ANNUAL SURVEY OF

Texas Insurance Law

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I. INTRODUCTION

This year's survey of Texas insurance cases harvested a smaller crop – 142, down from 150 last year and 300 two years ago. Here are some of the highlights of cases discussed in this article.

In *Greene v. Farmers Ins. Exch.*, No. 12–0867, 2014 WL 4252271 (Tex. Aug. 29, 2014), the Texas Supreme Court allowed an insurer to rely on a policy's vacancy clause to deny coverage, even though the vacancy did not cause the loss. The court also held that the "contractual liability" exclusion does not apply to poor workmanship, in *Ewing Constr. Co. v. Amerisure Ins. Co.*, 420 S.W.3d 30 (Tex. 2014).

The supreme court also addressed the consequences when an insurer pays a plaintiff but a hospital lien is not satisfied, *McAllen Hosps., L.P. v. State Farm Co. Mut. Ins. Co. of Tex*, 433 S.W.3d 535 (Tex. 2014), while a court of appeals decided whether an insurer can challenge the amount of a hospital lien, in *Allstate Indem. Co. v. Memorial Hermann Health System*, 437 S.W.3d 570 (Tex. App.—Houston [14th Dist.] 2014, no pet.).

The court of appeals also considered a new provision in the prompt payment of claims statute, which gives more time to a life insurer that files an interpleader. In *Prudential Ins. Co. v. Durante*, No. 08–12–00077–CV, 2014 WL 4259434 (Tex. App.—El Paso Aug. 29, 2014, pet. granted), the court held the insurer did not qualify for the extension.

The Fifth Circuit returned to one of its favorite *Erie*-guesses, despite the fact that the Texas Supreme Court has demurred on the issue several times. In *Star-Tex Resources, L.L.C. v. Granite State Ins. Co.*, 553 F. App'x 366 (5th Cir. 2014) (per curiam), the court looked outside the eight corners to consider extrinsic evidence to decide a liability insurer had no duty to defend, where the extrinsic evidence related solely to a fundamental issue of coverage that did not overlap with the merits. The Fifth Circuit also addressed whether an insurer had a disqualifying conflict that would let the insured choose its own lawyer, at the insurer's expense, in *Graper v. Mid-Continent Cas. Co.*, 756 F.3d 388, 393 (5th Cir. 2014).

Another case solved the *Gandy* problem of assigning an insured's claim to the plaintiff, *Great American Ins. Co. v. Hamel*, No. 08–11–00302–CV, 2014 WL 4656618 (Tex. App.—El Paso, Sept. 19, 2014, no pet.). And several cases dealt with plaintiff's inability to adequately segregate fees between recoverable claims and non-recoverable ones.

Finally, one thoughtful district court broke the trap of having an adequate "fair notice" state court pleading be judged by the stricter federal *Twombly-Iqbal* standard. *Esteban v. State Farm Lloyds*, No. 3:13–CV–3501–B, 2014 WL 2134598 (N.D. Tex. May 22, 2014).

II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile

Where a named insured rejected UIM and PIP coverages in writing and then renewed her policy seven more times, the insurer was not required to offer UIM and PIP coverage again. Further, the character of the policies as renewal policies was not altered by the fact that, in later years, her son was added as another named insured. *Cain v. Progressive County Mut. Ins. Co.*, No. 14–12–00954–CV, 2014 WL 4638923 (Tex. App.—Houston [14th Dist.] Sept. 18, 2014, no pet.).

Loss of use damages were not available for a total loss. An insured was hit by another driver, totaling the insured's tow truck. The driver's insurance company paid its policy limits, which replaced the truck. Then the insured sued his under-insured insurer, after it refused to pay him for his loss-of-use damages for not being able to operate his business for four months while he found a replacement truck. The court held that in a total-loss case, a chattel owner can recover only the market value of the property, not loss-of-use damages. *Am. Alternative Ins. Corp. v. Davis*, No. 10-13-00275-CV, 2014 WL 2917081 (Tex. App.—Waco June 26, 2014, pet. filed).

An automobile insurer was entitled to summary judgment where the policy unambiguously excluded coverage for an uninsured motor vehicle that was "owned by or furnished or available for the regular use of [the insured] or any family member." *Mata v. State Farm Mutual Insurance Co.*, No. 04-14-00239-CV, 2014 WL 6474223 (Tex. App.—San Antonio Nov. 19, 2014).

B. Homeowners

The supreme court held that a vacancy clause negated coverage, even though the vacancy did not harm the insurer. *Greene v. Farmers Ins. Exch.*, No. 12–0867, 2014 WL 4252271 (Tex. Aug. 29, 2014). The homeowner's insurance policy provided that coverage was suspended effective sixty days after the dwelling became vacant. It was undisputed that Greene's house was vacant, but it was also undisputed that the vacancy did not cause the fire. The court first considered the anti-technicality statute, Tex. Ins. Code § 862.054, which provides that a breach or violation of a policy warranty, condition, or provision does not render the policy or contract void and is not a defense to a suit for loss, unless it contributed to cause the destruction of the property. The court held the statute did not apply because the vacancy was not a "breach" of the policy.

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The court also distinguished its prior decisions requiring that an insurer show prejudice before a failure to comply with the policy excuses coverage. For instance, in *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691 (Tex. 1994), the court held that breach of a consent to settlement clause did not excuse liability, where the insurer was not prejudiced. S*ee also Lennar Corp. v. Markel Am. Ins. Co.*, 413 S.W.3d 750 (Tex. 2013). Similarly, the court held that late notice that did not prejudice the insurer would not void coverage in *PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 630 (Tex. 2008), and *Prodigy Communications Corp. v. Agric. Excess & Surplus Ins. Co.*, 288 S.W.3d 374 (Tex. 2009). The court distinguished these cases, holding that the vacancy clause in the present case was material, but the breaches in the other cases were immaterial.

Finally, the court distinguished its holding in *Puckett v. U.S. Fire Ins. Co.*, 678 S.W.2d 936 (Tex. 1984), where the court refused on public policy grounds to allow an insurance company to avoid coverage based on the insured's immaterial breach of a condition requiring an airworthiness certificate for the airplane that was insured. The court distinguished *Puckett* because in this case the court found there was no breach. Further, the court held that it is for the legislature and Texas Department of Insurance to decide what coverage should be and to establish public policy. The court reasoned that TDI had made a policy choice by approving the insurance form in this case, which allowed the limitation on coverage.

Justice Boyd, joined by Justice Willett, concurred, but he found the court's decision in conflict with the prior decisions in *PAJ, Prodigy*, *Lennar,* and *Hernandez*. Balancing consistency with disruption, the concurring justices would limit the prejudice requirement to those four cases applying to late notice and settlement without consent, but would not extend it further.

The standard mortgage clause in a residential insurance policy provides coverage to a mortgagee for a loss by fire of a vacant property, despite the policy's vacancy clause. *SWE Homes, LP v. Wellington Ins. Co.*, 436 S.W.3d 86 (Tex. App.—Houston [14th Dist.] 2014, no pet.). An insured's mortgagee sought coverage for a fire loss to a vacant dwelling. The insurer denied coverage on grounds that the vacancy clause excluded coverage. The court of appeals disagreed. The mortgage clause stated that the mortgagee could recover under the policy despite "any act or neglect of the mortgagor." The court concluded that although there was no coverage for the insured because the property had remained vacant for the period specified by the vacancy clause, the mortgagee could still recover because it had complied with all of the provisions in the mortgage clause. Interpreting the policy otherwise would render the mortgage clause meaningless and would violate section 862.055 of the Insurance Code, which prohibits the interest of a mortgagee under a fire insurance contract from being invalidated by an act of the mortgagor or an occurrence beyond the mortgagor's control.

In another homeowner's case, water damage was excluded as flood damage. An insured homeowner sought coverage for property damage caused by water diverted onto his property when a third party placed large cylinders across a drainage ditch. The insurer denied coverage, arguing that the overflow of water onto the insured's property was excluded from coverage as flooding, regardless of the cause of the overflow. The court of appeals agreed. Because the policy did not define "flood," the court used the common meaning "a rising and overflowing of a body of water." It did not matter that the overflow of water was caused by the presence of obstructions on top of a ditch in light of language in the policy that said it excluded the loss "regardless of … the cause of the excluded event[.]" *George v. State Farm Lloyds*, No. 07-12-00465-CV, 2014 WL 2481894 (Tex. App.—Amarillo May 19, 2014, no pet.).

C. Commercial Property

An insured that suffered property damage only to find that the property coverage it had was not what it requested was entitled to recover damages without obtaining a coverage determination from the court. *Insurance Alliance v. Lake Texoma Highport, LLC*, No. 05-12-01313-CV, 2014 WL 6466851 (Tex. App.—Dallas Nov. 19, 2014). The jury found that the insurance agency breached its contract with the insured to obtain property coverage of $15,000,000 without sublimits or co-insurance penalties. The agency argued that because the broker had given seventeen different policy versions that required the insured to get the court to determine what coverage was actually provided. The court of appeals rejected this argument and presumed that the jury resolved any questions about the insured's coverage when it made its damage findings. The jury was asked to determine the amount of coverage that would have been available, less the amount of coverage that was actually obtained.

Theft of copper sheeting owned by a customer was not covered by a warehouse company's commercial property policy, where it was covered by the customer's own policy. *United Nat. Ins. Co. v. Mundell Terminal Servs., Inc.*, 740 F.3d 1022 (5th Cir. 2014). The warehouse company had a policy that covered its business personal property and property held by others. However, the policy had an exclusion for property that was covered under another policy. The court held this exclusion applied. The court found that the customer's interests were insured under both the warehouse policy and the customer's own policy. The court concluded that the "other insurance" clause applied because the customer's insurance covered the same property interest in favor of the same party – i.e. the customer's interest in the copper.

The court rejected the warehouse company's argument that the court should not reach this conclusion, because that would subject the warehouse company to a subrogation claim by the customer's insurer. The court noted that the warehouse company could have purchased liability insurance for such a risk but did not.

A commercial property insurer's failure to give the mortgagee notice of cancellation did not affect the cancellation as to the insured. *Molly Props., Inc. v. Cincinnati Ins. Co.*, 557 F. App'x 258 (5th Cir. 2014) (per curiam). It was undisputed that the insurer gave cancellation notice to the insured and that the insured failed to pay its premiums. The court rejected the insured's argument that it was a third-party beneficiary of the contract between the insurer and the mortgagee. The court found no evidence that that agreement was made for the benefit of the insured.

An insured trucking company's video game consoles were stolen while in its terminal. *W.W. Rowland Trucking Co., Inc. v. Max Am. Ins. Co.*, 559 F. App'x. 253 (5th Cir. 2014). The parties agreed that theft was a covered peril. However, the insurer argued that an exclusion applied that required the insured's terminals to be "100% fenced, gated, locked, and lighted 24 hours per day, 7 days per week," or else the "[c]overage is null and void." An investigation showed that thieves had entered and left the terminal by cutting a hole in the fencing. The Fifth Circuit held that Texas's Anti-Technicality Statute applied, which requires a causal link between the breach in the policy provision and the loss in order for an insurer to deny a claim under a property insurance policy. Therefore, the court ordered the insurer to pay the claim.

A commercial building was "vacant" within the meaning of a commercial property policy where it had been unoccupied for several years. *Bedford Internet Office Space, LLC v. Travelers Cas. Ins. Co.*, No. 3:12–CV–4322–N, 2014 WL 4230315 (N.D. Tex. Aug. 25, 2014). The fact that it had been leased to a new tenant did not change the outcome, where the tenant had not yet moved in and neither the tenant nor the landlord were engaged in any "customary operations" as required by the policy.

A property owner's claims for water damage caused by a defective roof were barred by the exclusion for negligent work. *Mag-Dolphus, Inc. v. Ohio Cas. Ins. Co.*, No. H–13–08S2, 2014 WL 4167497 (S.D. Tex. Aug. 13, 2014). The court found that the exclusion was unambiguous. The court also held it was not against public policy for the insurer to rely on the exclusion, rejecting the insured's argument that the insurer should have inspected and noticed the defective work because the roof was replaced as a result of a prior leak claim.

D. Life insurance

Where a life insurance policy lapsed for non-payment of premium a year before the insured died, the life insurer did not

breach its contract by refusing to pay. *Lombana v. AIG Am. Gen. Life Ins. Co.*, No. 01–12–00168–CV, 2014 WL 810858 (Tex. App.—Houston [1st Dist.] Feb. 27, 2014, pet. denied).

An ex-wife was not entitled to proceeds under a life insurance policy where she was named as beneficiary prior to the divorce. The court relied on the statute that provides that a divorce makes an earlier designation of a spouse as policy beneficiary ineffective. No exceptions provided by the statute applied in this case. *Branch v. Monumental Life Ins. Co.*, 422 S.W.3d 919 (Tex. App.—Houston [14th Dist.] 2014, no pet.). The ex-wife also could not claim ownership of the policy based on her payment of premiums, where the prior court in the divorce action had awarded ownership to the husband.

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The *Branch* court also held that the fact that the insurer attached a sample policy to its interpleader petition did not affect the ex-wife's claim. The insurer was not required to attach the policy in issue, but could summarize its provisions. Further, in the interpleader action, it was the ex-wife's burden to prove her entitlement to the proceeds, not the insurer's burden to negate it.

A widow was entitled to fifty percent of life insurance proceeds where her husband filed a change of beneficiary form designating her as primary beneficiary for that portion, even though the form was rejected because it was ambiguous as to the contingent or additional beneficiary designations. Although the policy required a change of beneficiary form "in a form that meets our needs," the court found that the insured substantially complied with the change of beneficiary designation. Although the contingent beneficiary designation was unclear, it was undisputed that the designation of the widow as primary beneficiary for fifty percent was clear. *Prudential Ins. Co. v. Durante*, No. 08–12–00077–CV, 2014 WL 4259434 (Tex. App.—El Paso Aug. 29, 2014, pet. granted).

The death of an insured during the two-year contestability period bars a life insurance policy from becoming incontestable. *Mut. of Omaha Life Ins. Co. v. Costello*, 420 S.W.3d 873 (Tex. App.—Houston [14th Dist.] 2014, no pet.). The insured under a life insurance policy died within the two-year contestability period set forth in the policy. After investigating the claim, the insurer concluded that the insured had misrepresented her health history in the insurance application. It then denied the claim and rescinded the policy. The beneficiary sued to recover the policy proceeds and, after litigating for several years, argued that the insurer failed to contest the validity of the policy within two years by failing to institute its own court proceeding. The court of appeals rejected this argument. Section 1101.006 of the Insurance Code requires that a policy "must provide that a policy in force for two years from its date of issue during the lifetime of the insured is incontestable, except for nonpayment of premiums." The court found that the language "during the lifetime of the insured" means that an insured must survive the two-year contestability period for the policy to become incontestable. As a result, the insurer could challenge the policy's validity.

E. Title insurance

The Fifth Circuit held that a title insurance policy providing survey coverage covered a flowage easement that was larger than depicted by the survey. *Lawyers Title Ins. Corp. v. Doubletree Partners, L.P.*, 739 F.3d 848 (5th Cir. 2014). Doubletree bought land that it planned to develop. Lawyer's Title provided the title insurance and offered Doubletree expanded survey coverage. Doubletree later discovered a serious error in the survey: it substantially underrepresented the area of the property that was subject to a flowage easement that allowed the federal government to flood that portion of the property.

The policy originally excluded "any discrepancies, conflicts, or shortages in area or boundary lines, or any encroachments or protrusions, or any overlapping of improvements." Because Doubletree paid for survey coverage, this exception was amended to exclude only "shortages in area." The parties disputed the effect of this language. Lawyers Title argued that the policy still did not cover the flowage easement, because it was not a boundary line or encroachment. Lawyers Title argued that these terms referred to defects at the boundary of the property. On the other hand, Doubletree argued that the words could be read to also include the flowage easement.

The court found both interpretations were reasonable and, therefore, held that it had to construe the language of this exclusion in favor of coverage. The court went on to say that, because the policy was subject to two interpretations and was ambiguous, it could consider "extraneous evidence to determine the true meaning of the instrument." After considering correspondence related to the policy, the court again concluded that Doubletree's interpretation of the policy was reasonable.

The *Doubletree* court erred on this second point. The court cited *Italian Cowboy Partners, Ltd. v. Prudential Ins. Co. of Am.*, 341 S.W.3d 323, 333-34 (Tex. 2011). But that case – while it included an insurance company as a party – involved a lease, not an insurance policy. As the Fifth Circuit correctly recognized in other parts of its opinion, once a policy is subject to more than one reasonable interpretation, it is construed in favor of coverage, as a matter of law. While the courts may consider extraneous evidence to determine the true meaning of an instrument with regard to other types of contracts, that is not true with insurance policies.

The *Doubletree* court also held that the flowage easement exception in the policy did not apply, because it was ambiguous. The exception provided that the insurer did not insure against loss arising out of the "flowage easement"…"and shown on survey." The court found Doubletree's interpretation was reasonable and that this language could be taken to mean that only the easement as shown on the survey was accepted. Because the survey failed to show the full extent of the easement, it was not "shown on the survey."

Finally, the court held that an exclusion did not apply. The exclusion precluded coverage for any defect "created, suffered, assumed or agreed to by the insured claimant." The court agreed with Doubletree's argument that because Doubletree did not know the extent of the easement, it did not create, suffer, assume, or agree to it.

A dedication agreement that affected real property's historic status and use was not a defect in title. Although it affected the value of the property, it did not affect ownership. *McGonagle v. Stewart Title Guar. Co.*, 432 S.W.3d 535 (Tex. App.—Dallas 2014, pet. filed). The court further held that the dedication agreement also fit within an exclusion for defects and encumbrances "assumed or agreed to by the insured claimant." The evidence showed that the dedication agreement was attached to the purchase contract and was known to the buyers, even though they believed that the agreement was deleted.

An insured purchased several properties in Tulum, Mexico for hotel development. *Citigroup Global Markets Realty Corp. v. Stewart Title Guar. Co.*, 417 S.W.3d 592 (Tex. App.—Houston [14th Dist.] 2013, no pet.). It obtained title insurance for the properties. The title insurer researched the properties and learned of a 1981 decree by the Mexican federal government that appro-

priated land to create the Tulum National Park. However, the insurer's report noted the tracts purchased by the insured were not affected by the condemnation. The insurer did not list the decree as an exception from coverage in its title policies. In its efforts to develop the properties, the insured learned that several of the properties were not developable because they were subject to the decree and within the Park. The insured and its lender both filed suit against the title insurer.

The jury found the insured knew of an encumbrance on ten of the sixteen properties on the date of purchase. On appeal, the court held that sufficient evidence supported that finding. The evidence at trial showed that several of the insured's agents had discussed a decree in the zone where the property was located, that the property was in the park, and that they were aware of the risk that they might not be able to build anything because of zoning and archeological restrictions. Therefore, the insured knew of and assumed or agreed to the effects of the decree on those ten properties.

The jury also found the insured did not know about the decree and did not assume or agree to its effect as to six properties, but awarded zero damages. The court also found that the evidence was sufficient to support this result. The jury was asked to determine damages by selecting the lesser of the amount for which the properties were insured or the difference between the value of the insured estate as insured and the value of the insured estate as subject to the decree. Under the language "as insured," the properties were already taken or acquired by the decree in 1981. The jury could thus conclude that the value of the properties as insured was identical to their value subject to the decree.

F. Other policies

A policy styled as "Automated Teller Machine and Contingent Cash In Transit" that provided coverage for theft from an armored motor vehicle company did not require the insured to first exhaust all remedies against potentially responsible third-parties before the insurer would become obligated to pay for the loss. *Certain Underwriters at Lloyd's of London Subscribing to Policy Number: FINFR0901509 v. Cardtronics, Inc.*, 438 S.W.3d 770 (Tex. App.—Houston [1st Dist.] 2014, no pet.). The president of an armored car company who worked for Cardtronics, owner of several automated teller machines, stole $16,000,000. The insurer refused to pay, asserting that the policy required that Cardtronics first exhaust any remedies it had against the armored car company and any insurer for the armored car company.

The court rejected the insurer's argument as unreasonable. There was nothing in the policy that expressly required exhaustion of remedies. The coverage language said, "we will only pay for the amount of loss you cannot recover: (1) under your contract with the armored motor vehicle company; and (2) from any Insurance or indemnity carried by, or for the benefit of customers of, the armored motor vehicle company." The court rejected the argument that the "cannot recover" language required Cardtronics to first seek recovery from others before the insurer was obligated to pay. The insurer's construction conflicted with other provisions in the policy that required Cardtronics to submit a proof of loss by a certain deadline and the insurer to respond to the claim by a certain deadline, and Cardtronics to file suit by a certain deadline. None of these deadline provisions could apply if Cardtronics were first required to pursue recovery from others. The court harmonized the provisions of the policy by accepting Cardtronics' proposed construction that would require the insurer to pay whatever amount Cardtronics was unable to recover from others by the time its proof of loss was due. The court found this interpretation was reasonable and gave meaning to all of the provisions of the policy.

III. FIRST PARTY THEORIES OF LIABILITY

A. Breach of Contract

An insured debtor still had the right to sue a property insurer for underpayment of a water damage claim, even after foreclosure, where the amount of the claim was more than the amount of the debt. *Peacock Hospitality, Inc. v. Ass'n Cas. Ins. Co.*, 419 S.W.3d 649 (Tex. App.—San Antonio 2013, no pet.).

A court rejected a life insurance beneficiary's argument that the insurer breached an implied oral contract to reinstate a life insurance policy that had lapsed for non-payment of premium. *Lombana v. AIG Am. Gen. Life Ins. Co.*, No. 01–12–00168–CV, 2014 WL 810858 (Tex. App.—Houston [1st Dist.] Feb. 27, 2014, pet. denied) (mem. op.). The court found no evidence that the insurer's representative had authority to enter into such an oral contract and no evidence of the parties' "mutual assent" or meeting of the minds. Further, the beneficiary admitted she knew that a premium payment would be required for the policy to be reinstated, and it was undisputed that no premium payment was made.

The insureds in *Salazar v. State Farm Lloyds*, No. H-13-1904, 2014 WL 2862760 (S.D. Tex. June 24, 2014), sued their insurer for breach of the policy and extra-contractual duties for denying their claim for damage loss to the home interior caused by water leaking from plumbing pipes under the home. The court held that the insurance policy's dwelling foundation endorsement explicitly and unambiguously limited liability for foundation damage to fifteen percent of the dwelling limit of liability. Therefore, the insurer's motion for summary judgment on that issue was granted.

An insured's building incurred damage from a hailstorm. The insured did not give notice to the insurer about the damage for at least nineteen months. The insurer demonstrated that other, non-covered perils could have contributed to the insured's loss. Therefore, the court held that summary judgment in favor of the insurer should be granted on the breach of contract claim. Additionally, because the insured failed to provide summary judgment evidence to raise a genuine fact issue that they suffered an injury independent of their policy claim, summary judgment was also granted in favor of the insurer on the insured's statutory and common law bad faith claims. *Hamilton Prop. v. Am. Ins. Co.*, No. 3:12-CV-5046-B, 2014 WL 3055801 (N.D. Tex. July 7, 2014).

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

Where a life insurer properly denied coverage under a policy that had lapsed for non-payment of premium, the court also properly dismissed the plaintiff's claims for unfair insurance practices, deceptive trade practices, and breach of duty of good faith and fair dealing. *Lombana v. AIG Am. Gen. Life Ins. Co.*, No. 01–12–00168–CV, 2014 WL 810858 (Tex. App.—Houston [1st Dist.] Feb. 27, 2014, pet. denied).

In *USAA Texas Lloyd's Co. v. Menchaca*, No. 13-13-00046-CV, 2014 WL 3804602 (Tex. App.—Corpus Christi July 31, 2014, pet. filed), an insured's house was damaged in a hurricane. After submitting the claim to her insurer, the insurer said the damage was under the deductible amount so no payment would be made. The insured sued her insurer. At trial, the insurer stipulated to the reasonableness of the insured's electrician's estimate, which was over the deductible amount. The jury returned a verdict stating that the insurer did not fail to comply with the terms of the insurance contract, but found that the insurer did refuse to pay a claim without conducting a reasonable investigation. On appeal, the insurer argued that because the jury found no breach of contract, the insured's extra-contractual claims must fail. The

appeals court disagreed, holding that the insurer complied with the policy, but violated the insurance code, and the insurer would have been contractually obligated to pay policy benefits had the insurer complied with the insurance code. Therefore, the court affirmed.

A jury's failure to find an insurance broker liable for misrepresentations and unfair insurance practices was supported by evidence that the broker never made any direct misrepresentations to the insured or the insured's agent, and the broker provided the insurance policy that its intermediate broker requested. *Insurance Alliance v. Lake Texoma Highport, LLC*, No. 05-12-01313-CV, 2014 WL 6466851 (Tex. App.—Dallas Nov. 19, 2014).

Although the court in *Lawyers Title Ins. Corp. v. Doubletree Partners, L.P.*, 739 F.3d 848 (5th Cir. 2014), found in favor of the insured on coverage under a title insurance policy, the court nevertheless agreed that the insured failed to state a claim for statutory claims for unfair insurance and deceptive trade practices. The court found that the insurer had a reasonable basis for denying the claim, even though the court ultimately rejected that basis.

An insured sued his insurer for failing to conduct a reasonable investigation of his home foundation claim. The insurer hired both an engineer and plumber to investigate the claim, and both concluded that the foundation movement was not the result of a plumbing leak. The insured's expert was asked during his deposition if there was a problem with the investigation process, to which he answered "no." Therefore, the court found that the insurer was entitled to summary judgment on the issue of conducting a reasonable investigation. *Walker v. Nationwide Prop. & Cas. Ins. Co.*, 992 F. Supp. 2d 703 (W.D. Tex. 2014).

An insurance agent was entitled to summary judgment on the plaintiffs' misrepresentation claims, where there was no evidence that the agent made any false representations about specific terms of their policy. The plaintiffs alleged that the agent misrepresented coverage because they requested coverage for "all perils possible," but the policy contained an exclusion for negligent workmanship. *Mag-Dolphus, Inc. v. Ohio Cas. Ins. Co.*, No. H–13–08S2, 2014 WL 4167497 (S.D. Tex. Aug. 13, 2014).

The insureds did not have a reasonable basis for recovery against the investigator because the investigator was not engaged in the business of insurance, as defined in the Insurance Code.

An investigator was held not to be engaged in the business of insurance and thus not a proper party to a suit under the Insurance Code. *Michels v. Safeco Ins. Co. of Indiana*, 544 F. App'x 535 (5th Cir. 2013). Insureds sued both their homeowner's insurer and its investigator for violations of the Insurance Code, seeking coverage for smoke damage to their home that occurred during the Bastrop wildfires. The trial court dismissed the investigator, who was a non-diverse party, as improperly joined. The Fifth Circuit affirmed. It held that the insureds did not have a reasonable basis for recovery against the investigator because the investigator was not engaged in the business of insurance, as defined in the Insurance Code. The investigator was an engineer hired only to determine the cause and extent of damages to the home, knew nothing about the coverage of the policy, and made no decisions with respect to insurance coverage.

C. Prompt Payment of Claims

A court held that an insurer was liable for prompt payment penalties where the insurer filed an interpleader action but did not do so within ninety days as required by the statute. The court held that the insurer was not entitled to the additional thirty days and instead had to pay the claim within sixty days, because the insurer did not receive "notice of an adverse, bona-fide claim." The court held that there was no bona-fide adverse claim, where the widow was clearly entitled to fifty percent of the proceeds and the children were entitled to the other half. *Prudential Ins. Co. v. Durante*, No. 08–12–00077–CV, 2014 WL 4259434 (Tex. App.—El Paso Aug. 29, 2014, pet. granted).

An insured sued his uninsured-motorist insurer for failing to pay a claim in accordance with the five-day payment provision under Tex. Ins. Code § 542.057. That section requires an insurer to pay the insured within five business days after notice that the insurer will pay all or part of the claim. In this case, the insured and insurer were exchanging settlement offers, and the insured argued that the insurer was required to pay the amount it had offered in settlement within five days of making the offer, even though the insured rejected the offer. The court held that the fact the insurer "approved" part of the claim for settlement purposes is not a notice of acceptance for the purpose of the prompt-payment statute. *Terry v. Safeco Ins. Co. of Am.*, 972 F. Supp. 2d 965 (S.D. Tex. 2013).

A prompt pay violation does not turn on whether the insured suffered an independent injury or the reasonableness of the insurer's position. Because the insurer had a duty to defend and breached that duty, the insurer violated the statute by erroneously rejecting the insured's requests for a defense and delaying payment of fees and expenses incurred in the underlying litigation. *Admiral Ins. Co. v. Petron Energy, Inc.,* 1 F. Supp. 3d 501 (N.D. Tex. 2014).

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

Although the court in *Lawyers Title Ins. Corp. v. Doubletree Partners, L.P.*, 739 F.3d 848 (5th Cir. 2014), found in favor of the insured on coverage under a title insurance policy, the court nevertheless agreed that the insured failed to state a claim for breach of the duty of good faith and fair dealing. The court found that the insurer had a reasonable basis for denying the claim, even though the court ultimately rejected that basis.

Fees incurred in a coverage action are not an injury independent of the denial of policy benefits within the meaning of Chapter 541 of the Insurance Code. *Admiral Ins. Co. v. Petron Energy, Inc.,* 1 F. Supp. 3d 501 (N.D. Tex. 2014). A district court granted an insurer's motion for summary judgment as to all of the insured's claims for unfair insurance practices. In particular, the court found that there was insufficient evidence that the insured suffered any injury independent of the insurer's denial of policy benefits. The fees and litigation expenses incurred by the insured in this coverage action were not an independent injury.

The court erred by requiring proof of an independent injury other than the amounts owed under the policy. 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).

E. Fraud

A life insurer was not liable for fraud by nondisclosure related to information it gave a beneficiary about reinstating a lapsed policy, because there was no confidential or fiduciary relationship giving rise to a duty to disclose. Further, there was no evidence of any material misrepresentation to support a claim for fraud. *Lombana v. AIG Am. Gen. Life Ins. Co.*, No. 01–12–00168–CV, 2014

WL 810858 (Tex. App.—Houston [1st Dist.] Feb. 27, 2014, pet. denied).

F. ERISA

An ERISA plan administrator did not abuse its discretion by denying disability benefits to a plan participant. *Spenrath v. Guardian Life Ins. Co. of Am.*, 564 F. App'x 93 (5th Cir. 2014) (per curiam). An ERISA plan participant sued a plan administrator under ERISA for wrongfully denying her long-term disability benefits. In particular, the participant argued that the administrator failed to credit the medical evidence contained in the record that showed her disability. The administrator argued that it based its decision on the entire administrative record. The Fifth Circuit held that the administrator did not abuse its discretion. The evidence showed that the administrator examined the participant's medical evidence. Its denial letter specifically discussed much of the participant's evidence. A panel of independent medical specialists, upon which the administrator relied, also thoroughly considered the evidence. Further, the administrator did not abuse its discretion by failing to consider the participant's subjective evidence. Instead, it relied on the panel of medical specialists to determine whether there was a disparity between her subjective complaints and the objective findings, and the panel concluded there were discrepancies. Finally, the administrator did not abuse its discretion by relying on expert opinions that allegedly mischaracterized the evidence. None of the alleged errors in the expert testimony undermined the administrator's ultimate conclusion or affected the substantial nature of the evidence in its support. The administrator did not act arbitrarily by giving more weight to the conclusions of the independent experts than to the participant's providers.

Substantial evidence supported an ERISA plan administrator's decision to deny accidental death benefits. *McCorkle v. Metropolitan Life Ins. Co.*, 757 F.3d 452 (5th Cir. 2014). An ERISA plan beneficiary sought benefits under her deceased husband's accidental death coverage. Her husband, the plan participant, had visited his family doctor complaining of stress and trouble sleeping. The doctor ruled out depression and treated the participant for insomnia and anxiety with a prescription of Lunesta. One evening, he took Lunesta as prescribed and a few hours later shot himself. The coroner reported the death cause as "suicide," but noted that he was under the influence of Lunesta and thus did not "consciously and intentionally t[ake] his own life." The plan administrator denied benefits. The district court found the denial improper and reversed. In its review of the case, the Fifth Circuit emphatically noted that district courts are serving in an appellate role when they review administrative denials of benefits and that the administrator's determination must be affirmed unless it is arbitrary or not supported by at least substantial evidence, even if that determination is not supported by a preponderance. The Fifth Circuit held that substantial evidence supported the plan administrator's determination that the participant committed suicide. The participant died of a self-inflicted gunshot wound, not an accidental discharge of a gun. The possibility that the participant was hallucinating was insignificant in the court's analysis.

IV. THIRD PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile liability insurance

An exception to an exclusion did not create coverage for an injured employee. An employee was injured at work when his concrete truck rolled over. His employer did not subscribe to workers' compensation insurance. However, his employer filed a claim for his injuries under its business auto policy, and then assigned its insurance claim to the employee. The insurance policy provided that it did not insure bodily injury to an employee of the insured arising out of or in the course of employment by the insured. The employee argued that an exception to the exclusion applied: "But this exclusion does not apply to bodily injury to domestic employees not entitled to workers' compensation benefits or to liability assumed by the insured under an insurance contract." The employee argued that "domestic employee" is ambiguous because it could either refer to employees who work in a household or to employees who are citizens of the United States, and he would fall under the latter. The court held that "domestic employee" unambiguously referred to employees who work in a home. Consequently, the exception did not apply. *West v. S. Co. Mut. Ins. Co.*, 427 S.W.3d 576 (Tex. App.—Dallas 2014, no pet.).

B. Comprehensive general liability insurance

The fact that a general contractor entered into a contract in which it had agreed to perform construction in a good workmanlike manner did not trigger the contractual liability exclusion. *Ewing Constr. Co. v. Amerisure Ins. Co.*, 420 S.W.3d 30 (Tex. 2014). The contractor agreed to build tennis courts for a school district, but the tennis courts immediately started to flake, crumble, and crack. The liability insurer denied the contractor's claim. The liability insurer relied on the contractual liability exclusion, which excludes coverage for "'property damage' for which the insured is obligated to pay damages by reason of the assumption of liability in the contract or agreement."

The insurer argued that by agreeing to perform in a good and workmanlike manner, the contractor assumed liability in the contract and, therefore, the loss was excluded. The supreme court disagreed and instead agreed with the contractor that the agreement to build the tennis courts in a good and workmanlike manner did not enlarge the contractor's obligations beyond any general common law duty it had. Because the contract did not expand the contractor's obligations, there was not an "assumption of liability" within the meaning of the exclusion.

The supreme court also rejected the insurer's argument that if it held the exclusion inapplicable that would convert a liability policy into a performance bond. The court noted that, while this exclusion did not apply, other exclusions could.

The point the *Ewing* court made was applied, *Blanton v. Continental Ins. Co.*, 565 F. App'x 330 (5th Cir. 2014). At issue was whether a liability policy covered the insured's substandard conduct in installing and later repairing two diesel engines in a boat. After the decision in *Ewing*, the insurer conceded that the contractual liability exclusion did not preclude coverage. However, the court found that other exclusions applied. First, the defective installation and subsequent repairs were excluded by a provision that excluded liability arising out of a defect, deficiency, or inadequacy in "your product" or "your work." Moreover, the exception for loss that is sudden and accidental did not apply, because the underlying petition alleged that the defects appeared over time. The policy also excluded damage to "your product," which the court held clearly included the engines that the insured installed and later attempted to repair.

The loss of use claim by the boat owner was also excluded under a ship repairs liability policy, which excluded loss due to "demurrage, loss of time, loss of freight, loss of charter and/or similar and/or substituted expenses." The court held that the meaning of "demurrage" was well settled to include loss of use of a vessel. Further, the ship repairs liability policy also excluded "the expense of redoing the work improperly performed by [the insured] or on [the insured's] behalf or the cost of replacement of materials, parts or equipment furnished in connection therewith."

In *Crownover v. Mid-Continent Cas. Co.*, 757 F.3d 200

(5th Cir. 2014), homeowners initiated arbitration against their contractor, with the arbitrator determining that the homeowners had a meritorious claim for breach of the express warranty to repair contained in the contract. The contractor went bankrupt, so the homeowner sued the contractor's insurer. The insurer argued that an exclusion applied. The exclusion stated, "[t]his insurance does not apply to [ ] 'property damage' for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement." The Fifth Circuit held that, because the only ground on which the arbitrator awarded damages to the homeowners was breach of the express warranty to repair in the contract, the exception to the exclusion for "liability the insured would have in the absence of the contract or agreement" did not apply. Therefore, summary judgment in favor of the insurer was affirmed.

Under Texas law, "and" can be used disjunctively, rather than conjunctively. *Trammell Crow Residential Co. v. Am. Protection Ins. Co.*, 574 F. App'x 513 (5th Cir. 2014) (per curiam). Trammell Crow operated a number of apartment complexes in Colorado and was sued by residents due to a mold problem. APIC was paid funds from Trammell Crow's expense account to reimburse its defense costs. Trammell Crow then sued APIC, alleging that it was not required to reimburse APIC's defense costs. The question on appeal was whether APIC's costs and expenses in the litigation with the other insurer qualified as a "claim expense" under the APIC policy. A claim expense under the policy included expenses "incurred by the insured and by us[.]" Trammell Crow argued that APIC's defense costs were not claim expenses because they were incurred exclusively by APIC, rather than by both APIC and Trammell Crow. However, the Fifth Circuit determined that "and" in the definition was disjunctive, and that costs incurred by either or both Trammell Crow or APIC qualified as a "claim expense." Thus, the court held that Trammell Crow was required to reimburse APIC's defense costs up to the amount of the deductible under the policy.

The policy did not expressly exclude coverage for punitive damages. Therefore, the policy covered the punitive damages awarded against the insured in the underlying suit.

Punitive damages were covered by a CGL policy. A judgment including punitive damages was rendered against the insured in Colorado. The insurer denied coverage for the punitive damages award, arguing that it was against Colorado law to do so. Having determined that Texas law applied, the court concluded that the policy's plain language provided coverage for the judgment. The policy covered "those sums that [the insured] becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage'…." The policy did not expressly exclude coverage for punitive damages. Therefore, the policy covered the punitive damages awarded against the insured in the underlying suit. *Tesco Corp. (US) v. Steadfast Ins. Co.*, No. 01-13-00091-CV, 2014 WL 4257737 (Tex. App.—Houston [1st Dist.] Aug. 28, 2014, no pet.).

An "own, rent, or occupy" exclusion precluded coverage for a tenant that leased a portion of the property and conducted its operations there. The tenant "occupied" the premises, including the roof, which it damaged. *Liberty Mut. Fire Ins. Co. v. Lexington Ins. Co.*, No. 04–13–00586–CV, 2014 WL 4823614 (Tex. App.—San Antonio Sept. 30, 2014, no pet.).

C. Umbrella/excess insurance

Umbrella insurers were obliged to pay losses in excess of the underlying policies even though the underlying policies were exhausted by claims that would not have been covered by the umbrella policies. *Indem. Ins. Co. of N. Am. v. W&T Offshore, Inc.*, 756 F.3d 347 (5th Cir. 2014). W&T Offshore sustained significant damage to its energy exploration and development operations as a result of Hurricane Ike. W&T had several layers of coverage. The primary and umbrella policies allowed recovery for removal of debris expenses. The primary policies also allowed coverage for property damage and operators' extra expenses, but the umbrella policies did not. W&T's property damage and operators' extra expense claims exhausted the underlying policies. The umbrella insurers sought a declaratory judgment that they were not obliged to pay their policy limits for removal of debris, because the underlying policies were exhausted by claims that would not have been covered by the umbrella policies.

The district court accepted this argument, but the Fifth Circuit reversed. The Fifth Circuit relied on the plain language of a provision in the umbrella policies stating that they would pay amounts in excess of the "retained limit." That phrase was defined to include all sums above the underlying policy limits, without specifying that the underlying claims had to be covered. In contrast, another provision of the policy provided that the umbrella insurers had additional duties, including the duty to defend, when the underlying limits were exhausted by claims that would have been covered by the umbrella policy.

D. Homeowners liability insurance

A homeowner's liability policy did not cover the negligence of a son that led to the father's injuries, where the policy excluded coverage for bodily injury "to you or an insured." The father was defined as both "you" and "an insured." The court rejected the argument that the severability clause made a difference. That clause provided that "this insurance applies separately to each insured." No matter which insured's perspective was considered, the exclusion still excluded the father as "you" and "an insured." *Hodges v. Safeco Lloyds Ins. Co.*, 438 S.W.3d 698 (Tex. App.—Houston [1st Dist.] 2014, no pet.).

V. DUTIES OF LIABILITY INSURERS

A. Duty to defend

A liability insurer's duty to defend its homebuilder insured for claims for "property damage" caused by water leaks was triggered where the suit alleged that the injury manifested itself during the policy term. The duty was triggered where the suit alleged water damage that occurred during the policy period, even though it may have manifested or been discovered later. *Great Am. Ins. Co. v. Hamel*, No. 08–11–00302–CV, 2014 WL 4656618 (Tex. App.—El Paso, Sept. 19, 2014, no pet.).

A liability insurer had a duty to defend a city sued on several theories that could impose liability apart from any excluded liability for "inverse condemnation." *City of College Station, Tex. v. Star Ins. Co.*, 735 F.3d 332 (5th Cir. 2013). The city was sued by a real estate investment company that wanted to develop commercial property. Because of zoning issues with the city, the company sued the city alleging: (1) that the city's actions were discriminatory and lacked a rational basis violating its 14th Amendment right to equal protection; (2) that the city's repeated denials of requests for rezoning were arbitrary and capricious, violating its 14th Amendment right to substantive due process; (3) that the city's intentional actions in denying the zoning requests constitute a taking in violation of the Texas constitution; and (4) that

the city's individual council members had intentionally interfered with the company's existing and perspective contracts and business relationships for its development. The city's insurer refused to defend or indemnify the city, asserting that all of the claims fell within the "inverse condemnation" exclusion in the policy.

The court found that inverse condemnation is a legal term of art used to refer to an action brought by a property owner seeking just compensation for a regulatory "taking." The inverse condemnation exclusion excepted coverage for "any liability … actually or allegedly arising out of or caused or contributed to by or in any way connected with any principal of imminent domain, condemnation proceeding, [or] inverse condemnation … by whatever name called." The court found that the third cause of action fit within the exclusion, but the others did not. The court found that the city could be liable under the other theories independent of any liability arising out of the inverse condemnation. Therefore, the insurer had a duty to defend.

The Fifth Circuit held that an insurer did not have a disqualifying conflict that allowed the insured to choose its own defense counsel, in *Graper v. Mid-Continent Cas. Co.*, 756 F.3d 388, 393 (5th Cir. 2014). The court relied on *N. Cnty. Mut. Ins. Co. v. Davalos,* 140 S.W.3d 685 (Tex.2004), to reject the argument that an insured is entitled to select its own counsel when the *potential* for a conflict of interest exists. "Instead, the test to apply is whether 'the facts to be adjudicated in the [underlying] lawsuit are the same facts upon which coverage depends.'"

The court rejected the insured's argument that the rule should be flexible and permit a disqualifying conflict to arise when the insurer has hired attorneys who may be tempted to develop facts or legal strategy that ultimately could support the insurer's coverage position. The court rejected this argument and held that the "same facts" test in *Davalos* is the proper analysis.

Under this analysis, the court found that the fact issues raised by the reservation of rights letter were different from the facts at issue in the underlying infringement case. First, the underlying case raised the issue of limitations, and the insurer reserved its right to deny the claim because it occurred before the beginning of the policy. The court held these were different issues. On the limitations issue, the question was when the claim accrued, not when the accident infringement occurred. The court conceded that of course the claim could not accrue until after the infringing acts occurred. Nevertheless, the court concluded that the limitations determination would lack the specificity necessary to decide whether the claim was covered under the policy. An adjudication of when the plaintiff's claim accrued would not be a judicial ruling necessarily deciding when the infringing conduct occurred.

Second, the court held that the plaintiff's allegation that the insureds acted willfully in infringing the copyright did not raise the same issue as whether the insureds acted "with the knowledge that the act would violate the rights of another," within a policy exclusion. The court reasoned that "willful" under the Copyright Act includes both knowing and reckless conduct, so that a finding that the defendants acted willfully would not necessarily establish whether they acted knowingly within the meaning of the exclusion.

The court's reasoning on the first issue seems a bit facile. The court conceded that accrual would encompass the date the act occurred, because a plaintiff cannot discover his claim until after the act has occurred. Therefore, deciding that the plaintiff's claims accrued before a certain date would necessarily establish that the conduct occurred before a certain date. If the date for limitations was prior to the date for coverage under the policy, then litigating the accrual date would necessarily also litigate the occurrence date for purposes of denying coverage.

The Fifth Circuit reiterated that, in certain situations, a court may look to evidence outside the eight-corners in determining an insurer's duty to defend. *Star-Tex Resources, L.L.C. v. Granite State Ins. Co.*, 553 F. App'x 366 (5th Cir. 2014) (per curiam). An insured sought defense for a suit against it concerning an auto collision caused by the insured's employee. The insurer denied coverage, relying on the policy's exclusion for damages arising out of use of an auto. The insured argued that this exclusion did not apply because the petition in the underlying suit did not state that the employee was driving or operating an automobile at the time of the collision, only that the auto collision was caused by the employee's negligence. The Fifth Circuit held that, based on the pleadings, it could not determine whether there was a potentially covered claim, as other reasonable inferences were possible that would not place the employee in an automobile at the time of the accident. However, the court concluded that it could consider extrinsic evidence to determine whether the insurer owed a duty to defend because it was "initially impossible to discern whether coverage is potentially implicated and … the extrinsic evidence goes solely to a fundamental issue of coverage which does not overlap with the merits[.]" In particular, the court looked at a notice of claim sent to the insurer by the plaintiff, which stated that the employee was driving the car. In looking at the eight corners as well as this extrinsic evidence, the court held that the insurer had no duty to defend the insured.

A liability insurer owed a defense to a correctional facility sued for civil rights violations for withholding prescription medications from a prisoner. The civil rights endorsement in the policy covered "'bodily injury' caused by alleged civil rights violations, so long as such violations and any resulting injuries are not expected or intended from the standpoint of the insured." The claim arose when the insured withheld prescription medications from a prisoner, allegedly resulting in his death. In the underlying suit, the defendant invoked the medical malpractice limits provided for "health care" providers. The insurer argued that this position was inconsistent with the insured's position that withholding medications was not "medical services" within the meaning of the policy exclusion. The court noted that estoppel applies when a party takes one position and then later assumes a contrary position or when a party asserts to another's disadvantage or right inconsistent with the position the party previously took. The court held neither form of estoppel applied. The position taken in the underlying case did not involve the same language as the coverage case. Further, the position taken in the underlying case benefited the insurer by limiting the amount of the defendant's exposure. *LCS Corr. Svcs., Inc. v. Lexington Ins. Co.*, No. 2-13-CV-287, 2014 WL 1787771 (S.D. Tex. May 5, 2014).

An insurer did not owe a duty to defend the employee of an insured because the employee was not an "insured."

An insurer did not owe a duty to defend the employee of an insured because the employee was not an "insured." The pleading in the underlying suit alleged that the employee's actions were not in connection with his employment. Under the eight-corners rule, that allegation removed the employee from the definition of an "insured." The additional statement in the pleading that the employee alleged he was acting in the course and scope of his employment was insufficient to establish a duty to defend. The eight-corners rule focuses on the plaintiff's factual allegations, not the defendant's allegations. *Carter v. Westport Ins. Corp.*, 997 F. Supp. 2d 590 (S.D. Tex. 2013).

Doubts as to whether a complaint's allegations trig-

ger coverage should be resolved in the insured's favor. *Canal Ins. Co. v. XMex Transport, LLC*, No. EP-13-CV-156-KC, 2014 WL 4385941 (W.D. Tex. Sept. 4, 2014). An insured trucking company sought a defense from its insurer relating to litigation concerning a fatal truck accident. One plaintiff in the underlying suit alleged that the individual defendants were acting in the course and scope of their employment with the insured; another plaintiff alleged that they were not. None of the pleadings specifically identified the truck at issue. Yet the court concluded that the allegations in the pleadings were sufficient to trigger coverage under the policy. Following the general rule that "the insurer is obligated to defend if there is, potentially, a case under the complaint within the coverage of the policy," the court resolved doubts in the pleadings in favor of the insured.

Summary judgment favored an insured, but not an additional insured in *Burlington Ins. Co. v. JC Instride, Inc.*, No. H-13-2844, 2014 WL 3057063 (S.D. Tex. July 7, 2014). An insured general contractor was hired by a company to clean mud tanks owned by another company. An employee of the hiring company was injured when he got into a mud tank that contained caustic materials, contrary to the insured's representation to him. The employee sued the owner of the tank and the insured. The tank owner sought a defense as an additional insured from the insured's liability insurer. The insurer denied coverage on the grounds that the policy's employee exclusion applied. The insured also sought coverage, which was granted subject to a reservation of rights, but eventually denied on grounds that the policy's pollution exclusion applied. The district court considered both of these arguments in deciding the parties' cross-motions for summary judgment. The court concluded that the employee exclusion excluded coverage for the tank owner as an additional insured. The employee was "hired to do work for or on behalf of" the insured, by virtue of the contract between the employer cleaning company and the insured. Thus, the insurer had no duty to defend the tank owner. However, the court found that the insurer did have a duty to defend the insured. Although the caustic materials in the mud qualified as pollutants under the policy, the pollution exclusion did not apply because the employee was injured by entering the mud tank, not by a "dispersal" or emission of the caustic materials.

In reconsidering a prior decision, a district court found that it was correct in not considering extrinsic evidence to decide an insurer's duty to defend. The extrinsic evidence in question overlapped with the merits and contradicted the allegations in the underlying litigation. *Admiral Ins. Co. v. Petron Energy, Inc.,* 1 F. Supp. 3d 501 (N.D. Tex. 2014). Additionally, the policy's auto exclusion did not apply to preclude a duty to defend. Whether the tortfeasor in the underlying suit was alleged to be an employee of all employers or a single employer made no difference because a jury could conclude that the tortfeasor was an employee of only one of the employers. The court further concluded that the earlier ruling on the insurer's duty to indemnify was premature.

The court also determined that an insurer breached its contract by failing to tender a defense to the insured in an underlying suit. The court's earlier decision wrongly applied the independent injury test for "extra-contractual" damages, applicable under some sections of the Texas Insurance Code, to the insured's breach of contract claim. The insured did not need to show it suffered increased fees in the underlying suit, only that they had incurred legal expenses due to the insurer's failure to provide a defense. *Admiral Ins. Co. v. Petron Energy, Inc.,* 1 F. Supp. 3d 501 (N.D. Tex. 2014).

A garage liability insurer had neither a duty to defend nor a duty to indemnify an employee involved in an automobile accident that occurred while he was driving his employer's vehicle during a personal trip. The employee was not an "insured" under the policy because he was on vacation and his use of his employer's vehicle was in the capacity of a customer and unrelated to his employment. *Sentry Select Ins. Co. v. Home State Co. Mut. Ins. Co.*, 994 F. Supp. 2d 789 (E.D. Tex. 2013).

A regulatory complaint may be considered a "claim" under a "claims made and reported" policy. An insurance agency sued its liability insurer after the insurer denied coverage for the agency in an underlying suit. The insurer argued that it owed no duty to defend or indemnify because the "claim" occurred before the policy commenced. The court agreed. The policy provided coverage for "claims made and reported" during the policy period. Here, the plaintiff in the underlying suit had filed a complaint about the agency with the Texas Department of Insurance a year before the policy commenced. The court concluded that the complaint with TDI constituted a claim under two definitions in the policy: it was a "demand against any insured" and "a … regulatory investigation against any insured." *Regency Title Co., LLC v. Westchester Fire Ins. Co.*, 5 F. Supp. 3d 836 (E.D. Tex. 2013).

B. Duty to indemnify

Two insurers insured an ambulance company that was named in a personal injury lawsuit after a patient was injured while being loaded into an ambulance. *Nat'l Cas. Co. v. W. World Ins. Co.*, 553 F. App'x 373 (5th Cir. 2014). The insurers disputed which of them had a duty to indemnify the insured. One policy, issued by National Casualty, covered damages resulting from use of an auto; the other policy, issued by Western World, excluded damages resulting from use of an auto. The Fifth Circuit found that the damages resulted from use of an auto and that National Casualty had a duty to indemnify. Although the gurney was not touching the ambulance when the incident occurred, one of the EMTs was touching both the gurney and the ambulance and had begun the process of placing the patient into the ambulance.

An earlier appeal in the case regarding the duty to defend had determined that "the 'sole purpose' of the alleged attempt to place [the patient] in the ambulance was to use the ambulance"; "[t]he alleged attempt to load her into the ambulance 'directly caused' her injury"; and "[a]ttempting to load a patient onto an ambulance is 'not an unexpected or unnatural use of the vehicle.'" The court concluded that it was bound to this earlier opinion because it was now determined that the patient was injured while being placed into the ambulance.

Justice Owen dissented, reasoning that there was no "use" of an auto when the patient was dropped from a gurney just before EMTs were about to place her into an ambulance and, further, that the conclusions of the prior case were not binding because they were based on the pleadings, and not on the evidence at trial.

A liability policy did not cover an arbitration award against a law firm for improper billing practices. *John M. O'Quinn, P.C. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, No. 4:00-CV-2616, 2014 WL 3543709 (S.D. Tex. July 17, 2014). A class of plaintiffs sued their prior law firm seeking reimbursement of expenses associated with an earlier class action lawsuit because the expense reimbursement was not contemplated by the representation agreement. The plaintiffs prevailed and recovered the expenses and disgorgement of some fees the law firm had earned. The law firm sought indemnity from its umbrella insurance carrier, which denied the claim. The trial court granted summary judgment for the carrier, finding no coverage. The court found that the law firm did not suffer a "Loss" within the meaning of the policy because the damages awarded against the firm were restitutionary in nature. The court also found that the "Professional Legal Services" provision did not provide coverage because the firm's billing and fee-setting practices, from which the underlying suit arose, were not an integral part of the legal representation that

it provided to the plaintiffs. Additionally, any coverage would have been excluded because the loss arose from the firm's "gaining profit or advantage to which it was not legally entitled."

C. Settlements, assignments, and covenants not to execute

In the first successful case since *Gandy*, a court of appeals affirmed a judgment against an insurer in favor of a plaintiff who took an assignment of the insured's claims. In *Great American Insurance Co. v. Hamel*, No. 08–11–00302–CV, 2014 WL 4656618 (Tex. App.—El Paso, Sept. 19, 2014, no pet.), the court rejected the insurer's argument that it was not bound by the judgment against its insured, based on the Supreme Court's decision in *State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996). In *Hamel*, a home builder was sued after the homeowners discovered water damage caused by defective construction. The insurer refused to defend, contending that the loss was excluded. The plaintiffs then proceeded to a bench trial where they presented evidence of the builder's negligence and the extent of their damage. The trial court ruled in their favor. The builder then assigned to the plaintiffs its claims against the insurer. The plaintiffs proceeded to trial against the insurer, resulting in a judgment finding the insurer liable for the underlying judgment.

The insurer argued that under *Gandy*, the underlying judgment was not binding because it did not result from an "actual trial" as required by the policy language. The policy provided that suit could be brought against the insurer only to recover on a judgment that is "obtained after an actual trial." The court rejected this argument, holding that an insurance company cannot insist on compliance with an actual trial requirement where the insurer has breached its duty to defend.

The court also found sufficient evidence to support the trial court's findings that the builder defended himself in good faith, his testimony was truthful, and was not unduly influenced or affected by any stipulations or agreements or understandings between the parties. The court found there was no evidence that the underlying judgment was collusive or fraudulent. The court therefore concluded that the *Gandy* requirement of a "fully adversarial trial" was satisfied and the underlying judgment was therefore binding on the insurer.

The court also found *Gandy* distinguishable. The settlement and assignment of claims in *Gandy* was held invalid when: (1) it was made prior to an adjudication of plaintiff's claims against the insured in a fully adversarial trial; (2) the insurer had tendered a defense; and (3) either (a) the insurer has accepted coverage, or (b) the insurer has made a good faith effort to adjudicate coverage prior to the adjudication of the plaintiff's claim. The court found none of these factors present in this case.

An umbrella liability insurer sued its insured and the insured's commercial general liability insurer, seeking a declaration that it had no duty to indemnify the insured against a jury verdict. *Empire Indem. Ins. Co. v. N/S Corp*., 571 F. App'x 344 (5th Cir. 2014) (per curiam). The Fifth Circuit held that a settlement between the plaintiff and the insured in the underlying suit extinguished any obligation of the umbrella insurer to indemnify the insured. In particular, the settlement reached in the underlying suit contained an unconditional release. The agreed judgment, entered after the settlement was executed, could not revive the insured's liability. Because the insured was not, and could never be, legally liable for the judgment based on the full release in the settlement agreement, the umbrella insurer had no duty to indemnify.

D. Excess & primary coverage

An employee of an insured was involved in a car accident while driving a truck owned by another insured. The employer's insurer asked the truck insurer to tender a defense when the injured party sued the employer. The truck insurer declined, stating it would share the defense costs. The Fifth Circuit held that the "other insurance" clauses in the two insurers' policies did not limit liability or coverage based on the existence of other available insurance, so the clauses did not conflict, which would have resulted in the defense costs being shared pro rata. Because the clauses did not conflict, the court held that under the terms of the "other insurance" clauses, the truck insurer was obligated to provide primary coverage to the employer and was liable for the entirety of the defense. *Am. States Ins. Co. v. Ace Am. Ins. Co.*, 547 F. App'x. 550 (5th Cir. 2013).

An excess insurer's coverage was triggered even though the underlying insurers settled for an amount less than their policy limits. *Plantation Pipe Line Co. v. Highlands Ins. Co.*, No. 11-12-00029-CV, 2014 WL 4346160 (Tex. App.—Eastland Aug. 29, 2014, pet. filed). An insured pipeline company sought coverage relating to a leak in one of its underground pipelines. The pipeline company had many layers of insurance. It reached a settlement with its lower-level insurers for less than the full limits of those policies, but agreed to pay the difference between the underlying settlement amounts and the underlying policy limits. The pipeline company then sued its top tier excess liability insurer, which denied coverage, arguing that the lower-level insurers had not actually paid the full limits of their policies. The court disagreed. The policy did not require the lower-level insurers to pay "full policy limits" before coverage attached; it required them to pay "ultimate net loss." Although that phrase was not defined in the excess policy, it was defined in a lower-level policy, the terms of which were adopted by the excess policy. Under the lower-level policy, "ultimate net loss" meant "all sums which the insured or … his insurer, or both, become legally obligated to pay as damages, … by … settlement [.]" Using this definition, the court concluded that the excess insurer was liable because the pipeline company and the other carriers altogether paid a sum in excess of the attachment point of the excess policy.

VI. THIRD PARTY THEORIES OF LIABILITY

A. Fraud

A certificate submitted to a state agency was not misrepresentation of coverage. An insured pest control company sued its insurer and insurance agent for fraud and misrepresentation after the insurer denied liability coverage for a suit brought against the insured by a homeowner for an allegedly improper wood destroying insect inspection (WDI). The policy excluded WDIs from coverage, but the insurer issued a certificate of insurance sent to the Texas Department of Agriculture that did not list any categories of pest control work as excluded. Because the certificate filed with the state did not identify any exclusion, the insured argued that it reasonably relied on the fact that full coverage was provided. The court of appeals disagreed. The insured had previously acknowledged in the application for insurance and the renewal application that the insurance did not include coverage for liability arising from WDI. Also, the plain language of the endorsements in the original and renewal policies excluded coverage for inspection services. The certificate specifically stated that it neither amended, extended, or altered the

The certificate specifically stated that it neither amended, extended, or altered the coverage afforded by the policies and was furnished for information only.

coverage afforded by the policies and was furnished for information only. The court concluded that the policies and application would not have caused a reasonable person to believe that the insured had coverage for liability arising from inspections, including WDI. Consequently, the insured could not prove its causes of action for DTPA, insurance code violations, fraud, and negligent misrepresentation. *Simon v. Tudor Ins. Co.*, No. 05-12-00443-CV, 2014 WL 473239 (Tex. App.—Dallas Feb. 5, 2014, no pet.).

VII. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Attorney's fees

An award of attorney's fees was reversed and remanded where the plaintiff's attorney did not segregate time, or estimate the allocation of time, between breach of contract and statutory claims that allow fee recovery and negligence claims that do not allow fees. *Prudential Ins. Co. v. Durante*, No. 08–12–00077–CV, 2014 WL 4259434 (Tex. App.—El Paso Aug. 29, 2014, pet. granted).

In *United Nat'l Ins. Co. v. AMJ Investments, L.L.C.*, No. 14-12-00941-CV, 2014 WL 2895003 (Tex. App.—Houston [14th Dist.] June 26, 2014, no pet.), a building's owner and its property insurer disputed the amount the insurer should pay under the policy after the building sustained damage from a hurricane. The court of appeals upheld the bad faith claims that the lower court found against the insurer, but reversed the attorney's fee award. The insured's attorney used the lodestar method of proving attorney's fees, but had not kept billing records. Instead, he estimated the amount of time it took him for general tasks, such as discovery. The court held that the insured failed to introduce evidence that was sufficiently specific to permit the determination of a reasonable fee for its attorney's services, and reversed and remanded.

An insured did not have to segregate attorney's fees awarded against an insurance agency found liable for breach of contract and an insurance broker found liable for negligence where the insured's claims against both arose out of the same transaction and resulted in a single injury where the agency and broker failed to provide the coverage the insured requested. *Insurance Alliance v. Lake Texoma Highport, LLC*, No. 05-12-01313-CV, 2014 WL 6466851 (Tex. App.—Dallas Nov. 19, 2014). The court reasoned that although there was some testimony about actions specific to the broker, the jury could have determined that any fees the insured spent dealing with the broker would have been incurred anyway to bring its claims against the agency.

B. Mental Anguish

In *Great American Insurance Co. v. Hamel*, No., 08–11–00302–CV, 2014 WL 4656618 (Tex. App.—El Paso, Sept. 19, 2014, no pet.), the plaintiffs recovered mental anguish damages along with their property damage in a suit against the builder for negligent construction that allowed water damage. On appeal, the insurer argued that mental anguish damages were not recoverable, because the plaintiffs presented no evidence of any physical manifestations so that their mental anguish damages did not constitute damages because of "bodily injury." *See Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819 (Tex. 1997). The plaintiffs responded that their mental anguish was because of "property damage," and was therefore covered. The court did not accept either argument, but instead held that mental anguish is not recoverable based solely on negligent property damage, citing *City of Tyler v. Likes*, 962 S.W.2d 489 (Tex. 1997). The evidence in this case only showed that the builder was negligent, not that he acted with a heightened degree of misconduct that would allow a recovery of mental anguish damages.

VIII. DEFENSES & COUNTERCLAIMS

A. Accord & satisfaction

A property insurer's prior payment for a claim related to Hurricane Ike in 2008 did not support the defense of accord and satisfaction in a subsequent suit based on another claim arising from another storm. The court found evidence that the insurer issued a $2,500 settlement check, but there was no evidence that the insureds ever accepted it or released their claims. *Mag-Dolphus, Inc. v. Ohio Cas. Ins. Co.*, No. H–13–08S2, 2014 WL 4167497 (S.D. Tex. Aug. 13, 2014).

B. Allocation

Plaintiffs who suffered water damage to their home that covered several policy years were not required to allocate those damages between or among insurers or policies. *Great American Insurance Co. v. Hamel*, No. 08–11–00302–CV, 2014 WL 4656618 (Tex. App.—El Paso, Sept. 19, 2014, no pet.),

C. Attorney's fees for vexatious litigation

A federal magistrate abused his discretion by awarding attorney's fees against the insured's lawyers for unreasonably and vexatiously multiplying proceedings in violation of 28 U.S.C. § 1927. *Lawyers Title Ins. Corp. v. Doubletree Partners, L.P.*, 739 F.3d 848 (5th Cir. 2014). The Fifth Circuit held that there was no evidence that the attorneys had asserted the extra-contractual claims against the title insurer in bad faith, for any improper motive, or in reckless disregard of any duty owed to the court. Instead, the evidence showed that the attorneys felt obliged to assert the claims as compulsory counterclaims and had offered to put those claims on hold pending resolution of the breach of contract issues, but the insurer's attorneys had rejected this offer.

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

A beneficiary could not assert that an insurer was estopped from denying coverage on a life insurance policy that had lapsed for non-payment of premium. The court held that when a valid contract exists covering the alleged promise, a plaintiff cannot recover under promissory estoppel. In this case, the policy governed the terms under which the insurer would pay. Therefore, promissory estoppel would not apply. *Lombana v. AIG Am. Gen. Life Ins. Co.*, No. 01–12–00168–CV, 2014 WL 810858 (Tex. App.—Houston [1st Dist.] Feb. 27, 2014, pet. denied).

The court also found no evidence of continued negotiations or representations by any authorized person on behalf of the insurance company, so waiver did not apply.

E. Payment

Payment of an insurance settlement check to an insured without the endorsement of a mortgagee as copayee does not constitute payment to a "holder" and thus does not discharge the insurer of its liability. *Viewpoint Bank v. Allied Prop. & Cas. Ins. Co.*, No. 05-12-01370-CV, 2014 WL 3867810 (Tex. App.—Dallas Aug. 7, 2014, pet. filed). In settlement of an insurance claim, an insurer issued checks payable jointly to its insured and the insured's mortgagee. After the insured negotiated and deposited checks without the mortgagee's endorsement and retained all of

the proceeds, the mortgagee sued the insurer to recover payment. Relying on *McAllen Hospitals, LP v. State Farm Mut. Ins. Co. of Tex.*, 433 S.W.3d 535 (Tex. 2014), the court held that the insurer was not discharged from its liability on the underlying obligation or the checks under article 3 of the UCC. Additionally, the mortgagee had a conversion cause of action against the insurer under the UCC, and that remedy was not exclusive. Consequently, the insurer was obligated to pay the checks to the mortgagee.

F. Reformation

In *Lawyers Title Ins. Corp. v. Doubletree Partners, L.P.*, 739 F.3d 848 (5th Cir. 2014), the court held that an insurer was entitled to reform an insurance policy that was issued without the exception and coverage agreed to by the parties. The insurer and insured both agreed that a title insurance policy would include an exception for a flowage easement and additional survey coverage purchased by the insured. Due to a software error, the policy was issued without those forms. The court held that reformation is proper when (1) an original agreement exists between the parties, and (2) a mutual mistake occurred in reducing the agreement to writing. The evidence showed that the parties agreed to the easement and additional coverage, so the first prong was satisfied. The court also held the mistake was mutual because, even though the insurer unilaterally made the mistake, the insured knew a mistake had been made because it had agreed to the easement in the title commitment and had paid for the additional coverage that was mistakenly omitted.

G. Restitution

An insurer could not recoup payments under equitable theories of restitution, unjust enrichment, and subrogation, where the insurance contract addressed the issues in dispute. *Gotham Ins. Co. v. Warren E&P, Inc.*, No. 12–0452, 2014 WL 1190049 (Tex. Mar. 21, 2014). The insurer provided coverage for an oil well operator in case of an oil well blow out. After an oil well blew out and the insurer paid, the insurer then sought to recoup its payments based on its argument that the operator breached the insurance contract by not using due diligence and made misrepresentations about the amount of its interest.

The court held that the insurer could not proceed on its equitable claims because it was limited to contractual claims where the policy addressed the matter at issue. As shown by the insurer's contract claims, there were provisions in the policy that addressed the issues. There was some evidence that the operator breached the due diligence requirement in the policy by failing to use a proper blowout preventer. There was some evidence that the operator misrepresented its interest in the well, which affected the amount owed by the insurer. Therefore, the Court remanded for determination of the insurer's contract claims.

IX. PRACTICE & PROCEDURE

A. Appraisal

An appraisal award could not be disregarded for being non-itemized. *Michels v. Safeco Ins. Co. of Indiana*, 544 F. App'x 535 (5th Cir. 2013). Insureds sued both their homeowner's insurer and its investigator seeking coverage for smoke damage to their home that occurred during the Bastrop wildfires. The trial court granted the insurer's motion to compel appraisal. The insureds argued on appeal that the appraisal award should have been disregarded because it was not fully itemized and thus not in compliance with the policy. The Fifth Circuit disagreed and held that the insureds were estopped from making this argument, because the insureds' appraiser had requested that the umpire use a non-itemized, lump sum form. Further, the award substantially complied with the policy. The appraisers prepared itemized estimates, met to discuss them, and then submitted disputes to the umpire.

In *United Neurology, P.A. v. Hartford Lloyd's Ins. Co.*, 995 F. Supp. 2d 647 (S.D. Tex. 2014), the insured attempted to have an appraisal award regarding property damage caused by a hurricane set aside. The insured argued that the award was improper because the appraisers looked at causation in determining the award. The court held that appraisal panels act within their authority when they determine whether damage was caused by a covered event or was the result of non-covered pre-existing conditions like wear and tear, or in this case, neglect under the terms of the policy. Therefore, the insured's motion to set aside the award was denied.

The "law of the case" doctrine prevented an insured from re-litigating an insurer's liability under a homeowner's policy. *Farmers Group Ins., Inc. v. Poteet*, 434 S.W.3d 316 (Tex. App.—Fort Worth 2014, pet. denied). An insured's house was damaged by soot. She sought coverage from her home insurer. The insurer invoked the appraisal process, but failed to ever designate its appraiser and instead initiated a lawsuit asking the court to appoint an umpire. That suit was ultimately dismissed for want of prosecution. The insured then sued the insurer for breaching the contract. In an initial appeal of summary judgment, the court of appeals determined that the insured failed to present evidence of her damages by failing to segregate between covered and uncovered losses. However, the court remanded the case on the issue of the insurer's breach of the appraisal provision. In the remand, the parties disputed the scope of the trial. In particular, the insurer argued that the law of the case precluded retrial of any damages except for those associated with the appraisal process itself. The insured argued, however, that her recoverable damages should include the full amount of her claimed loss. She based her argument on the appraisal provision in the policy, which said that an award under that provision would be "binding" on both parties. Her point was that, had appraisal taken place, it would have determined the extent of her damages. The court agreed with the insurer, holding that the scope of the trial on remand was limited to the appraisal and the damages resulting from breach of the appraisal clause. The law of the case applied to preclude the insured from attempting to recover any damages relating to the property. Further, the court noted that an appraisal does not necessarily determine the amount of a covered loss. An appraisal amount may include both covered and uncovered losses, and causation is a liability question for the courts. Consequently, the insured was incorrect in arguing that the insurer would have compensated her for her loss, covered or not, if the insurer had complied with the appraisal provision.

B. Arbitration

The court in *Why Nada Cruz, L.L.C. v. Ace American Ins. Co.*, 569 F. App'x. 339 (5th Cir. 2014), held that an arbitrator did not exceed his powers in dismissing an arbitration where the insured did not file for arbitration until over two years after the date of the loss. The arbitrator held that the policy required that the request for arbitration be filed one year from the date of loss. A letter to the insurer stating that the insured would request arbitration did not meet the requirement for actually filing for arbitration.

C. Choice of law

A New York resident purchased an insurance policy, which, through a series of assignments, allowed a settlement trust to acquire the rights to the "pay on death benefits." After the insured's death, the settlement trust submitted a request to the insurer for payment. The insurer refused, arguing the rights were

fraudulently acquired as part of a stranger owned life insurance scheme. The settlement trust sued the insurer. The insurer argued that New Jersey law should apply because the policy application had choice of law contacts with New Jersey. The other two interested jurisdictions were Texas, where the insurer was domiciled and suit was filed, and New York, where the insured was a resident. New Jersey law conflicted with Texas and New York law on the issue of the insurer's ability to challenge the validity of the insurance policy based on the insurable interest requirement once the contestability period had expired. The court held that New York law applied, relying on *Restatement (Second) of Conflicts of Laws* section 192, which creates a choice of law presumption in favor of the jurisdiction where the insured was domiciled at the time she applied for life insurance. *American Nat'l Ins. Co. v. Conestoga Settlement Trust*, No. 04-13-00719-CV, 2014 WL 3734215 (Tex. App.—San Antonio July 30, 2014, pet. filed).

Texas law, and not Colorado law, applied in a liability coverage dispute regarding coverage for a Colorado judgment against an insured that included an award of punitive damages. *Tesco Corp. (US) v. Steadfast Ins. Co.*, No. 01-13-00091-CV, 2014 WL 4257737 (Tex. App.—Houston [1st Dist.] Aug. 28, 2014, no pet.). The court concluded that Texas law governed the scope of coverage under the policies by looking at various factors. In particular, the insurer had its principal place of business in Texas, the insured did business in Texas, the policies were negotiated and executed in Texas, and the policies were issued from underwriters in Texas through a Texas broker. The only connection to Colorado was that the underlying judgment was entered there. Moreover, applying Colorado law would invalidate a portion of the policy, whereas applying Texas law would uphold it. The court noted that the law favors applying the law of the state that would uphold the validity of the contract.

D. Discovery

The supreme court held that a request for other claim files was overly broad and that the trial court, therefore, abused its discretion by allowing such discovery. *In re Nat'l Lloyds Ins. Co.*, No. 13–0761, 2014 WL 5785871 (Tex. Oct. 31, 2014) (per curiam). Irving's home was damaged by storms in Cedar Hill in 2011 and 2012. She contended that the insurer undervalued her claims and sued for unfair insurance practices. She sought discovery of other claims handled by the same adjusters and adjusting company. The trial court allowed discovery limited to those adjusters and to other Cedar Hill policyholders. To support her contention that her claims were undervalued, Irving proposed to compare the insurer's evaluation of the damage to her home with its evaluation of damage to other homes. The supreme court held this discovery was overly broad because it was not probative of how the insurer handled Irving's claim. The court held there were too many variables regarding the other claims for them to be relevant to Irving's claim. The court noted that it was not holding that evidence of other claims can never be relevant in coverage litigation, but that it was irrelevant in this case.

E. Experts

In a suit against a builder for water intrusion damage to a home, the trial court properly allowed expert testimony from a repair contractor and an engineer regarding the extent and timing of the damage. *Great Am. Ins. Co. v. Hamel*, No., 08–11–00302–CV, 2014 WL 4656618 (Tex. App.—El Paso Sept. 19, 2014, no pet.). The court found both experts were sufficiently qualified by their experience and education to give opinions about the wetness of wood in the house and the progression of wood rot caused by the water leaks.

A building's owner and its property insurer disputed the amount the insurer should pay under the policy after the building sustained damage from a hurricane. *United Nat'l Ins. Co. v. AMJ Inv., L.L.C.*, No. 14-12-00941-CV, 2014 WL 2895003 (Tex. App.—Houston [14th Dist.] June 26, 2014, no pet.). The trial court found that the insurer had knowingly violated the Texas Insurance Code. The insurer argued on appeal that it could not have knowingly failed to settle the claim when its liability was reasonably clear because there was no evidence that its liability was "reasonably clear," and also argued that its reliance on expert advice is not evidence of bad faith. The court held that in some circumstances, reliance on expert advice can be evidence of bad faith. In this case, although the insurer argued it properly relied on its experts, there was evidence that the insurer agreed to pay for repairs as set forth in its consultant's estimate. Therefore, the jury could have concluded that once the insurer reached that agreement, it was no longer reasonable for the insurer to rely on the contrary opinion of other experts.

Where the insurer cross-examined the insured's witness about whether he was an expert and elicited testimony that he was an expert on determining damages under a policy, that provided sufficient expert testimony to calculate the money owed under a policy that fell short of the policy that was requested. *Insurance Alliance v. Lake Texoma Highport, LLC*, No. 05-12-01313-CV, 2014 WL 6466851 (Tex. App.—Dallas Nov. 19, 2014).

F. Hospital liens

The Texas Supreme Court held that a hospital's lien was not discharged by the insurer's settlement check made jointly payable to the hospital and plaintiff, where the plaintiff deposited the check without the hospital's knowledge or endorsement. *McAllen Hosps., L.P. v. State Farm Co. Mut. Ins. Co. of Tex*, 433 S.W.3d 535 (Tex. 2014). The court held that the check that was jointly payable to the injured party and the hospital did not constitute "payment" under the hospital lien statute, Tex. Prop. Code § 55.007. Therefore, the release was not valid, the cause of action was revived, and the hospital retained its lien.

The Texas Supreme Court held that a hospital's lien was not discharged by the insurer's settlement check made jointly payable to the hospital and plaintiff, where the plaintiff deposited the check without the hospital's knowledge or endorsement.

The court did not address whether the hospital had a direct action against the insurer because that issue was not properly raised. However, the court did strongly suggest that there would be no private cause of action, because no such remedy appears in the statute. The court also noted that the hospital had the ability to sue the bank that accepted the deposit without both required endorsements, but that remedy did not preclude the hospital seeking other remedies.

Another court held that an insurer subject to a hospital lien had standing to seek declaratory judgment

that the charges were unreasonable. *Allstate Indem. Co. v. Memorial Hermann Health System*, 437 S.W.3d 570 (Tex. App.—Houston [14th Dist.] 2014, no pet.). The hospital rendered services and treatment totaling $4,956.50 to Allstate's insured and perfected a hospital lien for that amount. Allstate then paid on behalf of its insured $2,118.12 to the injured plaintiff, without getting a release of the hospital lien. When the hospital sent a demand letter for the full amount, Allstate obtained a review, which found that the reasonable charges were only $1,081.88, which Allstate tendered to the hospital. Allstate then sued for declaratory judgment that it either had the right to challenge the reasonableness and necessity of the services or that the lien statute denied Allstate due process.

The court held that Allstate had standing to seek declaratory relief. Allstate was affected by the lien because Allstate paid the settlement funds that were subject to the lien. Allstate had a real and substantial controversy involving a genuine conflict of tangible interest and not merely a hypothetical dispute. The court also found that Allstate had alleged an injury to the extent the hospital was claiming it was entitled to pay more than Allstate asserted was reasonable.

G. Motion for new trial

An order granting a new trial was reversed on mandamus review. *In re United Servs. Automobile Ass'n*, No. 01-13-00508-CV, 2014 WL 4109756 (Tex. App.—Houston [1st Dist.] Aug. 21, 2014) (orig. proceeding). Insured homeowners sued their homeowner's insurance company for violations of the Insurance Code after their home was damaged by Hurricane Ike and a subsequent flood. Following trial, the jury awarded the insureds $400,000 in damages. The insureds moved for a new trial, which the trial court granted, and the insurer sought a writ of mandamus to overturn that order. The court of appeals granted the mandamus and ordered that judgment be entered on the verdict, finding that all five of the trial court's reasons for granting the motion were incorrect. In particular, the court of appeals found that it was an abuse of discretion to grant a new trial because: (1) the evidence supported the jury's finding that the insurer did not breach the policy by failing to make a payment within days of a notification of payment; (2) the insurer's closing argument did not violate the order in limine; (3) the jury's award for diminished value of the insured's home was not against the weight and preponderance of the evidence; (4) the jury's failure to award attorney's fees in the event of an appeal was consistent with the evidence because the insured's attorney never testified to the amount of fees reasonable or necessary for an appeal, only what the cost of an appeal would be; and (5) the jury's verdict as to mental anguish damages was supported by a finding that the insurer "knowingly" made misleading statements, because "knowingly" was included in one of the jury questions.

H. Removal and remand

Where a plaintiff sued State Farm Lloyds and its adjuster for unfair insurance practices, a separate State Farm entity could not remove the case to federal court claiming improper joinder of the adjuster and asserting diversity of citizenship. *Jongh v. State Farm Lloyds*, 555 F. App'x 435 (5th Cir. 2014) (per curiam). After Dr. Jongh filed suit against State Farm Lloyds and its adjuster, contending that they improperly investigated and underpaid her claims, State Farm filed an answer asserting that it had been incorrectly named as State Farm Lloyds. However, State Farm did not intervene or otherwise request that the state court substitute it as the proper party. State Farm then removed the case to federal court contending that the adjuster was improperly joined, that it was diverse, and that therefore the federal court had diversity jurisdiction. The case proceeded to a bench trial resulting in a take-nothing judgment in favor of the adjuster and State Farm.

The Fifth Circuit held that State Farm and State Farm Lloyds are separate entities. State Farm was never a party to the suit, as it had not been substituted in, and therefore lacked the authority to remove the case to federal court.

The court also rejected the argument that the adjuster was improperly joined to defeat diversity. State Farm Lloyds and the adjuster were both Texas citizens. There was no improper joinder to defeat diversity jurisdiction, because there was no diversity with any of the actual parties to the suit. While State Farm was diverse, it was not a party to the suit.

In a fairly routine case, a federal court held that the plaintiff could properly state claims for unfair insurance practices against an insurance adjuster. *Esteban v. State Farm Lloyds*, No. 3:13–CV–3501–B, 2014 WL 2134598 (N.D. Tex. May 22, 2014). The court rejected the insurer's argument that the adjuster was not subject to liability, because he was not an employee of the insurance company. The court rejected this argument because of the statutory language and holdings of the Texas Supreme Court and Fifth Circuit that establish that it is the adjuster's conduct that creates liability under Texas Insurance Code Chapter 541, not his status as an employee.

The court noted that the federal pleadings standard under *Twombly* and *Iqbal* is arguably more stringent than the Texas "fair notice" requirement.

In a very significant part of the court's decision, the court then considered whether the plaintiff's pleadings stated a claim against the adjuster. The court addressed what has been a very thorny issue for plaintiffs – In judging the sufficiency of the pleadings, does the federal standard or the Texas "fair notice" standard apply? The court noted that the federal pleadings standard under *Twombly* and *Iqbal* is arguably more stringent than the Texas "fair notice" requirement. This has proven to be a trap for plaintiffs who file state court petitions that are sufficient under the fair notice standard, but then are judged on removal under the more stringent federal standard. Application of the more stringent federal standard leads to dismissal of the plaintiff's claim, where a pleading that was insufficient under the "fair notice" standard would only require re-pleading.

The court concluded that fundamental fairness compelled applying the Texas "Fair Notice" standard and cited a Fifth Circuit opinion to that affect. *See De La Hoya v. Coldwell Banker Mex. Inc.*, 125 F. App'x 533, 537-38 (5th Cir. 2005).

The court then concluded that the plaintiff had sufficient allegations against the adjuster. She alleged that he improperly adjusted her claim; that his report failed to include many of her damages; that his estimate did not allow adequate funds to recover repairs; that he misrepresented the scope of damage as well as the amount of insurance coverage; that he engaged in the business of insurance and was therefore a person under Chapter 541; and that he had improperly adjusted her claim and misrepresented certain key facts. The court found these allegations while "relatively spare and lacking in specificity," were sufficient under the lenient Texas "Fair Notice" standard.

I. Res Judicata & collateral estoppel

Insureds' claims for damage from a water leak were not barred by res judicata or collateral estoppel based on the insurer's prior payment of a claim related to Hurricane Ike in 2008. The court found summary judgment evidence establishing that the later claim resulted from a subsequent storm. Therefore, the prior

litigation and claim settlement did not bar the subsequent suit. *Mag-Dolphus, Inc. v. Ohio Cas. Ins. Co.*, No. H–13–08S2, 2014 WL 4167497 (S.D. Tex. Aug. 13, 2014).

J. Severance & separate trials

A court issued a writ of mandamus compelling a trial court to grant severance of the plaintiff's breach of contract and unfair insurance practice claims under an uninsured/underinsured motorist policy. *In re Progressive Co. Mut. Ins. Co.*, 439 S.W.3d 422 (Tex. App.—Houston [1st Dist.] 2014, orig. proceeding). The court recognized that severance is not always required. However, the court cited several other courts that concluded severance is required with UM/UIM coverage because the insurer is not liable for breach of contract until the insured first proves that the other driver was negligent and under-insured, and the amount of the plaintiff's damages. The court concluded that it would be manifestly unjust to require the parties to engage in discovery on extra-contractual claims that was much broader than discovery on the breach of contract claim.

K. Standing

A ship owner that was harmed by an insured shipyard's negligence had standing to sue the shipyard's liability insurer. *Nat'l Liab. & Fire Ins. Co. v. R&R Marine, Inc.*, 756 F.3d 825 (5th Cir. 2014). A ship sank at a shipyard during Hurricane Humberto. The shipyard's liability insurer sued the shipyard and the vessel's owner to disclaim liability under the policy. The vessel owner counterclaimed that the policy obligated the insurer to cover all sums for which the shipyard became liable and also asserted negligence claims against the shipyard. The shipyard was found to be negligent and liable to the vessel owner. After determining the shipyard's negligence liability, the court analyzed whether its insurer was liable to the vessel owner under the policy. The Fifth Circuit held that the vessel owner had standing to bring its counterclaim against the insurer under Federal Rule of Civil Procedure 13(a), even though no final judgment had established the shipyard's liability at the time the counterclaim was filed, which would preclude standing under Texas law. The Federal Rules of Civil Procedure were controlling, and under Rule 13(a), which was designed to promote judicial economy, the owner's counterclaim was compulsory. The court further held that the insurer's liability was limited to its policy limits and reduced the damages award accordingly. The court also held that attorney's fees were unavailable to the vessel owner under chapter 542 of the Insurance Code, because that chapter does not apply to marine insurance. However, attorney's fees were recoverable under section 38.001 of the Texas Civil Practice & Remedies Code. Making an *Erie* guess, the court concluded that the vessel owner was a third-party beneficiary and could sue to enforce the policy and thus recover attorney's fees under section 38.001. Finally, the court reduced the judgment interest from 18% to 6%, because the 18%, derived from section 542.060 of the Insurance Code, did not apply to marine insurance.

A plaintiff's assignment of claims to her insurer precluded her from having standing to assert claims. *Pringle v. Atlas Van Lines*, No. 4:13-CV-571-O, 2014 WL 1577870 (N.D. Tex. Apr. 16, 2014). The plaintiff asserted that a moving company lost and damaged several of her items in a move. The insurer for the entity that arranged the move reached a settlement with plaintiff and paid the agreed amount, obtaining an assignment of her claims. However, plaintiff still brought suit against the entity that arranged the move and the mover. The court held the evidence established that plaintiff assigned the claims arising out of the shipment of her household goods to the insurer, and therefore, she lacked standing to pursue her claims against them.

Plaintiffs in a tort suit could not simultaneously sue an insurer and its insured. *In Re First Mercury Ins. Co.*, 437 S.W.3d 34 (Tex. App.—Corpus Christi 2014) (orig. proceeding). The family of a shooting victim sued a security company and its liability insurer, alleging negligence on the part of the company and fraud by the insurer in connection with a settlement agreement with another victim. The insurer filed a plea to the jurisdiction, contending that it was not directly liable to the family. The trial court denied the plea, and the insurer sought mandamus relief, which was granted. The court of appeals held that the family lacked standing because they did not have a direct claim against the insurer until final judgment or agreement established that the security company was liable to the family. The court also determined that the insurer lacked an adequate remedy by appeal because allowing the family to proceed simultaneously against the insurer and the insured would create potential conflicts of interest for the insurer, and evidence pertaining to the allegedly fraudulent settlement would introduce prejudicial evidence concerning the existence of insurance.

A similar decision was reached in *Debes v. General Star Indem. Co.*, No. 09-12-00527-CV, 2014 WL 3384679 (Tex. App.—Beaumont July 10, 2014, no pet.) (mem. op.). There, a landlord sued its tenant's property insurer for breach of contract, alleging that the insurer failed to compensate him under the policy for his losses arising from a fire in the leased property. The court held that the landlord lacked standing to bring the suit because he was neither an insured nor a third-party beneficiary to the policy. The policy named only the tenant as the insured, and there was no evidence that the tenant assigned her breach of contract claim to the landlord. Thus, the landlord lacked privity with the insurer to bring the claim. Further, the policy contained no language that showed an intent of the insurer and tenant to confer any benefit on the landlord. Consequently, the landlord was not a third party beneficiary to the policy.

The insurer's coverage suit and the underlying tort suits were not parallel actions because the insurer was not a party to the underlying suits and the insurer's duties under the policy were not before the state court.

A federal court denied an insured's motion to dismiss or abate a liability insurer's declaratory action in deference to the pending state court underlying tort suits. *Canal Ins. Co. v. Xmex Transp., LLC*, 1 F. Supp. 3d 516 (W.D. Tex. 2014). The insurer's coverage suit and the underlying tort suits were not parallel actions because the insurer was not a party to the underlying suits and the insurer's duties under the policy were not before the state court. Also, while the question of the insurer's duty to indemnify would require the federal court to address many of the factual questions at issue in the underlying state actions, there was no res judicata concern because the federal court could not rule upon the duty to indemnify until the underlying suits were over. Other factors under the *Trejo* and *Brillhart* standards supported the federal court retaining the insurer's action.

L. Subrogation

As a matter of first impression, the Waco Court of Appeals held that a workers' compensation carrier may use the MCS-90 endorsement to recover its subrogation interest from the automobile liability insurer of an employer. *S. Co. Mut. Ins. Co. v. Great West Cas. Co.*, 436 S.W.3d 348 (Tex. App.—Waco 2014,

no pet.). An employee was involved in a vehicle collision while acting in the course and scope of his employment. The collision injured the underlying plaintiff. The employer's liability insurance company denied coverage of the plaintiff's claims because the vehicle was not one covered by the policy. The plaintiff then sought compensation for his injuries through his workers' compensation carrier, which paid him. As the plaintiff's subrogee, the workers' compensation carrier sued the employer's liability insurer for the amount it paid the plaintiff, pursuant to a federal motor carrier endorsement, the MCS-90, which was attached to the liability insurer's policy with the employer. The liability insurer argued that the workers' compensation carrier could not recover through the MCS-90 endorsement because the endorsement was not applicable to disputes among insurers. The workers' compensation carrier argued that it could by asserting its subrogation rights. The court agreed with the workers' compensation carrier. The MCS-90 endorsement makes an insurer liable for any liability resulting from the negligent use of any vehicle by the insured, even if the vehicle is not covered under the policy. Because of its subrogation rights, the workers' compensation carrier gained the plaintiff's right to sue the liability insurer and recover under the MCS-90 endorsement.

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