the … insuring company: a. denies coverage[.]" The insurer argued that the other driver was not uninsured, because her policy applied at the time of the accident. The insured argued that the other driver became an uninsured driver because her insurer ultimately denied his claim. Looking to similar cases for guidance, the court of appeals concluded that the other driver was not an uninsured motorist within the policy's meaning, because she had liability coverage and there was no evidence that her insurer denied that she had coverage under her policy. The insured did not recover under the other driver's policy because he was barred by limitations. This did not amount to a denial of coverage under the insured's policy.

B. Comprehensive general liability insurance

A liability policy covered a homebuilder's voluntary repairs that were not consented to by the insurer, where the insurer could

not show prejudice. *Lennar Corp. v. Markel American Ins. Co.*, ___S.W.3d ___, 2013 WL 4492800 (Tex. August 23, 2013). Lennar agreed to remediation of several hundred homes after discovering that the exterior insulation and finish system that had been applied would cause water damage if not replaced. Markel, the insurer, argued that it could not be liable for any settlement reached without its consent. The court rejected this, concluding that Markel could not escape liability without showing that the voluntary settlements prejudiced it. The court rejected Markel's argument that it was necessarily prejudiced because there may have been fewer claims if the homebuilder had not acted voluntarily. The court held this was a fact issue that was resolved against the insurer.

The court also held that the voluntary settlements were sufficient to establish the "ultimate net loss" under the policy even without the insurer's consent – absent a showing of prejudice by the insurer.

The court also held that the cost to remove the exteriors of all the houses to locate those that were damaged and to find the damage was part of the loss "because of property damage" within the policy language. The court found that Lennar could not have located the damage, which was hidden, without removing the exteriors, and rejected the argument that these were preventative measures.

The court also held that the losses were covered by Markel's policy even though they very likely started before and continued after that policy year. The court relied on its prior holding that when a loss triggers more than one policy covering different periods, the insured may sue any insurer and it is up to the insurers to then allocate the loss among themselves according to their subrogation rights. The court rejected Markel's invitation to change that rule and allow only pro-rata recovery by the insured.

A renewal policy that contained a new exclusion different from the prior year nevertheless precluded coverage. The insured's 2002 policy provided coverage arising from an employee's injuries arising from third–party contractual relationships, but the 2003 policy excluded this. The court held that the new exclusion applied even though it changed the terms from the prior year. The new exclusion was listed on the face of the policy, a copy was attached as part of the policy, and the endorsement clearly provided that it changed the terms of the policy. The court rejected the argument that all renewals must be on the same terms as the prior policy, absent evidence of a mutual mistake or a prior agreement that the terms would be the same. *Materials Evaluation & Technology Corp. v. Mid-Continent Cas. Co.*, 519 F. App'x 228 (5th Cir. 2013).

In reaching its decision, the court discussed at length circumstances where an insured's failure to read the terms of the policy is excused, but held none of those instances applied.

C. Directors & officers liability insurance

Ambiguity in directors' and officers' liability policies had to be resolved in favor of coverage for the insured. *Gastar Exploration, Ltd. v. U.S. Specialty Ins. Co.*, No. 14-12-00118-CV, 2013 WL 3693603 (Tex. App.—Houston [14th dist.] Jul. 16, 2013, no pet.). Primary and excess D&O insurers denied coverage for a series of securities fraud lawsuits against their insured on grounds that the suits were related to other litigation that was filed prior to the policy periods. The policies were both claims-made policies. They contained two provisions that limited coverage for a claim made that related to a claim prior to the policy period, one which would exclude coverage for the suits and one which would not. The first was "Condition C," which excluded coverage of a claim initially made during the policy period that related to the facts or circumstances underlying another claim made prior to the policy period. The second was "Endorsement 10," which was a narrower exclusion because it only excluded claims made during the policy period but "arising out of, based upon or attributable to any pending or prior litigation as of 5/31/2000, or alleging or derived from the same or essentially the same facts or circumstances as alleged in such pending prior litigation." The court found that Condition C rendered Endorsement 10 meaningless because any claims that would be excluded by Endorsement 10 would already be excluded by Condition C. The provisions thus conflicted or created an ambiguity, and the court found that Endorsement 10 controlled over Condition C, and that coverage existed for the suits.

VI. DUTIES OF LIABILITY INSURERS

A. Duty to defend

An insurer had a duty to defend a city whose council members were sued for wrongful acts related to zoning of a shopping center. The policy contained an exclusion for liability arising out of "inverse condemnation." One of the claims was for inverse condemnation, but the court found that the other three claims could be established even without inverse condemnation, so there was the potential for coverage and, therefore, the duty to defend. The other claims were for discrimination, arbitrary decisions that denied the plaintiff substantive due process, and conspiracy to tortiously interfere with the plaintiff's contracts. *City of College Station v. Star Ins. Co.*, __ F.3d ___, 2013 WL 6028315 (5th Cir. Nov. 14, 2013).

A complaint that alleged "property damage" but no facts that showed property damage did not trigger the insurer's duty to defend. The facts alleged that drilling equipment was towed to the wrong location, resulting in wasted expense drilling a dry hole there, and damages for delay rentals at the proper location. Although the petition claimed "property damage" these facts did not show any. The court held it is the facts alleged that control, not the legal theories. *PPI Technology Services, L.P. v. Liberty Mutual Ins. Co.*, 515 F. App'x 310 (5th Cir. 2013).

A complaint alleging that consumers were induced to purchase ineffective weight loss products by false misrepresentations did not allege "bodily injury," because failing to achieve weight reduction means the body did not change, not that it was injured. *CSA Nutraceuticals GP, L.L.C. v. Chubb Custom Ins. Co.*, 505 F. App'x 298 (5th Cir. Jan. 2, 2013) (per curiam).

A company sued its insurer seeking reimbursement for defense costs associated with asbestos litigation. The insurer argued on appeal that it was only required to indemnify the insured for defense costs that arose from the covered occurrences and that to be covered the insured must actually incur liability from a judgment or settlement. The court disagreed, holding that the insurer was required to reimburse the insured for defense costs that included dismissed claims. *Certain Underwriters at Lloyd's London v. Chicago Bridge & Iron Co.*, 406 S.W.3d 326 (Tex. App.—Beaumont 2013, pet. denied).

Condo owners sued the residents' association for failing to maintain the property. The association counterclaimed alleging that the owners had made significant alterations to the exteriors of their units without prior written consent. The trial court held the association's insurer did not have a duty to defend the owners, because the association's counterclaim did not qualify as an "occurrence" under the policy. The appellate court agreed because the counterclaim was premised on the owners' intentional violation of the association's bylaws. *Brown v. Am. W. Home Ins. Co.*, No. 05-11-00561-CV, 2013 WL 873824 (Tex. App.—Dallas Jan. 3, 2013, no pet.) (mem. op.).

An employee of a store was murdered at work by men who

were able to enter the store through a vacant store next door. The shopping center landlord's liability insurer paid a settlement to the employee's family, and then sued the vacant tenant's liability insurer, alleging it had a duty to defend and a duty to indemnify for the settlement. The court held that the vacant store's insurer did owe a duty to defend in the underlying suit, as the landlord qualified as an additional insured under an endorsement. However, the court denied the landlord's liability insurer's motion for summary judgment as to the duty to indemnify, because the insurer did not establish that the amount paid was reasonable. *Fed. Ins. Co. v. Hanover Ins. Co.*, No. 3:11-CV-2661-D, 2013 WL 5339210 (N.D. Tex. Sept. 24, 2013).

The court's conclusion on the duty to indemnify seems questionable. The supreme court has held that the amount of a settlement is presumed to be reasonable and is binding on the breaching insurer, when the settling party paid with its own money with no guarantee of repayment. *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008).

A truck driver was injured while helping unload a concrete wall from his truck to the jobsite. He sued the business where he was delivering the wall. The business's insurer sought summary judgment declaring that the injury was excluded under the policy, so there was no duty to defend or indemnify. The court granted the insurer's motion, holding that the truck driver's status as an independent contractor providing a product to the job site fell outside of coverage. *Preferred Contractors Ins. Co. Risk Retention Group, L.L.C. v. Oyoque Masonry, Inc.*, No. 4:12-CV-1406, 2013 WL 3899332 (S.D. Tex. July 26, 2013).

A contractor's negligent plumbing work resulted in a water leak that caused substantial damage to several condos. His insurer sought a declaration that it had no duty to defend or indemnify the contractor on the numerous claims filed. The court agreed, holding that the policy did not insure the contractor for plumbing work. *Omega U.S. Ins., Inc. v. Jerry Heitzman Constr.*, No. G-12-317, 2013 WL 3208584 (S.D. Tex. June 24, 2013).

A contractor was sued for negligent work performed in constructing a college building, specifically for problems with water penetration. The contractor sued several of the subcontractors' insurers seeking a declaration that it was entitled to defense and indemnity. The contractor settled with all the defendants, except for Ace, the insurer for the security system subcontractor. The court held that Ace did not have a duty to defend or indemnify, because the property damage did not arise out of Ace's work. Additionally, even if the damage did arise out of Ace's work, the policy expressly stated that Ace had no defense obligations. *Swinerton Builders v. Zurich Am. Ins. Co.*, No. 4:10-CV-1791, 2013 WL 4483435 (S.D. Tex. Feb. 28, 2013).

An insured nursing home was sued by a deceased resident's family for negligence related to his death. The insured sought a declaration that the insurer owed it a defense and indemnity. The court held that the policy's prior knowledge exclusion did not apply to bar coverage for the underlying lawsuit. The exclusion applied if the insured had knowledge of the abuse, and the court held that the only person whose knowledge was imputable to the nursing home under the policy was the person who signed the policy application, the nursing home's president, who did not have knowledge of the alleged negligence. Therefore, the insurer had a duty to defend the nursing home. The insurer's motion for summary judgment on the duty to indemnify claim was denied, as genuine issues of material fact existed. *Arboretum Nursing & Rehabilitation Ctr. of Winnie, Inc. v. Homeland Ins. Co. of N.Y.*, No. V-10-69, 2012 WL 6161115 (S.D. Tex. Dec. 11, 2012).

After a contractor was sued for work done on apartments that were later converted to condos, the contractor's insurer sought declaratory relief that another insurer was also obligated to defend the contractor. However, there was an exclusion in that policy that did not allow coverage for work done to apartments that were later converted to condos. Therefore, the second insurer's motion for summary judgment was granted. *Am. Empire Surplus Lines Ins. Co. v. Nat'l Fire Ins. Co. of Hartford*, No. H-12-2313, 2013 WL 1194866 (S.D. Tex. March 21, 2013).

An insured sued its liability insurer over a delay in providing independent counsel of the insured's own selection. *Marquis Acquisitions, Inc. v. Steadfast Ins. Co.*, No. 05-11-01663-CV, 2013 WL 4083614 (Tex. App.—Dallas Aug. 14, 2013, no pet.). The underlying suit concerned a fire at an apartment complex the insured co-owned with others. The insured repeatedly sought to have the insurer hire the attorney of the insured's choosing and sent several letters claiming that a conflict of interest existed, but did not identify what the conflict was. In response, the insurer sought clarification of the conflict. After several months, the insured provided information showing a potential future conflict between the owners and managers of the apartment complex. The insurer then hired independent counsel for the insured, but did not hire the particular lawyer the insured desired. In response, the insured filed suit. The court held that the insurer did not breach its contract by failing to employ separate counsel in a timely manner, explaining, "We see nothing in *Segerstrom* [247 F.3d 218 (5th Cir. 2001)] or any other Texas law that would require an insurance company to immediately hire separate counsel for insured defendants based on an insured's unspecified and unsubstantiated allegations of a conflict of interest." Further, the insured suffered no damages as a result of any delay. The damages paid in the underlying suit were covered by the policies. The only damages sought by the insured were the fees it paid to the lawyer it wanted for his efforts to force the insurer to hire him. The court found these fees were not recoverable because they were attorney's fees standing alone without any additional actual damages. The court also concluded that the insurer's delay in providing the insured with separate counsel was not actionable as an unfair insurance practice. The delay also did not breach the insurer's duty of good faith and fair dealing since the delay was the result of a bona fide dispute over the existence of a conflict of interest that the insurer "continuously attempted to resolve."

A commercial general liability insurer owed a duty to defend its insured in a suit brought by a homeowner's association alleging

that the insured, the subdivision developer, had built inadequate roads. *Mid-Continent Cas. Co. v. Krolczyk*, 408 S.W.3d 896 (Tex. App.—Houston [1st Dist.] 2013, pet. filed). The insurer denied any duty to defend, based on two exclusions: the "your work" exclusion and the "earth movement" exclusion. The court held that neither exclusion abrogated the insurer's duty to defend. The "your work" exclusion did not preclude coverage because, under the allegations, while one "particular part" of the insured's work was allegedly defective, other parts of the road construction were not defective, and a liberal reading of the petition required a finding of coverage.

The "earth movement" exclusion also did not apply. The homeowner's association alleged that the road was damaged because the base washed out due to exposure to the elements. There was no allegation that this was due to movement of "land, earth, or mud," and the court would not interpret the exclusion to include movement of concrete or manmade materials. Therefore, the insurer owed a duty to defend to its insured.

Neither the insured nor the insurer was entitled to summary judgment on the question of whether the insurer owed a duty to defend, in *Olesky v. Farmers Ins. Exchange*, No. 01-110—545-CV, 2013 WL 3894890 (Tex. App.—Houston [1st Dist.] Jul. 30, 2013, pet. filed). An insured sought a defense from his homeowner's insurer. The underlying suit arose from a snowmobile accident that occurred in New York. The insured resided in Texas. The policy excluded coverage for bodily injury arising out of use of a motor vehicle, but an exception to that exclusion applied where the vehicle was not subject to motor vehicle registration and was not owned by the insured, among other requirements. The insured and insurer filed cross-motions for summary judgment, in which they primarily argued about whether the snowmobile had to be registered. The insured argued that Texas law applied and that Texas law did not require registration. The insurer argued that New York law applied and that New York law required registration. The court held that neither state's law required registration. Although the insurer was thus not entitled to summary judgment on this ground, the court would not render judgment in favor of the insured, either. The court held that it could not render judgment for the insured because he did not argue in his motion for summary judgment in the trial court that New York law also did not require registration.

The court also held the contractual liability exclusion did not bar coverage for the homeowner's property damage, because the homebuilder did not assume any contractual obligation in addition to the "general law" of implied warranty of good workmanship.

This is an odd result, as the dissent pointed out. The majority essentially refused "to construe and apply either statute or to determine whether the exception applies and thus whether the policy covers the [underlying] claims and whether [the insurer] is required by the terms of the [insured's] policy to provide a defense to the … claims. And it refuses to enter judgment in favor of [the insured], even though it declares the law to be such that [he] must necessarily be the beneficiary of its reading."

A first party insurer had no duty to defend or indemnify its insured and was entitled to judgment as a matter of law on that point. *United Nat'l Ins. Co. v. Mundell Terminal Svcs., Inc.*, 915 F. Supp. 2d 809 (W.D. Tex. 2012).

B. Duty to indemnify

A homeowner sued her homebuilder's insurer for indemnity for an arbitration award in favor of the homeowner related to construction defects. *Mid-Continent Cas. Co. v. Castagna*, No. 05-12-00383-CV, 2013 WL 4432353 (Tex. App.—Dallas Aug. 20, 2013, no pet. h.). The court held that the insurer had a duty to indemnify under the policies in place at the time the damage occurred, the 2001-2003 policies, but there was no duty to indemnify under the 2006-2007 policies, because the homebuilder was not a named insured for those years. The court also held the contractual liability exclusion did not bar coverage for the homeowner's property damage, because the homebuilder did not assume any contractual obligation in addition to the "general law" of implied warranty of good workmanship.

An insured roofing company was sued by a property owner for negligence and breach of contract. The roofing company's insurer agreed to defend it in the underlying case, but then sought a declaration that it had no duty to indemnify the roofing company. The court denied the request, holding that there had been no briefing as to whether the insurer had a duty to defend, and no finding that the same reasons that negated the duty to defend negated any possibility the insurer would ever have a duty to indemnify. Therefore, the court held the issue was not ripe for decision. *First Mercury Ins. Co. v. Horizon Roofing, Inc.*, No. 3:12-CV-03393-O, 2013 WL 1481988 (N.D. Tex. April 9, 2013).

A contractor made a demand for defense and indemnity to its subcontractor's insurer. The court held that the contractor was limited to indemnification coverage for certain claims brought by third-parties for personal injury or property damage, but that coverage did not extend to litigation for enforcement of the indemnification right. *One Beacon Ins. Co. v. Crowley Marine Servs., Inc.*, No. H-08-2059, 2012 WL 6201202 (S.D. Tex. Dec. 12, 2012).

A court held that an insurer did not have a duty to defend the insured because the claims in the underlying action fell outside of the "insured services" as defined in the policy. However, the court denied the insurer's motion for summary judgment on the duty to indemnify, because liability had not been established, holding that, "unlike the duty to defend, which turns on the pleadings, the duty to indemnify is triggered by the actual facts establishing liability in the underlying suit, and whether any damages caused by the insured and later proven at trial are covered by the terms of the policy." *Axis Surplus Ins. Co. v. Halo Asset Mgm't, L.L.C.*, No. 3:12-CV-2419-G, 2013 WL 5416268 (N.D. Tex. Sept. 27, 2013).

A federal court denied an insurer's motion for summary judgment on the issue of whether it had a duty to indemnify its insureds for a judgment. *Encompass Ins. Co. v. Hill*, No. 6:09-CV-460, 2013 WL 530280 (E.D. Tex. Feb. 12, 2013). Plaintiffs in the underlying suit obtained a judgment against the insureds for violations of the DTPA, breach of contract, and breach of warranty claims arising out of the sale of a home that had a number of defects. The insureds sought indemnity coverage from their homeowners policy, which denied the claim on grounds that the damages did not result from an "occurrence," were economic rather than property damage, were intentional acts precluded by an exclusion, and resulted from a business activity. The district court determined that a fact question existed as to whether the damages were the result of an "occurrence" because DTPA, contract, and warranty violations could be accidental rather than intentional. Similarly, because the underlying judgment made no finding regarding whether the insured's actions were intentional, the intentional act exclusion could not be found applicable as a matter of law. The court also found that a fact question existed on

whether the damages were economic rather than property damage, because the underlying causes of action are not determinative of this distinction. Finally, the fact that one of the insureds was a builder and contractor did not mean that the business activities exclusion automatically applied to preclude coverage.

C. Settlements, assignments, and covenants not to execute

An underlying judgment that was not the result of a fully adversarial trial was no evidence of damages in the *Stowers* suit against the insurers that failed to settle. *Yorkshire Ins. Co. v. Seger*, 407 S.W.3d 435 (Tex. App.–Amarillo, 2013, pet. filed). The Segers filed suit over the wrongful death of their son. Two of the insurers for the defendant, Diatom, refused to defend and refused to settle. The Segers then went to trial and obtained a judgment for $15 million each.

After the insurers refused to pay, Diatom assigned its claims to the Segers who then filed suit against the insurers. They then obtained findings that the insurers were negligent and received judgments for $35 million each.

The court of appeals had to consider the validity of the assignment and whether the underlying judgment was evidence of Diatom's damages, under the holdings in *State Farm Fire & Casualty Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996), and *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008).

First, the *Seger* court held that *Gandy* applied so that the underlying judgment was not any evidence of damages unless it was rendered after a fully adversarial trial. The court reasoned that the assignment implicated *Gandy's* concerns because it extended the litigation and distorted the litigation because Diatom had no financial exposure and no incentive to contest its liability or attempt to limit the assessment of damages.

The court then found that the award of damages in the underlying suit was not the result of a fully adversarial trial. A representative of Diatom appeared as a witness, but Diatom was not represented by counsel, did not announce ready, made no opening or closing statements, offered no evidence, and did not cross-examine any of the Segers' witnesses. As a result, the underlying judgment was not a fair determination of Diatom's damages and was no evidence of those damages. Because the Segers did not offer any other evidence of Diatom's damages, the court reversed and rendered judgment that the Segers take nothing.

The *Seger* court's holding appears to be unavoidable in light of *Gandy's* requirement of a fully adversarial trial. However, the court does shed a little light on what parties may do in the future, by noting that the Segers could have presented other evidence. It seems that when the underlying trial does not fairly determine the insured defendant's damages, the plaintiff should be able to establish those damages in a fully adversarial trial against the insurer. This would satisfy *Gandy's* requirement and seems necessary to avoid the insurer reaping a windfall by failing to provide the necessary defense in the underlying case that would have allowed a fully adversarial trial.

Another court held that an injured party could not sue the tortfeasor's insurer directly until the tortfeasor's liability has been finally determined by agreement or judgment. The court stated that a settlement agreement that contained an unconditional release of a company from all liability and a covenant by the plaintiff not to execute on the forthcoming state court judgment, relieved the company's insurer of its obligation to reimburse its insured. The court concluded that the unconditional release was in fact an unconditional release, despite language in the settlement agreement providing that nothing in the release would prevent the party from pursuing their claim against the insurer. *Empire Indem. Ins. Co. v. N/S Corp.*, No. 4:11-CV-166, 2013 WL 1103061 (E.D. Tex. March 15, 2013).

These two cases illustrate the problems facing insured defendants and plaintiffs when the insurer defaults and the defendant seeks protection by trying to give its insurance claim to the plaintiff. A fuller discussion of "the *Gandy* problem" and possible solutions can be found in Mark L. Kincaid, *"Settlements, Assignments, and Agreements Between Plaintiffs and Insured Defendants: What Can and Can't Be Done,"* Ins. Law Section, State Bar of Texas, 6th Ann. Adv. Insurance Law Course (2009). One other approach is for the plaintiff to acquire the insured's rights by a turnover order, as in the next case.

A court of appeals held that an insured's unasserted claim against its liability insurer was subject to turnover relief to the insured's judgment creditor. *D&M Marine, Inc. v. Turner*, No. 02-12-00399-CV, 2013 WL 4106365 (Tex. App.—Fort Worth Aug. 15, 2013). Although an insured's cause of action against its insurer is not subject to a turnover order when the insured is satisfied with its insurer's representation, there was no evidence in this case that the insured did not want to be indemnified through its coverage. The judgment creditors had the same interest as the insured would to pursue any bad faith or failure to indemnify claims against the insurer to maximum recovery. Therefore, the trial court did not abuse its discretion in ordering the insured to transfer its claims against the insurer that could have the possibility of satisfying the judgment creditors' judgment against the insured.

In another case, the injured party won a judgment against a construction company for injuries sustained in a car accident caused by the company's employee. Before the construction company's insurer paid the damages, the employee who caused the accident assigned to the injured party any claims he had against the insurer. The insurer paid the damage award after an appeal upheld the judgment. The injured party sued the insurer for failing to pay when the judgment was final, and asked for attorney's fees for pursuing the claim. However, the court of appeals held that once the insurer complied with the terms of the insurance policy and fulfilled its obligation to pay, the injured party's ability to enforce the agreement and compel the insurer to pay was exhausted. *Bisland III v. Financial Indemnity Co.*, No. 03-11-00228-CV, 2013 WL 3186192 (Tex. App.—Austin June 21, 2013, pet. denied) (mem. op.).

VII. THIRD PARTY THEORIES OF LIABILITY

A. Stowers duty & negligent failure to settle

Liability insurers did not breach their *Stowers* duties to settle by paying policy limits to settle claims against one insured, leaving no coverage remaining for another insured. *Pride Transp. v. Cont'l Cas. Co.*, 511 F. App'x 347 (5th Cir. 2013). An injured plaintiff sued the truck driver and trucking company for injuries suffered in a collision. The plaintiff offered to settle with the driver for the combined policy limits of $5 million, which the insurers accepted. That left no money to cover the claims against the trucking company, Pride. The court rejected Pride's argument that the insurer violated its duties by settling only on behalf of one insured.

The court relied on the holding in *Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312 (Tex. 1994), that an insurer has the right to settle a demand within policy limits and will not be liable to the other insured, unless the settlement was unreasonable. The court found, based on the severity of the injuries and aggravated liability facts showing that the driver falsified her driving logs so she could drive longer than allowed, the settlement on the driver's behalf was reasonable as a matter of law. The Fifth Circuit distinguished the lower court decision in *Am. W. Home Ins. Co. v. Tris-*

tar Convenience Stores, Inc., No. H–10–3191, 2011 WL 2412678 (S.D.Tex. June 2, 2011), where that court held the reasonableness of a settlement presented a fact issue. In the *Tristar* case, the initial offer would have released both defendants but was rejected, and the second offer, which was accepted, only included one defendant. The *Tristar* court held that the reasonableness of rejecting the first demand was a disputed question of fact. In contrast, in this case there never was an offer to settle with or release Pride.

The court also did not decide whether the *Stowers* demand was defective because it left the driver exposed for indemnity claims by Pride. The court noted that a proper *Stowers* demand must offer to completely release the defendant, but did not decide whether that changed the outcome. The settlement was still reasonable, and there was no coverage under the policy for any liability the driver might have to the company. The court noted that the insurer does not have to consider non-covered claims when deciding whether to accept the settlement.

B. Negligence

A contractor was supposed to be named as an additional insured on the subcontractor's insurance policy, but was not. The contractor cross-claimed against the subcontractor's brokerage agency for negligence. However, the court held that the contractor was not a client of the brokerage agency, so a duty of professional care was not owed to the contractor regarding the procurement of insurance as an additional insured. *Brannan Paving GP, LLC v. Pavement Markings, Inc.*, Nos. 13-11-00005-CV, 13-11-00013-CV (Tex. App.—Corpus Christi July 25, 2013, pet. filed).

C. Unfair insurance practices

In *Mid-Continent Cas. Co. v. Eland Energy, Inc.*, 709 F. 3d 515 (5th Cir. 2013), the Fifth Circuit addressed whether an insured could recover for unfair settlement practices and misrepresentations based on the insurer's conduct in secretly negotiating with and offering a settlement to a claimant, which the insured contended prejudiced its defense of a pending class action. The jury found that the insurer failed to give a prompt and reasonable explanation for making the settlement offer and made four misrepresentations of material facts. Specifically, the jury found the insurer: (1) misstated the law to its insured when it denied that a conflict of interest was created by its reservation of rights letter; (2) misrepresented that it did not pay more than $200 an hour for attorneys and hence would not pay more for the insured's separate counsel; (3) misstated that there was no coverage for costs to the insured's facility unless the insured obtained a written order; and (4) misstated the law when it maintained that it had an unavoidable duty to investigate the other claim. The district court and Fifth Circuit both held that none of these practices were shown to have caused any damages. The Fifth Circuit found no evidence of any causal nexus between any of the misrepresentations or the delayed notice and the amount the insured ultimately paid to settle the class action case.

The Fifth Circuit also addressed whether the insured had a common law cause of action and concluded it did not. This is discussed *post*.

The court in *Pride Transportation v. Continental Cas. Co.*, 511 F. App'x 347 (5th Cir. 2013), noted above, also held that the insurer's settlement on behalf of one insured that left no money for the other insured did not violate the unfair insurance practices statute. The court noted that the *Stowers* standards have been overlaid on the statute by *Rocor Int'l, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 77 S.W.3d 253, 255 (Tex. 2002). Thus, under both standards, the insured must establish that the terms were such that an ordinarily prudent insurer would accept them. The court found that Pride offered no evidence that the insurers failed to effectuate a prompt, fair, and equitable settlement. The court noted that, unlike many jurisdictions, "in Texas the common law imposes no duty on an insurer to accept a settlement demand in excess of policy limits or to make or solicit settlement proposals."

D. Deceptive trade practices & unconscionable conduct

A subcontractor who won a lawsuit filed against it was not entitled to attorney's fees under the DTPA because those damages are expressly excluded as a sole ground for recovery under the DTPA. *Brannan Paving GP, LLC v. Pavement Markings, Inc.*, Nos. 13-11-00005-CV, 13-11-00013-CV (Tex. App.—Corpus Christi July 25, 2013, pet. filed).

E. Breach of the duty of good faith and fair dealing

The Fifth Circuit addressed whether an insurer breached its duty of good faith and fair dealing by making a secret settlement offer to one party which undermined the insured's defense of another lawsuit in *Mid-Continent Cas. Co. v. Eland Energy, Inc.*, 709 F. 3d 515 (5th Cir. 2013). The insured argued that an insurer may be liable in the circumstances, based on language in earlier Texas Supreme Court cases. In *State Farm Mut. Auto Ins. Co. v. Traver*, 980 S.W.2d 625, 629 (Tex. 1988), the court suggested that an insurer might be liable if it "consciously undermined the insured's defense." In *Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 341 (Tex. 1995), the court stated that "as a general rule there can be no claim for bad faith when an insurer has promptly denied a claim that is in fact not covered" but the court did "not exclude, however, the possibility that in denying the claim, the insurer may commit some act, so extreme, that will cause injury independent of the policy claim." The insured argued that these two statements justified allowing a cause of action in the present case, based on the insurer's conduct. The Fifth Circuit rejected this argument, concluding that the statements were *dicta* that had not been followed in subsequent cases.

The insured also relied on the Fifth Circuit's decision in *Northwinds Abatement, Inc. v. Employers Ins. of Wausau*, 258 F.3d 3445 (5th Cir. 2001), where the court said that a reasonable jury could have found the defendant's "successful efforts to persuade the [insurer] to sue [its insured] baselessly" were sufficiently extreme and caused the insureds to pay significant defense costs. The Fifth Circuit distinguished the prior decision, because the judgment in that case arose from breach of statutory provisions, and the court stated there had been no breach of the duty of good faith and fair dealing.

The Fifth Circuit concluded that the insured failed to show that the insurer's mishandling of the claim under the policies and its motive to minimize its costs associated with the policies caused any injury independent from the policy claim.

In *PPI Technology Services, L.P. v. Liberty Mut. Ins. Co.*, 515 F. App'x 310 (5th Cir. 2013), the Fifth Circuit rejected a claim for breach of duty of good faith and fair dealing by a liability insurer after determining that there was no coverage. While this conclusion was correct, based on the absence of coverage, the Texas Supreme Court has held that the duty of good faith and fair dealing does not apply to liability insurers. *See Maryland Ins. Co. v. Head Indus. Coatings and Services, Inc.*, 938 S.W.2d 27 (Tex. 1996).

The court in *Chartis Specialty Ins. Co. v. Tesoro Corp.* held that the insured business failed to allege that its insurer committed any act so extreme as to cause the insured some injury separate and apart from the denial of coverage under the policy. Therefore, the insured failed to state a bad faith claim upon which relief could be granted. 930 F. Supp. 2d 653 (W.D. Tex. 2013).

F. Fraud

There was no fraud in attaching an exclusion to a renewal policy that changed the coverage, where that exclusion was listed

on the face of the policy, a copy was included with the policy, and the endorsement stated that it changed the terms of the policy. *Materials Eval. & Technology Corp. v. Mid-Continent Cas. Co.*, 519 F. App'x 228 (5th Cir. 2013).

VIII. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Lost profits

An insured could only recover market value damages, and not lost profits, for the total loss of his insured property. *Texas Farm Bureau Mut. Ins. Co. v. Wilde*, 385 S.W.3d 733 (Tex. App.—El Paso 2012, no pet.). An insured sued its insurer for breach of contract and other causes of action after the insurer denied his claim for the fire loss of his cotton-stripper. The trial court awarded damages for the market value of the cotton stripper, lost profits, attorney's fees, and treble damages. The court of appeals reversed, holding that the trial court's award of market value damages was error because no evidence of the cotton-stripper's market value immediately after the fire was presented at trial.

The court of appeals further held that, because the insured sought to recover the market value of the destroyed cotton-stripper, he was not also entitled to recover for the loss of its use or for lost profits. A plaintiff whose property is totally destroyed is limited to seeking market-value damages; whereas, a plaintiff whose property is not totally destroyed may elect to recover either market value, or cost-of-repair and loss-of-use damages, but not both. Because the insured was limited to seeking only market value damages for his cotton-stripper, the award of lost profits was an impermissible double recovery.

B. Attorney's fees

The trial court awarded attorneys' fees to an insurer in connection with a subrogation action related to property damage that occurred during the interstate shipment of equipment. The appellate court reversed, holding the Carmack Amendment preempted claims for attorneys' fees in state law claims involving interstate transportation of goods by a common carrier. *Daybreak Express, Inc. v. Lexington Ins. Co.*, No. 14-09-01032-CV, 2013 WL 5629813 (Tex. App.—Houston [14th Dist.] Oct. 15, 2013, no pet. h.).

An insured sued his insurer after it did not pay for damage to his property after a hurricane. The jury awarded the insured $7,833.01 in damages for breach of contract and $3,133.20 for attorney's fees. The insured appealed regarding the amount of attorney's fees, arguing that the reasonable fees were over $100,000. The insured had a contingent fee contract with his attorney, but argued that he could pursue an award of attorney's fees based on contingent fee or "per diem" basis. Although the amount of the fees requested was reflected in time sheets and affidavits, the court held that the fees were excessive and unreasonable, and the appellate court saw no abuse of discretion by the trial court. *Ware v. United Fire Lloyds*, No. 09-12-00061-CV, 2013 WL 1932812 (Tex. App.—Beaumont May 9, 2013, no pet.).

IX. DEFENSES & COUNTERCLAIMS

A. Misrepresentation or fraud by insured

The Fifth Circuit held that a new contestability period begins when a life insurance policy is reinstated and that two years must pass while the insured is alive. *Cardenas v. United of Omaha Life Ins. Co.*, ___ F.3d ___, 2013 WL 5433487 (5th Cir. Sept. 30, 2013). Cardenas sued to recover benefits under a life insurance policy on her daughter. The policy had lapsed but was then reinstated, but the daughter made a number of misrepresentations regarding her health in the reinstatement application. The court construed § 1101.006 of the Tex. Ins. Code and Tex. Admin. Code § 3.104(a) together to hold that a new contestability period started when the policy was reinstated, that the insured had to be alive for two years, and the reinstatement could only be challenged based on new misrepresentations made during the reinstatement period.

An insurer had to prove that its insured intended to deceive it in order to avoid the policy. *Medicus Ins. Co. v. Todd*, 400 S.W.3d 670 (Tex. App.—Dallas 2013, no pet.). A medical malpractice insurer brought a declaratory judgment action against its insured, alleging that the policy was void due to the insured's material misrepresentations in the application. After a jury decided that the insurer failed to prove that the insured made a material false representation with intent to deceive, the insurer appealed, arguing that it did not need to prove intent to deceive. The insurer argued that section 705.004 of the Texas Insurance Code did not require proof of intent. The court of appeals rejected this argument, holding that the insurer had to prove intent to deceive. Citing *Mayes v. Massachusetts Mutual Life Insurance Co.*, 608 S.W.2d 612 (Tex. 1980), and other cases, the court held that, although section 705.004 "has never expressly required the insurer to prove the insured intended to deceive the insurer with a misrepresentation in the policy application, the courts of Texas have consistently held that an insurer may not rescind a policy due to a misrepresentation in an insurance application unless the insurer proves the insured intended to deceive the insurer with the misrepresentation. We cannot vary from this long history of case law imposing this duty upon insurers."

The *Medicus* court rejected the theory that statutory changes had overturned a century of case law to no longer require that the insurer show intent to deceive. This argument has been in vogue with certain insurance practitioners. *See* Andrew Whitaker, *Rescission of Life Insurance Policies in Texas – Time to Correct Some Old Errors*, 59 Baylor L. Rev. 139 (2007).

B. Late Notice

In a case of first impression, the Fifth Circuit decided whether late notice excused a liability insurer from its duty to defend where, even though judgment had been rendered against the insured, that judgment was later reversed. *Jamestown Ins. Co., RRG v. Reeder*, 508 F. App'x 306 (5th Cir. 2013). Reeder sued several business partners who counterclaimed against him. The partners were successful in getting judgment against Reeder, but he ultimately got that judgment reversed by the Texas Supreme Court, which rendered a take nothing judgment in his favor.

The Fifth Circuit held that Reeder's delay in tendering notice to the insurer until fifty-six months after the first counterclaim was filed and thirty-one months after final judgment was rendered against him breached the notice provision as a matter of law. However, the court recognized that the insurer was excused from performance of its duty to defend only if it was actually prejudiced by Reeder's delayed notice.

The court recognized that failing to notify an insurer until after a default judgment has become final and non-appealable prejudices the insurer as a matter of law, but the Texas Supreme Court has not directly addressed whether an insured's failure to notify an insurer of an *appealable* final judgment is also prejudicial.

In this case, the court concluded that Reeder's delay did prejudice the insurer, even though the judgment was reversed. If the insurer had received notice while the suit was pending in the trial court, it could have undertaken Reeder's defense and minimized its insured's liability. Although Reeder ultimately minimized his liability by obtaining a reversal in the Texas Supreme Court, the insurer lost the opportunity "to form an intelligent estimate of its rights and liabilities before it is obliged to pay." The court

reasoned that Reeder's choice to litigate for more than four years before notifying the insurer prevented the insurer from making such an estimate, from helping Reeder prevail in the trial court, and from exercising its option to settle with the other parties – perhaps for less than the cost of Reeder's attorney's fees.

By noting higher fees as one type of prejudice, the court's reasoning indirectly suggests the answer to whether an insured can recover pre-notice attorney's fees. The prevailing rule is that the insurer is not liable for attorney's fees incurred before it receives notice. However, that principle was set before the more recent cases holding that late notice excuses the insurer from its duty to defend only if the insurer is prejudiced. It thus seems reasonable that an insurer should be freed of its obligation to pay pre-notice fees only to the extent it is prejudiced. For example, the insurer could show that it would have paid lower hourly rates and might be relieved of paying to that extent. This supports the idea that to show prejudice from late notice, an insurer must show that earlier notice would have made a difference.

X. PRACTICE & PROCEDURE

A. Parties

A worker was injured on the job when a Caterpillar excavator machine struck him in his lower back. The worker's insurer filed suit against Caterpillar as subrogee of the worker, and then Caterpillar filed a motion to designate the worker and his employer as responsible third parties. Caterpillar argued that the damage was caused by the worker's inadvertent manipulation of the machine or his employer's failure to properly train him. The court granted Caterpillar's motion. *Liberty Ins. Corp. v. Caterpillar, Inc.*, No. SA-13-CV-83-XR, 2013 WL 3166616 (W.D. Tex. June 20, 2013).

An insurer sought a declaration that it owed no duties to its insured because it learned that the insured was not operating a nail salon as represented in the insurance application. The insured filed a motion to dismiss for failure to join indispensable parties, the insurance agent and agency. The court held that whether the insured made material misrepresentations on its application was a completely separate cause of action from a suit for negligence on the part of the broker. However, the court held that the insurer failed to show that a claim actually existed and ordered that the insurer either amend its complaint to state a controversy or show cause why the case should not be dismissed. *Penn-Am. Ins. Co. v. Pampered Nails & Skin Care, L.L.C.,* No. H-12-1564, 2012 WL 5387200 (S.D. Tex. Nov. 1, 2012).

A contractor who was sued in an underlying suit filed a declaratory judgment against all of the subcontractors' insurers seeking a ruling that they owed a duty to defend in the underlying suit. One of the insurers sought leave to file a third-party complaint, to bring claims for contribution and subrogation against three insurance companies to allocate the costs of defending the contractor. The court held this impleader was proper as the third-party defendant's potential liability is dependent on the outcome of the main claim. *Shiloh Enter., Inc. v. Republic-Vanguard Ins. Co.*, No. SA-12-CV-00670-DAE, 2013 WL 5201232 (W.D. Tex. Sept. 13, 2013).

A court held that a motion to intervene filed by the estate of a man who was murdered at work was appropriately filed. The estate filed the motion to intervene in the declaratory judgment action filed by the employer's insurer who was asking for a ruling that it had no duty to defend the employer in the underlying lawsuit brought by the estate. *First Mercury Ins. Co. v. Rosenboom Welding & Fabrication, L.L.C.*, No. 3:12-CV-4374-L (BF), 2013 WL 4804494 (N.D. Tex. Sept. 9, 2013).

B. Standing

A federal court granted an insurer's motion to dismiss because the insurer had no contractual relationship with the plaintiff. Rather, the insurer insured the tortfeasor who had allegedly damaged the plaintiff's home. The plaintiff did not plead any facts allowing him to bring a claim directly against the tortfeasor's insurer. *Pena v. American Residentia Services, LLC*, No. H-12-2588, 2013 WL 474776 (S.D. Tex. Feb. 7, 2013).

A mortgagee lacked standing to sue an insurer. *Pak-Petro, Inc. v. Am. W. Home Ins. Co.*, No. 1:12-CV-247, 2013 WL 5356898 (E.D. Tex. Sep. 9, 2013). The policy language did not show any intent of the parties to grant the mortgagee status as either an insured or a third party beneficiary. The declarations page did not name the mortgagee as an insured or an additional insured on the policy. After the claim was made, the mortgagee was named retroactively as a mortgagee in an endorsement. However, under the policy language, the rights of a mortgage holder only encompassed those of another loss payee. As such, there was no contract between the insurer and the mortgagee, and the mortgagee had no standing to sue on the policy. The "equitable lien doctrine" did not give the mortgagee the same rights as an additional insured under the policy.

C. Choice of law

Texas law applied to claims against an insurer for its misconduct in handling liability claims against its insured and did not allow recovery for breach of the duty of good faith and fair dealing. *Mid-Continent Cas. Co. v. Eland Energy, Inc.*, 709 F. 3d 515 (5th Cir. 2013). The court declined to apply Louisiana law, which would have allowed such a claim. The court reasoned that Texas law applied because the insured was a Texas business, the policies were governed by Texas law, the relationship between the parties was centered in Texas, the agent prepared the notice of claim in Texas, and payments under the policies were sent to the insured in Texas. The fact that the claims arose because of hurricanes Katrina and Rita partly in Louisiana, did not tip the balance in favor of applying Louisiana law.

D. Abatement or stay of parallel suit

A party injured in a car accident sued the driver and won. The driver assigned his rights against his insurer to the plaintiff. The insurer filed suit in federal court seeking a declaration that the injured party's demand was not a proper *Stowers* demand. Five days later, before the injured party was served with the federal suit, she sued the insurer in state court. The insurer filed a plea in abatement, which the trial court denied, and then filed a petition for writ of mandamus, which the appellate court denied. The appeals court held the proper motion should have requested a stay and not an abatement, but even the requirements for a stay were not met. The court held that the injured party's suit sought broader relief that went beyond the insurer's pleadings in federal court and looked to state law as grounds for her claims. Therefore, the court stated that it could not say the trial court abused its discretion in declining to stay its proceedings in favor of the federal suit. *In re Old Am. County Mut. Fire Ins. Co.*, No. 03-12-00588-CV, 2012 WL 6699052 (Tex. App.—Austin Dec. 20, 2012, no pet.) (mem. op.).

A food manufacturer hired a company to package the food. The manufacturer required the packaging company to carry a general liability policy that named the manufacturer as an additional insured. The manufacturer later sued the packaging company for damages resulting from negligence in packaging the food. The insurer filed suit in Travis County seeking a declaratory judgment that no coverage existed under the policy for the manufacturer's claims. A few days later, the manufacturer sued the in-

surer in Smith County, and the insurer filed a plea in abatement requesting that the Smith suit be abated. The trial court denied the plea, and the appeals court affirmed holding that the insurer had not provided proper evidence in the record to establish the need for abatement, as neither petition was offered or admitted into evidence. *In re Truck Ins. Exch.*, No. 12-12-00183-CV, 2013 WL 1760793 (Tex. App.—Tyler April 24, 2013, no pet.).

E. Declaratory judgments, Abstention, and Anti-Injunction Act

Insurers sued their insured seeking declaration of the rights and obligations of the parties in underlying litigation. The court granted the insured's motion to dismiss holding that the Anti-Injunction Act prohibited the court from proceeding to consider the declaratory judgment, as none of the exceptions listed in the Act applied to this case, and granting declaratory relief would have the same effect on the pending state court suit as an injunction. *Ins. Co. of the State of Penn. v. Sabre, Inc.*, 918 F. Supp. 2d 596 (N.D. Tex. 2013).

A federal court abstained from exercising jurisdiction and dismissed a suit for declaratory judgment brought by an insurer against its insured. *AIX Specialty Ins. Co. v. Western States Asset Mgmt.*, No. 3:12-CV-4342-M, 2013 WL 4603775 (N.D. Tex. Aug. 29, 2013). The insurer's federal suit was filed first and involved many of the same parties and issues as were involved in the insured's subsequent state court suit. However, the relevant factors favored abstention. The insured sued some additional non-diverse defendants that were not named as parties in the federal suit, but all of the issues and parties in the federal suit were included in the state suit. Also, the insurer filed its suit in anticipation of the insured's state court action. This "reactive" litigation constituted improper forum shopping. The state court action could fully resolve the issues in the federal suit, and maintaining concurrent proceedings risked duplicative and inconsistent rulings. The forums were equally convenient, since they were in the same city, and no substantive motions had been presented in the federal suit. In light of these factors, abstention and dismissal were proper.

The Northern District of Texas conducted a similar abstention analysis in *Continental Ins. Co. v. Gifford-Hill & Co., Inc.*, and reached the same conclusion, dismissing an insurer's suit for declaratory judgment so that another insurer's suit, filed in California state court, could proceed. No. 3:12-CV-0925-D, 2013 WL 1875930 (N.D. Tex. May 6, 2013).

F. Removal and 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.*:

- *Yeldell v. Geovera Specialty Ins. Co.*, No. 3:12-CV-1908-M, 2012 WL 5451822 (N.D. Tex. Nov. 8, 2012);
- *Gutierrez v. Companion Prop. & Cas. Ins. Co.*, No. M-12-326, 2012 WL 5943617 (S.D. Tex. Nov. 27, 2012);
- *Espinoza v. Companion Commercial Inc. Co.*, No. 7:12-CV-494, 2013 WL 245032 (S.D. Tex. Jan 22, 2013);
- *Chandler Mgmt. Corp. v. First Specialty Ins. Corp.*, No. 3:12-CV-2541-L, 2013 WL 395577 (N.D. Tex. Jan. 31, 2013);
- *Boze Mem'l, Inc. v. Travelers Lloyds Ins. Co.*, No. 3:12-CV-4363-M, 2013 WL 775362 (N.D. Tex. Feb. 28, 2013);
- *Ross v. Nationwide Prop. & Cas. Ins. Co.*, No. H-12-3495, 2013 WL 1290225 (S.D. Tex. March 26, 2013);
- *Fantroy v. Dallas Area Rapid Transit*, No. 3:13-CV-0345-K, 2013 WL 2284879 (N.D. Tex. May 23, 2013);
- *Los Cucos Mexican Café, XXII, Inc. v. Allied Prop. & Cas. Ins. Co.*, No. H-13-1314, 2013 WL 3166339 (S.D. Tex. June 19, 2013);
- *W. States Asset Mgmt., Inc. v. AIX Specialty Ins. Co.*, No. 3:13-CV-00234-M, 2013 WL 3349514 (N.D. Tex. July 3, 2013);
- *Pena v. Geovera Specialty Ins. Co.*, No. 7:13-CV-255, 2013 WL 3779385 (S.D. Tex. July 16, 2013);
- *Riverview Mgmt. v. Int'l Ins. Co. of Hannover, Ltd.*, No. H-13-1099, 2013 WL 4401431 (S.D. Tex. Aug. 13, 2013);
- *Ridgeview Presbyterian Church v. Phila. Indem. Ins. Co.*, No. 3:13-CV-1818-B, 2013 WL 5477166 (N.D. Tex. Sept. 30, 2013);
- *Apex Golf Properties, Inc. v. Allstate Ins. Co.*, No. 2:13-CV-250, 2013 WL 5724523 (S.D. Tex. Oct. 21, 2013);
- *De Leon v. Travelers Lloyds of Tex. Ins. Co.*, No. 7:13-CV-468, 2013 WL 5744456 (S.D. Tex. Oct. 23, 2013).

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.*:

- *Wolf Horn Inv., L.L.C. v. Allied Prop. & Cas. Ins. Co.*, No. 2:12-CV-00244, 2012 WL 6738758 (S.D. Tex. Dec. 30, 2012);
- *Castlebrook at Ridgeview Homeowners Ass'n v. Starr Surplus Lines Ins. Co.*, No. 4:12CV652, 2013 WL 949860 (E.D. Tex. Jan. 30, 2013);
- *Landing Council of Co-Owners v. Fed. Ins. Co.*, No. H-12-2760, 2013 WL 530315 (S.D. Tex. Feb. 11, 2013);
- *Waldrop v. Guarantee Trust Life Ins. Co.*, No. 3:12-CV-02579, 2013 WL 664705 (N.D. Tex. Feb. 25, 2013);
- *Holmes v. Acceptance Cas. Ins. Co.*, No. 1:12-CV-584, 2013 WL 1819693 (E.D. Tex. Apr. 29, 2013);
- *Weber Paradise Apartments, LP v. Lexington Ins. Co.*, No. 3:12-CV-5222-L, 2013 WL 2255256 (N.D. Tex. May 23, 2013);
- *Bedford Internet Office Space, L.L.C. v. Travelers Cas. Ins. Co.*, No. 3:12-CV-4322-N-BN, 2013 WL 3283719 (N.D. Tex. June 28, 2013);
- *Lakewood Baptist Church v. Church Mut. Ins. Co.*, No. 3:12-CV-5111-M, 2013 WL 3487588 (N.D. Tex. July 11, 2013);
- *Guerrero Inv., L.L.C. v. Am. States Ins. Co.*, No. 7:12-CV-430, 2013 WL 5230718 (S.D. Tex. Sept. 17, 2013);
- *Jana Food Servs., Inc. v. Depositors Ins. Co.*, No. 4:13-CV-497-A, 2013 WL 5574433 (N.D. Tex. Oct. 9, 2013).

In these cases, the courts generally denied remand because the factual allegations against the non-diverse parties were not specific and individualized. For example, in *Guerrero Investments, L.L.C.,* the only reference to the non-diverse defendant was so vague that the plaintiff failed to identify a reasonable basis for recovery against it.

In *Jana Food Servs., Inc.*, the court held that the plaintiff did

not show any basis that the adjuster had any duty to plaintiff to deliver the insurance check, which he failed to do. The adjuster was entrusted by the insurer to deliver the check to plaintiff, so any failure to do that was not a duty he violated to plaintiff but rather a duty he violated to the insurer. Moreover, while the plaintiff might be able to bring a breach of contract claim against the insurer for miss-delivery of the check, there was no basis under Texas law for assertion of a negligence claim against the insurer, much less the adjuster, for miss-delivery of a check.

And in *Landing Council of Co-Owners*, the insured failed to specify how the non-diverse defendant, an agent, could be liable for breaching the policy or wrongfully denying coverage, leading the court to conclude that references to "Defendants" was "merely improperly lumping [the agent] in with the insurer in its list of legal causes of action without providing any factual basis for [the agent's] individual responsibility." Further, the misrepresentation claims in that case were not stated with enough particularity to satisfy Rule 9(b) because the petition did not indicate what specific statements were fraudulent.

A stipulation in a state court petition that damages were less than $75,000 precluded federal diversity jurisdiction. *Williams v. Companion Property & Cas. Ins. Co.*, No. A. H-13-733, 2013 WL 2338227 (S.D. Tex. May 27, 2013).

A court granted a defendant insurer's motion to remand where no federal question was presented in the insured's complaint. Although the insured alleged that his "causes of action involve questions of federal law," the causes of action were all Texas law claims. *Walter v. Old Am. County Mut. Fire Ins. Co.*, No. H-12-2581, 2012 WL 5818227 (S.D. Tex. Nov. 13, 2012).

G. Dismissal

A court amended its prior dismissal with prejudice of a *Stowers* claim. The claim was dismissed because it was not ripe, but the court dismissed the claim with prejudice. On motion to reconsider, the court concluded that the claim should have been dismissed without prejudice so that it could be repled when it became ripe. *OneBeacon Ins. Co. v. T. Wade Welch & Assocs.*, No. H-11-3061, 2012 WL 5456111 (S.D. Tex. Nov. 7, 2012).

H. Venue

A Texas insured sued its insurer after it denied a claim. The insurer sought to transfer the case to New York, where it and the agent were residents. The court looked at several factors, but honed in on the fact that the agent did not meet Texas's licensing requirements at the time the policy was issued. The court stated that Texas has a strong policy in favor of maintaining jurisdiction over actions involving unauthorized insurers doing business in Texas. Therefore, the motion to transfer was denied. *Jetpay Merchant Servs., L.L.C. v. Chartis Specialty Ins. Co.*, No. 3:13-CV-0401-M, 2013 WL 3387517 (N.D. Tex. July 8, 2013).

I. Default judgment

A federal court denied the plaintiff's motion for default judgment in a suit concerning who was the rightful beneficiary of life insurance proceeds because the plaintiff was not prejudiced by the defendant's delay in answering the suit. *Metropolitan Life Ins. Co. v. Johnson*, No. 4:12cv630, 2012 WL 3363117 (E.D. Tex. Jul. 3, 2013).

The appeals court found a final default judgment against an insurer for $20 million was void, as the insurer had never been served with process in the suit. The underlying lawsuit was against foster parents whose homeowner policy was with the insurer, and the foster parents had been sued for negligence related to the death of a child in their care. *In re Farmers Ins. Exch.*, No. 02-13-00144-CV, 2013 WL 2249186 (Tex. App.—Fort Worth May 23, 2013, no pet.).

J. Pleadings

An insured filed suit against its insurer and adjuster for breach of contract and violations of the Texas Insurance Code. The defendants filed a motion to dismiss the complaint for failure to state a claim. The court allowed the insured to amend the complaint twice. Although the insured added additional factual allegations, the majority of those pertained to errors by the appraisal board, an entity not part of this action. The court held the insured just alleged legal conclusions and recited the elements of the cause of action as to violations of the Texas Insurance Code, and that the insured had several opportunities to correct this defect and did not. The defendants' motion to dismiss was granted as to the statutory violations. *Springcrest Partners, L.L.C. v. Admiral Ins. Co.*, No. 4:12-CV-457-A, 2013 WL 1197780 (N.D. Tex. March 25, 2013).

A federal court denied a life insurer's motion for a more definite statement, finding that the complaint was not so vague as to preclude a responsive pleading. *Waldrop v. Guarantee Trust Life Ins. Co.*, No. 3:12-cv-02579-M, 2013 WL 2389875 (N.D. Tex. May 31, 2013).

K. Discovery

A discovery dispute occurred in a case where an insured sued his insurer for failing to adhere to multiple aspects of his homeowner's insurance policy. The insurer argued that the insured had no insurable interest in the case because he acquired the property through identity theft, a crime for which he was imprisoned. The insured wanted to conduct discovery on what the insurer knew or should have suspected regarding his misrepresentations when they decided to issue the policy. However, the court denied this request, as the court stated that failure to use due diligence to suspect or discover someone's fraud will not act to bar the defense of fraud to the contract. *Benbow v. Liberty Mut. Fire Ins. Co.,* No. A-12-CV-1164-LY, 2013 WL 5771172 (W.D. Tex. Oct. 24, 2013).

L. Experts

After settling with Direct TV regarding a fire that destroyed their home, the insureds sued their insurance company for lack of cooperation for not allowing the insureds access to the insurer's cause and origin fire expert in the case against Direct TV. The insureds argued they could have recovered more money from Direct TV if they had access to that expert. The appellate court upheld the trial court's summary judgment ruling in favor of the insurer. *Hennen v. Allstate Ins. Co.*, No. 13-12-00645-CV, 2013 WL 4773245 (Tex. App.—Corpus Christi Sept. 5, 2013, no pet. h.) (mem. op.).

In *Cox Operating, L.L.C. v. St. Paul Surplus Lines Ins. Co.*, the suit revolved around whether certain activities undertaken by the insured were covered under the insurance policy. The insured hired an expert to testify. The court held that the expert's opinions on what was required by the law, what types of recovery would have been required or prevented by the law, and how the law would categorize the damage caused by the storm, were not relevant because it would invade the purview of the court. His opinions on the behavior of hydrocarbons in water and the practicalities of oil spill clean-up were allowed as they were relevant regarding the effect on the insured's ability to repair flowlines and vessels in place. No. H-07-2724, 2013 WL 1752405 (S.D. Tex. April 23, 2013).

M. Class actions

The Supreme Court held that a class representative's stipulation that the class would not seek damages exceeding $5 mil-

lion was not effective to prevent application of the Class Action Fairness Act (CAFA), which gave the federal court jurisdiction over the case. *Standard Fire Ins. Co. v. Knowles*, 133 S. Ct. 1345 (2013). The plaintiff filed the proposed class action in state court, arguing that the insurer improperly failed to include general contractor fees on homeowners' insurance losses. The insurer removed the case to federal court under CAFA, 28 U.S.C. § 1332(d)(2). The statute provides federal court shall have jurisdiction when the matter in controversy exceeds the value of $5 million dollars and shall determine that value by aggregating the claims of the individual class members.

Knowles sought to avoid federal court jurisdiction by stipulating that he and the class would not seek more than $5 million. The court held this stipulation was not effective because it could not be binding. The plaintiff could not bind the other class members prior to certification of the class. In addition, the court foresaw circumstances where a later court might disregard the stipulation as unfair, or some other class representative might seek to represent the class without such a limitation. The court held that the district court had jurisdiction based on the aggregate amount of the claims and should have ignored the purported stipulation.

In another case, plaintiffs sought to certify a class, and the insurer removed the case to federal court. The court held the insurer proved by a preponderance of the evidence that there was more than $5 million in controversy, so the burden shifted to the plaintiffs to present evidence that the class claim fell below the jurisdictional amount, which they failed to do. Therefore, plaintiff's motion to remand was denied. *Magnum Minerals, L.L.C. v. Homeland Ins. Co. of N.Y.*, No. 2:13-CV-103-J, 2013 WL 4766707 (N.D. Tex. Sept. 5, 2013).

Because the appraisal award was binding, that meant the insured was not the prevailing party and the insurer did not breach its contract, so the insured was not entitled to recover attorney's fees.

An insured sued TWIA for damage to his home sustained by Hurricane Ike. The court dismissed the suit because there was a slab claim class action which the insured was a member of, as he had not opted out. The insured claimed he had not received proper notice of the class action. The court required that notice be sent by first class mail to potential class members, and there was no evidence that the notice sent to this insured was not received. The insured argued that due process required sending notice by certified mail. The court disagreed, and held that proper notice was given by first class mail, and the insured did not timely opt-out of the class. *Barkley III v. Tex. Windstorm Ins. Ass'n*, No. 14-11-00941-CV, 2013 WL 5434171 (Tex. App.—Houston [14th Dist.] Sept. 26, 2013, no pet. h.) (mem. op.).

N. Arbitration

Residents in a nursing facility filed suit against the nursing facility for negligence. The nursing facility filed a motion to compel arbitration based on written admission agreements signed by the residents that contained an arbitration clause. The residents argued that the clause did not apply because it did not comply with Tex. Civ. Prac. & Rem. Code section 74.451. The court held that section 74.451 is a law enacted for the purpose of regulating the business of insurance within the meaning of the federal McCarran-Ferguson Act, and is thus exempted from preemption by the Federal Arbitration Act. Therefore, the trial court was correct in denying the nursing facility's motion to compel arbitration. *Fredericksburg Care Co. v. Perez*, No. 04-13-00111-CV, 406 S.W.3d 313 (Tex. App.—San Antonio June 26, 2013, pet. filed).

A reinsurer sued an insurer for declaratory relief. The insurer moved to compel arbitration as allowed for in the Reinsurance Agreement. In prior litigation between the insurer and reinsurer, the insurer convinced the court that the scope of the proceedings did not involve the Reinsurance Agreement. The appellate court determined that these suits have always been about the Reinsurance Agreement, and thus the insurer was judicially estopped from compelling arbitration, as it argued against arbitration in the prior suit. *New Hampshire Ins. Co. v. Magellan Reinsurance Co., Ltd.*, No. 02-12-00196-CV, 2013 WL 1830349 (Tex. App.—Fort Worth May 2, 2013, no pet.).

O. Appraisal

An error by the umpire in excluding undisputed damage to a building's HVAC did not justify setting aside the entire award. *TMM Investments, Ltd. v. Ohio Cas. Ins. Co.*, 730 F.3d 466 (5th Cir. 2013). The court held that the umpire had no authority to exclude from the award an amount for HVAC damage that the two appraisers agreed on. The umpire only has the authority to act when there is a disagreement. Thus, the umpire erred in excluding HVAC damage. But the court joined the majority rule in holding that acceptable portions of the award should continue to bind the parties, despite an error in other parts of the award.

The court of appeals also held that the trial court erred by setting aside the award, because the appraisers had not exceeded their authority by determining causation. There was a dispute over what caused the damage and there was a dispute over damages to different parts of the roof, which the appraisers resolved. Although the court recognized that liability is for the court to determine and causation is related to liability, it is also related to damages, which the appraisers are to decide. Under the authority of *State Farm Lloyds v. Johnson*, 290 S.W.3d 886 (Tex. 2009), the court concluded that the appraisers acted within the scope of their authority.

Because the appraisal award was binding, that meant the insured was not the prevailing party and the insurer did not breach its contract, so the insured was not entitled to recover attorney's fees.

An insured sued TWIA for recovery for property damage under an insurance policy. TWIA moved to compel appraisal under the policy, but the trial court denied its motion. The appellate court directed the trial court to grant TWIA's motion to compel appraisal, finding that TWIA had not waived its right to appraisal, as it had demanded appraisal seven days after receiving notice that the insured intended to sue. The court stated the appraisal provision could not be disregarded simply because coverage or causation issues about whether the storm caused the roof damage may overlap with issues about the amount of the loss and repair costs. *In re Tex. Windstorm Ins. Ass'n*, No. 14-13-00632-CV, 2013 WL 4806996 (Tex. App.—Houston [14th Dist.] Sept. 10, 2013, no pet. h.) (mem. op.).

After a motel roof was damaged in a storm, the owners sued the insurer. The insurer filed a motion to compel arbitration as allowed for in the policy. The appellate court said the trial court should have granted the motion to compel arbitration, and that it could not be disregarded simply because coverage or causation issues about which storm caused the damage may overlap with issues about the amount of the loss and repair costs. *In re Pub. Serv. Mut. Ins. Co.*, No. 03-13-00003-CV, 2013 WL 692441 (Tex. App.—Austin Feb. 21, 2013, pet. denied) (mem. op.).

An insured suffered property damage, and hired Treider to

provide services in inspecting the claim. Treider recommended expert witnesses and gave advice to the insured on when to ask for an appraisal and how to proceed with the appraisal process. Treider specifically told the insureds not to refer to him as an expert as that may cause the insurer to object to him as an appraiser. An appraisal occurred, and the insured appointed Treider as its impartial appraiser. The appraisal award was over $300,000, and the insurer filed a motion to set aside the award because Treider was not an impartial appraiser. The court denied the insurer's motion to set aside the award, and found that the insurer failed to raise a fact issue that the award was a result of fraud, mistake, or accident. However, the court held the insurer did raise a fact issue on whether or not there was compliance with the policy with respect to the impartiality of an appraiser, and was allowed to conduct a trial on this one limited issue. *Amtrust Ins. Co. of Kan., Inc. v. Starship League City, L.P.*, No. 4:11-CV-672, 2013 WL 1222329 (E.D. Tex. March 25, 2013).

In *Culpepper III v. U.S. Fire Ins. Co.*, an insured's property was damaged in a hailstorm. An appraisal was completed, but the insured disagreed with the umpire's award and argued that the umpire exceeded his authority by deciding causation and coverage. The court held that appraisal is appropriate when the causation question involves separating loss due to a covered event from a property's pre-existing condition. Therefore, the court dismissed the case. No. 3:12-CV-01381-L, 2013 WL 1294086 (N.D. Tex. March 31, 2013).

An insurer did not waive appraisal by waiting to invoke it two months before the trial setting. Nor did the insurer's delay prejudice the insured. The insured did not show what expenses or fees would not have been incurred if appraisal had been invoked sooner. *In re GuideOne Mut. Ins. Co.*, No. 09-12-00581-CV, 2013 WL 257371 (Tex. App.—Beaumont Jan. 24, 2013, orig. proceeding).

P. Motions for summary judgment

An insured's hearsay statements about what an alleged expert said concerning her property damage could not defeat an insurer's no-evidence motion for summary judgment. *McGhan v. Farmers Ins. Exchange*, No. 13-11-00433-CV, 2012 WL 5944947 (Tex. App.—Corpus Christi Nov. 21, 2012, no pet.). An insured sued her insurer for denying her claim for storm damage to her roof without adequately inspecting her roof. The insurer obtained a no-evidence summary judgment, which was affirmed on appeal. The only evidence the insured presented was her own deposition, in which she testified that she did not know if there was storm damage to the roof because she did not get on the roof. She testified that a metal roof expert told her there was storm-related damages, but that expert was not designated, and the insured did not present his testimony by either affidavit or deposition. The insured's testimony about what the expert might have said was hearsay and it was not determined that he was an expert or that his testimony would be reliable.

Stipulated facts and 650 pages of evidence could not defeat summary judgment in *Bich Ngoc Nguyen v. Allstate Ins. Co.*, 404 S.W.3d 770 (Tex. App.—Dallas 2013, pet. denied). A life insurance beneficiary sued the insurer and agent, asserting various theories, arising out of the insurer's rescission of the policy due to the insured's alleged misrepresentations in the application about her health. The beneficiary sued the agent based on the insurer's rescission. The agent moved for summary judgment, to which the beneficiary responded with nearly 650 pages of evidence. The agent objected that the beneficiary did not specifically identify where an issue was addressed in the evidence. Sustaining the objection, the trial court granted the agent's motion. The court of appeals affirmed, holding that merely citing generally to voluminous summary judgment evidence is not sufficient to raise an issue of fact to defeat summary judgment. The court further held that the stipulations of the parties did not raise a genuine issue of material fact on any of the elements of the causes of action presented on summary judgment, even if they were relevant as to other causes of action.

Q. Severance & separate trials

After being hit by an uninsured motorist, the injured party sued her insurer for breach of contract and extra-contractual claims for violations of the Texas Ins. Code and breach of the duty of good faith and fair dealing. The insurer filed a motion to sever and abate the extra-contractual claims from the contract claim for the uninsured motorist benefits, which the trial court denied. The appellate court reversed, holding that Texas case law establishes that severance and abatement of extra-contractual claims is required in many instances in which an insured asserts a claim to uninsured or underinsured motorist benefits, and that in this instance the facts of the case required a severance to prevent manifest injustice. *In re Old Am. County Mut. Fire Ins. Co.*, No. 13-12-00700-CV, 2013 WL 398866 (Tex. App.—Corpus Christi Jan. 30, 2103, no pet.).

The same result was reached in another UIM case. The insured was injured in a car accident with an underinsured motorist. The insured's UIM insurer offered to settle the claim for $850 and later $1,000. The insured sued his insurer for breach of contract, breach of the duty of good faith and fair dealing, violations of the Insurance Code, violations of the DTPA, and common law fraud. The insurer moved to sever the insured's breach of contract claim from his extra-contractual claims, which the trial court denied. The appeals court granted mandamus relief and ordered the trial court to sever the claims, holding that when the insurer has made an offer to settle the contract claim, a severance of the tort and contract claims is required to avoid undue prejudice to the insurer in its defense of the coverage dispute. The appeals court held that the insured's argument that the insurer made just a small offer in order to sever the claim was a fact question, on which mandamus will not issue. *In re Allstate Prop. & Cas. Ins. Co.*, No. 14-12-00867-CV, 2012 WL 5987580 (Tex. App.—Houston [14th Dist.] Nov. 29, 2012, no pet.).

R. Court's charge

In *Brannan Paving GP, LLC v. Pavement Mark-*

ings, Inc., Nos. 13-11-00005-CV, 13-11-00013-CV (Tex. App.—Corpus Christi July 25, 2013, pet. filed), a contractor sued a subcontractor for breach of contract by failing to name the contractor as an additional insured on its liability policy. A death occurred because of the work done, and the contractor found out at that time that the subcontractor had not named it as an additional insured. The court allowed a waiver instruction following the first jury question about whether there was a breach of contract. The jury answered no, in response to the question whether the subcontractor failed to comply with its agreement with the contractor.

The appeals court held that the waiver instruction was improper because, although the facts may indicate a lack of enforcement by the contractor in ensuring that the subcontractor complied with the contract, that inaction did not show an intent to yield the right. One important fact the court looked to was that the contractor did not discover the failure to obtain additional insured coverage until after the accident occurred, and the accident occurred just two months after hiring the subcontractor.

The court also held that the trial court's inclusion of a valid theory of liability and an improper affirmative defense instruction in the same question with only one answer blank created the type of confusion that the *Casteel* presumed-harm analysis was designed to address.

Questions in a jury charge concerning agency were properly submitted to the jury in *Fire Ins. Exchange v. Kennedy*, No. 02-11-00437-CV, 2013 WL 441088 (Tex. App.—Fort Worth Jan. 31, 2013, pet. denied). An insured homeowner sued her insurer in connection with its handling of her property claim, complaining about a vendor the insurer hired to perform repairs. The case proceeded to trial, and the jury returned a verdict in favor of the insured on her breach of contract, DTPA, and breach of the duty of good faith and fair dealing claims. On appeal, the insurer argued that the jury questions asking if the vendor was the agent of the insurer and if the vendor's negligence caused the damage were improperly submitted.

The court held that these questions were properly submitted because the pleadings and some evidence supported their submission. Even if their submission were improper, it was harmless because the jury found that the vendor's negligence did not cause the occurrence and did not reach the question regarding damages based on the vendor's negligence.

The court also rejected the insurer's argument that the insured failed to segregate her covered damages from her non-covered damages under the doctrine of concurrent causation. While noting that insureds are only entitled to recover the portion of damage caused solely by a covered peril, the court concluded that the insured's damages were adequately segregated because the court's charge expressly instructed the jury to award damages "caused solely by a covered peril."

While noting that insureds are only entitled to recover the portion of damage caused solely by a covered peril, the court concluded that the insured's damages were adequately segregated because the court's charge expressly instructed the jury to award damages "caused solely by a covered peril."

XI. OTHER ISSUES

A. Excess & primary coverage

A federal court determined that excess policies were not triggered because the applicable retained limits were not exhausted. *Indemnity Ins. Co. of N. Am. v. W&T Offshore, Inc.*, No. 4:12-CV-02469, 2013 WL 4483473 (S.D. Tex. Aug. 12, 2013).

An insured business lost over 150 offshore platforms during Hurricane Ike. The court held that the underlying insurance could only be exhausted by claims that were also covered by the excess liability policies. Therefore, because the insured's physical damage and operators extra expense claims were not insured by the Excess Liability policies, they could not be used to reduce or exhaust the underlying insurance. The court granted the excess insurer's summary judgment motion, holding that since the underlying insurance was not exhausted, coverage under the excess policies was not triggered, and there was no coverage for the costs for removal of debris. *Indem. Ins. Co. of N. Am. v. W&T Offshore, Inc.*, No. 4:12-CV-2469, 2013 WL 4039594 (S.D. Tex. July 31, 2013).

A company had four barges that transported cutter stock that contained contaminants that were not detected. Before the contaminants were discovered, the barges made multiple deliveries. There were several insurance policies that would be triggered, depending on the definition of an "occurrence." The court held that after the barges became contaminated, each loading and delivery resulting in contamination – i.e. each shipment and delivery of the contaminated bunkers to each customer – created liability for the company. Therefore, each instance of loading, transporting, and delivering a customer's bunkers was a separate occurrence. Each separate occurrence triggered a separate policy limit under the primary policies, and thus the excess insurer's motion for summary judgment was granted. *Axis Ins. Co. v. Buffalo Marine Servs., Inc.*, No. H-12-0178, 2013 WL 5231619 (S.D. Tex. Sept. 12, 2013).

B. Subrogation

After a nursing center discovered water damage and mold in its newly-constructed facility, it sued the contractor and recovered $3 million in damages from the contractor's insurer. The contractor then assigned its contract rights against the subcontractors to the insured. The subcontractors argued that it was not the contractor's right to assign, but the contractor's insurer's right. The appellate court held that the subrogation provision in the policy did not preclude the contractor from assigning its claims against subcontractors, and reversed the trial court's summary judgment ruling in favor of the subcontractors. *Concierge Nursing Centers, Inc. v. Antex Roofing, Inc.*, 2013 WL 1912342 (Tex. App.—Houston [1st Dist.] May 9, 2013, no pet.).

An insured's insurer had standing, as subrogee of insured, to bring an equitable subrogation suit against the insured's subcontractor. The insurer was stepping into the insured's shoes in pursuit of the insured's claims against the subcontractor and others for its involuntary payment of a debt on the insured's behalf for which the subcontractor could be liable because of its negligence. Further, the subcontractor failed to argue in its motion for summary judgment that the insurer's payment was voluntary, so that could not be grounds for reversal. *Stico Mut. Ins. Co., RRG v. Advanced Polymer Coatings, Inc.*, No. 08-12-00011-CV, 2013 WL 4854311 (Tex. App.—El Paso Sept. 11, 2013, no pet.).

C. Surplus lines & Unauthorized insurance

A company marketed, sold, and administered a collateral protection coverage program for "buy here, pay here" car dealers. Under the program, a portion of the fee was used to purchase

stop-loss coverage, and the remainder of the fee was placed in a bank account of a Producer Owned Insurance Company wholly owned by the car dealer. The company filed suit against the Tex. Department of Insurance and two of its competitors, seeking injunctive relief concerning the legality of the program and arguing that it was not regulated by TDI as it was not an insurance product. The court held that the collateral protection insurance program was subject to regulation by TDI. *Sidecars, Inc. v. Tex. Dept. of Ins.*, No. 03-10-00720-CV, 2013 WL 2395189 (Tex. App.—Austin May 30, 2103, pet. filed).

D. Public Adjusters

After a hurricane damaged condos, the condo owners hired a public insurance adjuster to handle its claim. The claims were only partially paid by the insurer, so the condo owners hired a law firm to obtain an additional recovery. The law firm was able to obtain a substantial recovery, but the public adjuster maintained that it was also entitled to a percentage fee on that recovery. The condo owners filed suit against the public adjuster, seeking declaratory relief that the public adjuster was not entitled to any more money under the contract. The condo owners argued that because the contract with the public adjuster did not list his license number, as required by the state, the contract was void. The appellate court reversed summary judgment in favor of the insured, stating that the deficiency in the contract can be addressed administratively rather than by avoidance and that the evidence raised a fact issue as to whether the contract violated public policy. Therefore, the trial court erred in concluding as a matter of law that the contract was against public policy. *Int'l Risk Control, L.L.C. v. Seascape Owners Ass'n, Inc.*, 395 S.W.3d 821 (Tex. App.—Houston [14th Dist.] 2013, pet. denied).

E. Liens

After a settlement was obtained in a car accident case, the insurer paid the plaintiffs, making the checks out to the individual plaintiffs and the hospital, jointly. The plaintiffs' banks both negotiated the checks, allowing the plaintiffs to cash them without obtaining the hospital's endorsement. The hospital filed suit against the insurer, alleging that it violated the Texas Hospital and Emergency Medical Services Lien statutes for settling without resolving the hospital's liens. The trial court granted summary judgment for the insurer, holding that the insurer fulfilled its obligations under the hospital lien statute by issuing and delivering co-payable settlement drafts, as joint-payees with the hospital. The appeals court agreed. *McAllen Hospitals, L.P. v. State Farm Co. Mut. Ins. Co. of Tex.*, No. 13-11-00330-CV, 2012 WL 5292926 (Tex. App.—Corpus Christi-Edinburg Oct. 25, 2012, pet. granted) (mem. op.).

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