Annual Survey of TEXAS Insurance Law

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I. INTRODUCTION

The most significant events in Texas insurance law this year did not happen. The Supreme Court did not decide whether a policyholder must show an "independent injury" beyond policy benefits in order to recover under the Texas Insurance Code because the parties in *In re Deepwater Horizon* settled on the eve of oral argument. The Texas Department of Insurance did not move forward on Texas Farm Bureau's proposal to put arbitration clauses in policies sold to homeowners in counties with high storm risk or a high incidence of policyholder lawsuits, apparently punting the issue to the Legislature. And the Legislature did not try to pass a bill to restrict or eliminate policyholder protections because the Legislature does not meet in even-numbered years.

But this is about to change. Taking the place of *In re Deepwater Horizon* before the Texas Supreme Court is *USAA Texas Lloyds v. Menchaca*, which was argued on October 10, 2016. USAA v. Menchaca, (Tex., No. 14-0721), available at http://www.search.txcourts.gov/Case.aspx?cn=14-0721&coa=cossup The principal issues are: (1) whether an insured must prove an injury independent from denied policy benefits to recover under Insurance Code Chapter 541, or if not; (2) whether the jury's failure to find that USAA did not comply with the insurance contract precludes the insured from recovering policy benefits under the Insurance Code. Menchaca sued under the policy and the Insurance Code after USAA determined her homeowner's policy covered Hurricane Ike damages to her home, but her total damage fell below her deductible. After hearing how USAA conducted the investigation and listening to competing experts argue over the amount of storm related losses Menchaca suffered, the jury answered "yes" to the question asking whether USAA violated the Insurance Code by not reasonably investigating her claim, answered "no" to the question asking whether USAA failed to comply with the insurance contract, and awarded Menchaca $11,350 for unpaid policy benefits and $130,000 for attorney fees. USAA moved for post-judgment verdict in its favor, arguing the jury had found that the policy was not breached and that precluded bad-faith or extra-contractual liability. The trial court denied USAA's motion. The court of appeals affirmed the trial court's judgment for Menchaca. *USAA Texas Lloyds v. Menchaca*, No. 13-13-00046-CV, 2014 WL 3804602 (Tex. App.—Corpus Christi 2014, pet. granted).

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When the Legislature convenes, expect bills like those that failed last session. They would have (1) limited recovery for property damage claims; (2) allowed insurers to force suits into federal court; (3) immunized insurance company adjusters from liability for unfairly low estimates and other misconduct, while criminalizing excessive estimates by policyholders and their public adjusters; (4) required policyholders to document every detail of their damages as a prerequisite to filing suit; and (5) shortened limitations to one year. Last session's Senate Bill 1628 by Sen. Larry Taylor and House Bill 3646 by Rep. John Smithee were offered in response to perceived abuses arising from hailstorm claims, but both bills proposed changes that would have affected all property damage claims. The bills died after substantial opposition from businesses and others. Potentially bearing on possible legislation this session, the House Committee on Insurance was charged last November with an interim study that examines available data on the cost of weather-related property insurance claims and the "incidence of litigation" of these claims, studies whether these data reveal trends or patterns over time, identifies what the drivers of these trends might be, and identifies the impacts of "claims litigation" on the property insurance market and on consumers. Interim Committee Charges, Texas House of Representatives, 84th Leg., (Nov. 2015) at 33, available at http://www.house.state.tx.us/_media/pdf/interim-charges-84th.pdf

As with other survey periods, hundreds of cases involving insurance were decided by the state and federal courts this survey year. For consumer lawyers, however, none are more important than *Menchaca*. The most significant of the remaining decisions are discussed below.

Another event this year that bears solemn mention is the loss a great advocate for consumers and policyholders. Mark L. Kincaid, who coauthored this article for many years, passed away in January. (See page 77). The authors of this years' edition knew and worked closely with Mark for many years and are grateful for all we learned from him about law, legislation, and life. It is our privilege to carry on his legacy. He was a beloved friend and is sorely missed.

II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile

The Texas Supreme Court held that the owner of personal property that has been destroyed and not just partially damaged may recover loss-of-use damages and therefore, those damages may be recovered under the underinsured motorist provision in the owner's auto policy. *J&D Towing LLC v. American Alternative Insurance Corp.*, 478 S.W.3d 649 (Tex. 2016). J&D lost its only tow truck in an accident, settled with the other driver's insurance for policy limits, and then claimed damages for the time it was out of business under its own policy's underinsured protection. The trial court awarded J&D damages for its lost profits, but the appeals court reversed and rendered judgment for the insurance company. The court followed cases holding that loss-of-use damages were recoverable only when a vehicle could be repaired. Citing the modern trend of allowing recovery, the Texas Supreme Court reversed. According to the court, the distinction between loss-of-use damages for partially damaged property versus destroyed property was unpersuasive and that allowing recovery was consonant with the full-and-fair-compensation tort principle.

The amount of a policy's UM/UIM limits was a question of law that should not have been submitted to the jury. *Liberty Mut. Ins. Co. v. Sims*, No. 12-14-00123-CV, 2015 WL 7770166 (Tex. App. — Tyler Dec. 3, 2015, pet. denied) (mem. op.). A commercial automobile insurer appealed the trial court's entry of a $1,000,000 judgment against it following a jury trial. The plaintiff, a commercial driver, was hit by an underinsured motorist and sought UM/UIM benefits from his employer's commercial auto policy. Right before the trial, the insurer tendered $250,000, which it contended were the available UIM limits. The plaintiff then amended his petition alleging that the commercial insurer's UIM limits were actually $1,000,000, as it initially stated in its discovery responses. Before jury selection, the insurer submitted its supplemental discovery responses, stating that its limits were only $250,000, and seeking a ruling on that issue as a matter of law. The trial court declined to rule on the limits as a matter of law, and the trial proceeded. The jury found the limits were $1,000,000, and that the plaintiff's damages were over $2 million. On appeal,

the insurer argued that the UIM limits were only $250,000 as a matter of law, and that the UIM limits should not have been submitted to the jury, and were material only to calculating the amount of the judgment after the verdict. The court of appeals first determined what the policy's UIM limit was, and concluded the policy unambiguously set the limit at $250,000. The policy's declarations page noted the limits were $1,000,000, but also noted the policy's endorsements "may reduce the amount payable to less than the stated limit of insurance." The policy attached an endorsement that listed UIM coverage limits of $250,000, which was controlling. Contrary to the plaintiff's position, the insurer's discovery responses did not create a fact question for the jury. Further, the insurer's mistakes in its discovery responses did not change the trial court's obligation to review and make a legal determination of the policy's terms and UIM limits.

B. Homeowners

The Texas Supreme Court, without granting petition for review, has requested and received merits briefing on whether a fence attached to an insured's house is a "structure attached to the dwelling" (with the same policy limit as the dwelling itself), as the homeowner contends, or is an "other structure on the residence premises" (with a policy limit of 10% of the dwelling's), as the insurer contends. *Nassar v. Liberty Mutual Fire Insurance Company,* No. 15-0978 (Tex.) http://www.search.txcourts.gov/Case.aspx?cn=15-0978&coa=cossup) The court of appeals, in a split decision, sided with the insurer. *Nassar v. Liberty Mut. Fire Ins. Co.,* 478 S.W.3d 65 (Tex. App.—Houston [14th Dist.] 2015, pet. filed).

In *Nassar*, the insured's fence, which attached to his dwelling, sustained $58,000 in damage from Hurricane Ike, well within the policy limit for the dwelling and "any structures attached to the dwelling". However, the insurer insisted the fence was not part of the dwelling but rather an "other structure on the residence premises" with a policy limit of 10% of the dwelling, or $24,720. The policy said:

COVERAGE A (DWELLING)

> We cover:
>
> 1. the dwelling on the residence premises shown on the declarations including structures attached to the dwelling.
>
> 2. other structures on the residence premises set apart from the dwelling by clear space. This includes structures connected to the dwelling by only a fence, utility line or similar connection. The total limit of liability for other structures is the limit of liability shown on the declaration page or 10% of Coverage A (Dwelling) limit of liability, whichever is greater.

The policy did not define "structures" in subsection (1) or "other structures" in subsection (2).

A majority of the court of appeals held that the policy language was unambiguous and the insured's proposed interpretation of the policy language claiming the fence is part of the structure would render meaningless the subsection that "includes structures connected to the dwelling only by a fence." The majority explained:

> If a fence attached to the dwelling already is part of the dwelling under subsection (1) as a "structure . . . attached to the dwelling," then any structure connected to the attached fence likewise would become a "structure . . . attached to the dwelling" under subsection (1). And, if any structure connected to the attached fence already is part of the dwelling under subsection (1), then no purpose would be served by the language in subsection (2) providing for distinct treatment of "other structures" that are "connected to the dwelling by only a fence . . . ."

Further, the court affirmed summary judgment on the extra-contractual claims finding no breach of contract, no extreme conduct that could support a bad faith claim without a breach of contract, and "there is no general fiduciary duty between an insurer and its insured." Lastly, the court rejected the insured's arguments disputing an appraisal award based in part on a waiver theory and affirmed summary judgment in favor of the insurer.

A homeowner's policy provision setting forth a "reconstruction cost less depreciation" standard for dwelling loss was held to be a limitation of liability provision on which the insurer had the burden of proof. *Ayoub v. Chubb Lloyds Ins. Co. of Tex.*, 641 F. App'x 303 (5th Cir. 2016). The insureds' home was damaged when pipes burst during a severe cold front. The insurer and the insureds disagreed on the full extent of the insureds' covered loss. After striking insureds' expert on depreciation, the district court granted summary judgment for the insurer, concluding that the insureds could not meet their burden of proof. The Fifth Circuit reversed. Under Texas law, an insured has the burden of proving his losses, while an insurer has the burden to prove a contractual limitation of liability or cap on what it will have to pay out. Here, the policy's Verified Replacement Cost endorsement contained the following sentence: "If you have a covered partial loss to your dwelling or another structure, and do not begin to repair, replace or rebuild the lost or damaged property within 180 days from the date of loss, we will only pay the reconstruction cost less depreciation." In isolation, that sentence seemed to be a measure of damage, rather than a limit on coverage. However, viewed in context, the sentence was clearly part of a limitation on coverage provision and was the insurer's burden to prove. The sentence was part of an endorsement that began with limitation language: "Our limit of liability for covered losses…." The insurer also acknowledged that all but the last sentence of the endorsement was a limit of liability. Further, the insurer's interpretation was not reasonable: "It makes no sense to put the onus on the insured to prove they did not begin repairs on the dwelling within 180 days in order to have access to a lesser recovery—a burden they would never seek." Construing the final sentence of the endorsement consistently with its other parts, the court concluded the insurer had the burden of establishing the depreciation of the property, and reversed the lower court's summary judgment.

C. Commercial Property

A Water Exclusion Endorsement stating that the insurer "will not pay for loss or damage caused directly or indirectly by . . . [w]ater that backs up or overflows or is otherwise discharged from a sewer, drain, sump, sump pump or related equipment" unambiguously excludes all such water damage whether the origin of the overflow or back up is inside or outside the insured's property. *Kelley Street Associates v. United Fire and Casualty Co*., No. 14-14-00755-CV, 2015 WL 7740450 (Tex. App.—Houston [14th Dist., Nov. 30, 2015, no pet.) (mem. op). Kelley's building flooded after City of Houston employees repaired a water meter and valves on the street in front of the building. According to Kelley, in making the repairs city workers dislodged debris that then traveled through the water main into Kelley's building, damaging toilet flush valves and causing septic holding tanks to fill rapidly, pushing septic water up through floor drains and flooding the building. Kelley argued the exclusion applied only to an overflow of water originating outside the insured's plumbing system and not to losses caused by an internal plumbing problem. The court rejected Kelley's argument, refusing to rewrite the policy language and noting that, unlike the water exclusion, other provisions of the policy described coverage or exclusions based on whether the loss's origin was internal or external to the insured's property. The court also rejected Kelley's claim that the word "drain" did not include floor drains, concluding that nothing in the dictionary definitions of the word limited it to a "pipe to remove water from a building to a treatment facility or body of water," as asserted by Kelley.

A policy deductible provision was unambiguous and meant 5% of the aggregate sum of the insured value of each damaged property. *Saratoga Resources, Inc. v. Lexington Ins. Co.,* 642 F. App'x 359 (5th Cir. 2016) (*per curiam*). A policy insured various oil and gas properties owned by the insured, each of which had a different insured value. These properties were damaged by Hurricane Isaac. The insurer and the insured disagreed how the deductible should be calculated. The policy stated that the deductible was "5% of Total Insurable Values at the time and place of the loss . . . If two or more deductible amounts apply to a single occurrence, the total to be deducted shall not exceed the largest deductible applicable unless otherwise stated." The insured argued this meant the deductible should be calculated to be 5% of the value of the property with the highest total insured value, whereas the insurer argued this meant the deductible was 5% of the total insurable values of all damage properties, added together. The Fifth Circuit agreed with the insurer. The policy was not ambiguous. Only one interpretation gave meaning to all parts. The words "total" and "values" indicated that more than one value was to be included in the calculation. The court rejected the insured's argument that "Total" was part of the term "Total Insurable Values Per Interest" used in a different part of the policy because, if the drafters of the deductible provision had intended to refer to that part, they would have included the qualifier "Per Interest." Because the insured sought to depart from the ordinary meaning of "Total Insurable Values" and could not establish a technical or different meaning applied, its interpretation was held to be unreasonable.

D. Life insurance

Substantial evidence supported an ERISA plan administrator's denial of accidental death benefits. *Hagen v. Aetna Ins. Co.*, 808 F.3d 1022 (5th Cir. 2015). A beneficiary sought to recover the benefits from her husband's group life insurance plan, issued and administered by Aetna. The policy provided accidental death benefits. It excluded benefits for a loss caused by illness, infection, use of alcohol and intoxicants, or medical treatment. While the policy was in place, the insured fell and fractured his hip. He ultimately died a couple of weeks afterwards. The autopsy report stated the cause of death was "complications of blunt force trauma" from the hip fracture, and listed contributory causes of COPD, chronic alcoholism, and hypertensive cardiovascular disease. The beneficiary submitted a claim for benefits, but Aetna denied it. After urging her claim a second time, Aetna concluded his death was more consistent with "his pulmonary compromise, and not his injuries from the fall," and that the fall was caused by his overall poor health status. The beneficiary argued that Aetna had a conflict of interest and its claims process was procedurally unreasonable because Aetna took 400 days to make a determination, a medical opinion purportedly relied upon was missing, and Aetna did not take precautions to avoid bias. The Fifth Circuit disagreed. The delay in the determination did not support an inference it was a "fishing expedition." The missing medical opinion was explained by Aetna as a medical review that was initially requested but later determined to be unnecessary because there was sufficient evidence to deny the claim without it. Also, the fact that Aetna gave different reasons for its first and second denials was not evidence of procedural unreasonableness, but rather demonstrated Aetna's review process involved giving the claim a meaningful second look. The evidence was also insufficient to show a history of biased claims administration: the fact the nurse who reviewed the beneficiary's claims had denied a majority of the claims she had reviewed, without additional information of the context, did not show that the claims administration was biased. Having found Aetna's administration process was not biased, the court then considered the substantive issue of whether the insured's fall was due to or contributed to by his illness. The beneficiary argued that the insured had no symptoms of illness before the fall, and the evidence showed he slipped or tripped. However, the court held there was sufficient evidence in the record to support Aetna's denial. Two days before the fall, the insured reported to his doctor that he felt fatigued and dizzy, and his doctor noted that he was weak, tired, and had trouble breathing. The medical records overall reflected the insured's complaints and low functionality resulting from his COPD. Consequently, the evidence was sufficient to permit Aetna to conclude the fall was due to or contributed to by illness and deny the claim, even accounting for Aetna's conflict of interest.

The statutory requirements of interpleader were satisfied: there was a single fund and adverse claimants competing for it.

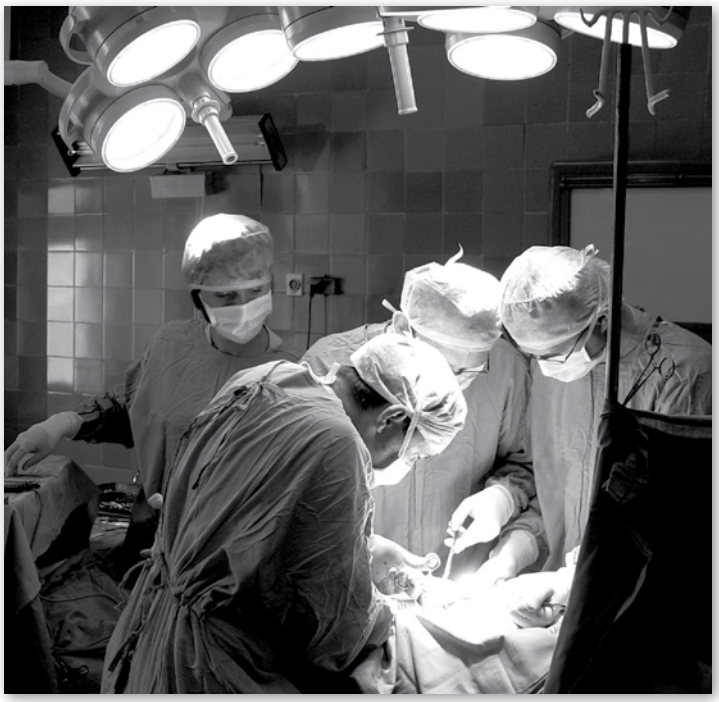
A life insurer was permitted to interplead life insurance proceeds and be dismissed as a party over objection. *Jackson Nat'l Life Ins. Co. v. Dobbins*, No. 3:16-CV-0854-D, 2016 WL 4268770 (N.D. Tex. Aug. 15, 2016). The defendant claimants objected to the insurer's dismissal, arguing that dismissal was premature and prejudicial because they might have counterclaims against the insurer in connection with its performance of obligations under the policy or its duty to deal fairly and in good faith. The court concluded, however, that the insurer could be dismissed and discharged of further liability under the policy. The claimants could still bring claims in a separate lawsuit unrelated to the policy proceeds, and neither explained why a certified copy of the policy was necessary before the insurer could be dismissed. The statutory requirements of interpleader were satisfied: there was a single fund and adverse claimants competing for it. The

insurer was also entitled to attorney's fees to be paid from the policy proceeds.

E. Health insurance

In *Crose v. Humana Ins. Co.*, 823 F.3d 344 (5th Cir. 2016) an insured's spouse sued his health insurer for breach of contract and unfair insurance practices after it denied healthcare coverage related to the insured's stroke. The insured ingested ecstasy the night before his stroke. He had little prior medical history. The insurance policy contained a causation exclusion for "Loss due to being intoxicated or under the influence of any narcotic unless administered on the advice of a health care practitioner." The policy did not define the term "narcotic." At issue was whether "narcotic" included ecstasy. The insured argued that a reasonable definition was the common one used in federal and state criminal law as well as in medical and pharmaceutical contexts, which limit "narcotic" to drugs derived from a plant, such as opiods, and classify ecstasy as a "hallucinogen" instead of a "narcotic." The court, however, adopted the much broader definition proposed by the insurer: "a drug affecting mood or behavior which is sold for non-medical purposes, especially one whose use is prohibited or under strict legal control but which tends nevertheless to be extensively used illegally." In reaching its decision, the court circumvented the normal rule of construction that an ambiguous policy terms must be construed in favor of coverage by concluding the insured's definition was not reasonable because it was overly "technical." Having found ecstasy to be a narcotic, the court then considered whether the insured's stroke was "due to" being intoxicated or under the influence of ecstasy. The court concluded the record showed that: ecstasy causes hypertension, hypertension causes strokes, the insured took ecstasy and had a stroke due to hypertension. The court held this was sufficient to prove proximate causation necessary for the exclusion to apply and bar coverage, even though many people who take ecstasy do not have strokes.

A Texas Insurance Code provision requiring health insurers to make coverage determinations and pay providers' claims within specified time or face penalties did not apply to self-funded plans or state government plans. *Health Care Serv. Corp. v. Methodist Hosps. of Dallas*, 640 F. App'x 314 (5th Cir. 2016). Chapter 1301 of the Texas Insurance Code requires healthcare insurers to make coverage determinations and pay claims made by preferred healthcare providers within a specified time or face penalties. Anticipating that a hospital would seek relief under Chapter 1301, a health plan administrator, BCBSTX, sought a declaration Chapter 1301 did not apply to it as the administrator of self-funded health plans, plans providing benefits to state employees, or plans in its BlueCard program. The Fifth Circuit held Chapter 1301 did not apply to those plans because BCBSTX did not provide coverage through its "health insurance policy" when it administers the plans at issue, nor was it a "person" with whom an "insurer" contracts to perform administrative services. Although BCBSTX is a licensed insurance carrier and authorized to issue health insurance policies in Texas, it did not provide payments through its "health insurance policy" when administering the plans at issue in this case. Under its administration agreement, BCBSTX did not provide benefits for medical expenses, but merely distributed claim payments from plans to providers. The Fifth Circuit also concluded the FEHBA preempted Chapter 1301 in the context of federal employee plans (see Preemption section below).



In an ERISA case, an insurer did not abuse its discretion in denying benefits where there was evidence that the medical services were rendered after the insured's employment was terminated. *Kidder v. Aetna Life Ins. Co.,* No. SA-14-CV-665-XR, 2016 WL 1241549 (W.D. Tex. Mar. 28, 2016). The insured had a health plan through his employer. He underwent a back surgery, and his insurer denied coverage for it. The insurer stated the claim was not payable because his coverage ended before he received the services. The surgery was in April. The insurer argued the insured's employment ended on March 31, that his termination was effective April 1, and his health coverage also ended on April 1. However, the insurer was notified by the employer of the insured's termination on May 26, and the insured did not get a letter notifying him of the termination of his plan benefits and his COBRA options until May 23. The insured contacted the COBRA administrator but did not submit an election form or pay a COBRA premium. The insured claimed he was not terminated on March 31, but rather he was on an unpaid leave of absence, and that the COBRA notice was untimely. Furthermore, he tried to send premium checks to the insurer during his leave of absence, but they were returned with a letter explaining it did not know how to apply it. The court found the insurer did not abuse its discretion in denying the insured's claim. There was substantial evidence in the administrative record that the insured's employment had been terminated. The insurer was informed by the employer that his employment was terminated on March 31. A personnel form from the employer stated the same thing. And a letter from the COBRA administrator on June 1 stated that the date of coverage loss was March 31. As a result, the insurer's decision to deny benefits was proper, and the insurer was entitled to summary judgment.

F. Disability insurance

An insured worker was not entitled to disability benefits because she failed to present evidence of a competent disability certification by an approved practitioner. *Trejo v. Board of Trustees of the Employees Retirement Sys. of Tex.*, No. 03-14-0060-CV, 2016 WL 105947 (Tex. App. — Austin Jan. 6, 2016, no pet.) (mem. op.). After her claim was denied, the worker argued on appeal that the Board of Trustees of the Employees Retirement System of Texas erred in finding her not to be disabled during her employment because she had been continually hobbled by her back problems and missed much work throughout this period. However, the

disability plan's text unambiguously stated: "The Employee will be conclusively deemed not to be disabled if employed and compensated in any manner." Whether or how often the employee missed work or her capabilities while working was not determinative. The Board, accordingly, did not act unreasonably in deeming her not to be disabled during the time she continued to work. The more critical question was whether the Board acted unreasonably in determining this Plan provision effectively meant that any medical records from the time the employee continued to work could not be evidence of a disability and, in turn, could not provide "objective medical evidence" to support the employee's doctor's certification opinion. The court held the Board was not unreasonable in this regard. If the employee was conclusively deemed not to have been disabled for as long as she was employed, one could reasonably infer as the Board did, that any condition or impairment reflected in her medical records from her employment period cannot, by definition, rise to the level of a "Total Disability" and is thus no evidence of one. Because the doctor's certification was not founded (nor could be founded) on any bases other than those reflected in those records, it followed that his opinion vouching for the employee's claimed disability was not competent proof of a "Total Disability" and could not suffice as the required certification of one.

The insured argued that the coverage provision expanded the definition of "theft" to include losses from employee forgery.

An ERISA plan administrator's denial of a participant's claim for long-term disability benefits was not an abuse of discretion. *Burell v. Prudential Ins. Co. of America*, 820 F.3d 132 (5th Cir. 2016). An insured was diagnosed with multiple sclerosis (MS) in 2008. He went on medical leave and filed for long-term disability benefits in 2011, and a few months later stopped working altogether. In support of his claim, the insured submitted medical records from his doctors and psychiatrist. The administrator (also the insurer) had a nurse and neurologist review the claim. The neurologist found that the insured's MS diagnosis was unsupported by his medical records, and that job stress was the source of his complaints, not a neurological disorder. The nurse concluded that the insured's claim of depression and anxiety was not sufficient to prevent him from working. Based on their reports, the administrator denied the claim. On an administrative appeal, a neuropsychologist performed an evaluation of the insured and found he did not suffer any cognitive impairment, and so the administrator again denied the claim.

On appeal to the Fifth Circuit, the insured argued the administrator should be given a less deferential standard of review than abuse of discretion because it was both the administrator and the insurer. The court disagreed, however, because the plan expressly granted the administrator discretionary authority. The court next considered whether the insured was entitled to long term disability benefits. Although the administrator conceded the insured met the requirements for the MS diagnosis, the MS diagnosis alone was insufficient to establish coverage. Under the policy, the insured's MS needed to render him "unable to perform the material and substantial duties of [his] regular occupation." None of the health care providers the administrator consulted found that the insured had physical or cognitive impairments, which left the administrator with the "permissible choice" between its consultant's position or that of the insured's physicians. The fact that the Social Security Administration had found the insured disabled and entitled to SSA benefits was insignificant because the eligibility criteria differed, and so the administrator did not need to give the SSA determination any particular weight.

G. Other policies

The term ''theft" in a commercial crime insurance policy did not include a loss from an employee's forgery of security documents. *Tesoro Refining and Marketing Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, No. 15-50405, 2016 WL 4166173 (5th Cir. July 29, 2016). An insured oil and gas company sought coverage under its commercial crime policy for losses from its employee's alleged forgery of line of credit documents that suggested a customer was adequately collateralized. The insured sought coverage under the employee theft provision, which stated, that "theft shall also include forgery." In its definition section, the policy defined "theft" as "the unlawful taking of property to the deprivation of the insured." The insured argued the coverage provision expanded the definition of "theft" to include losses from employee forgery. The court, however, found the insured's interpretation was unreasonable because it viewed the sentence about forgery in isolation. The policy also had a separate, limited coverage for forgery that excluded coverage for forgery by employees. The court did "not consider it reasonable to read the policy as excluding all employee forgery involving commercial paper from the 'Forgery or Alteration' insuring agreement, only then to include all kinds of employee forgery under the 'Employee Theft' insuring agreement." The court thus found that the policy unambiguously required a "theft" as defined to mean an "unlawful taking" for coverage to apply. The court also concluded the employee's conduct did not amount to a theft. In reaching its conclusion, the court considered, as the insured posited, whether the employee had committed a theft by deception under Texas criminal law, and found that he did not because there was no evidence that the forged security documents were a substantial or material factor in the insured's decision to continue selling fuel to the customer.

III. FIRST PARTY THEORIES OF LIABILITY

A. Breach of Contract

The insured's warehouse and day care center were damaged in Hurricane Ike. After appraisal, the insurer paid the insured the determined damage, which the insured deposited. Months later, the insured brought a breach of contract claim for the contents damage against the insurer. The court held the insurer's timely payment of the appraisal award estopped the insured from maintaining a breach of contract claim against the insurer. *Quibodeaux v. Nautilus Ins. Co.*, No. 15-40567, 2016 WL 3644641 (5th Cir. July 7, 2016).

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

As we reported last year, the Fifth Circuit certified a significant question to the Texas Supreme Court regarding the continued validity of *Vail v. Texas Farm Bureau Mutual Ins. Co.* in Chapter 541 cases. *In re Deepwater Horizon*, 807 F. 3d 689 (5th Cir. 2015). That case arose from the Deepwater Horizon oil spill. Liberty Insurance Underwriters, Inc. insured Cameron International Corporation, the manufacturer of the blowout preventer used on the Deepwater Horizon. After the spill, Cameron settled with the well owner, BP, and sought policy benefits from Liberty to help cover the settlement. Liberty refused to pay, on account of the complicated indemnification arrangement between the parties involved in the spill, and so Cameron sued. Cameron alleged Liberty violated Chapter 541 by wrongfully denying its

claim under the policy, and sought as actual damages only the policy benefits that Liberty denied and its attorney's fees related to the suit. Liberty argued that, under the Fifth Circuit's decision in *Great American Ins. Co. v. AFS/IBEX Financial Services, Inc*., Cameron was required to assert some injury other than the policy benefits and attorney's fees to maintain a Chapter 541 claim. However, that case is in conflict with *Vail v. Tex. Farm Bureau Mut. Ins. Co*., in which the Texas Supreme Court held that an insured who is wrongfully denied policy benefits need not show any injury independent from the denied policy benefits. 754 S.W.2d 129 (Tex. 1988). Given the importance of this question to Texas state law, the Fifth Circuit submitted a certified question to the Texas Supreme Court: "namely, the availability of a cause of action under the Texas Insurance Code where the insurer wrongfully denied the policy benefits but caused the insured no damages other than those denied benefits." The court noted that if the issue had arisen immediately following *Vail*, it would not have required certification, but the subsequent case of *Provident American Insurance Co. v. Castañada*, 988 S.W.2d 189, 198-99 (Tex. 1998), and its interpretation by the Fifth Circuit in *Great American* as setting out the opposite rule from *Vail*, created a question about Texas law requiring clarity: is *Vail* still good law? The specific question certified by the court was:

> Whether, to maintain a cause of action under Chapter 541 of the Texas Insurance Code against an insurer that wrongfully withheld policy benefits, an insured must allege and prove an injury independent from the denied policy benefits?

However, we will not get an answer from this case. A few months after this opinion and certified question were issued, Cameron and Liberty reached a compromise, and, at their joint request, the court withdrew the certified question and dismissed the appeal. As a consequence, we are left with the ongoing mess of federal cases that contradict *Vail*, misapply the plain language of § 541.151, ignore the mandate of liberal construction in §541.008, and create an absurd result by which a statute meant to remedy unfair claim practices does not allow the insured to recover the claim.

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

An employee of an insured was injured in a hit-and-run accident while driving a company vehicle covered under the policy. The insured filed a claim with the insurer under its policy's uninsured motorist provision. The insurer denied the claim on the basis that the insured had declined uninsured motorist coverage. The insured met with the insurance agent who presented him with a falsified insurance policy showing the insured had rejected uninsured motorist coverage. The insured later found the document reflecting that it had not rejected uninsured motorist coverage, and the insurer paid the uninsured motorist benefits. The insured sued the insurer and insurance agency for causes of action under the DTPA and the Insurance Code, breach of contract, and breach of the duty of good faith and fair dealing. The insurance agency's suit was severed, and the trial court granted its motion to dismiss all claims against the insurance agency. Surprisingly, the court held that many of the sections sued for did not apply to the insurance agency and the alleged misrepresentation about coverage to the insured did not cause its damages. Thus, the court upheld the dismissal of all claims against the insurance agency. *Tex. City Patrol, L.L.C. v. El Dorado Ins. Agency, Inc.*, No. 01-15-01096-CV, 2016 WL 3748780 (Tex. App.—Houston [1st Dist.] Jul. 12, 2016, no pet.).

A trial court abused its discretion by denying a worker's compensation carrier's plea to the jurisdiction as to a claimant's bad faith claims. *In re Illinois Employers Insurance of Wausau,* No. 14-16-00032-CV, 2016 WL 3131823 (Tex. App. — Houston [14th Dist.] June 2, 2016, orig. proc.). The claimant suffered a compensable injury in 1978 that resulted in a heart condition, requiring the worker's compensation carrier to pay for his disability and medical expenses. The insurer did not appeal the initial order that it make the payments. In subsequent years, the claimant submitted additional medical expenses related to his condition. The Texas Workers' Compensation Commission ordered them paid, and the carrier appealed. The carrier was successful in one of its appeals, at which time the reviewing trial court found the claimant's heart condition was unrelated to his workplace accident. However, that ruling was overturned by the court of appeals.

The claimant then brought actions of common law bad faith and violations of the Texas Insurance Code in connection with the carrier's handling of his claims. The carrier responded by asserting that the claimant had no statutory extra-contractual or common law bad faith causes of action in light of *Texas Mutual Ins. Co. v. Ruttiger,* 381 S.W.3d 430 (Tex. 2012), and filed a plea to the jurisdiction. The claimant argued Ruttiger did not have any retroactive application to his claims. The issue on petition for mandamus relief was whether the claimant could pursue common law and statutory bad faith claims arising from the carrier's 2015 denial of worker's compensation benefits relating to a pre-1989 injury and agency determination of benefits. The court summarized the legal history, noting that the workers' Compensation Act in effect in 1978 governed the claimant's claims for benefits. In 1989, the statute was amended to prevent a worker from maintaining those claims in connection with the carrier's improper handling of compensation claims, and *Ruttiger* overruled prior case law that allowed injured workers to pursue common law bad faith causes of action related to claims handling. So the question was whether *Ruttiger* barred bad faith claims based on post-*Ruttiger* conduct but pertaining to a pre-1989 compensable injury. With very little explanation, the court held the bad faith claims were not available to the claimant because the asserted bad faith conduct occurred after *Ruttiger* was decided.

D. ERISA

United Healthcare Ins. Co. actively tried to get several cases against it dismissed relating to its pattern of failing to pay pre-approved bills at various medical providers. In *Tex. Gen. Hosp., L.P. et al. v. United Health Care Co. et al.,* a medical provider relied on pre-approval from an insurer, United Healthcare, prior to treating almost 2,000 patients. No. 3:15-CV-02096-M, 2016 WL 3541828 (N.D. Tex. Jun. 28, 2016). However, after treatment was provided, the insurer only paid a quarter of the bills for these 2,000 patients. The provider sued the insurer alleging that it led the provider to believe that the medical services provided to the insurer's subscribers would be covered under the plans, the insurer wrongfully denied or reduced coverage under the terms of the plans, and that the insurer's calculations of benefits resulted in substantial underpayment to the provider. The insurer sought to dismiss the provider's claims for failure to state a claim, but the court held that the provider's allegations contained enough facts to give the insurer adequate notice as to which provisions of ERISA were breached. The court also stated the claims should not be dismissed as the provider should be excused from exhausting administrative remedies because of the insurer's alleged failure to provide meaningful access to administrative remedies and the futility of further efforts by the provider. *See also Allied Ctr. for Special Surgery, Austin, L.L.C. v. United Healthcare Ins. Co*., No. H-16-1273 (S.D. Tex. Aug. 9, 2016) (holding that insurer was not entitled to dismissal of

claims in suit brought by medical providers against insurer for not paying full amount of pre-approved claims); *Outpatient Specialty Surgery Partners, Ltd. v. United Healthcare Ins. Co.,* No. 4:15-CV-2983, 2016 WL 3467139 (S.D. Tex. Jun. 24, 2016) (allowing claim for breach of fiduciary duty against the insurer as the breach was based on insurer's alleged failure to provide plan documents as requested, not based on a claim for benefits).

A worker sued her employer's benefit plan for wrongful denial of benefits and attorney's fees under ERISA. The worker was diagnosed with encephalopathy, major depressive disorder, and frontal lobe syndrome. She received short-term and long-term disability benefits. However, several doctors said they had no concerns from a cognitive standpoint with her intention to return to work. Therefore, the plan terminated her long-term benefits. Her appeal was denied, as the plan found she no longer had a physical disability and (b) she had used the maximum amount of benefits - 24 months - for a mental disability. The court held the plan did not abuse its discretion in denying continued benefits: the report showed she had significant improvement and a normal electroencephalography, supported by the administrative record. *Sarmiento v. Metro. Life Ins. Co*., No. H-15-1943, 2016 WL 3906757 (S.D. Tex. Jul. 13, 2016).

E. RICO

The Fifth Circuit affirmed a district court's dismissal of the plaintiffs' RICO complaint for failing to state a claim, holding that the plaintiffs did not plausibly allege that their injuries were proximately caused by the alleged RICO violations. *Shannon v. Ham*, 639 F. App'x 1001 (5th Cir. 2016) (per curiam). The plaintiffs were farmers who sought to purchase crop insurance. The defendant was an insurance agent who allegedly misrepresented he was licensed to sell crop insurance through mail and telephone communications, prompting plaintiffs to purchase crop insurance from him. Seven years after initially purchasing the insurance, the plaintiffs alleged the defendant mishandled their policies and claims, costing them over $200,000. The court held that the plaintiffs' complaint did not show a causal connection between the defendant's lack of an insurance license and his mishandling of their policies. A RICO claim requires a plaintiff to show that the RICO predicate offense proximately caused his injury. Here, the basic complaint was that the defendant did not have the proper license to write crop insurance policies, the injurious conduct alleged was mail and wire fraud, and the injury was when "the quality of [defendant's] services was well below that of a licensed and qualified crop insurance agent." The court reasoned the causation theory did not plausibly allege proximate cause between the fraud and the mishandled claims. If the lack of licensure was plausibly the cause of the injury, "common sense" dictates that it would have manifested itself during the first seven years of their relationship, and the fact they were satisfied with service for seven years "casts significant doubt on the idea that any loss is directly attributable to" the lack of a license. The court did not address—and perhaps neither did the pleadings—whether the plaintiffs had any claims in the first seven years of the relationship, or whether insurance licensure helps to assure that agents know how to properly handle claims.

The Fifth Circuit affirmed a district court's dismissal of the plaintiffs' RICO complaint for failing to state a claim, holding that the plaintiffs did not plausibly allege that their injuries were proximately caused by the alleged RICO violations.

IV. AGENTS, AGENCY, AND VICARIOUS LIABILITY

A. Individual liability of agents, adjusters, and others

An insured purchased insurance for his deceased father's mobile home and property. The insured told his insurance agent that the property was vacant. However, the insurance policy and application obtained for the insured did not cover vacant properties. When the mobile home was consumed in a grass fire, the insurance company denied the claim stating the property was not insured because the insured had lied on the application and stated the property was occupied. The insured did sign the application but says he was not aware of that provision, as he told the agent the property was unoccupied. The insured sued the insurer, the insurance agency and the agent. The trial court found in favor of the defendants, ruling against the insured. However, the appellate court reversed the ruling, holding that an affidavit provided by the insured that he told the insurance company several months prior to the loss that the property was vacant created a genuine issue of material fact to defeat the summary judgments. *Wallace v. AmTrust Ins. Co. of Kansas, Inc., et al*., No. 10-14-00209-CV, 2016 WL 3136875 (Tex. App.—Waco Jun. 2, 2016, no pet.).

V. THIRD PARTY INSURANCE POLICIES & PROVISIONS

A. Comprehensive general liability insurance

"Physical injury" and "replacement" are not ambiguous in CGL "your product" and "impaired property" exclusions and exclude coverage for property damage and consequential losses incurred during safety repairs made to avoid the risk of catastrophic losses that the policy would cover. *U.S. Metals Inc. v. Liberty Mut. Group, Inc.*, 490 S.W.3d 20 (Tex. 2015). After discovering that flanges supplied by U.S. Metals were leaking, and fearing the risk of fires and explosions that posed, ExxonMobil ("Exxon") replaced them, which required shutting down two refineries in order to cut out the flanges, unavoidably destroying or damaging the adjoining parts and structures of the diesel units to which the flanges were welded. Exxon sued U.S. Metals for the costs of replacement and the loss of use of the refineries, which U.S. Metals settled. U.S. Metals sought indemnity under its CGL policy in federal court. Liberty Mutual defended its denial of coverage, relying on Exclusion K ("Property Damage to Your Product") and Exclusion M ("Damage to Impaired Property or Property not Physically Injured"). Responding to certified questions from the Fifth Circuit, the Texas Supreme Court said, first, that Exclusion K barred recovery for loss of U.S. Metal's own product, the defective flanges, noting that U.S. Metals was not claiming them anyway. The court then turned to Exclusion M, which denies coverage of damages to property, or for the loss of its use, if the property was not physically injured or if it was restored to use by replacement of the flanges, and thus became "impaired property" excluded by Exclusion M. The existence and extent of coverage thus depended, on whether Exxon's property was (1) physically injured or (2) restored to use by replacing the flanges. The court held the mere installation of defective flanges did not cause physical injury and leaks from the flanges, which would have caused physical injury, were averted by Exxon's replacement and repair work. The court also held that because the diesel units

were "restored to use" by replacing the flanges, they were impaired property to which Exclusion M applied, denying coverage for Exxon's loss of their use.

General contractor was not entitled to recover any damages based on its defense costs in the underlying suits from its subcontractor's CGL insurer because the total amount paid by the insurer exceeded the sum of the defense costs. *Coreslab Structures (Texas), Inc. v. Scottsdale Ins. Co*., No. 14-14-00865-CV, 2016 WL 4060256 (Tex. App. — Houston [14th Dist.] July 28, 2016, no pet.). A Houston building sustained water damage during two separate rain events, and the insured asserted claims against various parties including the general contractor and its subcontractor. The general contractor demanded a defense as an additional insured under the subcontractor's insurance policy. The CGL insurer refused to pay the general contractor's defense costs, saying there was no additional-insured coverage. The general contractor's insurer paid some of its defense costs. The general contractor then sued the subcontractor's insurer, asserting, among other things, a claim for statutory bad faith under Chapter 541 of the Insurance Code. The trial court granted a partial summary judgment, ruling that the insurer had a duty to defend the general contractor and pay for some of its defense costs in the underlying suit. In its suit against the insurer, the general contractor sought to recover attorney's fees and expenses its defense counsel billed in the underlying law suit but that it did not actually pay. On appeal, the insurer argued the general contractor was not entitled to damages in connection with attorney's fees or costs incurred in the underlying suit because the total amount it and the contractor's insurer paid exceeded the sums of the defense costs in the underlying suit and attorney's fees and costs in the instant suit. The court agreed.

Without granting petition for review, the Texas Supreme Court requested merits briefing on whether Exxon Mobil is an "additional insured" under liability policies issued to a service contractor whose work at the Exxon Mobil refinery ended three years before the injuries leading to the underlying suit against Exxon Mobil occurred. *Liberty Surplus Ins. Corp. and Commerce & Industry Ins. Co v. Exxon Mobil Corporation*, No. 16-0074 (Tex., Sept. 2, 2016) (case detail at http://www.search.txcourts.gov/Case.aspx?cn=16-0074&coa=cossup). Affirming Exxon Mobil's summary judgment against the insurers, the court of appeals relied on Endorsement 3, which stated that "WHO IS AN INSURED is amended to include as an insured any person or organization with whom you have agreed to add as an additional insured by written contract but only with respect to liability arising out of your operations . . . ." (emphasis added). The court held Exxon Mobil's summary judgment evidence that the service contractor (Wyatt Field Service Company) had worked on that part of the refinery that caused the injuries was sufficient to show "liability arising out of [Wyatt's] operations" and that neither Texas law nor the policy language require the named insured to be liable for the underlying injuries, that the additional insured be blameless for them, or that "operations" be read to require that the "operations" be ongoing at the time of the liability is incurred. *Liberty Surplus Ins. Corp., v. Exxon Mobil Corporation*, 483 S.W.3d 96 (Tex. App.—Houston [14th Dist.] 2015, pet. filed).

B. Construction liability insurance

Evidence extrinsic to the policy could not be used to interpret an unambiguous policy term under the parol evidence rule. *Broughton v. Castlepoint Nat'l Ins. Co*., No. 15-20708, 2016 WL 4245449 (5th Cir. Aug. 10, 2016) (per curiam). A group of homeowners sued the general contractor that built their cluster of five homes. The contractor filed a claim with its commercial insurer. The insurer denied the claim based on the policy's "Tract Housing" exclusion that excluded bodily injury, property damage, and personal and advertising damage caused by an insured's operations "incorporated into a 'tract housing' project or development," which was defined to mean "any housing project or development that includes the construction of five or more residential buildings in any or all phases of the project or development." The contractor and the homeowners settled their suit, which included entry of a final judgment that awarded damages to the homeowners. After, the homeowners sued the insurer, asserting breach of contract arising out of the denial of the contractor's claim. The issue on appeal was whether the Tract Housing exclusion excluded coverage for construction of more than five units or on five or more units. The homeowners argued that a questionnaire submitted to the contractor by the insurer and the deposition testimony of the insurance agent created a fact issue on the scope of the exclusion that would defeat the insurer's motion for summary judgment and provide coverage as a matter of law.

The Fifth Circuit disagreed. The policy was not ambiguous—on its face, the exclusion unambiguously excluded claims for construction defects on a project of five or more units. The questionnaire and deposition testimony were not part of the policy and were thus parol evidence. Although parol evidence may be introduced to determine the meaning of ambiguous policy terms, it cannot be considered to determine the meaning of unambiguous policy terms, nor can it be admitted to create an ambiguity. Because the policy unambiguously excluded the contractor's work on the homeowners' five homes, the questionnaire and deposition testimony could not be admitted and were not material to their breach of contract claim. The eight-corners rule applicable in duty to defend cases was not relevant or applicable to this case.

C. Directors & officers liability insurance

On November 9, 2016, the Texas Supreme Court heard argument on whether the D&O "insured v. insured" exclusion for claims made against any insured by a person who succeeds to the interest of the insured bars a claim by the insured's assignee. *Great American Ins. Co. v. Primo,* No. 15-0317. The court of appeals, with one justice dissenting, held the exclusion did not bar the claim. *Primo v. Great Am. Ins. Co.*, 455 S.W.3d 714 (Tex. App.—Houston [14th Dist.] 2015, pet. granted). Primo was an officer and director of Briar Green Condominiums. Briar Green asserted a claim against Travelers, its fidelity insurer, asserting that Primo had taken from its account. Travelers paid the claim and Briar

Green assigned to Travelers all its claims against Primo. Travelers then sued Primo, who tendered his defense request to Great American, the D&O insurer. Great American denied the claim under the "insured versus insured" exclusion, which excluded claims "made against any Insured … by, or for the benefit of, or at the behest of … any person or entity which succeeds to the interest of [Briar Green]." The court of appeals held Travelers was an assignee of Briar Green's rights, but that did not make it a successor in interest. The case law on successor-in-interest includes a party that acquires the other party's rights and responsibilities. While Travelers acquired Briar Green's rights under the policy, it did not acquire any of Briar Green's responsibilities. Further, the policy did not define successors in interest and the term was at least ambiguous regarding whether it included or did not include an assignee. Therefore, the court of appeals concluded the trial court erred in rendering summary judgment for Great American based on the exclusion.

A directors and officers insurer is liable for the costs to defend against a disgorgement claim, even if insuring against disgorgement is against public policy. *Burks v. XL Specialty Ins. Co*., No. 14-14-00740-CV, 2015 WL 6949610 (Tex. App.—Houston [14th Dist] Nov. 10, 2015), *appeal dismissed by agrmnt., opinion not withdrawn* 2015 WL 191988 (Jan. 12, 2016). The claim was made by the Chapter 11 bankruptcy plan agent against Burks, the company's CFO, seeking return of company property and cancellation of the company's future obligations to him under a separation agreement. The company's claims-made D & O carrier, XL Specialty Insurance Company, refused to advance defense costs to Burks, contending that (1) the agent's claim was made after the policy's termination date and could not be deemed timely made under the "interrelated claims" clause because the agent's claim was not the same as made in earlier shareholder derivative actions against Burks; and that (2) there was no duty either to advance defense costs to Burks or to indemnify him for the settlement he reached with the plan agent following XL's denial of coverage because, as a matter of law, the policy definition of "loss" did not apply to a claim for disgorgement. The trial court granted summary judgment to XL and the court of appeals reversed, holding that agent's claim was "interrelated" with the earlier shareholder claims; and that neither the agent's claim nor the settlement agreement proved that the claim was solely for disgorgement. "Further, no Texas court has held that insuring a settlement of a claim seeking restitution or disgorgement is against public policy or otherwise generally 'uninsurable under the law' of Texas; nor has the Legislature enacted any legislation on point. Under these circumstances, we cannot hold as a matter of law that the parties intended for a settlement such as this one to be excluded from coverage."

D. Other policies

An insured home purchaser lacked evidence to support his claims of negligent misrepresentation and breach of contract against a title insurer. *Love v. Chicago Title Ins. Co*., No. 05-15-00154-CV, 2016 WL 4045400 (Tex. App. — Dallas Jul. 26, 2016, no pet.). The insured purchased a title policy in connection with his purchase of property. He alleged that he rented the property to tenants and had the home remodeled. Several years later, his tenants were told by the police that the home actually belonged to the insurer, and the insured alleged that the insurer had deeded the property back to itself. The insurer argued that the insured actually owned the adjacent property, a vacant lot. The motion was supported by deeds showing the chain of title of both addresses. The chain of title to the vacant lot showed that the insured conveyed the lot to a different person, but after he added a statement that the property was "also known as" the adjacent address. Four days later, the vacant lot was conveyed back to the insured. Once again, the property description was identical to the description in the title policy with the addition of "also known as" the adjacent address. The chain of title to the adjacent address (with the house) showed a deed to the title insurer from individuals not a party to this case. The court held that the trial court properly granted the insurer's no-evidence summary judgment. As to the negligent misrepresentation claim, which was not pled, there was no evidence that the insurer made any representation that the legal description in the title policy applied to the developed property. As to the breach of contract claim, there was no evidence that the insurer acted on the insured's behalf in issuing the title policy. It did not undertake any contractual obligations to ensure that a flawless title was transferred, but only that such title was transferred that the insurer would insure despite any flaws. Any and all activities performed by the insurer or its agents that are indispensable to the determination of insurability constitutes acts in its own behalf and not on behalf of a prospective grantee or lienholder to whom the policy will finally issue.

VI. DUTIES OF LIABILITY INSURERS

A. Duty to defend

An insured company was sued for alleged infringement by another company, and the insured requested its insurer defend it. *Awards Depot, L.L.C. v. Scottsdale Ins. Co*., No. H-15-3201, 2016 WL 613909 (S.D. Tex. Feb. 16, 2016); 2016 WL 1090110 (S.D. Tex. March 21, 2016) (motion to reconsider denied). A "Knowing Violation of Rights of Another" exclusion in the policy excludes coverage for "personal and advertising injury" caused by or at the direction of the insured with the knowledge that the act would violate the rights of another and would inflict 'personal and advertising injury." The plaintiff in the underlying suit alleged the insured acted with knowledge that its conduct would violate the plaintiff's rights in its trade dress and would inflict "personal and advertising injury." Therefore, the court held the insurer had no duty to defend the insured in the underlying lawsuit. See also *Laney Chiropractic and Sports Therapy, P.A. v. Nationwide Mut. Ins. Co*., No. 4:15-CV-135-Y, 2016 WL 3916005 (N.D. Tex. July 20, 2016) (holding insurer had no duty to defend because complaint did not state a claim for misappropriation of advertising ideas, which would have been covered under the policy, but rather merely stated a claim for trademark infringement, which the policies excluded from coverage).

B. Duty to indemnify—Four corners rule—Conflict of defense counsel

In *Allstate County Mut. Ins. Co. v. Wootton*, 494 S.W.3d 825 (Tex. App.—Houston [14th Dist.] 2016) pet. filed, response requested (Tex. No. 16-0546) http://www.search.txcourts.gov/Case.aspx?cn=16-0546&coa=cossup, the court held that there is only a narrow exception to the "four corners" rule, which allows extrinsic evidence on the duty to defend only if it is "impossible" to tell whether the coverage is "potentially implicated" by looking only at the claim and the policy. That exception did not apply, the court concluded, because the tort plaintiff alleged negligent entrustment in the operation of a covered vehicle, which triggered coverage and thus precluded consideration of extrinsic evidence to show that the driver was an employee of the insured thus bringing the claim within a policy exclusion. Though the insured was entitled to a defense, the court held that the insured was not entitled to choose its own defense counsel paid for by the insurer because the insured's summary judgment motion had raised only a "potential" conflict of interest of defense counsel. "On appeal, the Woottons assert that Gonzalez, Sr. [the tort plaintiff] pleaded facts

sufficient to give fair notice of a negligent-entrustment claim and that adjudication of the negligent-entrustment claim will require adjudicating facts upon which coverage depends. They also claim a conflict of interest exists because Allstate conditioned its defense of the Woottons upon an unreasonable extra-contractual demand that the Woottons agree to the attorney chosen by Allstate, thus allegedly subjecting them to waiver of their right to invoke the rule allowing them to obtain independent counsel. Because the Woottons did not assert either of these arguments as grounds for summary judgment in their motion, we cannot affirm the trial court's summary judgment on either of these grounds."

An insurer owed a duty to indemnify its insured home builder. *Great Am. Lloyds Ins. Co. & Mid-Continent Cas. Co. v. Vines-Herrin Custom Homes, et al.*, No. DC-03-6903, 2016 WL 4486656 (Tex. App.—Dallas Aug. 25, 2016). After a builder lost in arbitration to a homeowner for negligent construction, the builder assigned its rights against its insurer to the homeowner, as the insurers had refused to defend the builder in the underlying lawsuit. The court held that the insurers provided coverage to the builder during the entire period the house was built until the time damages first manifested. Therefore, "actual damages must have occurred during the coverage provided by [the insurers]," and the insurer owed a duty to indemnify to the builder.

An employee of an insured business was killed on the job by an energized line operated by a co-worker. After the insured settled with the employee's estate, the insurer sought declaratory judgment that it owed no duty to indemnify the insured for the settlement under the policy terms. The court held the insurer had no duty to indemnify the insured because the policy provided coverage for "bodily injury by accident" that had not been caused by the intentional conduct of the employer. The court noted the insured knew that the power lines were live yet still had its employee working in close proximity to the live wires, which violated the safety manual. *Liberty Ins. Corp. v. Dixie Elec., L.L.C.*, 637 F. App'x 113 (5th Cir. 2015).

A "professional services" exclusion applied to plaintiffs' allegations against an insured engineering firm, relieving insurer of its duty to defend but not its duty to indemnify, which cannot be determined at the pleadings stage. *Hartford Casualty Insurance Company v. DP Engineering, L.L.C.*, 827 F.3d 423 (5th Cir. 2016). DP requested Hartford provide a defense for suits arising from a crane accident at Entergy's nuclear power plant: Entergy's suit for property damage and workers' suits for personal injuries and wrongful death. The suits alleged several acts or omissions relating DP's failure to perform a load test that would have avoided the accident. Hartford refused the defense and brought a declaratory judgment action contending that it had no duty to defend or indemnify based on the "professional services" exclusion. The district court ruled for Hartford on both duties. The Fifth Circuit affirmed the district court's no duty to defend ruling, but reversed the district court's no duty to indemnify holding, stating that "[t]he underlying lawsuits here involve complex facts and multiple allegedly negligent parties,. . . there is 'an array of possible factual and legal scenarios' that could have caused the crane and stator to fall, some of which may create coverage[,] [and that] [t]he allegations in the underlying lawsuits here do not conclusively foreclose that facts adduced at trial may show DP Engineering also provided non-professional services, which would be covered under the policy."

The district court granted summary judgment for the insurer on the insured's indemnity claim, in part, on the ground that policy Exclusion M precluded coverage for "damage that occurr[ed] during the replacement process to property other than [the flanges] - in this case, the temperature coating, the gaskets, the piping, and the insulation." The Fifth Circuit previously certified four questions to the Texas Supreme Court regarding the interpretation of this policy. The supreme court held that the insulation and gaskets destroyed in the process were not restored to use, but were replaced. Because they were not impaired property to which Exclusion M applied, the cost of replacing them was covered by the policy. Therefore, the Fifth Circuit reversed and remanded the district court's holding for further proceedings consistent with the Texas Supreme Court's opinion. *U.S. Metals, Inc. v. Liberty Mut. Group, Inc.*, No. 13-20433, 2016 WL 3689181 (5th Cir. Jul. 11, 2016).

An insurer moved to dismiss the portion of an insured's declaratory judgment claim that would establish the insurer's obligation to pay future defense costs and indemnity payments for potential future lawsuits that implicate one or more of the umbrella policies. The insured, Boy Scouts of America, conceded that it received pre-suit claims that had not evolved into actual litigation. Therefore, the court held any determination of the duty to defend or indemnify was premature because it was unknown whether suit would be filed or whether a judgment or settlement would be reached. *Boy Scouts of Am. v. Nat'l Union Fire Ins. Co. of Pittsburgh PA,* No. 3:15-CV-2420-B, 2016 WL 495599 (N.D. Tex. Feb. 8, 2016).

An insurer had no duty to defend or indemnify its insured, a builder and plaintiff in the underlying suit. *Vinings Ins. Co. v. Byrdson Servs.*, LLC, No. 1:14-CV-525, 2016 WL 3626226 (E.D. Tex. Jun. 17, 2016). The insured builder sued an individual to foreclose on its lien on the defendant's property when it was not paid for the repair work it performed, and the defendant filed a counterclaim against the builder alleging it did not timely complete his reconstruction contract and the work was defective. In the coverage suit, the insurer filed a motion for summary judgment arguing it had no duty to defend or indemnify the builder because the factual allegations in the underlying suit did not fall within the necessary policy language to trigger coverage for "property damage." The builder did not respond to the motion. The counterclaim in the underlying suit stated the builder did not properly lay the slab, necessitating it to be redone and resulting in delays that displaced him from his home. While the court found the pleading fell within the scope of the policy's "property

damage" coverage, it was specifically excluded from that coverage under the "your work" exclusion as "property damage" arising from the builder's work on the property. As such, the insurer had no duty to defend. The court further found that because the insurer had no duty to defend, the possibility that it had any duty to indemnify was negated. The court noted that, while it could look outside the state court pleadings in determining the duty to indemnify, the parties submitted very little extrinsic evidence and thus no additional information was presented to alter the court's analysis.

VII. THIRD PARTY THEORIES OF LIABILITY

A. Breach of contract

A tenant caused damage to her apartment complex when her dryer caught on fire. The apartment complex's insurer paid for the damages, and then sought reimbursement from the tenant under the Reimbursement Provision in the lease. Under Texas law, landlords have no obligation to repair premises conditions that a tenant caused, and they are not restrained from contracting with tenants for reimbursement of associated repair costs. Here, the tenant signed a reimbursement provision in her lease, and therefore, the Texas Supreme Court reversed the appellate court's judgment invalidating the Reimbursement Provision on public-policy grounds, and remanded the case for consideration of the tenant's remaining defenses to enforcement of the Reimbursement Provision. *Philadelphia Indem. Ins. Co., et al. v. White*, 490 S.W.3d 468 (Tex. 2016).

An automobile insurer did not breach its contract or any other duty when it paid a settlement within policy limits. *Martin v. State Farm Mut. Auto. Ins. Co*., No. 05-14-01473-CV, 2016 WL 1104878 (Tex. App. — Dallas Mar. 22, 2016, pet. denied) (mem. op.). After an insured's son was involved in a car accident, the other driver filed a liability insurance claim with the insured's insurance company, State Farm. The insured sued State Farm even though it paid the claim, alleging State Farm breached its contract and exercised bad faith by determining the insured's son was at fault. The court of appeals affirmed the insurer's summary judgment finding that the insurer did not breach the contract. The insured argued that State Farm took action to "limit [his] contract rights" under the policy and withheld reimbursement for property damage to the extent of the deductible. But the court noted that the other driver filed a claim for property damage against the insured that was within the scope of coverage, and State Farm settled the claim within the policy limits and without any liability to the insured. The policy also allowed State Farm to "settle or defend, as we consider appropriate." There was no evidence that State Farm breached the contract or acted in bad faith. State Farm satisfied its duty under the policy to settle the claim as it considered appropriate, and satisfied its duty under *Stowers* to accept a reasonable settlement demand within policy limits.

B. Unfair insurance practices

Violations of the Texas Insurance Code need to be pleaded with specificity, or the allegations may be found deficient. This is precisely what happened in *Columbia Mut. Ins. Co. v. Trewitt-Reed-Lacy Funeral Home, Inc*., No. 4:15-CV-568-A, 2016 WL 524597 (N.D. Tex. Feb. 5, 2016). An insured's property was damaged in a storm, but her insurer refused to pay arguing the damage was caused by a previous storm that the insured had received compensation for but failed to repair. The insurer filed a declaratory judgment action, and the insured counterclaimed for unfair insurance practices, bad faith, and breach of contract. The court held that the alleged violations of the Texas Insurance Code were conclusory and did not contain allegations as to who said what, when, and where, and how the harm was caused. Because those facts were missing the court found the allegations to be deficient, and dismissed the claims for violations of the Texas Insurance Code and bad faith.

C. Fraud

An insured company's claim for fraud against its insurer was dismissed because the insured did not state, "with particularity the circumstances consisting of fraud or mistake," because it failed to include any facts regarding time, place, and content of any false representation during the insurer's attempt to effectuate settlement of the insurance claim. Instead, the insured relied on the substantial disparity between the public adjuster's estimate and the insurer's estimate to infer that the insurer did not make a good faith effort to settle the insured's claim. *Columbia Mut. Ins. Co. v. Cedar Rock Lodge, L.L.C.*, No. 1:15-CV-111-P-BL, 2016 WL 1059677 (N.D. Tex. March 17, 2016).

VIII. SUITS BY INSURERS

A. Declaratory relief

An insurer filed for declaratory relief after its insured's car was in an accident that injured another party. The driver of the car was not the insured. Rather, the insurance company argued the driver of the car was specifically excluded on the policy. The insurer also filed a motion for summary judgment asserting that its policy provided no coverage for the collision because the insured's truck was driven by an excluded driver. The appellate court affirmed the trial court's summary judgment ruling in favor of the insurer. *Antoine v. Am. Service Ins. Co., Inc*., No. 09-14-00235-CV, 2016 WL 422524 (Tex. App.—Beaumont Feb. 4, 2016, no pet.).

B. Subrogation

Employees of a sub-contractor were injured due to the contractor's negligence. The sub-contractor's worker's compensation insurer paid benefits to them. The contractor asked the worker's compensation insurer to waive its subrogation rights, which it refused to do, and the trial court granted a motion for summary judgment in favor of the contractor that the worker's compensation insurer take nothing on its subrogation claim. However, the appellate court reversed the underlying ruling. Because the sub-contractor had no duty to indemnify the contractor for its own negligence in the contract, the sub-contractor never assumed liability for the injuries in this case and thus had no contractual duty to seek a waiver of subrogation rights from its insurer. The court looked to the indemnity clause of the contract to determine what liabilities the sub-contractor had assumed, and found only those instances in which the subcontractor promised to indemnify the contractor would trigger the sub-contractor's obligation to obtain a waiver of subrogation rights from its insured. The sub-contractor did not agree to indemnify the contractor for personal injury claims attributable to its own negligence. Because the sub-contractor was not required to indemnify the contractor under the contract, it did not "assume liability" under the insurance provisions of the contract. Because the sub-contractor did not "assume liability" for the damages alleged in this suit, it was not contractually obligated to cause its insurer to waive its subrogation rights against the contractor. *Ins. Co. of the State of Penn. v. Roberts*, No. 01-15-00453-CV, 2016 WL 3902163 (Tex. App.—Houston [1st Dist.] July 14, 2016, pet. granted).

C. Fraud by insured

An insured was required to repay all amounts his

insurer paid to him and on his behalf under the "loss of use" policy because he made fraudulent representations with regard to his claim for per diem payments and living expenses while his property was being repaired. *Safeco Insurance Company of Indiana v. Igwe*, No. AU-14-CV-587-DAE, 2016 WL 866360 (W.D. Tex. Mar. 3, 2016). An insured sued his homeowner's insurer for breach of contract and violations of the Texas Insurance Code after the insurer failed to fully pay two claims made under the policy. The insurer counterclaimed for fraud in connection with the insured's second claim. The trial court granted the insurer's motion for summary judgment so that the insurer's fraud claim was the only issue at trial. After his home was water damaged, the insured lived outside his home while the insurer assessed and repaired the damage. The policy covered living expenses in the event the premises were rendered uninhabitable due to a covered event. The insurer made some payments to cover temporary housing and meals while the insured lived outside his home. The insurer attempted to find a long-term housing option, but the insured rejected it as too small and unworkable for his family. He stated in particular that he had a wife and four children living with him. However, during trial the insured admitted his wife and children were living elsewhere and only visited him on weekends or when school was out, which contradicted his statements to the insurer. Additionally, the insured had requested per diem expenses for his entire family every day during the nearly four-month period while the home was being repaired. At trial, he testified that he did not actually provide all of the meals to his family. He testified he needed two hotel rooms to store his children's belongings, but he was also reimbursed for driving to his home to obtain their belongings from time to time. The court found that the insurer acted in good faith in attempting to relocate the insured and that the insured intentionally lied to the insurer and misrepresented his family's living situation. In the court's view, the insured committed fraud, which under the terms of the policy, rendered the policy void. The insured was found liable to the insurer for the amounts it paid him for per diem expenses and temporary housing.

IX. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Policy benefits

The insured-oilfield drilling contractor was hired to drill a well, and purchased an insurance policy that covered "well out of control" events such as blowouts. After a blowout occurred, the contractor sought costs from the insurer for running a casing, liner, extra drilling time, and pro-rated logging. The contractor won in the trial court, and the insurer appealed arguing those costs were not caused by an occurrence, and thus were not a covered loss. The court held the only reasonable interpretation of the insurance policy's language is that the scope is limited to re-drill expenses incurred because of an occurrence, i.e. the well out of control event. Applying the undisputed facts to the policy's plain language, the casing and liner costs were not incurred as a result of an occurrence, as they would have been incurred even if a blowout did not occur. Therefore, the court reversed the summary judgments in favor of the insured on the coverage issue, and rendered judgment in favor of the insurer, declaring the disputed expenses were not covered under the insurance policy. *Gemini Ins. Co. v. Drilling Risk Mgmt., Inc.*, No. 04-15-00318-CV, 2016 WL 3625666 (Tex. App.—San Antonio July 6, 2016, pet. filed).

B. Attorney's fees

An insurer was entitled to an award of attorney's fees from another insurer under Tex. Civ. Prac. & Rem. Code § 38.001(8). *Colony Nat'l Ins. Co. v. United Fire & Cas. Co.*, No. 5:14-CV-10-JRG-CMC, 2016 WL 3896832 (E.D. Tex. Apr. 14, 2016). United Fire & Casualty Company entered into an insurance contract with its insured to provide additional insurance coverage for Carothers Construction, Inc. But United refused to provide a defense to Carothers when it was sued, and so Carothers' insurer, Colony National Insurance Company paid all necessary fees and expenses to defend it in the underlying suit. Colony, as subrogee to Carothers, then sued United for breach of contract and prevailed. Colony then moved for attorney's fees, and the court granted the motion. United's breach caused Colony to bring suit to force United to pay what it owed, and Colony incurred attorney's fees in prosecuting the suit. The award of reasonable attorney's fees is mandatory under Tex. Civ. Prac. & Rem. Code § 38.001(8), and because Colony prevailed on its breach of contract claim and recovered damages, it was entitled attorney's fees. The amount of fees was supported by affidavit and detailed time records, and was not disputed.

An insurer's attorney's fees were reasonable and therefore deducted from the policy benefits held in the registry of the court in an interpleader action. *Dearborn Nat'l Life Ins. Co. v. Jeitani*, No. SA:15-CV-855-DAE, 2016 WL 3546434 (W.D. Tex. Jun. 22, 2016). As a disinterested stakeholder, the insurer was entitled to recover the reasonable costs and attorney's fees associated with bringing the interpleader action. Its attorney submitted an affidavit to prove the costs fees, and the court awarded the amount requested.

An insured was not entitled to attorney's fees because it did not plead a breach of contract claim against either its insurer or agent. *Integon National INS. Co. v. Rizo*, NO. 3:14-CV-1641-G-BK2016 WL 3647796 (N.D. Tex. Mar. 22, 2016). An insurer filed a declaratory judgment action seeking declaration it owed no duty to defend or indemnify its insured in connection with an automobile accident. The insured filed a cross-claim against its agent for DTPA and Insurance Code violations. The parties settled the case, and the insured filed a motion seeking reimbursement for attorney's fees, arguing it was entitled to reimbursement because it was the prevailing party in a declaratory judgment action wherein the substantive law involved a breach of contract. However, the court disagreed. The court first observed the Texas declaratory judgment statute is not a basis for attorneys' fees in federal actions because the statute is procedural in nature, not substantive, and the federal statute did not authorize attorney's fees. Further, the insured never brought a claim for breach of contract against the insurer or the agent and thus was not a prevailing party under section 38.001 of the Texas Civil Practice and Remedies Code.

A court enforced a mediated settlement agreement between an insured and a plan administrator, but the administrator was not entitled to attorney's fees in connection with the enforcement. *Sanders v. Unum Life Ins. Co. of Am.*, No. SA-15-CV-310-DAE, 2016 WL1436695 (W.D. Tex. Apr. 11, 2016). An insured under a long-term disability benefits plan and the plan's administrator mediated their claims against each other and signed a mediated settlement agreement. The administrator tendered a check to the insured's attorney, pending execution of the final release and dismissal of the suit. However, the insured refused to sign the release, and so the administrator filed a motion to enforce the settlement agreement and requested attorney's fees. The court granted the motion to enforce but denied the request for attorney's fees. The evidence showed there was offer, acceptance, and meeting of the minds, and the agreement complied with Tex. R. Civ. P. 11 because it was written and filed with the court. The insured was therefore ordered to sign the final release and comply with the settlement agreement. However, the

administrator was not entitled to attorney's fees. The claims for which attorney's fees could have been claimed were released by the settlement agreement and were separate from the right to fees regarding enforcement of the mediated settlement agreement. The administrator did not provide any statutory support for its request. Therefore, its request was denied without prejudice.

An insurer interpleaded the proceeds of a trade credit insurance policy. The court found that the insurer should receive attorney's fees in accordance with the general rule in interpleader cases. *Coface N. Am. Ins. Co. v. Woodlands Exp., LLC*, No. 4:15-CV-621, 2016 WL 4361462 (S.D. Tex. Aug. 15, 2016). The court noted that, although the case was simple, one of the claimants improperly protracted the proceedings by filing an "inconsistent" response to the insurer's motion to dismiss and by filing counterclaims against the insurer that were not supported by law. The court found that the lodestar calculation of fees was reasonable and made an award in accordance.

X. DEFENSES & COUNTERCLAIMS

A. Limitations

In a breach of contract action between the two named parties, an insurer was the bonding agency for INet on the contract at issue. The insurer asserted the affirmative defense that the claim was barred by statute of limitations, and the district court dismissed DFW's claim against the insurer, Hartford, on that basis. The Fifth Circuit reversed and remanded holding the contract was not abandoned or terminated over a year before suit was brought. *Dallas Fort Worth Int'l Airport Bd. v. INet Airport Sys., Inc.*, 819 F.3d 245 (5th Cir. 2016).

An insured's suit for breach of contract against his disability insurer was time barred. *Fernandez v. Mut. of Omaha Ins. Co.*, 630 F. App'x 232 (5th Cir. 2015) (per curiam). Following discontinuance of benefits payments under a disability insurance policy, the insured brought action against his insurer for breach of contract as well as violations of the Texas Insurance Code and the Texas Deceptive Trade Practices Act. The policy contained a three-year limitations period. At issue was when the insured's cause of action accrued. The insured argued his cause of action did not accrue and commence the running of the limitations period until the policy ended on its own terms in September 2013, meaning that the latest possible date he could have filed suit would have been three years later in September 2016. By contrast, the insurer argued the cause of action accrued after the coverage was terminated under the policy, i.e., June 15, 2009, and the limitations period began to run on September 15, 2010, which accounted for the 15-month grace period after the last disability payment was issued on June 15, 2009. Accordingly, the last possible date the insured could have filed suit would have been September 15, 2013, two weeks before the insured filed his suit. Both the district court and the Fifth Circuit agreed with the insurer. The insured was required to submit an annual form to remain eligible for continued coverage under the policy, but he failed to submit one following the insurer's request in May 2009. Under the Policy, the 15-month grace period for sending the form began to run on the 2009 request date. Once the grace period ended, the 3-year limitations period under the policy began to run. This meant the insured would have been required to file suit on his contract claims under the policy by August 2013. Because he did not file suit until the following month, his contractual claims were time-barred. Additionally, the court concluded the insured's extra-contractual claims and his claims for violations of the Texas Insurance Code and the Texas Deceptive Trade Practices Act expired no later than two years after he received the insurer's letter notifying him that it would not continue to cover his claims. Accordingly, his suit on those claims was also time-barred.

The court concluded that the insured's extra-contractual claims and his claims for violations of the Texas Insurance Code and the Texas Deceptive Trade Practices Act expired no later than two years after he received the insurer's letter notifying him that it would not continue to cover his claims.

A homeowner's claims against an insurer were barred by limitations. *Meredith v. Rose*, No. 05-15-00054-CV, 2016 WL 4205686 (Tex. App. — Dallas Aug. 9, 2016, no pet.) (mem. op.). After purchasing a townhome, the homeowner learned a home warranty had never issued. The homeowner sued the builder, his company, and the home warranty company that was to provide a warranty on her home. The homeowner later amended her petition to add claims against the insurer that was to issue the warranty. The insurer moved for summary judgment on the basis of limitations. At issue was whether the discovery rule applied—that is, whether the homeowner's injury was inherently undiscoverable and objectively verifiable—and, if it applied, when the homeowner discovered or in the exercise of reasonable diligence should have discovered the injury. The homeowner's claims for negligence, gross negligence, and negligent misrepresentation were based on the actions of the builder allegedly as agent for the insurer. Thus, these causes of action against the insurer accrued at the same time as they accrued against the builder. Although she sued the builder within the limitations period, she did not sue the insurer until more than two years later, thus barring her claims against the insurer with a two-year statute of limitations. Her claims with four-year limitations were also barred because the homeowner knew or should have known she did not receive a warranty as represented. Although she received a sample warranty book when she closed on the house, she did not receive a validation sticker for a warranty within ninety days of her receipt of the sample, as clearly stated in the sample. Further, the type of injury, i.e., the existence of a home warranty, was not inherently undiscoverable. The homeowner could have inquired with the warranty provider about the status of the warranty, and in fact learned there was no warranty from another HOA member after he called to inquire. Thus, even if the discovery rule applied, the homeowner's claims were barred.

B. Misrepresentation or fraud by insured

An insured's misrepresentations in applying for coverage voided the policy. *Perfit Vision v. Mount Vernon Fire Ins. Co.*, No. H-15-408 (S.D. Tex. Sep. 22, 2016). The owner of a corporate entity, which in turn owned an eyewear store named Perfit Vision, obtained a one-year casualty policy for his business, naming him individually, "DBA Perfit Vision." The owner filed a claim with the insurer, reporting that the store was burgled over a weekend. The insurer denied the claim. When he applied for the policy, the owner was required to disclose earlier policies and information about claims and cancellations of coverage. In his application, the owner expressly warranted he had not made a claim under a policy in the preceding three years when, in reality, he had filed

two similar claims during that period. This misrepresentation rendered the policy void. The court also found the owner did not have standing to bring the claim. The policy's named insured was the individual doing business as Perfit Vision. But the court found "the appending of 'DBA Perfit Vision' to [the owner's] name is a nullity because it was registered to the company. [The owner] cannot buy insurance in his name on a distinct company's assets nor sue for their loss. [The owner] has not shown precisely what his interest is in Eyewear." In other words, the DBA was really a DBA of a corporate entity, not of the individual owner. The company, under either name, had no standing to complain of a breach of a policy issued to the individual owner.

C. Preemption

A Texas Insurance Code provision requiring health insurers to make coverage determinations and pay providers' claims within specified time or face penalties did not apply to federal employee benefit plans. *Health Care Service Corp. v. Methodist Hosps. of Dallas*, 640 F. App'x 314 (5th Cir. 2016). Chapter 1301 of the Texas Insurance Code requires healthcare insurers to make coverage determinations and pay claims made by preferred healthcare providers within a specified time or face penalties. Anticipating a hospital would seek relief under Chapter 1301, a health plan administrator, BCBSTX, sought a declaration that Chapter 1301 did not apply to it as the administrator of health plans providing benefits to federal employees because the Federal Employee Health Benefits Act of 1959 (FEHBA) preempts it. BCBSTX serviced benefit plans for federal employees in Texas. Preemption under the FEHBA occurs when the FEHBA contract terms at issue relate to the nature, provision, or extent of coverage or benefits, and the state law relates to health insurance or plans. Here, the parties did not dispute that the contract terms related to coverage or benefits, so the only issue was whether Chapter 1301 related to health insurance or plans. The hospital argued Chapter 1301 does not relate to the FEHBP plans because it permits a claim for statutory penalties only after an affirmative coverage decision and therefore requires no substantive coverage determination. The Court disagreed: "By imposing penalties for late payments of approved claims, Chapter 1301 also imposes claims-processing deadlines on FEHBP carriers." Because Chapter 1301 would directly affect the operation of the plans and expand FEHBP carriers' duties under the plans, it related to health insurance or plans. The FEHBP therefore preempted Chapter 1301.

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

An insured moved to strike nearly all of the insurer's affirmative defenses, claiming they were "mere boilerplate statements lacking a factual or legal context." The Court noted that the Fifth Circuit has never held that the plausibility standards of *Twombly* and *Iqbal* apply to affirmative defenses. Rather, affirmative defenses are examined under the less stringent "fair notice" standard of *Woodfield*. The court held the insured's affirmative defenses in this case provide the insured with fair notice as they are sufficiently articulated such that the plaintiff is not unfairly surprised. *Frederick v. Am. Heritage Life Ins. Co*., No. 4:15-CV-01982, 2016 WL 2839284 (S.D. Tex. May 13, 2016).

XI. PRACTICE & PROCEDURE

A. Choice of law

An insured business and its insurer sued the manufacturer of a failed component on an underwater structure in an offshore production installation that caused the structure to fall to the sea floor. The business alleged $400 million in damage. The district court granted summary judgment for the manufacturer based upon the maritime economic loss doctrine. Then the insurer sought leave to amend its complaint, alleging for the first time that Louisiana law applied. The Outer Continental Shelf Lands Act (OCSLA) prescribes the applicability of either maritime law or adjacent state law as "surrogate federal law" to govern the Outer Continental Shelf. The court held since the incident did not disrupt maritime commercial activities, maritime law did not apply, reversing and remanding the case for further proceedings under Louisiana law. *Petrobras Am., Inc., Certain Underwriters at Lloyd's v. Vicinay Cadena, S.A*., 815 F.3d 211 (5th Cir. Mar. 7, 2016). The court later noted that its holding did not address waiver of choice of law argument outside of the OCSLA context. No. 14-20589, 2016 WL 3974098 (5th Cir. July 22, 2016).

B. Jurisdiction

An insurer filed a declaratory judgment action in federal court arguing it was not required to defend or indemnify its insured contractor in a lawsuit brought against it. The court held the insurer failed to show that no facts could possibly be proven in the underlying case that would trigger a duty to indemnify. Moreover, the insurer admitted in its own pleadings that it needed discovery to establish a lack of a duty to defend or indemnify. Therefore, the case was dismissed. *Mid-Continent Cas. Comp. v. Christians Dev. Co., Inc*., No. A-16-CA-31-LY, 2016 WL 1734114 (W.D. Tex. Apr. 28, 2016).

An insured was hit by a US Postal Service worker. The insured's insurance company sued the United States in state court for negligence. USPS removed the case to federal court pursuant to the Federal Tort Claims Act (FTCA) and filed a motion to dismiss for lack of jurisdiction, which the court granted. The court held that because the insurer alleged its insured was injured by a federal government employee acting within the scope of her employment for USPS, the insurer must proceed with this action under the Federal Tort Claims Act. Therefore, the state court had no jurisdiction to consider this action, and therefore, under the derivative jurisdiction doctrine, the federal court did not have subject matter jurisdiction either. Under the derivative jurisdiction doctrine, when a case is removed from state to federal court, "the jurisdiction of the federal court is derived from the state court's jurisdiction." Since the state court did not have subject matter jurisdiction, the federal court did not either. However, the federal court would have jurisdiction if the insurer had originally filed its lawsuit in federal court. *Colonial Co. Mut. Ins. Co. v. U.S.,* No. SA-15-CV-917-XR, 2015 WL 7454698 (W.D. Tex. Nov. 23, 2015).

C. Venue

Factors for forum non conveniens weighed in favor of dismissing a liability insurer's coverage action against an insured developer and general contractor. *Crum & Forster Specialty Insurance Company v. Creekstone Builders, Inc*., 489 S.W.3d 473 (Tex. App. — Houston [1st Dist.] 2016, no pet.). Prior to the trial of a construction defects lawsuit, the insurer filed a declaratory judgment action against the insureds seeking a declaration that it had no coverage obligation to them under the policies at issue. The insureds moved to dismiss, arguing the insurer had failed to join the plaintiff from the South Carolina construction defects suit, a necessary party, and the case would more appropriately be resolved in South Carolina. The court of appeals held that the case should be dismissed on forum non conveniens grounds.

The insurer was a non-resident plaintiff, which meant its forum choice was entitled to substantially less deference than if it were a Texas resident. One of insureds was a South Carolina entity. The condominiums that were the subject of the underlying construction defects suit were located in South Carolina, the plaintiffs in that suit had obtained a judgment in South Carolina, the witnesses were located in South Carolina, and a related suit was pending in South Carolina federal court. At least some of the insured's sources of proof and witnesses were located in South Carolina, and the insurer's employees who would be witnesses would be required to travel regardless of which state the trial was in. Although Texas had an interest in adjudicating the dispute because one insured and the broker that issued the policies were in Texas, the greater interest lay in South Carolina because the only insured that was party to the judgment in the construction defects suit was a South Carolina entity. Thus, although the case involved a connection to Texas, it was more appropriately characterized as a South Carolina controversy. The fact that the insured failed to present evidence at the hearing was not automatically fatal to its ability to meet its forum non conveniens burden, as the insured had attached evidence to its motion to establish the relevant facts.

D. Discovery

The court upheld the trial court's ruling requiring GEICO to produce three years of invoices and supporting documents, evidencing GEICO's payment of claims involving charges and fees associated with the towing and storage of its insureds' vehicles in a three-county area. *In re Gov't Employees Ins. Co.*, No. 09-15-00436-CV, 2015 WL 9311656 (Tex. App.—Beaumont Dec. 23, 2015, pet. denied).

E. Experts

An engineer's expert affidavit finding hail damage was insufficient to prove the loss occurred during the policy period. *Stagliano v. Cincinnati Ins. Co.*, 633 F. App'x 217 (5th Cir. 2015) (per curiam). The insureds owned several commercial properties. After a hail storm, the insureds submitted a claim for damage to one of the properties, which the insurer paid. Approximately one year and eight months later, the insureds submitted claims for some of their other properties damaged in the same storm, which the insurer denied. After suit commenced, the insurer moved for summary judgment, arguing that the insureds could not establish that the damage to their properties was caused by a hail storm that took place within the policy period. In support, the insurer submitted an affidavit from one of its property claims managers, which stated the roofs of the properties at issue had hail damage from "multiple storms," some of which may have occurred after expiration of the policy. In opposition, the insureds submitted an expert affidavit from a structural engineer who inspected the property and testified "hail did in fact occur" on the date in question and that the hail was consistent with the damages he observed. The Fifth Circuit, like the district court before it, held that the insureds failed to meet their burden of proving the loss occurred during the policy period. The engineer's affidavit was "little more than an allusion to his credentials, a recitation of the hail damage observed, and a conclusory, 'subjective opinion' that the damage resulted from a hail storm within the policy period." It was not supported by any facts or explanation of the basis for concluding that the observed damage was due to a particular hail storm during the policy period.

An insured's expert report and testimony withstood an insurer's Daubert challenge. *Overcoming Word Praise Center, Internat'l v. Philadelphia Indem. Ins. Co.*, No. 7:15-cv-00060-O, 2015 WL 11120668 (N.D. Tex. Oct. 13, 2015). An insured retained an expert to testify about its lost profits following alleged storm damage to its business property. The expert's report included a statement that the building's damages were caused by hailstorm. The cause of damages was central to the dispute between the insured and its insurer. The insurer sought to strike the expert on grounds there was "an analytic gap between [the expert's] opinion on lost sales and the basis for his conclusion." The court, however, found that the testimony was reliable. The expert was permitted to assume that the water damage was caused by the storm and assume that this event caused the lost profits. In other words, he could assume the ultimate fact of liability for the purposes of opining on what the damages would be if that fact were found true. The insurer also argued the expert's opinion was based on improper "other sources," referring to the insured's profit and loss statements and a sample of similarly situated businesses, as well as statements by the insured. The court found the expert reasonably relied on these sources, because experts may base opinions on facts or data the expert has been made aware of or personally observed, even if the sources themselves are not admissible

A defendant internet installation company could not strike an insurer's designated fire experts. *Allstate Ins. Co. v. Helmsco Inc.*, No. 6:15-CV-114, 2016 WL 3232726 (W.D. Tex. Feb. 16, 2016). A home insurer, as subrogee of its insureds, filed suit for damages that arose from a fire at the insureds' residence. The suit asserted that the defendant failed to properly ground an antenna and related components, which contributed to causing the fire. The defendant sought to preclude the insurer's three fire experts. However, the court found they were all qualified and their opinions would assist the trier of fact. Moreover, each was going to testify about his own observations and not simply repeat each other's opinion.

In the same case, by separate motion, the defendant sought to exclude the insurer's three damage experts for failing to provide reports. *Allstate Ins. Co. v. Helmsco, Inc.*, No. 6:15-CV-114, 2016 WL 3223324 (W.D. Tex. Feb. 2, 2016). The experts were all employees of the insurer, but even so the insurer was obliged to give a detailed expert witness report under Rule 26, because it did not establish that the employees were not specially employed to provide expert testimony or that their duties as employees did not regularly involve giving expert testimony. Rather than exclude the witnesses' testimony, the court ordered they provide reports.

F. Arbitration

An annuity-payment assignee did not impliedly waive right to arbitrate by bringing action against annuity issuers and assignors. *RSL Funding, LLC v. Pippins*, No. 14-0457, 2016 WL 3568134 (Tex. Jul. 1, 2016) (per curiam). The assignee had arbitration agreements with the annuity sellers, but neither the assignee nor the sellers had arbitrations agreements with the insurers that wrote the annuities. The assignee sued one of the insurers and the sellers, and then later sought to initiate arbitration with the sellers and stay the suit pending completion. The lower courts found that the assignee waived its right to arbitrate by its litigation conduct involving both the sellers and the insurer. The Texas Supreme Court held that the assignee did not waive its right to arbitrate by litigation conduct, but nevertheless affirmed. Under the court's decision in *Perry Homes v. Cull*, a party's right to arbitrate may be waived by its substantially invoking the judicial process to the other party's detriment, in view of the totality of the circumstances. 258 S.W.3d 580 (Tex. 2008). Here, the assignee sued the insurer (with which there was no arbitration agreement) seeking a judgment declaring the parties' rights under the assignments, but did not allege any dispute with the sellers, who, at that time supported the assignee's actions. According to the court, "the existence of possible future disputes among parties to agreements where there is no current dispute among them … does not weigh in favor of a party having waived its right to arbitrate possible future disputes by filing suit when there are no disputes." Arbitrable disputes between the assignee and the sellers arose through the sellers' filing of a counterclaim, but the counterclaim was dismissed in a week, followed immediately by the assignee's dismissal of all of its claims against the sellers. Thereafter, the sellers filed a separate suit in district court seeking to withdraw annuity payments the insurance company had paid into the court registry, and within two weeks, the assignee sought arbitration against the sellers. The assignee sought arbitration in less than eight months, a delay the court found too short to prove a waiver of the right to arbitrate. The discovery conducted by the assignee was served on the insurer and concerned non-arbitrable disputes. The discovery against the sellers was initiated by the insurer, and not by the assignee. The assignee's actions having the insurance company pay the funds at issue into the court's registry did not create a dispute with the sellers. After concluding that the assignee had not waived its right to arbitrate by litigation conduct, the court nevertheless affirmed the lower court's decision to deny the motion to stay the litigation. The assignee did not challenge one ground on which the lower court could have ruled, namely that the assignee failed to join its assignees in the arbitration.

A doctor did not expressly waive his right to arbitrate his claims against a health care provider. *Sofola v. Aetna Health, Inc*., No. 01-15-00387-CV, 2016 WL 67196 (Tex. App. — Houston [1st Dist.] Jan 5, 2016, no pet.) (mem. op.). Aetna Health, Inc. sued a doctor for fraud and breach of contract, alleging he doctor was improperly sending patients to an out-of-network facility in which he held an ownership interest to draw more money from Aetna. The doctor was a participating provider of health care services to Aetna's members, and their agreement contained an arbitration provision applying to "any controversy or claim arising out of or relating to this Agreement," but carved out equitable claims. The doctor moved to compel arbitration. In the course of litigation, the doctor filed multiple pleadings asserting his right to arbitration, and Aetna filed pleadings indicating an agreement to arbitrate. Eventually, the doctor withdrew his pending arbitration motion "without prejudice" and filed a counterclaim "subject to the arbitration agreement." In response, Aetna argued the doctor's notice of withdrawal of his motion to dismiss acted as a judicial admission and estopped him from later seeking arbitration—essentially a waiver. The court disagreed, finding neither express nor implied waiver of the right to arbitrate. Express waivers of arbitration must be clear and specific, and acts merely inconsistent with the right to arbitrate are insufficient to demonstrate express waiver. The parties' agreed motion requesting new docket control dates did not constitute an express waiver of arbitration rights, even though it contained a statement that the doctor intended to withdraw his motion to compel arbitration, because it was not a clear waiver and also mentioned the parties' efforts to agree to arbitration. The court also held there was no implied waiver. Implied waiver of arbitration occurs when a party has substantially invoked the judicial process and caused the other party to suffer prejudice. Neither the doctor's plea to the jurisdiction regarding Aetna's equitable claims nor his motion for summary judgment on the single remaining claim amounted to substantially invoking the judicial process. The plea to the jurisdiction was intended to address the equitable claims Aetna brought to avoid arbitration, and the motion for summary judgment expressly stated it was subject to the arbitration agreement. Any arguable prejudice Aetna suffered from delay or expense was attributable to its attempt to plead around the arbitration agreement. Consequently, the doctor did not waive its right to arbitration.

Insureds and agent were compelled to arbitrate their claims against an insurer. *Hudson Ins. Co. v. Bruce Gamble Farms*, No. 13-115-00098-CV, 2015 WL 6758654 (Tex. App.—Corpus Christi, Nov. 5, 2015, no pet.) (mem. op.) An insurer challenged the trial court's order denying its motions to compel arbitration of the lawsuit filed by its insureds, a group of farmers, and of its agent's cross-petition against the insurer for indemnity. The insurer filed two motions to compel arbitration, one addressing the insureds' suit and the other addressing the agent's third party action. The insured farmers' policies contained an arbitration clause, which they argued was unconscionable because they did not have a copy of the relevant terms (mandatory "Basic Provisions" propounded by the Department of Agriculture and published in federal regulations) when they entered into the insurance contracts. The court disagreed, however, because none of the insureds asserted they were unaware of the Basic Provisions or that the provisions were unavailable for review. Also, the fact that the policy declaration sheets specifically stated they formed only a "part of" the policy provisions should have put the insured farmers on notice of the Basic Provisions. Regarding the motion to compel arbitration against the agent, the agent argued the agency contract containing an arbitration clause was not with it but with a different entity and therefore did not apply to it. However, the agent, not the other entity, signed and returned several other documents related to the role of the agent, and the insurer paid the agent, not the other entity, commissions in accordance with the agency contract. The agent therefore "insisted that it be treated as a party" to the agency contract and, in doing so, subjected itself to the arbitration clause.

An insurer's appointed special deputy receiver was required to arbitrate its common law claims against the insurer's attorney for breach of fiduciary duty. *Rich v. Cantilo & Bennett, L.L.P.,* No. 03-15-00408-CV, 2016 WL 611804 (Tex. App. — Austin Feb. 9, 2016, pet. filed). An attorney agreed to represent an insurer and other defendants in a suit against it. The representation agreement stated, "Any dispute regarding payment shall be submitted to arbitration." Several years later, the Texas Commissioner of Insurance placed the insurer into liquidation and appointed a special deputy receiver over the insurer. The receiver was statutorily authorized to pursue claims on behalf of the insurer's policyholders, shareholders, and creditors. The receiver sued the attorney, bringing several statutory and common law causes of action including fraudulent transfers under the

Uniform Fraudulent Transfer Act and the Insurance Receiver Act, as well as breach of fiduciary duty, aiding and abetting breach of fiduciary duty, and negligence. The receiver alleged that the attorney billed and was paid only by the insurer for services he provided to co-defendants, knew of the insurer's financial condition but continued to act to its detriment by receiving weekly payments from the insurer, and purported to represent one of the insurer's officers and thereby creating a conflict of interest. The suit sought damages and fee disgorgement. The attorney moved to stay proceedings and compel arbitration, that the trial court denied, but the court of appeals reversed. The receiver took the position that the arbitration agreement was only applicable to claims that the receiver inherited from the insurer but not to claims that arose solely by virtue of the receiver's appointment or that belong to the insurer's creditors. The court agreed that if the insurer would be bound by the arbitration agreement with respect to particular claims, then the receiver would also be bound on those claims, but not for claims the insurer itself could not have brought. The court thus held that the statutory claims raised under the Insurance Code and the UFTA were not subject to the arbitration agreement. However, the actions for breach of fiduciary duty, conspiracy, and negligence accrued independently of the receiver's appointment and arose under the representation agreement. For those claims, the receiver stood in the shoes of the insurer and was thus bound by the arbitration agreement to the same extent as the insurer. The court held that all of those common-law claims were subject to arbitration because they concerned the attorney's billing for services he did not perform for the insured and thus were "regarding payment."

An insurer could not be forced to arbitrate two subrogation actions brought after it had withdrawn from a voluntary arbitration forum.

An insurer could not be forced to arbitrate two subrogation actions brought after it had withdrawn from a voluntary arbitration forum. *Watts Regulator Co. v. Texas Farmers Ins. Co.*, No. 02-16-00025-CV, 2016 WL 3569423 (Tex. App. — Fort Worth Jun. 30, 2016, pet. filed). Insurer, a former member of a voluntary arbitration forum, brought claims for subrogation against a manufacturer, a member of an arbitration forum. Under the terms of the arbitration forum agreement, a member could withdraw by giving 60 days' notice, if there was no pending arbitration before it. The insurer had previously given its notice to withdraw from the arbitration forum, and the parties did not have arbitration agreements with each other. The trial court denied manufacturer's motions to compel arbitration. The question on appeal was whether claims that accrued prior to the insurer's decision to withdraw from the forum were nevertheless subject to arbitration through the arbitration forum even though they were not pending cases before an arbitration panel at any time during the insurer's association with the arbitration forum. Here, the arbitration agreement at issue was not between the manufacturer and the insurer as parties to a contract or parties to an overall transaction that incorporated an arbitration clause by reference. Instead, each party unilaterally signed a form provided by the arbitration forum, and the claims at issue were unrelated to the breach of any agreement between the parties. The arbitration agreement form expressly states that no company shall be required to arbitrate any claim or suit if it is not a signatory company unless it has given written consent. When the insurer sued the manufacturer, it was no longer a signatory. The arbitration agreement form's plain language addresses which cases—not claims—were still subject to arbitration upon a signatory's withdrawal. Because they were not "cases then pending before arbitration panels," these two subrogation actions did not fall within the post-withdrawal cases that would remain subject to arbitration. The same basic facts and issue were considered and the same conclusion reached by the Beaumont Court of Appeals in *Watts Regulator Co. v. Foremost County Mut. Ins. Co.*, No. 09-16-00033-CV, 2016 WL 4045502 (Tex. App. — Beaumont Jul. 28, 2016, pet. filed) (mem. op.).

Parties had to submit the question of whether the case should be arbitrated to an arbitrator. *Beaumont Foot Specialists, Inc. v. United Healthcare of Tex., Inc.*, No. 1:15-CV-216, 2016 WL 9703796 (E.D. Tex. Dec. 22, 2015). A plaintiff healthcare provider performed medical services for patients covered by health plans insured or administered by United Healthcare in exchange for a timely payment at a reduced contractual rate. The healthcare provider sued United for violating the agreement by making incorrect or untimely payments. United moved to compel arbitration and further argued an arbitrator, and not the court, should determine whether the parties' agreement required arbitration. The court found the parties clearly agreed that an arbitrator should determine whether the dispute should be submitted to arbitration. The agreement stated that the parties would "resolve all disputes between us" by submission to arbitration in accordance with AAA procedures. The AAA's Commercial Arbitration Rules and Mediation Procedures provide that the arbitrator "shall have the power to determine the existence or validity of a contract of which an arbitration clause forms a part." Consequently, the court concluded the dispute should be referred to arbitration, and it took no position on the enforceability or scope of the arbitration clause, leaving that to determination by the arbitrator.

An insured farming entity sued its insurer for failing to pay its claim. The insurer moved to arbitrate the case under the terms of the policy. The arbitration clause provided that if the parties "fail to agree on any determination made by [the insurer]," the disagreement will be resolved through binding arbitration. Disagreement and determination are not defined in the policy, so the plain meaning applies. The court held the insured filed suit because it disagreed with the insurer's determination. Therefore, its claim falls within the scope of the arbitration clause and should be arbitrated. *Hudson Ins. Co. v. BVB Partners*, No. 13-15-00163-CV, 2015 WL 6758540 (Tex. App.—Corpus Christi Dec. 1, 2015, pet. denied).

G. Appraisal

Two buildings were damaged in a hurricane. The umpire in the appraisal process based his decision for damages partially on the plaintiff's failure to mitigate damages by up keeping the buildings. The court held the appraisal panel acted within their authority when they determined whether the damage was caused by a covered event or non-covered pre-existing conditions like wear and tear, under the terms of the policy. *United Neurology, P.A. v. Hartford Lloyds Ins. Co.*, 624 Fed. Appx. 225 (5th Cir. 2015).

After an insureds' home was damaged by a tornado, an appraisal occurred to determine the loss. The insurer paid the insured $17,000 less than the appraisal award, arguing it had paid a restoration crew $17,000 for clean-up of the home after the tornado. However, the court held these affidavits regarding the clean-up costs were not part of the original motion for summary

judgment and should not have been considered. Therefore, the insureds were entitled to the full appraisal award. *Halton v. Am. Risk Ins. Co.*, et al., No. 05-15-00864-CV, 2016 WL 2609286 (Tex. App.—Dallas May 5, 2016, pet. granted).

By paying an appraisal award, an insurer was entitled to summary judgment on an insured's claims against it. *Anderson v. Am. Risk Ins. Co.*, No. 01-15-00257-CV, 2016 WL 3438243 (Tex. App. — Houston [1st Dist.] Jun. 21, 2016, no pet.) (mem. op.). An insured brought contractual and extracontractual claims against her home insurer after her house was damaged during a storm. After reporting the damage to her insurer, an adjuster inspected the property within three days and recommended an initial payment amount and a completion payment amount. Over four months, the insurer made a series of payments, greater than the adjuster's initial payment but less than the total he recommended. The insured sued for breach of contract, prompt payment violations, and breach of the duty of good faith and fair dealing. The insurer invoked appraisal and subsequently paid the appraisal award. The insurer then moved for summary judgment on all claims. The court of appeals held that the insurer did not breach the contract because it paid the appraisal award and thus fulfilled its obligations under the policy. The fact that the insurer did not pay the amount of the award earlier, alone, did not raise a fact issue on the breach of contract claim. Regarding the prompt payment statute, the court held the insurer was entitled to summary judgment because it timely paid the appraisal award. The court also held that the insurer did not breach the duty of good faith and fair dealing: the insurer did not breach the contract, and insured did not present evidence the insurer did something so extreme that would cause independent injury nor failed to timely investigate the claim. The evidence demonstrated only a bona fide dispute about the amount necessary to compensate the insured for the damage to her home. Further, the insurer inspected the property three days after the loss was reported. The court reached the same result concerning the insured's DTPA bad faith claim.

Regarding the prompt payment statute, the court held that the insurer was entitled to summary judgment because it timely paid the appraisal award.

A federal district court found that timely payment of an appraisal award precluded contractual and extra-contractual recovery and addresses the "written notice" requirement of Prompt Payment of Claims Act. *Cantu v. State Farm Lloyds*, No. 7:14-CV-456, 2016 WL 5372542 (S.D. Tex. Sep. 26, 2016). In a case involving hail damage to property, the court ordered an abatement until proper notice was provided under § 541.154 of the Insurance Code. During the abatement period, the insureds demanded appraisal under their policy but did not file any confirmation of proper notice until several months later. Following appraisal, the insurer paid the appraisal award, less depreciation and deductible. Following payment, the insureds sought to lift the abatement, amend their pleadings, and conduct discovery; the insurer sought to lift the abatement and filed a motion for summary judgment. The court denied the insureds' motion to lift the abatement to conduct discovery, but granted the insurer's motion to grant the summary judgment. The insureds were not entitled to conduct discovery because they "failed to identify any additional discovery likely to create a fact issue as to each essential element" or "explain their basis for believing depositions, written discovery, and a copy of the claim file would create a fact issue on their claims." Further, the insureds were estopped from maintaining a breach of contract claim as a matter of law based on the insurer's timely payment of the appraisal award. The insurer properly deducted prior payments from the appraisal award and timely investigated the claim. The insureds also asserted breaches of §§ 541 and 542, fraud, and bad faith. The court found that because there had been no breach of contract, there was likewise no bad faith conduct absent injury independent of the policy benefits. And as the bad faith causes of action related solely to the insurer's investigation and handling of the policy claim, the insureds did not allege an action that would constitute an independent injury. The prompt payment and fraud claims similarly failed. In sum, because the insurer complied with the appraisal provision (invoked by the insureds), the insureds were estopped from asserting a breach of contract claim as a matter of law absent a viable breach of contract claim, the insureds' extracontractual claims could not survive.

H. Motions for summary judgment

An insured daycare was sued after a child left in a bus unattended was injured. The insured daycare reported the incident to its agent, but the court held that the daycare did not report the incident to the insurer timely under the policy. The report to the agent did not qualify as notice to the insurer. Therefore, summary judgment was granted in favor of the insurer on the issue of duty to defend and indemnify. *Evanston Ins. Co. v. Cheetah, Inc.*, No. 7:15-CV-082, 2016 WL 4494440, (S.D. Tex. Aug. 26, 2016).

Four crew members on a boat were severely injured. The policy insuring the boat stated the boat was insured in the amount of $550,000, with a protection and indemnity limit of $500,000 and a crew sublimit of $100,000. The insurer moved for summary judgment that it owed only $100,000 total to the four injured crew members. The court held that "crew sublimit" had one clear and definite legal meaning, "a group of people associated in common activity." If the insured was entitled up to $500,000 for crew claims, there would be no purpose in including the sublimit in the policy, therefore, the crew sublimit would be rendered meaningless in violation of Texas law on contract interpretation. Therefore, summary judgment was granted in favor of the insurer. *United Specialty Ins. Co. v. Porto Castelo, Inc.*, No. H-15-1036, 2016 WL 2595072 (S.D. Tex. May 5, 2016).

An injured motorcyclist did not adequately present evidence on his promissory estoppel claim to avoid an insurer's no-evidence summary judgment. *Chambers v. Allstate Ins. Co.*, No. 05-15-01076-CV, 2016 WL 3208710 (Tex. App. — Dallas Jun. 9, 2016, pet. denied) (mem. op.). A motorcyclist sued an automobile insurer that insured the driver that struck him, asserting a claim for promissory estoppel concerning his medical expenses. The motorcyclist alleged an adjuster for the insurer made two oral promises to pay "all medical expenses which had currently been incurred" directly to the providers and approximately $3,000 for the motorcycle directly to the motorcyclist. He alleged the insurer did not make any of the promised payments. The trial court granted the insurer's no-evidence motion for summary judgment. On appeal, the court considered whether the motorcyclist (a pro se litigant) had adequately connected the evidence in the record to the elements of promissory estoppel. The court disagreed with the motorcyclist's position that evidence of the insurer's undisputed promise to pay approximately $3,000 in property damage for the motorcycle constituted evidence of a promise to also pay more than $200,000 in medical expenses. Statements at

the hearing were also not summary judgment evidence. The motorcyclist argued at the hearing that he relied on "affidavits of fact" contained in "the appendix that went with [the amended petition] and stuff." However, no affidavits filed by the motorcyclist in this case or in the cause of action from which this case was severed were attached to or cited in his summary judgment response. As such, the motorcyclist did not itemize the evidence or otherwise connect it to the elements of his claim.

I. Severance & separate trials

A UM/UIM auto insurer was entitled to sever and abate extra-contractual claims from breach of contract claim. *In re AAA Tex. County Mut. Ins*. Co., No. 12-15-00277-CV, 2016 WL 4395817 (Tex. App. — Tyler Aug. 18, 2016, orig. proc.) (mem. op). An insurer sought mandamus relief from the trial court's orders denying its motion to sever and abate its insured's extra-contractual claims and compelling discovery. Following an accident, the insured sued its auto insurer for breach of contract under the UIM portion of his policy, violations of the DTPA, and the Insurance Code. The insurer filed a motion to sever and abate the extra-contractual claims, which the trial court denied. The court of appeals found the denial incorrect, explaining that, in most circumstances, an insured may not prevail on a bad faith claim without first showing that the insurer breached the contract, and further, in the context of UIM coverage, an insurer is under no contractual duty to pay UIM benefits until the insured proves that the insured has UIM coverage, that the other driver negligently caused the accident that resulted in covered damages, the amount of the insured's damages, and that the other driver's insurance coverage is deficient. As a result, Texas case law establishes that severance and abatement of extra-contractual claims is required in many instances in which an insured asserts a claim for UIM benefits. Here, the insurer contested liability for breach of contract, and the insured had not established liability. The insured's extra-contractual claims would be rendered moot by a determination the insurer was not liable on the breach of contract claim. The insured also sought production of documents related to the insurer's claim handling process and procedures. The court found that, "while these may be relevant to the extra-contractual claims, they are irrelevant to the breach of contract claim and privileged from discovery." Because the insured's extra-contractual claims ultimately could be rendered moot, the insurer was not required to put forth the effort and expense of conducting discovery, preparing for a trial, and conducting voir dire on those claims. Severance of the extra-contractual claims was thus required.

An insurer was not entitled to mandamus relief concerning the denial of its motion for severance because it delayed too long in filing its petition. *In re Farmers Tex. County Mut. Ins. Co*., No. 13-16-0098-CV, 2016 WL 1211314 (Tex. App. — Corpus Christi Mar. 28, 2016, orig. proc.) (mem. op.). Insureds were injured in an automobile accident with an uninsured driver. They sued the uninsured driver and their automobile insurer asserting claims based on the UM/UIM provisions of their policy. The insurer moved to sever and abate the extra-contractual claims against it until a final judgment was rendered on their contractual causes of action. The trial court denied the insurer's motion, but the insurer delayed filing its petition for mandamus relief for eight months after the trial court's denial of its motions and six months after the trial court denied rehearing. Under these circumstances, the court of appeals concluded that the insurer did not meet its burden to obtain mandamus relief and denied the insurer's petition for writ of mandamus.

J. Bifurcation of damages

An insured's failure to introduce evidence to allocate damages between covered and uncovered losses was fatal to the claim. *One Way Investments, Inc. v. Century Surety Co*., No. 3:14-cv-02839-D (N.D. Tex. Sep. 21, 2016). An insured had a commercial property insurance policy covering its hotel. The property was damaged in a severe hailstorm, and the insured submitted a claim for wind and hail damage, seeking the cost to repair or replace the roof, air conditioning units, and damage to the interior walls. The adjuster concluded that the damage was less than the amount of the deductible, and so the insurer did not pay the claim. The insured sued, asserting contractual and extra-contractual causes of action, and the insurer moved for summary judgment, arguing there was no expert testimony that the property damage was caused by wind, and its expert testimony showed the property damage was caused by wear and tear. The court found the insured did not introduce any evidence that would enable a reasonable jury to estimate the amount of damage or the proportionate part of the damage caused by a covered cause, here hail and wind. The insured's experts' reports only provided estimates of the cost to repair the property and some evidence that the property was damaged by hail, but neither provided evidence from which a reasonable jury could allocate damage from wear and tear, on the one hand, and wind and hail, on the other. The insured thus failed to create a genuine fact issue concerning whether its damages were covered by the policy. The court further noted that the insureds' expert reports did not provide evidence that the damages sought for repairs were reasonable and necessary; they only provided an estimate of the cost to repair the property. Concerning the extra-contractual causes of action, the court found that there was a bona fide dispute regarding the coverage that precluded liability for bad faith and insurance code violations. The insurer presented expert testimony from its adjuster, who concluded that wear and tear, not hail, caused the damage, which was a reasonable basis to deny coverage. The insured did not provide any evidence to refute that conclusion or enable a jury to find the insurer did not have a reasonable basis to deny the claim.

K. Removal and Remand

Once again this year, in suits where adjusters or agents were named as defendants, insurers continued to seek removal based on improper joinder, and insureds continued to seek remands. The trend seemed to crest, as can be observed by the number of cases. Plaintiffs lawyers, be forewarned: at least one court views this trend in removal and remand as an improper tactic by insureds, rather than as one initiated by insurers attempting to forum shop. In *Patel v. Acceptance Indemnity Ins. Co*., No. 4:15-CV-944-A (N.D. Tex. Jan. 28, 2016), the court noted that the case was "but another off a long line of cases in which attorneys for an insured-plaintiff joined as a defendant in a lawsuit filed against an insurance company to recover policy benefits the insurance adjuster of another representative of the insurance company in an effort to removal of the case from state court to federal court."

Remand was **granted** in the following cases: *B&B Car Wash v. State Auto. Mut. Ins. Co*., No. 3:16-CV-1800-B, 2016 WL 4494323 (N.D. Tex. Aug. 25, 2016) (insurer did not respond to motion to remand and therefore did not meet burden to prove improper joinder); *Exxon Mobil Corp. v. St. Paul Fire & Marine Ins. Co*., No. 6:15-CV-875, 2016 WL 4491869 (E.D. Tex. Aug. 5, 2016) (Exxon properly stated claim against non-diverse contractor for breach of contract for allegedly failing to procure excess liability coverage for Exxon); *Spar Enterprises, LP v. Cincinnati Ins. Co*., No. 5:15-CV-00661-RP (W.D. Tex. Oct. 30, 2015) (although claims against adjuster for breach of contract and

bad faith likely could not be maintained, DPTA and Insurance Code claims could be maintained and pleading sufficiently stated those claims under fair notice standard); *Royal Architectural Prods. Ltd. v. Acadia Ins. Co*., No. 2:16-CV-00265, 2015 WL 7313405 (N.D. Tex. Nov. 19, 2016) (insured alleged specific factual allegations against non-diverse adjusters that stated a plausible claim under Ch. 541); *Manziel v. Seneca Ins. Co*., No. 3:15-CV-03786-M, 2016 WL 3745686 (N.D. Tex. Jul. 13, 2016) (non-diverse adjuster was properly joined where insureds pled facts that adjuster failed to prepare estimates, falsely represented there was no hail damage to insured property, and failed to maintain effective communication thereby prolonging and delaying resolution of insured's claim, which were sufficient to sustain claim under § 541.060(a)(2)); *Exchange Servs., Inc. v. Seneca Ins. Co*., No. 3:15-CV-01873-M, 2015 WL 6163383 (N.D. Tex. Oct. 16, 2015) (adjusters were properly joined when insured alleged adjusters estimated payment far below repair costs, made errors in valuing claim with intent of minimizing the loss, conducted an incomplete investigation, failed to consider insured's public adjuster's estimates, and failed to provide reasonable explanation for value, which were sufficient facts to sustain a claim under § 541.060(a)(7)); *Chen v. Metropolitan Lloyds Ins. Co. of Tex.*, No. 4:15-CV-00501-RC-DBB, 2016 WL 675805 (E.D. Tex. Feb. 19, 2016) (adjuster properly joined when insured alleged adjuster was hired by insurer to perform inspection and adjust claim, his inspection generated an estimate of damage including certain repairs and totaling a certain amount less than the policy deductible, he stated there was no hail storm damage to roof shingles and that damage was wear and tear and that inspection of interior revealed no water damage, and he conducted a substandard and improper inspection of the property that grossly undervalued cost of repairs and yielded unrealistic amount to underpay coverage); *Clark Restoration Consultants, LP v. Columbia Mut. Ins. Co*., No. 2015 WL 6956579 (N.D. Tex. Nov. 10, 2015) (applying 12(b)(6) standard, court held adjuster was properly joined in suit for violation of § 541.060 where insured alleged adjuster selected biased appraiser because conduct occurred prior to settlement of claim); *Roach v. Allstate Vehicle & Prop. Ins. Co*., No. 3:15-3228-G, 2016 WL 795967 (N.D. Tex. Feb. 29, 2016) (adjuster could be held liable under § 541.060(a)(2); pleading specifically alleged adjuster failed to effectuate equitable settlement conducing a substandard inspection, failing to include many of the damages in his report, misrepresenting cause of, scope and cost to repair damages, and making other specified misrepresentations upon which insured relied); *Leidy v. Alterra Am. Ins*. Co., No. H-15-2497, (S.D. Tex. Oct. 15, 2015) (insureds properly alleged claim against adjuster under § 541.060(a) by pleading that adjuster "conducted a substandard, results-oriented inspection… and failed to discover covered damages and/or fully quantify covered damages," that adjuster's investigation as inadequate and lasted "approximately one hour," and that adjuster "misrepresented material facts," and further alleging in Motion to Remand that adjuster's results-oriented investigation led to a coverage decision based on his incorrect belief that there was no hailstorm at the property when there were heavy storms throughout the area on the date in question); *Shade Tree Apartments, LLC v. Great Lakes Reinsurance (UK) PLC*, No. A-15-Ca-843-SS, 2015 WL 8516595 (W.D. Tex. Dec. 11, 2015) (applying Texas fair notice pleading standard, insured sufficiently pled claim for violation of § 541.060 by alleging adjuster conducted substandard inspection, as evidenced by report, which failed to include specified items of damage and did not allow adequate funds to cover repairs to restore home, and further misrepresented cause, scope, and cost of repair and amount of coverage, which both insured and insurer relied upon and caused insured's damage, and adjuster gave negligent advice about how property could be repaired to prevent further damage); *Puente v. Pillar Ins. Co*., No. 4:16-0138, 2016 WL 931059 (S.D. Tex. Mar. 11, 2016) (complaint gave fair notice of claims under § 541.060(a) by alleging adjuster misrepresented to insured that damage was not covered); *Western Healthcare, LLC v. Nat'l Fire and Marine Ins. Co*., No. 3:16-CV-00565, 2016 WL 4039183 (N.D. Tex. Feb. 29, 2016) (granting remand and inviting motion for attorney's fees); *Polansky's Wrecker Serv. v. Universal Underwriters Ins. Co.,* No. 6:15-CV-170 (W.D. Tex. Dec. 21, 2015) (consolidated actions were severed so that cases naming non-diverse adjuster as defendant could be remanded); *Landero v. Liberty Ins.,* No. 1:16-CV-008-P-BL, 2016 WL 3866358 (N.D. Tex. Jun. 15, 2016) (insureds sufficiently pled § 541.060 claim against adjuster where they pled "three facts that rise above the statutory boilerplate and conclusory allegations which are insufficient under the federal pleading standard .... First, [insureds] allege that [adjuster] inspected the property for fifteen minutes. Second, [insureds] claim that [adjuster] made coverage decisions without providing reasonable explanations. Finally, [insureds] assert that [adjuster] made note of damage caused by the storm, and then declined to list that damage in his report."); *Sai Hotel Group Ltd. v. Steadfast Ins. Co*., No. W-15-CV-263, 2015 WL 6511434 (W.D. Tex. Oct. 27, 2015) (internal adjuster was proper party where he was unlicensed in Texas, failed to perform thorough investigation, grossly underestimated extent of damage to property, and the insurer relied exclusively on the adjuster's substandard investigation in determining what amounts, if any, to pay the insured).

Plaintiffs lawyers, be forewarned: at least one court views this trend in removal and remand as an improper tactic by insureds, rather than as one initiated by insurers attempting to forum shop.

Remand was **denied** in the following cases: *Lopez v. United Property & Cas. Ins. Co*., No. 3:16-CV-0089, 2016 WL 3671115 (S.D. Tex. Jun. 11, 2016) (adjuster improperly joined in insured's action against home insurer); *Fernandez v. Allstate Fire & Cas. Ins. Co*., No. 3:15-CV-2689-D, 2015 WL 6736675 (N.D. Tex. Nov. 4, 2015) (agent improperly joined where claims were asserted against all defendants generally and only alleged misrepresentation specific to agent was true); *Hernandez v. Safeco Ins. Co. of Indiana,* 3:15-CV-4016-L, 2016 WL 4217838 (N.D. Tex. Jun. 27, 2016) (insured failed to state claims for relief under DTPA and Texas Insurance Code against adjuster); *Gonzalez v. Security Nat'l Ins. Co*., No. H-15-2785, 2016 WL 1222151 (S.D. Tex. Mar. 29, 2016) (amending petition to allege less than $75,000 in damages after removal was ineffective to destroy diversity jurisdiction where original petition failed to specify allegations regarding adjuster's actions); *James v. Chubb Custom Ins. Co*., No. 4:15-CV-3102 (S.D. Tex. Jan 21, 2016) (considering summary-judgment type evidence to conclude that sole in-state defendant was the producer/broker of the policy and not party to policy, which precluded it from any liability under claims brought by insured); *Resendez v. Scottsdale Ins. Co*., No. 1:15-CV-1082-RP, 2016 WL 756576 (W.D. Tex. Feb. 26, 2016) (applying state "fair notice"

standard to pleadings and concluding that non-diverse agent did not owe duty to disclose that policy did not cover flooding or water damage, thereby precluding recovery on that basis); *Walters v. Metropolitan Lloyds Ins. Co. of Tex.*, No. 4:16-CV-307, 2016 WL 3764855 (E.D. Tex. July 14, 2016) (adjuster improperly joined where plaintiffs alleged "only boilerplate allegations" that adjuster was "improperly trained to handle claims of this nature and performed an unreasonable investigation of Plaintiffs' damages," and utilized "unfair settlement practices" and nothing more); *Johnson v. Travelers Home and Marine Ins. Co.*, No., 2016 WL 4061146 (S.D. Tex. Jul. 29, 2016) (allegation that adjuster performed an "outcome oriented and unreasonable investigation" stated a conclusion without identifying any specifics that made adjuster's investigation "unreasonable"); *Elizondo v. Metropolitan Lloyds Ins. Co. of Tex.*, No., 2016 WL 4182729 (E.D. Tex. Aug. 8, 2016) (adjuster improperly joined where petition alleged insurer used adjusters to investigate claim and general allegations that adjuster was inadequately trained and failed to thoroughly investigate, conducted outcome-oriented investigation, made misrepresentations and omissions and unfairly investigated claim); *Young v. Travelers Personal Security Ins. Co.*, No. 4:16-CV-235, 2016 WL 4208566 (S.D. Tex. Aug. 10, 2016) (allegations against adjuster were conclusory, "formulaic recital of the statutory elements," and lacked specificity to state a claim); *Kelcey v. Penn-America Ins. Co.*, No. 4:16-CV-337-A, 2016 WL 3647626 (N.D. Tex. Jun. 30, 2016) ("[Plaintiffs] seem to believe that because they have parroted the language of the Texas Insurance Code and DTPA they have pleaded claims that would suffice under Rule 8. They have not. Instead, they have alleged mere labels and conclusions, which the court is not bound to accept as true…. [P]laintiffs say that [adjuster] made misrepresentations, but they do not allege what he said to whom or when. Nor do they allege what actions they took in reliance on any specific representations or how they were harmed….They do not allege any damages caused by [adjuster] individually. Nor have they alleged any actions outside the scope of [adjuster's] employment."); *Monclat Hospitality, LLC v. Landmark Am. Ins. Co.*, No. 4:15-CV-632-A, 2015 WL 5920757 (N.D. Tex. Oct. 8, 2015) (insured did not properly plead claim for conspiracy between insurer and adjuster because corporation cannot conspire with itself and there was no allegation that adjuster was acting outside scope of agency, and because conspiracy to breach contract is not actionable); *Meritt Buffalo Events Ctr., LLC v. Central Mut. Ins. Co.*, No. 3:15-CV-3741-D, 2016 WL 931217, N.D. Tex. Mar. 11, 2016) (finding that adjusters cannot be held liable under §§ 541.060(a)(1), (a)(2)(A), and (a)(7) because only insurance companies can be held liable under those sections, and that allegations supporting other claims were conclusory); *Southlake Campus, Inc. v. Allstate Ins. Co.*, 4:15-CV-720-A, 2015 WL 7587355 (N.D. Tex. Nov. 25, 2015) (factual allegations related to adjuster in declaratory judgment action were "nothing more than mere conclusions" and no facts would lead to conclusion that insured suffered any damage from adjuster's conduct).

One case was of particular interest because the court initially denied the insured's motion to remand but subsequently found sua sponte that it lacked jurisdiction. *Petree v. Metropolitan Lloyds Ins. Co. of Tex.*, No. 3:16-CV-0735-G, 2016 WL 3090592, 2016 WL 4211764 (N.D. Tex. 2016). In the initial order, decided on June 3, 2016, the court found that the insured's allegations that adjusters "were inadequately trained and failed to thoroughly investigate the damages" and "set about to deny properly covered damages" were conclusory and did not provide a reasonable basis to predict insureds could recover against adjuster. However, the court later reviewed the insured's amended complaint, which alleged additional claims against the adjuster, and in its order of August 9, 2016, concluded the insured pled a potentially valid claim for relief against the adjuster under section 541.060(a)(1) of the Texas Insurance Code. This time, the insureds alleged the adjuster misrepresented material facts relating to the coverage. In particular, the insureds alleged the adjuster failed to thoroughly investigate the damages and "focused exclusively on finding a cause of loss that would be readily excluded under the [insurance] [p] olicy." Specifically, the insured claimed that the adjuster "ignored the moisture that was entering the property via the wind driven rain (a covered cause of loss) and focused exclusively on water that was allegedly entering the property via groundwater (an excluded loss)." According to the court, which applied the federal pleading standard, the insured had "pleaded factual content that allows the court to draw the reasonable inference that [the adjuster] is liable for the misconduct alleged." Lesson: plead specifically the misrepresentations made or the errors in the adjustment.

Apparently recognizing some division among the district courts and inconsistency in decisions, the Fifth Circuit recently weighed in on whether state or federal pleading standards apply in improper-joinder analysis and unambiguously concluded that "a federal court must apply the federal pleading standard." The court explained:

> At bottom, the improper-joinder analysis in the context of removal and remand is solely about determining the federal court's jurisdiction. That is it. As state courts never consider the scope of such jurisdiction, this analysis applies to federal courts exclusively. When determining the scope of its own jurisdiction, a federal court does so without reference to state law, much less state law governing pleadings.
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> …
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> In concluding that a plaintiff has not stated a claim against a nondiverse defendant under a Rule 12(b)(6)-type analysis in this context, the federal court decides only that it has jurisdiction over the plaintiff's claims against the diverse defendants — not that the plaintiff does not have a claim at all against the nondiverse defendant. This is because the federal court never has diversity jurisdiction over a claim against a nondiverse defendant.

IEVM v. United Energy Grp., Ltd., 818 F.3d 193 (5th Cir. 2016). Consequently, Plaintiffs are advised to take care that their petitions would meet federal pleading standards if there is any risk of removal. Additionally, in reviewing or comparing the district courts' decisions cited above, take note of what pleading standard was applied, because several cases were decided before the IEVM opinion was issued.

The federal courts were also presented with other insurer removals and insured motions for remand based on different fact situations. *Clear Vision Windshield Repair, LLC v. Allstate Fire and Cas. Ins. Co.*, No. 3:15-CV-880-L, 2015 WL 11120588 (N.D. Tex. Oct. 30, 2015) (remand granted in case involving multiple named plaintiffs where there was only one real plaintiff because various insureds had assigned their claims to one plaintiff; therefore, there were no individual claims to aggregate and amount in controversy was less than $75,000; petition's statement that it sought greater relief lacked credibility); *Cantu v. Allstate Vehicle & Prop. Ins.* Co., No. 7:16-CV-084 (S.D. Tex. Apr. 28, 2016) (diversity jurisdiction existed because insured's damages exceeded $75,000, where pleadings reflected $24,000 in actual damages, as well as requests for attorney's fees, penalties, and exemplary damages); *Beaumont Foot Specialists, Inc. v. United Healthcare of Tex., Inc.*, No. 1:15-CV-216, 2016 WL 9257026 (E.D. Tex. Dec.

14, 2015) (two of the defendants in the case were "acting under" a federal officer or agency while engaging in conduct that was the subject of the original petition, which invoked protection of federal forum under 28 U.S.C. § 142(a)(1)).

Finally, *Air Evac EMS, Inc. v. Texas*, presented a fairly unique situation. No. A-16-CA-060-SS, 2016 U.S. Dist. LEXIS 106460 (W.D. Tex. Aug. 11, 2016). In that case, an emergency transportation service provider, Air Evac, sued the Texas Department of Insurance Worker's Compensation Division, the Commissioner of Insurance and the Commissioner of Workers' Compensation in their official capacities to challenge several provisions of the Texas Workers Compensation Act that limited the amount Air Evac could charge for its services, arguing that the Texas statutes are preempted by the federal Airline Deregulation Act (ADA). The district court dismissed Air Evac's complaint, concluding that, while it had subject matter jurisdiction over the case, it should abstain under *Colorado River Water Conservation District v. United States*, 434 U.S. 800 (1976). Further, Air Evac did not meet the requirements of the Ex parte Young exception to Eleventh Amendment immunity because it failed to show an imminent or threatened enforcement proceeding.

L. Motions for new trial

A court of appeals reversed an order granting a new trial in a UM/UIM case. *In re State Farm Mut. Auto. Ins. Co*., 483 S.W.3d 249 (Tex. App. — Fort Worth 2016, orig. proc.). An insured sued his auto insurer to recover UIM benefits for injuries sustained in a low speed rear end collision. The jury awarded only $198 in damages for past medical care, and the trial court granted the insured's motion for new trial. The insurer petitioned for writ of mandamus. The court of appeals found the trial court's order granting new trial was facially sound, as it was understandable, reasonably specific, and based on evidence presented at trial. Nevertheless, the court of appeals held that the jury's finding that the insured sustained no compensable pain and suffering was supported by the evidence. The court summarized the trial evidence at some length, including testimony of the insured, his wife, and his doctors. Among other things, the court pointed out that the accident was low speed, causing less than $800 damage to the insured's car. The jury heard conflicting evidence about the severity of the injuries and whether they were caused by the collision. Given the presence of conflicting evidence, the jury's finding that the insured sustained no compensable physical pain and suffering was not so clearly against the "great weight and preponderance of the evidence" as to be clearly wrong and unjust. The order granting new trial was reversed.

XII. OTHER ISSUES

A. Subrogation

A settlement agreement did not bar a worker's compensation insurer, as assignee, from enforcing its subrogation and reimbursement rights connected to worker's past medical treatment. *Continental Ins. Co. v. Dawson*, 642 F. App'x 309 (5th Cir. 2016) (per curiam). A worker was severely injured on the job in Iraq. The employer had a workers' compensation policy, and the worker also had health insurance through an ERISA plan. The worker was treated in Germany, and his health insurer paid for the initial overseas medical treatments. The worker's compensation carrier paid for subsequent treatments. When the worker later sued the company that managed his living quarters in Iraq for his injury, both insurers intervened and asserted liens for the amounts they had paid. The worker and the worker's compensation carrier entered into a settlement agreement, approved by the US Department of Labor, under which the carrier agreed to pay a lump sum for a discharge of liability for past medical care. After the worker's suit settled and the worker's compensation carrier was paid for the full amount of its lien under their settlement agreement, the health insurer filed a claim with the Department of Labor against the worker's compensation carrier for the reimbursement of medical benefits it paid. The two insurers agreed to settle the claim, and in exchange for a payment, the health insurer assigned its subrogation and reimbursement rights to the worker's compensation carrier, which then sued the worker. The question on appeal was whether the earlier settlement agreement between the worker and the worker's compensation carrier precluded the carrier from enforcing the subrogation rights assigned to it by the health insurer and limited its recovery from the worker to the amount of its lien that was specified in the settlement and that had already been paid. The settlement agreement stated that the carrier would provide payment for medical treatments that "should arise prior to the approval of this agreement." According to the court, this meant the parties agreed the carrier would only be required to pay for future medical expenses incurred between the date of the agreement and the date of its approval by the Department of Labor, rather than for all past medical expenses before execution. Thus, the settlement agreement did not require the carrier to repay the health insurer for the worker's past medical treatment and did not preclude the carrier's recovery of the subrogation and reimbursement rights the health insurer assigned to it. Additionally, the court held the health insurer did not waive its rights before assigning them.

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Remembering Mark L. Kincaid

This year we lost a legal giant and a marvelous person. Mark L. Kincaid passed away on January 19, 2016, at the all-to-young age of 56. It is a great loss, personally and professionally, to the many people who knew and loved him. But he leaves a legacy of legal work that will benefit Texans for years to come.

Mark began his legal career as a law clerk for Texas Supreme Court Justice Franklin Spears, before going to work for two notorious force majeures in consumer law, Joe Longley and Phil Maxwell. With Longley & Maxwell, Mark tried and argued many cases and became involved at the Texas Legislature.

One of Mark's early accomplishments was his most well-known. The case was *Vail v. Texas Farm Bureau Mut. Ins.Co.*, 754 S.W.2d 129 (Tex. 1988), which concerned an insured who was wrongly accused of arson by his insurer. Finding violations of the duty of good faith, the DTPA, and what was then Chapter 21.21 of the Insurance Code, the jury awarded Mr. Vail damages in the form of actual property damages set by the insurance policy, treble damages, and attorney's fees. Surprisingly, the Texas Supreme Court upheld the verdict and greatly expanded the law on policyholders' rights and remedies, holding that there was a right to recover under the DTPA and the Insurance Code for unfair claims settlement practices. The court also held that the loss of contract benefits could be a form of actual damages recoverable for bad faith claims practices. *Vail* is the seminal case forging a trail to treble damages based on the loss of policy benefits. It is still good law, despite the federal courts' disregard of it. The case is testament to Mark's creativity and depth of knowledge.

Mark also had an impressive career lobbying at the Legislature to advance the interests of consumers and policyholders. He acted as friend to the Interim Joint Committee on Deceptive Trade Practices from 1987-1988, and helped prevent the Legislature from restricting either the DTPA or article 21.21. In 1991, Mark participated in co-drafting the claims handling portions of H.B. 2, which enacted the first "prompt pay" provisions involving "any insurer," placed the burden of proof on the insurer to prove the applicability of a policy exclusion, and created the Office of Public Insurance Counsel. Fittingly, Mark was appointed to that office by Governor Richards in 1994. In 1995, Mark helped to codify *Vail*, so that the Insurance Code now prohibits certain defined "unfair settlement practices," including the very conduct *Vail* declared to be an unfair settlement practice. Mark's legislative work continued in the 2015 session, in which S.B. 1628 was introduced and would have overruled *Vail's* damages holding by requiring "an injury independent of the harm resulting from the insurer's denial of policy benefits." But, largely thanks to Mark, this attempt to repeal Vail's damage holding was rejected. We can continue to learn from Mark's work: the Mark L. Kincaid Papers were donated to the Texas Legislative Reference Library. They include legislation, bill analyses, testimony transcripts, PowerPoint presentations, and correspondence with interested parties. This body of work will help others continue Mark's path of legislative advocacy.

For many years, Mark served with distinction on the State Bar's Pattern Jury Charge Committee on Business and Consumer Law, including as its Chair. He also co-authored, with Christopher W. Martin, the *Texas Practice Guide: Insurance Litigation*, published by West, and wrote numerous papers, including a CLE article published for the State Bar's Eighth Advanced DTPA/Insurance/Consumer Law Course that reached iconic status for legislative intent researchers. (Mark L. Kincaid, *Unfair Insurance Practices—The Law Under Vail, Watson & the 1995 Amendments*, State Bar of Texas 1995.) The readers of this Journal will recognize him as the lead author of the Annual Insurance Law Update for many years.

Mark was an adjunct professor at the University of Texas School of Law, where he taught insurance law. He liked his students and always treated them to beers at the end of the semester. And they liked him, too. Many were inspired by him to work in insurance law.

Mark was liked and admired by just about everyone who knew him, including his adversaries. One remarkable illustration is that he met his best friend and law partner, Russ Horton, because they were opposed to each other on a case.

At the time of his death, Mark was a founding partner of the Austin firm George, Brothers, Kincaid & Horton, LLP, and President-Elect of the Texas Trial Lawyers Association. He is sorely missed at his firm and TTLA.

We both considered Mark to be a dear friend and mentor for reasons that would be clear to anyone who knew him. He was fun and funny; diligent and organized; honest and fair. He praised a job well done and provided constructive criticism. He found the good in everyone. He took many cases simply because he wanted to help those in need.

One of Mark's essential qualities was treating everyone with respect, without exception. This quality, coupled with his obvious intellect, made him a great lawyer. But it also made him *become* a lawyer. Mark believed everyone deserved respect and dignity and so, if someone was abused or mistreated, he wanted to right that injustice. He was ideologically inspired and inspiring as a lawyer. The "fire in his belly," as he put it, never dulled when it came to helping individuals fight bullies. He fearlessly did what was right. We are all fortunate that he did.

– Elizabeth von Kreisler and Suzette E. Selden