The most significant and often-cited case was the Texas Supreme Court decision in *USAA Tex. Lloyds Co. v. Menchaca*.

Annual Survey of TEXAS Insurance Law

By Suzette E. Selden,* Jonathan D. Selden, ** and Dennis L. Grebe***

I. INTRODUCTION

As usual, 2017-18 was a busy time for courts ruling on Texas insurance law cases. The most significant and often-cited case was the Texas Supreme Court decision in *USAA Tex. Lloyds Co. v. Menchaca*, 545 S.W.3d 479 (Tex. 2018). The original opinion was issued on April 7, 2017, but the court withdrew its original opinion, and re-issued a new opinion and judgment on April 13, 2018. The court stated its reasoning for the new opinion was to "fulfill our duty to eliminate confusion regarding the court's previous decisions addressing insureds' claims against their insurance companies." Following the new *Menchaca* decision, there was a flurry of cases reanalyzing holdings in light of *Menchaca* and remanding to the lower courts to revisit the relevant issues given the new case law.[1]

In addition to *Menchaca,* a federal district court analyzed the new pre-suit notice laws outlined in Texas Insurance Code section 542A.003, and gave attorneys significant guidance as to how these statutory requirements will be enforced.[2] While another court ruled that an insurer did have a duty to defend an insured against allegations she negligently operated a car, even though her husband, who was excluded from the policy, was actually driving the car.[3]

The Texas Supreme Court held an insurance carrier cannot indirectly recover from an injured party the proceeds which it contractually agreed not to pursue directly from a third party.[4] And in an underinsured motorist case, the trial court severed the contractual and extra-contractual claims, but refused to abate the extra-contractual claims. On appeal, the insured argued that under the new ruling in *Menchaca*[5] abatement of extra-contractual claims is no longer required in a UIM case where the UIM claim is disputed. The appellate court disagreed, and directed the trial court to abate the extra-contractual claims.[6]

These and many other decisions are discussed below.

II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile

Insured sued automobile liability insurer for settling a collision claim against him without his permission. Insured, pro se, filed suit in justice court alleging fraud, violations of the Texas Deceptive Trade Practices Consumer Protection Act, and violations of Chapter 541 of the Insurance Code. Insurer responded with traditional and no-evidence motions for summary judgment asserting the terms of its insurance policy allowed it to settle claims it deemed appropriate and there was no evidence it committed fraud, violated the DTPA, or Chapter 541. The justice court granted insurer's motion and insured appealed to the county court at law. Insurer again filed its motions for summary judgment and insured responded, alleging, among other things, that the insurer was relying on the wrong policy because it differed from the "approved" policy he obtained from the Commissioner of Insurance. The county court granted summary judgment in favor of insurer without specifying whether it was on traditional or no-evidence grounds. Insured appealed, arguing the insurer's summary judgment motion was based on a "fabricated" policy and that created a genuine issue of material fact. Insurer responded, acknowledging there was a dispute about which policy was in force at the time of the collision, but argued it was nonetheless entitled to summary judgment.

The court held "although the structure of the language of the policies differed slightly, the language of the relevant portions of the two policies setting out [insurer]'s obligations is nearly identically worded." Both policies, it held, "seem to impose the same requirements and obligations on [insurer]" and did not create a fact issue whether insurer was authorized to settle the claim. Nevertheless, "for the sake of argument," it reviewed the remaining issues as though the insured's version of the policy was correct. Insured argued policy language that insurer would pay for damages for which an insured "is legally liable" required it to determine if insured was legally responsible for damages and prohibited it from paying if insured was not. Insurer disagreed, arguing the "legally liable" language required it to pay damages after a court or other adjudicative body determined its insured was responsible for damages, but that its authority to settle claims was completely separate and allowed it to settle claims "without the need for a legal determination of responsibility to avoid the expense of litigation when it determines that settling is 'appropriate.'" The court held the insurer's "construction is consistent with the plain meaning of the provisions requiring [it] to pay when an insured is legally liable for damages and empowering [it] with the discretion to settle suits or claims where appropriate." After reviewing applicable appellate law and finding insurer's interpretation consistent, the court found the terms of its policy were not ambiguous and gave the insurer discretion to settle claims without its insured's consent and without the need for a judicial determination. *Martin-De-Nicolas v. AAA Tex. Cnty. Mut. Ins. Co.*, No. 03-17-00054-CV, 2018 Tex. App. LEXIS 2747 (Tex. App.–Austin Apr. 19, 2018, no pet. h.) (mem. op.).

Insured sued underinsured motorist ("UIM") insurer and its claims handler for breach of contract and violations of the Texas Insurance Code, including failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement; failing to promptly provide a reasonable explanation of the basis for the insurer's denial of a claim or offer of a compromise settlement; failing within a reasonable time to affirm or deny coverage of a claim; refusing to pay a claim without conducting a reasonable investigation; and requiring the insured to file a lawsuit to have the insurer comply with its contractual duties. Insurer filed special exceptions, alleging insured's claim of the "exhaustion doctrine" was not recognized in Texas and her breach of contract claims were premature under the Supreme Court's decision in *Brainard v. Trinity Universal Insurance Co.*, 216 S.W.3d 809 (Tex. 2006) (insurer under no obligation to pay UIM claim until insured obtains judgment establishing the liability and underinsured status of the other driver). Insured moved to strike. After allowing the insured a chance to amend her petition (which she refused), the trial court sustained the insurer's special exceptions, denied insured's motion to strike, and dismissed her claims with prejudice.

The court of appeals affirmed the trial court's order and holding that, because the insured's petition did not say she got a judgment against the other driver, "she failed to establish the existence of a duty or obligation" on the insurer and her breach of contract claims were premature. The court held the insured's "exhaustion doctrine" claim—that she was legally entitled to her UIM policy benefits because her settlement exhausted all policy limits—was in direct conflict with *Brainard's* holding that a settlement did not trigger insurer's contractual duty to pay. "Whatever the virtues of a contrary rule might be, as an intermediate court, we are bound to follow the rule laid down in *Brainard* unless and until the supreme court reconsiders or revises it." *Weber v. Progressive Cnty. Mut. Ins. Co.*, No. 05-17-00163-CV, 2018 Tex. App. LEXIS

The court found the terms of its policy were not ambiguous and gave the insurer discretion to settle claims without its insured's consent and without the need for a judicial determination.

784 (Tex. App.–Dallas Jan. 26, 2018, pet. filed) (mem. op.).

Insured sued his underinsured motorist (UIM) insurer after his minor next friend was injured in an automobile collision while riding as a passenger in a stolen vehicle. Insurer denied the claim based on an exclusion in its policy that "coverage…will not apply…[t]o bodily injury sustained by you or a relative while using any vehicle, other than a covered auto, without the permission of the owner." Insured filed declaratory action asking the court to disregard the exclusion because his next friend, as passenger, was not "using" the vehicle. Insurer sought and obtained summary judgment and insured appealed.

The court of appeals held the insured's next friend was "using" the vehicle as that term is understood within the context of auto insurance policies and that his "status as a passenger, alone, constitutes 'use' of the vehicle."

The court of appeals held the insured's next friend was "using" the vehicle as that term is understood within the context of auto insurance policies and that his "status as a passenger, alone, constitutes 'use' of the vehicle." It relied on a three-part test outlined in *Mid-Century Ins. Co. of Tex. v. Lindsey*, 997 S.W.2d 153 (Tex. 1999): (1) the collision must have arisen out of the inherent nature of the automobile; (2) it must have arisen within the "territorial limits" of an automobile, and the actual use must not have terminated; and (3) the automobile must produce the injury and not "merely contribute" to it. Having found the insured's next friend satisfied those elements for use of the vehicle, the court affirmed the judgment of the trial court. *Salinas v. Progressive Cnty. Mut. Ins. Co.*, No. 07-16-00361, 2017 Tex. App. LEXIS 9334 (Tex. App.–Amarillo Oct. 4, 2017, no. pet. h.) (mem. op.).

B. Homeowners

Insureds made a claim under their homeowners insurance policy for damage to their roof, which was causing water to leak inside. Their insurance agent testified that he looked at the roof when the insureds applied for insurance and did not see any previous hail damage. The insurance adjuster reported to the insurer that some of the damage was caused by a hailstorm that occurred prior to the policy being purchased, and that there was minor wind damage. At trial, the insureds won, and the insurer appealed. The court affirmed the trial court's award finding that the insurer was liable for the damage to the home, as well as for extra-contractual damages, as the jury could have reasonably inferred that the damages were caused by the insurer who failed to effectuate a prompt, fair and equitable settlement of the claim when its liability had become reasonably clear. *State Farm Lloyds v. Vega*, No. 13-16-00090-CV, 2018 Tex. App. LEXIS 2592 (Tex. App.–Corpus Christi April 12, 2018, pet. filed).

Insureds sued their insurer for failing to pay claim for water damage to their home caused by a hurricane, after water entered their home through the doors. Insurer argued that an exclusion applied for a loss caused by a hurricane to the interior of a building unless direct force of "wind or hail makes an opening in a roof or wall and rain enters through this opening and causes damage." The insureds argued that a doorway is an opening in the wall, and therefore, since the water leaked in through the door, i.e. opening in a wall, it should be covered. The trial court found the exclusion in the policy was not ambiguous, and that any conflict in the evidence was for the jury to decide. The jury found that the insurer did not fail to comply with the policy, and the insureds appealed arguing the trial court "improperly submitted a question of law — what the exclusionary language of an insurance policy means — to the jury." The question submitted to the jury at issue in this case was, "Did [the insurer] fail to comply with the insurance policy with respect to [the insureds'] claims arising from Hurricane Ike?" The insureds also argued a jury instruction should have been given with the question that basically said an opening in a door created by wind through which rain enters and causes damage is covered under the policy.

The appellate court affirmed the trial court's ruling in favor of the insurer, holding that the exclusion was not ambiguous, there was not any conflict in the law, and that any conflict in the evidence was for the jury to decide. Additionally, the requested jury instruction was properly refused by the trial court, as the relevant words in the insurance policy were to be given their ordinary meaning, rather than telling the jury in an instruction how to construe the relevant contract terms. *Iler v. RVOS Farm Mut. Ins. Co.*, No. 09-16-00011-CV, 2018 Tex. App. LEXIS 10783 (Tex. App.–Beaumont Nov. 16, 2017, pet. denied).

C. Health Insurance

Hospital (insureds' beneficiary) sued health insurer alleging underpayment of out-of-network claims under the Employee Retirement Income Security Act (ERISA) and Texas law. Insurer sued back, alleging fraud, negligent misrepresentation, and unjust enrichment in the hospital's billing practices. Trial court dismissed the hospital's ERISA claim in a bifurcated bench trial and then tried the remaining state law claims to a jury. The hospital moved for judgment as a matter of law on the insurer's fraud and negligent misrepresentation counterclaims, which the court granted. The jury rejected the hospital's remaining state law claim and the court entered judgment denying relief to both parties. The hospital moved for attorneys' fees, but the court denied those as well. Both sides appealed.

The court of appeals largely upheld the rulings of the trial court. It found there was no way the insurer could have "justifiably relied" on any alleged misrepresentation by the hospital because of the insurer's sophistication, "red flags," and the insurer's own thorough investigation found no fraud. The court affirmed the trial court's judgment on the hospital's ERISA claim because the hospital "did not identify specific claims for which it sought recovery" and "there was no evidence [insurer] failed to make determinations under the terms of its plans." It noted the insurer "processed claims by applying the coverage formula under its health care plan terms," it never denied the claims, and paid them "according to the 'reasonable and customary amount' as defined under the plan language." *N. Cypress Med. Ctr. Operating Co., Ltd. v. Aetna Life Ins. Co.*, 898 F.3d 461 (5th Cir. 2018).

D. Other Policies

A company sought to recover under its commercial-crime insurance policies upon realizing it had invested a portion of its pension-plan assets in a Ponzi scheme. Through the receiver process, the company was able to recover its principal invested, as well as some earnings. Coverage in the policy was limited to property the company "owned" and the parties disagreed whether the company owned the lost principal and interest. The court ultimately declined to read "own" to cover the lost profits. They applied the plain meaning of the word and concluded the company did not own funds which it was fraudulently induced to loan to someone else. Further, the court determined the company did not sustain a loss. Although the company earned less on its investment than it would have had it invested with honest money managers, the loss was categorized as "purely theoretical" and would not be covered by the policy. *Cooper Indus., Ltd. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 876 F.3d 119 (5th Cir. 2017).

III. FIRST PARTY THEORIES OF LIABILITY

A. Breach of Contract

The much anticipated ruling by the Texas Supreme Court in *USAA Texas Lloyds Co. v. Menchaca*, 545 S.W.3d 479 (Tex. 2018), clarified questions that had arisen about language used in the prior case ruling. The insured contacted her homeowners' insurance company after Hurricane Ike to report storm damage to her home. The adjuster sent out to evaluate the home damage found minimal damage, resulting in the insurer declining to pay the insured because the damages did not exceed the deductible. At the insured's request, a second adjuster was sent out to evaluate the damage, and he reached the same conclusion as the first adjuster. The insured then sued the insurer for breach of the insurance policy and for unfair settlement practices in violation of the Texas Insurance Code.

At the jury trial, when asked in Question 1 of the jury charge whether the insurer failed "to comply with the terms of the insurance policy with respect to the claim for damages," the jury answered "No." Question 2 asked whether the insurer engaged in various unfair or deceptive practices, including whether the insurer refused "to pay a claim without conducting a reasonable investigation with respect to" that claim. The jury answered "Yes." Then in Question 3, the jury was asked to determine the amount of the insured's damages that resulted from either the insurer's failure to comply with the policy or its statutory violations, calculated as "the difference, if any, between the amount the insurer should have paid to the insured for her storm damages and the amount that was actually paid. The jury answered "$11,350."

Both parties asked for judgment in their favor. The insurer argued that because the jury did not find that the insurer failed to comply with the policy in Question 1, the insured could not recover for bad faith or extra-contractual damages as a matter of law. The insured argued the court should find in her favor based on the jury's answers to Questions 2 and 3, neither of which required a "Yes" to Question 1. The trial court found in favor of the insured, with the court of appeals affirming. The Texas Supreme Court granted the insurer's petition for review.

The insurer relied on *Provident American Insurance Co. v. Castañeda*, 988 S.W.2d 189 (Tex. 1998), to argue that an insurance company's "failure to properly investigate a claim is not a basis for obtaining policy benefits." The insured relied on *Vail v. Texas Farm Bureau Mutual Ins. Co.*, 754 S.W.2d 129 (Tex. 1988), where the Texas Supreme Court stated that an insurer's "unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld." The Texas Supreme Court admitted in *Menchaca* that the precedent in this area is confusing, and noted that this case presented an opportunity to "provide clarity regarding the relationship between claims for an insurance-policy breach and Insurance Code violations."

The primary issue in *Menchaca* is whether an insured can recover policy benefits as "actual damages" caused by an insurer's statutory violation without a finding that the insured had a contractual right to the benefits under the insurance policy. The court noted that generally the answer to this question is no. However, it outlined five distinct but interrelated rules that govern the relationship between contractual and extra-contractual claims in the insurance context:

First, as a general rule, an insured cannot recover policy benefits as damages for an insurer's statutory violation if the policy does not provide the insured a right to receive those benefits.

Second, an insured who establishes a right to receive benefits under the insurance policy can recover those benefits as actual damages under the Insurance Code if the insurer's statutory violation causes the loss of the benefits.

Third, even if the insured cannot establish a present contractual right to policy benefits, the insured can recover benefits as actual damages under the Insurance Code if the insurer's statutory violation caused the insured to lose that contractual right.

Fourth, if an insurer's statutory violation causes an injury independent of the loss of policy benefits, the insured may recover damages for that injury even in the policy does not grant the insured a right to benefits.

And, fifth, an insured cannot recover *any* damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits.

The General Rule

The insured in *Menchaca* argued that she could recover policy benefits as damages resulting from the insurer's statutory violation because that claim was independent from her claim for policy breach. The court rejected this independent-claims argument holding that the Insurance Code only allows an insured to recover actual damages "caused by" the insurer's statutory violation. The court stated, "[i]f the insurer violates a statutory provision, that violation – at least generally – cannot cause damages in the form of policy benefits that the insured has no right to receive under the policy."

The insurer then tried to argue that an insured can only recover policy benefits as damages on a breach-of-contract claim and can never recover policy benefits as damages on a statutory-violation claim. However, the court disagreed, stating, "[w]hile an insured cannot recover policy benefits for a statutory violation unless the jury finds that the insured had a right to the benefits under the policy, the insured does not *also* have to prevail on a separate breach-of-contract claim based on the insurer's failure to pay those benefits."

The much anticipated ruling by the Texas Supreme Court in *USAA Texas Lloyds Co. v. Menchaca*, clarified questions that had arisen about language used in the prior case ruling.

The Entitled-to-Benefits Rule

The court noted that it did not reject the *Vail* rule in *Republic Ins. Co. v. Stoker*, 903 S.W.2d 338 (Tex. 1995) or in *Castañeda.* The *Vail* rule is "an insured

who establishes a right to benefits under the policy can recover those benefits as actual damages resulting from a statutory violation." *Stoker* and *Castañeda* stand for the rule that "an insured cannot recover policy benefits as damages for an insurer's extra-contractual violation if the policy does not provide the insured a right to those benefits." The difference in the two rules is whether there is a right to benefits under the policy.

The Benefits Lost Rule

In this context, the court stated it has recognized that an insurer that "violates the statute by misrepresenting that its policy provides coverage that it does not in fact provide can be liable under the statute for such benefits if the insured is 'adversely affected' or injured by its reliance on the misrepresentation." Additionally, when an insurer's statutory violations prejudice the insured, the insurer may be estopped from denying the benefits that would have been owed under the policy as if the risk had been covered. In this situation, the insured can recover "any damages it sustains because of the insurer's actions," even though the loss is not covered under the policy. The benefits lost rule can also be applied when the insurer's statutory violation caused the policy not to cover losses that it otherwise would have covered.

The Independent Injury Rule

The court further described this rule by stating, "an insured can recover actual damages caused by the insurer's bad-faith conduct if the damages 'are separate from and … differ from benefits under the contract.'" An example of this might be mental anguish. This rule does not apply if the insured's statutory or extra-contractual claims "are predicated on," "flow from," or "stem from" policy benefits. The second part of the independent-injury rule states there is no recovery for *any* damages beyond the policy benefits for an insurer's statutory violation unless the violation causes an injury independent from the loss of benefits. The court noted that this type of claim would be rare, and that the court has yet to encounter one.

The No-Recovery Rule

The last rule basically follows from the first four rules. There can be no recovery based on an insurer's statutory violation for *any* damages unless the insured proves a right to receive benefits under the policy or an injury independent of a right to benefits.

The insurer asked the court to outline how parties should submit claims for policy benefits to a jury, where the insured has asserted both a breach of contract claim and a statutory violation claim, and policy benefits are sought as damages for both. The court noted that it generally agrees with the charges outlined in the Pattern Jury Charge, but that their holding today clarifies that to establish "causation of policy benefits as damages" on a statutory-violation claim, the jury "must find that the violation caused the insured to lose benefits she was otherwise entitled to receive under the policy." A proper jury charge must include an appropriate instruction or question to prove that element. To avoid any conflict, the court should confirm that the jury answers the entitlement-to-benefits question only once. In this case, the court said that the trial court may have done better to just submit Question 2 (to show that the insurer violated the statute) and Question 3 (to establish both the statutory violation caused by the insured's actual damages in the form of policy benefits and that the insurer breached the contract by failing to pay the benefits the insured was entitled to under the policy), and omitting Question 1.

The court held that the jury's answer to Question 1 as "No," was not fatal to the insured's case. As these rules above outline, an insured does not have to prevail on a separate breach of contract claim to recover policy benefits for a statutory violation. The court held that the lower courts erred in disregarding the jury's answer to Question 1, as it was not immaterial.

The insurer argued that because the court found the trial court erred in disregarding Question 1, that the Texas Supreme Court should reverse and render in the insurer's favor. However, the court disagreed, stating the answers to Questions 2 and 3, constitute a finding that the insured was entitled to receive benefits under the policy, in the amount of $11,350. The jury's answer to Question 3 constituted a finding that the insurer's statutory violation caused the insured to lose policy benefits that the insurer should have paid.

The court held the jury's answers to Questions 1, 2 and 3 created a fatal conflict. The court looked to whether there was a preservation of that error. The only exception to the preservation of error requirement is a fundamental error, which did not occur in this case. Moreover, to preserve error on fatally conflicting jury answers, the parties must raise the objection before the trial court discharges the jury. In this case, neither party timely objected. The insured in this case obtained all the findings necessary to recover on her statutory-violation claim. The insurer is the one who must rely on the conflicting answer in Question 1 to prevent the insured from recovering based on the answers to Questions 2 and 3. Therefore, the court held that the insurer bore the burden to object, as it was the party who must rely on the conflicting answer to avoid the effect of answers that established liability. Because neither party preserved the error, the court could not consider the conflicting jury answers as a basis for reversing the trial court's judgment.

The Texas Supreme Court reversed and remanded the case for a new trial because of the parties' confusion over the court's relevant precedent, as well as the court's clarification of the requirements to preserve error based on conflicting jury answers.

Justice Hecht concurred in the judgment, but for different reasons than the plurality opinion. He disagreed that an objection before the trial court dismissed the jury was necessary to preserve error. He stated the case must be retried because each party insisted on a favorable judgment, which could not be rendered based on the conflicting answers in the jury verdict.

The dissent, written by Justice Green, held that under the five rules outlined, the insurer was entitled to judgment in its favor because the insured failed to prove that the insurer was contractually obligated to pay benefits under the homeowners policy, which is required to recover policy benefits for a violation of the Tex. Ins. Code. Because the jury's answer to question 3 was less than the policy deductible, the dissent said the insured failed to establish a right to receive policy benefits, and she is not entitled to recover any damages for the insurer's Insurance Code violation under the court's no recovery rule. Moreover, the jury's answer to Question 1 rejected the insured's claim that she had a right to unpaid benefits under the policy, and therefore, she is not entitled to recover policy damages for the insurer's Insurance Code violation. Because the insured is not entitled to damages, there is no reason to remand her case. Additionally, the dissent held that the insurer's post-verdict motions were sufficient "to bring this question [of conflicting answers] to the trial court's attention," and thus, error was preserved. The dissent would render judgment that the insured taking nothing, and held that, under the no-recovery rule, the court should enter judgment in the insurer's favor since the answers establish the insured did not satisfy her burden of proof and is not entitled to any recovery. *USAA Tex. Lloyds Co. v. Menchaca*, 545 S.W.3d 479 (Tex. 2018).

Insureds made a claim on their homeowners insurance policy for interior and exterior damage after Hurricane Ike. Insurer paid almost $5,000 for exterior damage, but denied the interior

damage was caused by the hurricane. Insured sued for breach of contract, breach of duty of good faith and fair dealing, fraud, and Insurance Code violations and sent a demand for almost $400,000. Insurer pled excessive-demand defense ("a creditor who makes an excessive demand upon a debtor is not entitled to attorneys fees for subsequent litigation required to recover the debt"), but the trial court excluded all evidence of the demand and did not allow insurer to submit a jury question on it. Jury found both parties breached the insurance contract, but the insured breached it first. It also found the insurer was liable for Insurance Code violations, breach of its duty of good faith and fair dealing, and fraud. Insurer moved for a take-nothing judgment, arguing the insured's prior breach of contract excused it from honoring the policy. The trial court denied the motion, disregarding the jury's findings about the insured's breach of contract, and rendered judgment for the insureds for contractual and extra-contractual damages. The court of appeals affirmed. The Supreme Court affirmed the appellate court's judgment in part—allowing its judgment on the demand defense, but remanded to the appellate court for further proceedings on the issue of whether the trial court improperly disregarded the jury's findings "in light of" its recent decision in *Menchaca*.[7] The court noted it had never addressed the issue of whether the excessive-demand defense applies to an insured's demand on an insurer. But, "[e]ven if it does," the court said, the insurer offered no evidence it tendered and the insured refused the amount actually due under the policy. On that issue, the court said, "[w]e find no fault in the court of appeals' analysis." However, the court remanded the issue of whether the insurer waived its extra-contractual arguments because it only addressed the breach of contract claim in its briefing and advised the court to look to the new *Menchaca* ruling for guidance on this issue. *State Farm Lloyds v. Fuentes*, 549 S.W.3d 585 (Tex. 2018).

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

Due to clarification of the law by the Texas Supreme Court in *Menchaca*,[8] the Fifth Circuit in *Aldous v. Darwin Nat'l Assurance Co.*, 889 F.3d 798 (5th Cir. 2018) granted the insured's petition for panel rehearing and vacated the district court's dismissal of the insured's claims under Chapter 541 of the Texas Insurance Code. Because *Menchaca* repudiated the independent-injury rule, clarifying instead that "an insured who establishes a right to receive benefits under an insurance policy can recover those benefits as 'actual damages' under the statute if the insurer's statutory violation causes the loss of benefits." The insurer did not contest that *Menchaca* cast aside the independent-injury rule, but instead offered several other grounds on which the court should affirm the denial of the insured's extra-contractual claims. The Fifth Circuit found those alternative arguments would best be addressed by the district court for the first time on remand.

Perrett v. Allstate Ins. Co., No. 4:18-CV-01386, 2018 U.S. Dist. LEXIS 97405 (S.D. Tex. June 11, 2018) is the first case decided that analyzes whether or not a pre-suit notice properly complies with the new requirements of Texas Insurance Code section 542A.003. An insured sued its insurer for claims relating to damage arising out of Hurricane Harvey, alleging violations of the DTPA, the Tex. Ins. Code, and breach of contract. The insured's attorney sent the insurer a notice letter alleging the insurer violated the Tex. Ins. Code and DTPA. The insurer moved to abate under Tex. Ins. Code section 542A.003, which requires the plaintiff seeking damages to give prior written notice of the complaint and the damages, including fees, "not later than the 61st day before the date a claimant files an action." The insurer argued that the notice did not include, "a statement of the acts or omissions giving rise to the claims and the amount of reasonable and necessary attorney's fees incurred by the claimant" or a statement that a copy of the notice was provided to the claimant. Counsel for the insured argued the notice letter satisfied section 542A.003(a)'s requirements.

Perrett v. Allstate Ins. Co. is the first case decided that analyzes whether or not a pre-suit notice properly complies with the new requirements of Texas Insurance Code section 542A.003.

Section 542A.003 of the Tex. Ins. Code states, "not later than the 61st day before the date a claimant files an action to which this chapter applies in which the claimant seeks damages from any person, the claimant must give written notice to the person in accordance with this section as a prerequisite to filing the action." The notice must include, "(1) a statement of the acts or omissions giving rise to the claim; (2) the specific amount alleged to be owed by the insurer on the claim for damage to or loss of covered property; and (3) the amount of reasonable and necessary attorney's fees incurred by the claimant, calculated by multiplying the number of hours actually worked by the claimant's attorney, as of the date the notice is given and as reflected in contemporaneously kept time records, by an hourly rate that is customary for similar legal services." If an attorney provides notice on behalf of a client, the written notice must include that a copy of the notice was given to the claimant. The court shall abate the action for 60 days if it finds that the person filing the abatement did not, for any reason, receive a presuit notice complying with Section 542A.003, and the defendant timely requested the abatement.

The notice in this case was sent 60 days prior to suit being filed. The issue is whether the letter satisfied the pre-statutory requirements. First, the insurer argued the notice letter did not provide "a statement of the acts or omissions giving rise to the claims." The court noted this letter contained several paragraphs explaining how the insurer breached the insurance contract and duty of good faith by conducting a poor examination of the damage and by failing to pay the claims. The letter specified the provisions of the DTPA and Tex. Ins. Code allegedly violated. It also listed the damages sought, and included appraisal reports for the damage calculations. Therefore, the court held the letter sufficiently stated the acts or omissions giving rise to the claims.

The insurer also argued the letter did not include the reasonable and necessary attorney's fees incurred by the claimant. The court noted that although the Tex. Ins. Code requires the attorney fees be "calculated by multiplying the number of hours actually worked by the claimant's attorney, as of the date the notice is given and as reflected contemporaneously kept time records, by an hourly rate that is customary for similar legal services," Tex. Ins. Code section 542A.003(b)(3), does not require that those calculations be in the presuit notice. Since the attorney's fees were stated in the presuit notice, the court held this requirement was met.

However, the claimant's attorneys failed to meet the requirement under section 542A.003(c), that "[i]f an attorney or other representative gives the notice required under this section on behalf of a claimant, the attorney or representative shall: (1) provide a copy of the notice to the claimant; and (2) include in the notice a statement that a copy of the notice was provided to the claimant." The attorney's response to the motion to abate did not dispute or respond to the insurer's argument that the notice letter did not contain a statement that the letter was provided to the claimant. An email showing that the claimant was aware of

the demand was not enough to meet the requirement. The court held that because the letter did not contain a statement that it was provided to the claimant, the case was abated until 60 days after the insured received proper written notice.

The court in *Perrett* gives attorneys significant instruction as to how Tex. Ins. Code section 542A.003 will be enforced. The court was satisfied with a description of the acts giving rise to the claim and with only listing the amount of the attorney's fees, rather than specifically showing the method for calculating the fees. However, the court strictly enforced the rule that the notice letter must be provided to the claimant and state that it was provided to the claimant. Even if the client is informed of the demand, the court held that was not enough. *Perrett v. Allstate Ins. Co.*, No. 4:18-CV-01386, 2018 U.S. Dist. LEXIS 97405 (S.D. Tex. June 11, 2018).

C. ERISA

An insured while traveling for work, contracted coccidioidomycosis, a fungal infection, by inhaling fungal spores, that ultimately resulted in the removal of one of his eyes. He was insured by an employee benefits insurance plan, which was subject to ERISA, and the plan included an "Accidental Death and Dismemberment and Life Insurance Policy." The insured submitted a claim for his eye, which the insurer denied stating in part that "the loss of sight was not due to an Accident as defined by the policy independent of Sickness and all other causes." The insured filed an administrative appeal, but the insurer upheld the claim denial. The insured then filed this suit. Courts construing ERISA plan provisions "are to give the language of the insurance contract its ordinary and generally accepted meaning if such a meaning exists." After applying the ordinary principles of contract interpretation, if the plan terms remain ambiguous, then the court can construe the terms strictly in favor of the insured. The court noted that (1) the policy states that "Accident" does not include "Sickness;" (2) the policy requires an "Accident" be "independent of Sickness;" and (3) the policy requires that an "Injury" "result in loss independently of Sickness." Accident was defined in the policy as "a sudden, unexpected, unforeseeable and unintended event, independent of Sickness and all other causes." The court said the definition of "Accident" states that the term does not include "disease, bodily or mental infirmity or medical treatment thereof." The Fifth Circuit held that a fungal infection falls under a Sickness, and that the loss of an eye from a fungal infection is not an "Accident" within the meaning of the policy. Both parties cited the Centers for Disease Control which describes coccidioidomycosis as a "type of fungal disease" that can make people "sick." The court noted that the loss of sight from this fungal infection was not "independent of Sickness," and therefore, was not covered under the policy. The insured argued that his fungal infection did fall under "Accident," because the definition of "Accident" did not expressly mention fungal infection but did specifically provide that a bacterial or viral infection could not constitute an "Accident." The court disagreed, saying that other terms in the policy, such as "bodily or mental infirmity" and "Sickness," do cover fungal infection, and therefore, the clause regarding bacterial and viral infections cannot be read to remove fungal infections by implication. Food poisoning is covered under "Accident," as defined in the policy, and the insured also tried to argue that a fungal infection was similar to food poisoning as it also is unpredictable in contraction. The court disagreed, stating the policy provided no support for including fungal infection in the provision that included accidental food poisoning within the definition of "Accident." Therefore, the court affirmed the judgment of the district court in favor of the insurer. *Ramirez v. United of Omaha Life Ins. Co.*, 872 F.3d 721 (5th Cir. 2017).

IV. AGENTS, AGENCY, AND VICARIOUS LIABILITY

A. Individual Liability of Agents, Adjusters, and Others

An insured's home roof was damaged in a hailstorm. The insurer assessed the damage and paid the insured who hired a roofer to repair the roof. The insured sued the roofer alleging that he falsely represented himself to be a public adjuster in violation of Tex. Ins. Code section 4102.051 and that he made misrepresentations about his services. The court held the roofer falsely upheld himself to be a public adjuster. Under Tex. Ins. Code section 4102.207:

(a) Any contract for services … that is entered into by an insured with a person in violation of Section 4102.051 may be voided at the option of the insured.

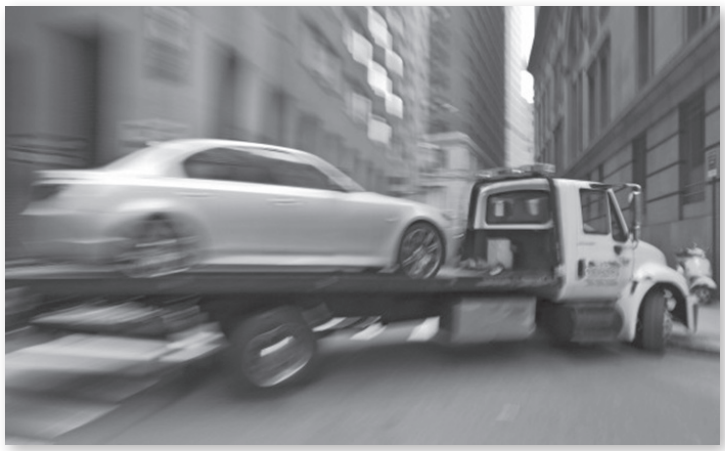
(b) If a contract is voided under this section, the insured is not liable for payment of any past services rendered, or future services to be rendered, by the violating person under that contract.

Therefore, the agreement with the roofer was void, and the insured was not liable for any past or future services rendered by the roofer. Moreover, the court enforced the death penalty sanction against the roofer because he refused to produce material evidence even when lesser sanctions were imposed. The court held this conduct provided an independent basis for a knowing and intentional violation of the DTPA, and upheld judgment for insured against roofer because by contracting to pursue insured's best interest and to reach settlement with insurer, the roofer agreed to advocate on the insured's behalf, which is not allowed under Tex. Ins. Code section 4102.051 as he cannot hold himself out to be a public adjuster when he is not licensed. *Hill v. Sprackelen*, No. 05-17-00829-CV, 2018 Tex. App. LEXIS 5313 (Tex. App.–Dallas July 12, 2018, pet. filed).

V. THIRD PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile Liability Insurance

Insured and his 18 year-old step-daughter were killed in a car accident. Step-daughter's estate and wrongful death beneficiary ("claimants") sued insured's estate and obtained a final judgment against insured. Insurer tendered state-minimum policy limits, but excluded coverage for the remainder of the judgment citing "family member" exclusions in the applicable personal auto and liability umbrella insurance policies. The auto policy excluded coverage "for you or any family member for bodily injury to you or any family member" except for the minimum amount required by law. It defined "you" as the named insured shown on the declarations page and the spouse if a resident of the same household. The declarations page showed the insured and his spouse—his step-daughter's mother—as named insureds. It defined "family member" as "a person who is a resident of your household and related to you by blood, marriage, or adoption."



The umbrella policy's family member exclusion was broader, defining insured as the named insured and residents of the named insured's household who are the named insured's relatives and anyone under the age of 21 under the care of the named insured." Claimants refused tender and sued insured's estate and insurer. Both sides filed actions for declaratory judgment and cross-motions for summary judgment to determine whether the decedent step-daughter was a "family member" under the policies and if that condition limited coverage to the state-minimum limits. The trial court granted summary judgment for insurer and claimants appealed. The court of appeals held the deceased step-daughter was a "family member" for purposes of the exclusion because she was related "by blood" to her mother, who was one of the named insureds, and was a resident of her household. It rejected the claimants' arguments that the family member exclusion did not apply to the insured step-father because he was the at-fault driver and not related to the claimant by blood, marriage, or adoption. "Nothing in the auto policy," the court said, "limits the definition of 'you' to an at-fault insured." Furthermore, even if it did, it said the insured was related to his step-daughter "by marriage, or affinity" which it defined as "[t]he relation that one spouse has to the blood relatives of the other spouse." (citing Black's Law Dictionary 70 (10th ed. 2014)). It held the auto policy's family member exclusion unambiguously excluded coverage for the insured over the required state-minimum limits. It likewise rejected the claimants argument that the broader umbrella policy exclusion was against public policy. "Precedent, however, requires us to conclude otherwise," it said, because the Supreme Court has upheld the family member exclusion in auto policies as long as it provides the state-minimum coverage and "[t[he same public policy considerations apply to the family member exclusion contained in the umbrella policy." It affirmed the trial court's judgment and ordered the claimants to pay the insurer's costs. *Kidd v. State Farm Mut. Auto. Ins. Co.*, No. 05-16-01387-CV, 2018 Tex. App. LEXIS 2620 (Tex. App.–Dallas Apr. 12, 2018, pet. filed) (mem. op.).

A charter bus was involved in a motor vehicle accident that killed nine people and injured more than forty others. The five million dollar insurance policy was quickly exhausted by settling claims with a portion of injured passengers. The unsettled passengers initiated a involuntary bankruptcy petition against the charter bus company. The dispute involved whether proceeds of a debtor-owned liability insurance policy are property of the bankruptcy estate when the policy limit is insufficient to cover a multitude of tort claims. The Fifth Circuit explained due to the siege of tort claimants that threatened the estate above policy limits, the policy proceeds should be categorized as property of the estate. The court highlighted these facts represented "limited circumstances," giving rise to an equitable interest of the debtor in having the policy proceeds applied to satisfy as many claims as possible. The determination as to the enforceability of the initial settlement with a portion of the injured passengers was left for another day. *In re OGA Charters, L.L.C.*, 901 F.3d 599 (5th Cir. 2018).

VI. DUTIES OF LIABILITY INSURERS

A. Duty to Defend

A roof subcontractor obtained insurance to cover its work performed on a building. The subcontractor's insurance policy obligated the insurer to defend the subcontractor and any "additional insured" against any suit seeking damages for "property damage" covered by the policy. A person is an "additional insured" provided that the subcontractor agreed by written contract to designate a person as such. The contract between the subcontractor and general contractor did require the subcontractor to obtain a general liability policy and to designate the general contractor as an additional insured. Even though the contract between the subcontractor and general contractor was not signed by the general contractor, the court held that the contract was still valid because the insurance policy did not expressly state the contract had to be signed by all parties. Therefore, the general contractor was an "additional insured" under the policy.

Applying the eight corners rule, the Fifth Circuit held that the subcontractor's insurer had a duty to defend the general contractor in the lawsuit brought by the property owner. The lawsuit alleged that the general contractor was responsible for numerous material deficiencies affecting portions of the project, including the roof. This would fall under coverage for "property damage" in the subcontractor's insurance policy. The general contractor argued that the insurer violated the Insurance Code by knowingly misrepresenting the subcontractor's insurance coverage in order to avoid defending the general contractor in the suit, and that this violation caused the general contractor to incur defense costs as extra-contractual damages. The Fifth Circuit agreed, applying the recently decided case *USAA Texas Lloyds Co. v. Menchaca*, 545 S.W.3d 479 (Tex. 2018). Following *Menchaca*, the Texas Supreme Court outlined two rules that are directly relevant to this case. The "entitled to benefits" rule provides that "an insured who establishes a right to receive benefits under the insurance policy can recover those benefits as 'actual damages' under the [Insurance Code] if the insurer's statutory violation causes the loss of benefits." The "independent injury rule" has two parts: (1) if an insurer's statutory violation causes an injury independent of the insured's right to recover policy benefits, the insured may recover damages for that injury even in the policy does not entitle the insured to receive benefits and (2) an insurer's statutory violation does not permit the insured to recover any damages beyond policy benefits unless the violation causes an injury that is independent from the loss of benefits. The court noted that "as the phrase 'beyond policy benefits' suggests, the independent-injury rule does not restrict the damages an insured can recover under the entitled-to-benefits rule. Rather, the independent-injury rule limits the recovery of *other* damages that 'flow' or 'stem' from a mere denial of policy benefits." Because the general contractor was entitled to a defense from the subcontractor's insurer, the court held if the general contractor established that the insured's alleged misrepresentations caused it to be deprived of that benefit, the general contractor could recover the resulting defense costs it incurred as actual damages under Ch. 541–without limitation from the independent injury rule. Additionally, if the general contractor proves that the subcontractor's insurer committed the statutory violation "knowingly," it may recover treble that amount. *Lyda Swinerton Builders, Inc. v. Okla. Sur. Co.*, 903 F.3d 435 (5th Cir. 2018) (withdrawing its prior opinion in this case, and substituting the new holding in light of *Menchaca*).

After a car accident, all parties reported to the police and insurance company that the driver at fault was the named insured of the car. However, the person actually driving the car was specifically excluded under a named driver exclusion in the policy. The insurer discovered the insured was not the driver of the car right before her deposition. The insurer then sent a letter to the injured party denying coverage for the claim pursuant to the driver exclusion provision in the policy. Counsel for the insured owner of the car withdrew, and judgment was ultimately rendered against the insured, who assigned her potential claim against her insurer to the injured party. The injured party sued the insurer for negligence, breach of contract, breach of the duty of good faith and fair dealing, and violations of the DTPA. The injured party argued that the insurer had a duty to defend the insured in the negligence suit. The lower court granted summary judgment in

favor of the insurer stating it had no duty to defend the insured. This court applied the eight-corners rule holding the insurer did have a duty to defend the insured. Even though the insured admits in her deposition that it was not her driving the car, but her husband, who was specifically excluded from the policy, under the eight-corners rule, the court noted that it could not consider such extrinsic evidence as it directly contradicts the injured party's allegations. The court held the insurer was required to defend the insured against allegations that she negligently operated the car, even if the allegations were false or fraudulent. Therefore, the court reversed the summary judgment issued by the lower court in favor of the insurer and remanded the case to the trial court. *Avalos v. Loya Ins. Co.*, No. 04-17-00070-CV, 2018 Tex. App. LEXIS 5629 (Tex. App.–San Antonio July 25, 2018, pet. filed).

An armed gunman entered a nightclub and injured a server. The server required significant medical treatment. She sued the nightclub's operators along with the security company on duty the night she was injured. The server took a default judgment against the security company, as it did not answer, and then sought payment from the security company's insurer. The insurer filed a declaratory judgment seeking a determination that it did not owe a duty to defend or indemnify the security company, as it did not receive notice of the initial lawsuit until over 40 days after the default judgment was entered against its insured. The trial court held that no duty to defend or indemnify was owed by the insurer to its insured because of the insured's delay in providing notice of suit, which also meant the server could not recover against the insurer. The Fifth Circuit affirmed the trial court's decision, stating the delayed notice prejudiced the insurer as a matter of law and relieved the insurer of liability under the policy. *Nautilus Ins. Co. v. Miranda-Mondragon*, 711 Fed. Appx. 214 (5th Cir. 2017).

In affirming summary judgment in insurer's favor, an appellate court reiterated when an insured fails to comply with the notice-of-suit provisions of the policy, an insurance company is not required *sua sponte* to defend its insured. In this case, the injured party's attorney notified insurer of the lawsuit and his intention to proceed with a default judgment against its insured. Following the default judgment, the injured party sued insurer for enforcement of the default judgment. Due to insured's failure to notify his insurer that he expected his insurer to provide a defense, insurer's duty to defend was not triggered. Given a default judgment was obtained, insurer established, as a matter of law, that it was prejudiced by the lack of notice and summary judgment in favor of insurer was appropriate. *Egly v. Farmers Ins. Exch.*, No. 03-17-00467-CV, 2018 Tex. App. LEXIS 1253 (Tex. App.–Austin Feb. 15, 2018, pet. denied).

A minor patron sued a restaurant and its owner for a variety of claims including intentional torts, negligence, gross negligence, and Dram Shop liability as a result of the restaurant's owner over-serving and drugging the patron at the restaurant and then sexually assaulting her at a nearby hotel. Insurer initially provided the owner a defense before seeking declaratory judgment that it had no duty to defend or indemnify the restaurant. The trial court granted insurer's motion for summary judgment based on the liquor-liability and intentional-act exclusions. With respect to the duty to defend, the Fifth Circuit went through the "eight-corners" rule, and explained minor's complaint makes clear that her damages clearly stemmed from her intoxication at the hands of the restaurant. The policy excluded coverage for injuries arising out of or resulting from a criminal act committed by any insured. As her damages arose from a criminal act, the insurer had no duty to defend the underlying suit. Likewise, as for the duty to indemnify, the Fifth Circuit determined the criminal act exclusion bars all coverage. It explained the insurer had no duty to indemnify because the minor's damages arose out of the criminal act of giving alcohol to a minor. *Century Sur. Co. v. Seidel*, 893 F.3d 328 (5th Cir. 2018).

The insurer was required to defend the insured against allegations that she negligently operated the car, even if the allegations were false or fraudulent.

VII. THIRD PARTY THEORIES OF LIABILITY

A. Breach of Contract

Following a fire in a condominium complex, the unit owners sued the property manager and insurance agent for breach of contract and negligence. Due to a lack of contractual relationship, the contract claim against the agent was dismissed. Pursuant to their contract, the HOA Board had the sole responsibility to ensure the proper insurance coverage was in effect. However, the property manager was charged with providing recommendations as to the adequacy of the insurance coverage. The property manager had advised the Board to raise policy limits on two occasions. The Board heeded his advice the first time, but ignored it the second time. The Board asserted the manager's failure to re-advise them of the need to increase the amount of insurance caused its damages. In reasoning the manager did not breach his contract, the court explained, there was no evidence that another warning that the property was underinsured would have caused the Board to increase the amount of insurance. Absent this evidence, the Board failed to establish the manager's failure to advise them caused any damages. With respect to negligence claims, the court advised an insurance broker has common-law duties (1) to use reasonable diligence in attempting to place the requested insurance and (2) to inform the client promptly if unable to do so. This obligation does not extend to the insurance agent. As such, the court declined to place a duty of care on the insurance agent. Therefore, the appellate court affirmed the trial court's granting summary judgment in favor of the agent and property manager. *Ruch v. Ted W. Allen & Assoc., Inc.*, No. 01-15-01081-CV, 2017 Tex. App. LEXIS 9830 (Tex. App.–Houston [1st Dist.] Oct. 19, 2017, pet. denied).

B. Deceptive Trade Practices & Unconscionable Conduct

A woman purchased a new car, and called an insurance agency to discuss coverage for her vehicle. The receptionist at the insurance agency quoted rates from several companies, and told her that the new car would be covered by her existing insurance until she found a new policy. The new car's windshield was broken during an attempted theft, and the existing insurer would not pay the claim, as the new car was not added to the policy. The woman sued the insurance agency she had contacted for the receptionist misrepresenting she was an agent, as well as for claims of negligence and breach of contract. The trial court struck all references to any assumption by the receptionist regarding whether the new car would be covered under the existing insurance policy.

To prevail on a DTPA claim, the plaintiff must prove that (1) the plaintiff is a consumer, (2) the defendant engaged in false, misleading or deceptive practices, and (3) these acts constituted a producing cause of the consumer's damages. The court affirmed the trial court's granting summary judgment in favor of the agency on this issue as it held there was no evidence in the record that any misrepresentation regarding the receptionist's licensure was a producing cause of the woman's damages. *Wagley v. Neighborhood Ins. Specialists*, No. 14-16-00859-CV, 2018

Tex. App. LEXIS 3295 (Tex. App.–Houston [14th Dist.] May 10, 2018, pet. filed).

VIII. SUITS BY INSURERS

A. Subrogation

A truck driver was injured during the course and scope of his employment while at a customer's asphalt terminal. The driver received workers' compensation benefits from his employer's workers' compensation carrier. Subsequently, the driver sued a third party, the owner of the asphalt terminal, and carrier asserted a subrogation interest in any recovery from the third party defendant. At the trial court, it was undisputed that the worker's compensation carrier had executed a "waiver of subrogation." The carrier asserted it waived a direct recovery from the third party; however, it maintained the right to indirectly recover from the driver when he received the settlement funds. The Supreme Court, citing over twenty years of unanimous case law to the contrary, disagreed and held that a carrier cannot indirectly recover from an injured party the proceeds which it contractually agreed not to pursue directly from the third party. The dissent argued that although there was a subrogation waiver, that endorsement did not waive the separate statutory reimbursement allowed by Tex. Labor Code section 417.002. The majority opinion disagreed, holding that an insurer's wavier of the right to subrogation encompassed a waiver of the right to reimbursement. Additionally, when insurer waived its right to recover benefits it paid to employee, it received a higher premium for assuming that risk, making reimbursement inappropriate. *Wausau Underwriters Ins. Co. v. Wedel*, No. 17-0462, 2018 Tex. LEXIS 519 (Tex. June 8, 2018), reh'g denied (Oct. 19, 2018).

IX. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Policy Benefits

Insurer appealed a trial court decision that its Texas personal auto policy covered punitive damages awarded against its insured. The court of appeals issued an opinion and judgment, but then withdrew it and reissued a substitute opinion and judgment after both parties sought rehearing. The court held the "plain language" of the policy did not cover punitive damages and remanded the case to the trial court. The ruling hinged on the policy's language that insurer "will pay damages for bodily injury or property damage for which any covered person becomes legally responsible because of an auto accident." The court dissected the definitions of the three operative terms: "damages," "for," and "bodily injury." "Damages," it said, simply meant "a sum or money to compensate for an injury;" "for" meant "in exchange as the equivalent of;" and "bodily injury" meant "physical damage to a human being's body." That language, when piled together, "has only one reasonable interpretation: a promise to pay a sum of money as compensation for the bodily injuries sustained by an injured person." The court rejected the insured's (who had assigned his rights against the insurer to the injured party under a turnover order) argument that the term "bodily injury" contemplated punitive damages and the policy did not specifically exclude punitive damages. In so doing, it addressed and declined to follow another Texas appellate court holding the same policy language covered punitive damages. *See Manriquez v. Mid-Century Ins. Co. of Tex.*, 779 S.W.2d 482 (Tex. App.—El Paso 1989, writ denied). The court noted the *Manriquez* decision relied on other appellate decisions granting punitive damage coverage for slightly different policy language that promised to pay "all sums which the insured shall become legally obligated to pay as damages because of…bodily injury." It faulted the *Manriquez* court for "effectively add[ing] the all sums language to the policy" and said "that we cannot do." Furthermore, it said the absence of a policy exclusion for punitive damages "cannot confer coverage." It avoided the insurer's alternative public policy argument against punitive damage coverage because, having found the plain meaning of the policy did not cover punitive damages, it was unnecessary. *Farmers Tex. Cnty. Mut. Ins. Co. v. Zuniga*, 548 S.W.3d 646 (Tex. App.–San Antonio 2017, pet. filed).

X. DEFENSES & COUNTERCLAIMS

A. Limitations

Insureds received their homeowners insurance offer package in June 2013 that contained (1) a notice that their old policy was not being renewed, (2) an offer for a new policy, (3) a comparison of the old and new policy, and (4) a new endorsement that limited coverage to situations where a covered peril (such as hail) punctures a roof or renders it functionless, and explicitly excluded coverage for denting and scratching. The offer package did not include a copy of the proposed policy but urged the insureds to review the policy and to contact their insurance agent for more information. The insureds purchased the new policy. Three years later, a hailstorm occurred in April 2016 cosmetically damaging the insureds' roof. In January 2017, the insureds sued their insurance company and agent for violations of the Tex. Ins. Code sect. 541 for claims relating to the insurance packet. A person must bring an action under that chapter before the second anniversary of either (1) the date the unfair practice occurred; or (2) the date the person discovered or, by the exercise of reasonable diligence should have discovered that the unfair practice occurred. The insureds argued that the limitations was tolled until the hail storm in April 2016. Before then, they argue that the "exercise of reasonable diligence" would not have permitted them to discover the basis for their claims, that the entire policy was not included in the packet, that the summary comparison had misleading language, and that their agent did not actually write the letter encouraging the insureds to contact him about their policy. The Fifth Circuit disagreed holding that reasonable diligence would have allowed the insured to find out each of the alleged claims prior to the hailstorm. Therefore, the claim was time barred, as the statute was not tolled based on the discovery rule. *Sideman v. Farmers Grp.*, No. 17-51106, 2018 U.S. App. LEXIS 25855 (5th Cir. Sept. 12, 2018).

XI. PRACTICE & PROCEDURE

A. Jurisdiction

A property owner, Bell, sold Texas property to a buyer and transferred the proceeds of the sale to Goldsmith, a friend. A year after the sale of the property, the U.S. government told the buyer it had a lien on the property. The title insurance company had to pay the federal government for the release of the lien. Insurer sued Bell, a Texas resident, and Goldsmith, a Louisiana resident under the Texas Uniform Fraudulent Transfers Act for alleged fraudulent transfers. The court of appeals, affirming the trial court's ruling, held Goldsmith did not purposefully avail herself of the state of Texas for personal jurisdictional purposes. On appeal, insurer asserted Goldsmith made the following contacts with Texas: (1) weekly telephone calls with a Texas resident; (2) knowingly making eighty-one transfers to a bank account in Texas; (3) held a lien on three vehicles in Texas; and (4) accepted and deposited sales proceeds from a Texas resident derived from Texas real property. The Supreme Court highlighted purposeful availment requires that a defendant "seek some benefit, advantage or profit by availing itself of the jurisdiction." The Supreme Court determined Goldsmith did not seek a benefit from the phone calls and upheld the lower courts' rulings by determining Goldsmith's contacts were too attenuated to establish jurisdiction. *Old Republic Nat'l Title Ins. Co. v. Bell,* 549 S.W. 3d 550 (Tex. 2018).

B. Venue

In this case there are 11 pending lawsuits in four different counties against multiple Farmers entities. The Texas Supreme Court held that because these suits allege contractual and extra-contractual causes of action based on Farmers' handling of residential property damage claims arising out of Hurricane Harvey, these cases are related and that transfer to a single pretrial court for coordinated pretrial proceedings would result in a more efficient pretrial of the related cases. However, the court declined to appoint a judge from Harris County, stating that it disfavors requests to appoint specific judges. *In re Farmers Ins. Co. Hurricane Harvey Litig.*, MDL 18-0547, 2018 Tex. LEXIS 737 (Tex. July 27, 2018).

In another multi-district litigation panel, the Texas Supreme Court denied an insurer's motion for rehearing of remand of tag along cases, holding that nine cases that had been removed from the MDL 2 Pre-trial Panel were properly remanded to their original trial courts. The court held that these remanded cases did not contain claims of standard or common business practices, which was the reason the MDL 2 cases had been transferred together. The insurer argued that since the lawyers had the benefit of the MDL discovery, they cannot later have their case "prosecuted in a vacuum." The court disagreed, stating that argument would preclude remand of any case once it is placed in an MDL pre-trial court. *In re Farmers Ins. Co. Wind/Hail Storm Litig.*, MDL No. 16-0142, 2018 Tex. LEXIS 704 (Tex. July 13, 2018).

C. Discovery

Insured brought contractual and extra-contractual claims against her insurer based on a car accident with an underinsured motorist. The extra-contractual claims were severed and abated. In the underlying contractual claim, the handling adjuster verified insurer's responses to interrogatories. As such, insured noticed the adjuster's deposition. Insurer's motion to quash was denied and insurer sought mandamus relief. The court of appeals granted relief and determined the adjuster's deposition was not relevant to any asserted claim or defense, as questions about uninsured motorist coverage await determination of primary liability and damages. *In re Liberty Cnty. Mut. Ins. Co.,* 537 S.W.3d 214 (Tex. App.–Houston [1st Dist.] 2017, no pet.).

D. Arbitration

A farmer purchased a crop revenue coverage insurance policy through an insurance agency. The insurance policy contained an arbitration clause that referred to the insurer and farmer. The insurance agency was not named in the policy, nor did anyone from the agency sign the agreement. The farmer lost a crop and claimed he promptly contacted the insurance agency to report the loss. The claim was denied on several bases, including that the farmer did not provide timely notice to the insurer. The dispute was arbitrated, and the farmer lost on the issue that he did not timely provide notice of his claim. The farmer then sued the agency and agent for breach of fiduciary duty and deceptive trade practices. The agency moved to compel arbitration, which the farmer opposed arguing that the agency was a non-signatory to the arbitration agreement, but the trial court granted the agency's request. The agency won the arbitration, with the arbitrator deciding it had the right to arbitrate even though the agency was a non-signatory to the policy. The trial court confirmed the arbitration award, and the court of appeals affirmed. The farmer filed a petition for review with the Texas Supreme Court. The Texas Supreme Court held that given the absence of clear and unmistakable evidence that the farmer agreed to arbitrate arbitrability in a dispute with a non-signatory, compelled arbitration could not precede a judicial determination that an agreement to arbitrate existed. Therefore, the trial court should have determined whether a valid agreement existed between the farmer and the agency before any issue was referred to arbitration. Arbitrators lack authority to resolve a dispute absent a valid arbitration agreement. There are only six scenarios where arbitration with a non-signatory may be required: (1) incorporation by reference, (2) assumption, (3) agency, (4) alter ego, (5) equitable estoppel, and (6) third-party beneficiary.

The court held that the insurer did not have control over the agency's actions in relaying information from the farmer to the insurer, and therefore the insurer did not exercise control over the agency, so arbitration could not be compelled on an agency argument. Additionally, direct-benefits estoppel did not apply because the farmer was not attempting to sue the agency under the contract, but then avoid the arbitration clause in the contract. The farmer's claims against the agency are independent of the insurance policy, as they are general, non-contract obligations. Because the farmer and the agency did not agree to arbitrate any matter - not the question of arbitrability and not the merits of the dispute - the farmer should not have been compelled to arbitrate. Moreover, the agency and estoppel theories do not apply. Therefore, the court reversed the court of appeals' judgment, vacated the arbitration award, and remanded the case to the trial court for further proceedings. *Jody James Farms, JV v. Altman Grp, Inc.*, 547 S.W.3d 624 (Tex. 2018).

E. Appraisal

An insured submitted claims to its insurer for damage sustained to its apartment complexes. After the damage amount could not be agreed to, the insurer demanded appraisal as set out in the insurance policy. The insured then filed suit against the insurer, after which the insurer filed a motion to compel appraisal and abate the lawsuit. The trial court denied the insurer's motion to compel appraisal and request for abatement, and the insurer filed a petition for writ of mandamus to the appellate court. No claim of illegality was made against the insurer which would allow a waiver of the appraisal process in the contract. Moreover, the court held a waiver of the appraisal right did not occur, as an impasse was not reached in the case before the appraisal clause was invoked. An "impasse" is "the apparent breakdown of good-faith negotiations." The court held that even though the insured and insurer were arguing about the cost of repairs, that alone was not notice of an impasse. Additionally, the court noted the insured never notified the insurer that it refused to discuss the matter further prior to the appraisal request. It was only after the insured filed suit that the insurer had notice of the impasse, and by that time, it had already invoked the appraisal clause. Therefore, the appellate court vacated the order denying the insurer's motion to compel appraisal and abate, ordered the parties to engage in the appraisal process, and abated the lawsuit pending the completion of the appraisal

The Texas Supreme Court held that given the absence of clear and unmistakable evidence that the farmer agreed to arbitrate arbitrability in a dispute with a non-signatory, compelled arbitration could not precede a judicial determination that an agreement to arbitrate existed.

process. *In re Acceptance Indem. Ins. Co.*, No. 04-18-00231-CV, 2018 Tex. App. LEXIS 7795 (Tex. App.–San Antonio Sept. 26, 2018, pet. filed).

An insured filed a lawsuit against his homeowners insurer after his house was damaged. Insurer invoked the appraisal process and timely paid the cash value of the appraisal award. The trial court granted insurer's motion for summary judgment on the contractual and extra-contractual claims, as the insurer timely paid the award and the insured failed to show he suffered damages above and beyond the failure to receive policy proceeds. The court cited to *USAA Tex. Lloyds Co. v. Menchaca*, No. 14-0721, 2017 Tex. LEXIS 361 (Tex. April 7, 2017), to state that the insured must establish that the statutory violation caused an injury that is independent from the loss of benefits. Insured appealed and argued several covered items were excluded from the appraisal award. The court of appeals highlighted the insured failed to amend his pleadings to assert one of the three grounds to set aside the appraisal award. Further, the insured failed to move for the trial court to set aside the appraisal award. As such, the award bound the parties to the amount of the loss, and the insurer's tender of the amount owed estopped the insured from bringing a breach of contract claim. Likewise, insured's extra-contractual claims were barred by the controlling nature of the appraisal award. *Zhu v. First Cmty. Ins. Co,* 543 S.W.3d 428 (Tex. App.–Houston [14th Dist.] 2018, pet. filed) (It should be noted this case was decided prior to the new *Menchaca* ruling and cites to the old *Menchaca* case).

Insured submitted claim to his insurer after his property was damaged in a storm. Insurer said damage did not exceed deductible, so no payment was made. Insured then sued insurer for contractual and extra-contractual claims. The insurer invoked the appraisal process provided for in the policy, and the case was abated pending completion of the appraisal. Insurer timely paid the appraisal award, and the trial court granted summary judgment in insurer's favor holding payment of the appraisal award estopped the insured from maintaining a breach of contract claim and precluded the extra-contractual claims. On appeal, insured argued the court of appeals should reconsider its prior precedent based on the *Menchaca* decision that said a statutory bad faith claim could be proven without a corresponding breach of contract claim. However, the appellate court distinguished *Menchaca* on the basis it did not involve the payment of an appraisal award. Further, the court of appeals discussed the five rules outlined in *Menchaca* and explained the insurer was still entitled to summary judgment. *Ortiz v. State Farm Lloyds*, No. 04-17-00252-CV, 2017 Tex. App. LEXIS 10395 (Tex. App.–San Antonio Nov. 8, 2017, pet. filed).

An insured school district sued the Texas Windstorm Insurance Association for its handling of the school's Hurricane Ike claims. TWIA invoked the appraisal process which awarded $10.8 million in damages. TWIA failed to pay the award and argued the damages were not caused by covered perils, wind and hail. Rather, TWIA asserted the policy explicitly excluded damage caused by or resulting from "rain, whether driven by wind or not unless wind or hail first makes an opening in the walls or roof of the described building." Ultimately, the matter proceeded to trial where the jury awarded the school district $9.6 million in damages. TWIA appealed and argued, in part, the school district failed to establish the damages reflected in the appraisal award were caused by covered perils. Appraisal clauses generally estop a litigant from contesting damages; however, liability questions are reserved for the courts, especially when different causes are alleged for a single injury to property. The court explained, under the doctrine of concurrent causes, the insured is entitled to recover that portion of the damage caused solely by the covered peril. The matter was remanded, in part, to allow the parties to offer expert evidence to establish whether or not the damage was caused by a covered peril. *Tex. Windstorm Ins. Ass'n v. Dickinson Indep. Sch. Dist.*, No. 14-16-00474-CV, 2018 Tex. App. LEXIS 8083 (Tex. App.–Houston [14th Dist.] Oct. 4, 2018, no pet.).

Insured sued homeowners insurer for breach of contract and extra-contractual claims after he disagreed with its damage appraisal on a water damage claim. The trial court appointed an umpire to rule between the two appraisers, and the umpire sided with the insurer. Insured moved to vacate the award and appoint a new umpire because the award was "clearly a product of mistake." At the same time, insurer had a pending motion for summary judgment. The trial court denied the insured's motion, affirmed the umpire's award, and granted the insurer summary judgment on the insured's contractual claim. Insurer filed a second motion for summary judgment attacking the extra-contractual claims, which the trial court granted. Insured appealed, alleging the trial court erred in denying his motion to vacate and granting summary judgment to the insurer. The court of appeals sided with the insurer and affirmed the trial court's decisions. It acknowledged "mistake is one of the few grounds upon which an insurance appraisal award may be vacated," but that only applies when "the award fails to speak what the appraisers intended." Mere disagreements between appraisals are not mistakes and the umpire's decision to choose one over the other did not mean "'the appraisal resulted from accident or mistake.'" (quoting *MLCSV10 v. Stateside Enters., Inc.*, 866 F. Supp. 2d 691, 702 (S.D. Tex. 2012). The court also held that "mere omission of some aspect of damage" from the disputed appraisal is not sufficient to establish a mistake. The court upheld the trial court's summary judgment disposing of the insured's contractual claim because the insured based his appeal of that issue on the court's failure to grant his motion to vacate—which the appellate court affirmed. The court next addressed the insured's extra-contractual claims. It found the trial court's granting of summary judgment was proper because, in each instance, the insured failed to show evidence of actual damages or independent injury that resulted from his extra-contractual claims. Quoting the Supreme Court's recent decision in *USAA Tex. Lloyds Co. v. Menchaca*, 545 S.W.3d 479 (Tex. 2018), the court held an insured can only recover bad-faith damages if they are different from the benefits due under the contract. The court said the insured "cited us to no evidence of him suffering damages, much less to evidence of any injury causing damages independent of the benefits under the [insurer's] insurance policy." *Abdalla v. Farmers Ins. Exch.*, No. 07-17-00020-CV, 2018 Tex. App. LEXIS 3358 (Tex. App.–Amarillo May 14, 2018, no pet. h.).

F. Severance & Separate Trials

Insured sued underinsured motorist (UIM) insurer alleging breach of contract and extra-contractual claims after receiving the policy limits from the other party's insurer for injuries from a car accident. Citing *Brainard v. Trinity Universal Ins.* Co., 216 S.W.3d 809 (Tex. 2006), insurer moved to sever and abate the extra-contractual claims. Insured objected to abatement, citing the Texas Supreme Court's recent decision in *USAA Texas Lloyds Co. v. Menchaca*, 545 S.W.3d 479 (Tex. 2018), that held contractual and extra-contractual claims are "distinct and independent" of each other. The trial court severed the extra-contractual claims, but did not abate them. Insurer sought mandamus relief from the court of appeals, which said "[w]e believe the plaintiffs read *Manchaca* [sic] too broadly." *Menchaca*, it held, did not bluntly apply to UIM cases because, for one thing, it "never mentions *Brainard*, much less overrules or limits *Brainard*." For that to happen, the Supreme Court would have to do it itself. "When the Texas Supreme Court's decisions create uncertainties, 'it is [the Supreme Court's] duty to settle the conflicts in order that the confusion

will as nearly as possible be set to rest…'" (citing *Trapp v. Shell Oil Co.*, 145 Tex. 323, 198 S.W.2d 424, 427 (1946)).

The court cited its sister court dealing with a congruent post-*Brainard* issue this year: "[W]hatever the virtues of a contrary rule might be, as an intermediate court, we are bound to follow the rule laid down in *Brainard* unless and until the supreme court reconsiders or revises it." *Weber v. Progressive Cnty. Mut. Ins. Co.*, 2018 Tex. App. LEXIS 784 (Tex. App.–Dallas Jan. 26, 2018). Nevertheless, the court swiftly concluded "we believe the holding in *Menchaca* is consistent with the holding in *Brainard*." Quoting *Brainard,* it agreed UIM insurance is unlike other first-party insurance contracts because it relies on tort law to determine an insured's right to recover policy benefits. "[A] 'UIM contract is unique because, according to its terms, benefits are conditioned upon the insured's legal entitlement to receive damages from a *third* party.'" Having settled that, it moved on to whether it was improper for the trial court to refuse to abate the insured's extra-contractual claims. It cited two post-*Menchaca* appellate decisions that denied discovery on extra-contactual UIM claims that had been severed and abated. *See In re Allstate Fire & Cas. Ins. Co.*, 12-17-00266-CV, 2017 WL 5167350, at *4 (Tex. App.–Tyler Nov. 8, 2017, orig. proceeding)(mem. op.); *In re Liberty Mut. Ins. Co.*, 01-17-00363-CV, 2017 WL 4414033, at *4 (Tex. App.–Houston [1st Dist.] Oct. 5, 2017, orig. proceeding). The cases were instructive, the court reasoned, because they acknowledged discovery on contractual claims may be irrelevant to extra-contractual claims and protected an insurer from expending litigation resources on extra-contractual claims that could be rendered moot.

The court disregarded two pre-*Menchaca* appellate decisions used by the plaintiffs to show a "trend" allowing discovery on extra-contractual UIM claims. *See In re Luna*, 13-16-00467-CV, 2016 WL 6576879, at *1 (Tex. App.–Corpus Christi Nov. 7, 2016, orig. proceeding); *In re Garcia*, 04-07-00173-CV, 2007 WL 1481897, at *1 (Tex. App.–San Antonio May 23, 2007, orig. proceeding). "We do not believe either *Luna* or *Garcia* is inconsistent with the continued viability of *Brainard*," the court ruled. It noted that, in both cases, the extra-contractual claims had been severed and abated, and the court allowed discovery relevant to the breach of contract claims—something the insured was presumably free to do in this case as well. The court highlighted *Menchaca* did not involve a UIM claim or whether contractual and extra-contractual claims should be severed and abated. Therefore, the court granted the insurer's petition for writ of mandamus and directed the trial court to vacate the portion of its order denying the insurer's motion to abate, and abate the extra-contractual claims. *In re State Farm Mut. Auto. Ins. Co.*, 553 S.W.3d 557 (Tex. App.–San Antonio 2018, no pet. h.).

Insured was involved in a car accident with an uninsured driver which was not made a party to the underlying suit. Instead, insured sued insurer under the uninsured motorist provision of her policy. In her petition, insured alleged breach of contract, bad faith, as well as various violations of the DTPA and Insurance Code. The trial court denied insurer's motion to sever and abate the extra-contractual claims from the underlying claim until insured proved her contractual right to UIM benefits. The court of appeals granted mandamus and instructed the trial court to sever and abate the extra-contractual claims. The court noted an insured first has to show insurer is liable on the contract before the insured can recover on extra-contractual claims against an insurer for failing to pay or settle an underinsured claim. The court reasoned insurer was in a catch-22 situation and would be prejudiced by its submission of settlement offers. Absent a severance, insurer would have to decide whether to admit or exclude evidence of a settlement offer which jeopardizes the successful defense of the other claim. Specifically, in the contract claim, insurer will insist on excluding evidence of a settlement offer to negate liability. However, in the extra-contractual claims, insurer would insist on admitting the settlement offer to negate liability. Therefore, severance and abatement was appropriate. *In re Germania Ins. Co.*, No.13-18-00102-CV, 2018 Tex. App. LEXIS 2834 (Tex. App.–Corpus Christi April 23, 2018, no pet.).

G. Evidence

Insureds sued homeowners insurer after it denied their storm damage claim. Insurer filed traditional and no-evidence motion for summary judgment. Insureds responded with late-filed evidence, including two expert reports and an affidavit, and the insurer objected in writing. The trial court granted the insurer's summary judgment motion without specifying the grounds for the judgment, and failed to rule on the insurer's objections. The appellate court affirmed the trial court's judgment and held insured's summary judgment evidence was incompetent, as the reports were not verified or authenticated. The Texas Supreme Court noted that if purported summary-judgment evidence presents a defect in "form," the defect cannot provide "grounds for reversal unless specifically pointed out by objection by an opposing party with opportunity, but refusal, to amend." (citing Tex. R. Civ. P. 166a(f)). Moreover, if the insurer complained of a defect in form, the insurer was obligated to object and also obtain a ruling on its objection. The appellate court must have thought the defects complained of were substantive, which can be complained of for the first time on appeal. However, the defect the insurer complained of was one of form, so the insurer was required to obtain a ruling on the objection from the trial court. Therefore, the Texas Supreme Court reversed and remanded to the appellate court, holding that because insurer failed to obtain a ruling on its evidentiary objections to the affidavit's form from the trial court, the appellate court improperly disregarded it. *Seim v. Allstate Tex. Lloyds*, 551 S.W.3d 161 (Tex. 2018).

XII. OTHER ISSUES

A. Multiple Insurers

Insured sued two related underinsured motorist insurers for failure to pay claims after he settled with the liability carrier and another underinsured motorist carrier that covered the vehicle he was driving at the time of an automobile collision. The insurers denied the claims based on the "other insurance" provisions in their policies that deemed their coverage "excess over any other collectible insurance." The trial court granted summary judgment for the insurers and the court of appeals reversed and remanded, after which the parties stipulated to the tortfeasor's liability and the insured's total damages—which were less than the amount the insured recovered from the liability and primary

UIM carriers. Insured argued at trial that his UIM policies should both pay because "if you buy five life insurance policies, you get paid five times," but the trial court again found in favor of the insurers. Insured appealed arguing the "other insurance" language violated Sec. 1952.106 of the Insurance Code. The appellate court affirmed because the "other insurance" provisions did not prevent the insured from recovering his actual damages caused by the underinsured motorist. *Elwess v. Tex. Farm Bureau Mut. Ins. Co.*, 538 S.W.3d 776 (Tex. App.–Eastland 2017, no pet. h.).

B. Excess & Primary Coverage

An insured general contractor was hired to build a courthouse, and hired subcontractors to perform different construction roles. In addition to a first layer of insurance, the insured purchased a second layer of insurance that would kick in after the first layer was depleted. The construction did not go well, and the insured was fired from the job and the dispute was arbitrated with the final award totaling over $8 million. The insured brought subcontractors into the arbitration and settled with the subcontractors for around $4.5 million. After the first layer of coverage was exhausted, the insured looked to the second layer insurer who argued that the remaining amount fell under uncovered damages in the policy. The court held that the insured bore the burden to show that the subcontractor settlement proceeds were properly allocated to either covered or non-covered damages. Because the insured did not provide a detailed allocation, the Fifth Circuit affirmed the district court's granting summary judgment in favor of the second layer insurer. *Satterfield & Pontikes Constr., Inc. v. U.S. Fire Ins. Co.*, 898 F.3d 574 (5th Cir. 2018).

C. Worker's Compensation

Fuentes v. Texas Mut. Ins. Co., No. 04-16-00662-CV, 2018 Tex. App. LEXIS 2881 (Tex. App.–San Antonio Apr. 25, 2018, no pet.) involves a beneficiary's entitlement to workers' compensation benefits following her husband's death on the way to work. Insured worked at an air force base in San Angelo, Texas. Insured was tasked with delivering his crew's timesheet each week to the employer's office in San Angelo. He was permitted to fax the timesheets; however, he routinely dropped the time sheets off on his way to work at the air force base. Insured was involved in car accident on his way to the employer's office before starting his work day at the air force base.

The court reiterated travel to and from work is statutorily excluded from course and scope of work. This exclusion is commonly referred to as the "coming and going" exclusion. If an employee's ultimate destinations are home and work, the coming and going exclusion must be analyzed. The Texas Supreme Court has explained that for a claimant to recover for an injury occurring while traveling, he must show that the injury occurred while in "furtherance of his employer's affairs or business" and that the injury "originated in the employer's work, trade, business, or profession." The furtherance factor is generally met by traveling to and from work as "an employee's travel to and from work makes employment possible and furthers the employer's business, satisfying" the furtherance requirement.

Origination is a separate inquiry in which the court looks at many factors, including (1) whether the employment contract expressly or impliedly required the travel involved; (2) whether the employer furnished the transportation; (3) whether the employee was traveling on a special mission for the employer; and (4) whether the travel was at the direction of the employer, such as requiring the employee to bring tools or other employees to work or another location. After a fact intensive analysis, the court determined the insured's travel failed to meet the origination element. The court focused on the fact the insured worked on a separate worksite, was not reimbursed for travel, and was not in a company vehicle. Therefore, the court affirmed the trial court's summary judgment in favor of the insurer. *Fuentes v. Tex. Mut. Ins. Co.*, No. 04-16-00662-CV, 2018 Tex. App. LEXIS 2881 (Tex. App.–San Antonio Apr. 25, 2018, no pet.).

** Suzette E. Selden is an attorney at Selden & Company PC in Austin focusing on insurance litigation. She was selected by Thomson Reuters for inclusion in 2012-2015, 2017-2019 Texas Rising Stars® publication. Suzette currently is a committee member of the State Bar of Texas Women in the Profession Committee. She previously served as the President of the Capital Area Trial Lawyers Association. In 2002, Suzette graduated with highest honors from Brigham Young University with a B.A. in Communications, and with high honors from the University of Houston Law Center in 2006.*

*** Jonathan D. Selden is an attorney at Selden & Company PC in Austin, focusing on consumer and personal injury litigation. He currently serves as a committee member of the State Bar of Texas Jury Service Committee. He received a JD degree from Gonzaga University School of Law in 2003 and a BA degree from Brigham Young University in 2001.*

**** Dennis Grebe is an attorney at Burns Anderson Jury & Brenner, L.L.P. in Austin, focusing on workers' compensation defense. In 2010, Dennis graduated from Trinity University with a B.A. in Economics and then received his law degree from the University of Texas School of Law in 2014.*

---

1 *See Aldous v. Darwin Nat'l Assurance Co.*, 889 F.3d 798 (5th Cir. 2018); *Lyda Swinerton Builders, Inc. v. Okla. Sur. Co.*, 903 F.3d 435 (5th Cir. 2018); *State Farm Lloyds v. Fuentes*, 549 S.W.3d 585 (Tex. 2018); *Abdalla v. Farmers Ins. Exch.*, No. 07-17-00020-CV, 2018 Tex. App. LEXIS 3358 (Tex. App.–Amarillo May 14, 2018, no pet. h.).

2 *Perrett v. Allstate Ins. Co.*, No. 4:18-CV-01386, 2018 U.S. Dist. LEXIS 97405 (S.D. Tex. June 11, 2018).

3 *Avalos v. Loya Ins. Co.*, No. 04-17-00070-CV, 2018 Tex. App. LEXIS 5629 (Tex. App.–San Antonio July 25, 2018, pet. filed).

4 *Wausau Underwriters Ins. Co. v. Wedel*, No. 17-0462, 2018 Tex. LEXIS 519 (Tex. June 8, 2018).

5 *USAA Tex. Lloyds Co. v. Menchaca*, 545 S.W.3d 479 (Tex. 2018).

6 *See In re State Farm Mut. Auto. Ins. Co.*, 553 S.W.3d 557 (Tex. App.–San Antonio 2018, no pet. h.).

7 *USAA Tex. Lloyds Co. v. Menchaca*, 545 S.W.3d 479 (Tex. 2018).

8 *Id.*