Annual Survey of Texas Insurance Law 2003

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I. INTRODUCTION

Perhaps the most discussed case of the year was the United States Supreme Court opinion in *State Farm Mut. Auto. Ins. Co. v. Campbell*, 123 S. Ct. 1513 (2003). The case focused on the reasonableness of a punitive damages award in a suit against State Farm for its failure to settle a liability claim within policy limits. The Supreme Court criticized the use of evidence of other misconduct by State Farm. While recognizing that other acts need not be identical to be relevant, the Court concluded that the significant amount of evidence used that had nothing to do with third-party lawsuits was error.

In addition to *State Farm*, there were many state court decisions impacting insurance law, including the Texas Supreme Court decision that held that diminished value is not part of the insured cost of repairing an automobile. A number of appellate cases dealt with claims for mold damage cause by water leaks, and the courts considered the use of experts in these and other insurance cases. A couple of courts revisited the issue of insuring punitive damages, and reaffirmed that they are insurable under Texas law.

But before discussing any of these decisions, it is necessary to address a number of significant changes enacted by the Texas Legislature.

II. LEGISLATIVE CHANGES

A. Form deregulation

Historically, standard policy forms for automobile insurance were promulgated by the Texas Department of Insurance, and all insurers writing automobile insurance in Texas were required to use these forms. Residential property insurers could use either standard forms or forms from national insurers or organizations that were approved by the Texas Department of Insurance. Senate Bill 14 deregulated the use of policy forms in those areas, allowing insurers to draft their own policies. Act of June 11, 2003, 78th Leg., R.S., ch. 206, § 2.01, 2003 Tex. Sess. Law Serv. ch. 206, §2.01 (to be codified as an amendment to Tex. Ins. Code art. 5.145).

B. Limitations for unfair discrimination

Senate Bill 14 changed the statute of limitations for unfair discrimination claims brought under article 21.21-8 from one year to two years. Act of June 11, 2003, 78th Leg., R.S., ch. 206, §12.03, 2003 Tex. Sess. Law Serv. ch. 206, §12.03 (to be codified as an amendment to Tex. Ins. Code art. 21.21-8, § 3(c)). The bill also made the two-year limitations period subject to the discovery rule. *Id.*

C. Water damage claim

In Senate Bill 127, the Legislature carved out an exception to article 21.55 of the Texas Insurance Code (relating to the prompt payment of claims) for claims relating to water damage. Act of June 11, 2003, 78th Leg. R.S., ch. 207, § 2.01, 2003 Tex. Sess. Law Serv. ch. 207, § 2.01 (to be codified as Tex. Ins. Code art. 21.55A). The statute delegates

to the Commissioner of Insurance the authority to adopt rules that "require more prompt, efficient, and effective processing and handling [of claims] than the processing and handling required under Article 21.55[.]" *Id.* at § 3(a). At the time of this writing, the new rules had not been promulgated.

D. *Stowers* Doctrine

In House Bill 4, the Legislature revised provisions of the article 4590i cap on wrongful death damages. Act of June 11, 2003, 78th Leg., R.S., ch. 204, § 10.01, 2003 Tex. Sess. Law Serv., ch. 204, § 10.01. The former statute provided that the cap "shall not limit the liability of any insurer where facts exist that would enable a party to invoke the common law theory of recovery commonly known in Texas as the '*Stowers* doctrine.'" *See* Tex. Rev. Civ. Stat. Art. 4590i § 11.02(c) (Vernon 2001). Insureds argued that the statute indicated a legislative intent that under certain circumstances the insurer would be responsible for damages in excess of the caps. *See, e.g., Spohn Hosp. v. Mayer*, 72 S.W.3d 52 (Tex. App.–Corpus Christi 2001), *rev'd on other grounds* 104 S.W.3d 878 (Tex. 2003). The new statute attempts to eliminate that argument, providing that "[t]he liability of any insurer under the common law theory of recovery commonly known in Texas as the '*Stowers* Doctrine' shall not exceed the liability of the insured." Tex. Civ. Prac. & Rem. Code § 74.303(d).

E. Prompt payment of health care provider claims

Senate Bill 418 provides for the regulation and prompt payment of health care providers under certain health benefit plans and establishes penalties for violations of statutory provisions. Act of June 17, 2003, 78th Leg., R.S., ch. 214, 2003 Tex. Sess. Law Serv. ch. 214.

F. Mold remediation

House Bill 329 relates to the regulation of mold assessors and remediators. Act of June 11, 2003, 78th Leg. R.S., ch. 2005, 2003 Tex. Sess. Law Serv. ch. 2005. The Act exempts a property owner from civil liability for damages related to mold remediation if the property is certified. *Id.* at § 1 (to be codified at Tex. Occ. Code § 1958.303).

G. Amount of insurance required by lenders

Some lenders have required consumers to insure their homes for an amount that at least equals the loan value. Considering the value of land, there are cases where this requirement results in the consumer being required to purchase a higher level of insurance for a home than is needed to replace the home in the event of a total loss. House Bill 1338 provides that no lender may require, in connection with certain financing arrangements, a borrower to purchase homeowners, mobile or manufactured home, or other residential property insurance coverage in an amount that exceeds the replacement value of the dwelling and its contents. Act of June 20, 2003, 78th Leg., R.S., ch. 538, § 1, 2003 Tex. Sess. Law Serv. ch. 538, § 1, (to be codified as an amendment to Tex. Ins. Code art. 21.48A).

H. Recodification of the Texas Insurance Code

House Bill 2922 makes nonsubstantive revisions to the Texas Insurance Code, including the provisions relating to unfair insurance practices. Act of June 21, 2003, 78th Leg., R.S., ch. 1274, 2003 Tex. Sess. Law Serv. ch. 1274. The Act becomes effective April 1, 2005, giving us two years to begin referring to violations of article 21.21 as violations of article 541.

III. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile

The Texas Supreme Court held that the plain language of the standard personal automobile policy covering the cost to "repair or replace" the vehicle does not include diminished value when the vehicle has been fully and adequately repaired. *American Manuf. Mut. Ins. Co. v. Schaefer*, ___ S.W.3d ___, 2003 WL 22417186 (Tex., Oct. 17, 2003). This holding, of course, trumps the contrary conclusion reached in cases such as *State & County Mut. Fire Ins. Co. v. Macias*, 83 S.W.3d 304 (Tex. App.–Corpus Christi 2002, pet. filed).

The Supreme Court also held that an automobile borrowed without the owner's permission was not a "temporary substitute" vehicle and was not covered by the driver's policy. *Progressive County Mutual Ins. Co. v. Sink*, 107 S.W.3d 547 (Tex. 2003). McCauley's truck was disabled, so he borrowed a car from his employer. He did not have permission and did not believe he had permission to use the car. McCauley subsequently wrecked the vehicle. The policy covered property damage but excluded any vehicle used "without a reasonable belief that the person is entitled to do so." This exclusion did not apply to "your covered auto." That phrase included any auto used as a "temporary substitute" for any other insured vehicle because of its breakdown. The majority held that the policy language had to be given the meaning of the words as understood by the general public. The court concluded that the general public would not expect coverage for a car that was driven without permission. The dissenters felt the policy covered any substitute vehicle, and did not depend on whether the car was used without permission.

B. Homeowners

In *United Services Auto. Ass'n v. Gordon*, 103 S.W.3d 436 (Tex. App.–San Antonio 2002, no pet. h.), the court held that homeowners could not recover under extracontractual theories for the insurer's failure to pay a claim for foundation damage caused by a plumbing leak, where they failed to prove any damages apart from those stemming from the denial of the claim. The court repeated dicta found in other decisions stating that an insured is not entitled to recover extracontractual damages unless the conduct caused damages independent of the injury resulting from the wrongful denial of policy benefits.

This erroneous conclusion conflicts with *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129 (Tex. 1988), which held:

> The Vails suffered a *loss* at the time of the fire for which they were entitled to make a claim under the insurance policy. It was not until Texas Farm wrongfully denied the claim that the Vails' loss was transformed into a legal *damage*. That damage is, at minimum, the amount of policy proceeds wrongfully withheld by Texas Farm. The fact that the Vails have a breach of contract action against Texas Farm does not preclude a cause of action under the DTPA and article 21.21 of the Insurance Code. Both the DTPA and the Insurance Code provide that the statutory remedies are cumulative of other remedies. . . . It is well settled that persons without insurance are allowed to recover based on false representations of coverage, . . . and that an insurer may be liable for damages to the insured for its refusal or failure to settle third-party claims. . . . It would be incongruous to bar an insured – who has paid premiums and is entitled to protection under the policy – from recovering damages when the insurer wrongfully refuses to pay a valid claim. Such a result would be in contravention of the remedial purposes of the DTPA and the Insurance Code. . . .

754 S.W.2d at 136-37 (citations omitted).

The fallacy of the *Gordon* court's reasoning is shown by its holding that the insureds could not recover additional living expenses because the policy only covered such expenses that had been "incurred." Admitting that the insureds suffered such a loss outside the contract, the court acknowledged the insureds in fact had extracontractual damages, if such were required. Further, in *Luna v. North Star Dodge Sales, Inc.*, 667 S.W.2d 115, 118-19 (Tex. 1984), the supreme court held that a consumer could recover the cost of a rental replacement vehicle, as consequential damages, without actually incurring that expense. The same reasoning should apply to the cost of replacement housing as consequential damages.

A landlord who acquired ownership of real property was not entitled to recover benefits under the former landlord's fire insurance policy. The lease required that the landlord and tenant each maintain appropriate insurance for their respective interests, and the policy provided that it could not be assigned without the insurer's written consent. *Automobile Ins. Co. v. Young*, 85 S.W.3d 334 (Tex App.–Amarillo 2002, no pet. h.).

Homeowners were not required to provide receipts and written documentation to recover additional living expenses. The court held the policy was ambiguous and could be construed to allow written documentation or an examination under oath. Because the insureds gave an examination under oath, they did not have to provide documentation. *Beacon Nat'l Ins. Co. v. Glaze*, 114 S.W.3d 1 (Tex. App.–Tyler 2003, pet. denied). It seems a simpler rationale supports the court's conclusion. The policy expressly required an accurate record of repair expenses and required receipts and documents justifying the inventory of personal property. The presence of these express requirements for personal property precludes implying such a requirement for additional living expenses. *Inclusio unius est exclusio alterius*.

Where an insurance agency knew the insured had died, but had conversations with the son about continuing the policy, sent renewal notices to the son, and accepted renewal premiums from the son, there was sufficient evidence to show a contract to provide insurance and a breach of that contract when the agency allowed the policy to lapse. *Live Oak Ins. Agency v. Shoemake*, 115 S.W.3d 215 (Tex. App.–Corpus Christi 2003, no pet h.).

Homeowners sued their insurer for coverage for water damage and mold. The insureds asserted that their home became untenantable, entitling them to alternate living expenses under the policy. As a matter of first impression, the court concluded that an untenantable home is one that cannot be used for the purposes for which it is intended and cannot be restored, using ordinary repairs, without unreasonable interruption of the occupancy. That definition creates a reasonable person standard; thus, the occupant's subjective belief that the home is not up to their "standard of living" is not competent evidence of untenantability. *Flores v. Allstate Texas Lloyd's Co.*, 229 F. Supp.2d 697 (S.D. Tex. 2002).

In *Flores v. Allstate Texas Lloyd's Co.*, 278 F. Supp.2d 810 (S.D. Tex. 2003), the court held that the HOB policy covers mold damage to the dwelling or personal property that ensues from an otherwise covered water damage event under the policy.

Based on the reasoning in *Flores v. Allstate Texas Lloyd's Co.*, 278 F. Supp.2d 810 (S.D. Tex. 2003), the court rejected the insurer's argument that the homeowners' policy excluded all mold claims. *Salinas v. Allstate Texas Lloyd's Co.*, 278 F. Supp.2d 820 (S.D. Tex. 2003). The court further found that the policy provision repealing the mold exclusion for personal property coverage in the standard homeowners' policy did not also repeal the mold exclusion for dwelling coverage. The mold exclusion, the court observed, applied on its face to both dwelling and personal property damage, not merely dwelling coverage, and its partial repeal created no ambiguity. The court accepted the plaintiffs' argument that the "ensuing loss" provision provides coverage for certain mold losses that result from otherwise covered water damage events, but rejected the plaintiffs' contention that the policy should also cover mold damage resulting from an excluded loss, like deterioration.

C. Life insurance

An insured's statement that he had not been told he had cancer was a representation, not a condition precedent, so the insurer had to prove it was a misrepresentation in order to avoid paying the claim. *Protective Life Ins. Co. v. Russell*, 119 S.W.3d 274 (Tex. App.–Tyler 2003, pet. denied). The court analyzed the difference between representations and conditions, such as good health clauses. The court concluded that the language at issue was a representation. The insured had been told only that it was possible he had cancer, so the court concluded there was no misrepresentation. Therefore, the insurer was liable for the policy benefits, attorney's fees, penalties under article 21.55, and prejudgment interest.

AN EMPLOYER DOES NOT HAVE AN INSURABLE INTEREST IN THE LIFE OF AN EMPLOYEE WHOSE TERMINATION WOULD CAUSE NO FINANCIAL HARDSHIP TO THE COMPANY.

The court also held that the insurer waived any misrepresentation defense by failing to give the notice within ninety days after discovering the falsity of the representations, as required by article 21.17. The insurer could not rely on the exemption in article 21.35, because the incontestability clause was not absolute and therefore did not comply with the statute.

A life insurer was not entitled to summary judgment on its defense that the insured committed suicide. The autopsy report, inquest, and investigative report did not conclusively show that the insured committed suicide. Further, the beneficiary raised a fact issue by proof that the insured had many reasons to live, had not left a suicide note, and was not shown to have pulled the trigger on the gun that killed him. *Price v. American National Ins. Co.*, 113 S.W.3d 424 (Tex. App.–Houston [1st Dist.] 2003, no pet. h.).

An insured's designation of

his former spouse as beneficiary was a constructive fraud on the community, absent proof that the gift was fair to the surviving spouse – such as proof that the deceased had sufficient community property to reimburse his surviving spouse for the gift. Therefore, the surviving spouse was entitled to the proceeds. *Madrigal v. Madrigal*, 115 S.W.3d 32, (Tex. App.–San Antonio 2003, no pet. h.).

An employer does not have an insurable interest in the life of an employee whose termination would cause no financial hardship to the company. Lacking the necessary insurable interest, the company held the policy benefits in constructive trust for the insured's estate. *Torrez v. Winn-Dixie Stores, Inc.*, 118 S.W.3d 817, (Tex. App.–Fort Worth, 2003, pet. filed).

Former employees brought an action against their employer seeking a declaration that the employers did not have an insurable interest in corporate-owned life insurance policies on the lives of their employees. *Mayo v. Hartford Life Ins. Co.*, 220 F. Supp.2d 714 (S.D. Tex. 2002). The court agreed, noting that there was no showing that any covered employee was a "key man."

In reaching the same conclusion in a companion case, *Mayo v. Hartford Life Ins. Co.*, 220 F. Supp.2d 794 (S.D. Tex. 2002), the court reasoned that the employer lacked an insurable interest in the corporate-owned life insurance policies where the policy was one of 350,000 taken out on the lives of all members of the employer's group health plan. An employer does not gain an insurable interest by virtue of the fact that the purpose of the policy was to defray the cost of replacing the insured upon his death.

In *Moody Nat'l Bank v. GE Life & Annuity Assurance Co.*, 270 F. Supp.2d 875 (S.D. Tex. 2003), the bank, as assignee of life insurance policy that was used to collateralize a loan, sued the insurer to recover when the insured borrower died after the policy lapsed. The bank relied on a prelapse letter from the insurer that recognized the assignment, to claim promissory estoppel. The court concluded that the bank did not rely on the insurer's alleged promise to pay. Further, any reliance on the alleged promise was unreasonable, because it was inconceivable that the insurer would guarantee payment regardless of the policy lapse and without negotiation or any consideration. Finally, the bank did not suffer any damages from the alleged promise, because it did not loan any additional money to the insured.

D. Disability insurance

Several insureds bought disability policies from an insurer. The policies contained a promise to refund 80% of the premiums if the insureds had no claims for ten years. After the policies had been in force for many years and premiums were refunded under these provisions, the insurer sold the policies and assigned them to a second insurer. The second insurer canceled the policies after nine years, cutting off the premium refunds. When the insureds sued the first insurer, it contended the transfer was a "novation," which insulated it from any liability. The court held that the insurer failed to conclusively establish this defense. Language telling the insureds there would be "no change" in their contracts and that the assumption was not a waiver or release of any rights raised a fact issue on whether the insureds intended to release the first insurer. *Vandeventer v. All American Life & Cas. Co.*, 101 S.W.3d 703 (Tex. App.–Fort Worth 2003, no pet. h.).

The *Vandeventer* court also found the insureds stated a claim for an "illusory contract," which would entitle them to a refund of their premiums. The contracts were illusory because they contained a provision giving the insurer the right to cancel the group at any time, which would not bind the insurer to perform the premium refund provision.

The court in *General Electric Capital Assurance v. Van Norman,* 209 F. Supp.2d 668 (S.D. Tex. 2002), held that the daughter (as sole heir to all of the father's estate) was entitled to the proceeds from his accidental death and dismemberment policy under the Family Code provision disqualifying the former spouse, who was designated as the policy beneficiary prior to the divorce.

E. Title Insurance

A title insurer was not liable for failing to disclose an outstanding encumbrance. The title commitment was merely a statement of the terms under which the insurer would issue the policy, not an abstract affirming the state of the title; therefore, the insurer was not liable for fraud or negligent misrepresentation. There was no representation regarding the title. Because the deal never closed, the title insurer was not liable for breach of contract. Finally, the title insurer was not liable for breach of the duty of the good faith and fair dealing, because the title insurer never became an insurer. *Hispanic Housing & Education Corp v. Chicago Title Ins. Co.*, 97 S.W.3d 150 (Tex. App.–Houston [1st Dist.] 2002, pet. denied).

F. Commercial property

A commercial property insurer owed the more expensive cost of a comparable roof, despite its contention that an identical roof was cheaper. The term "like" in the policy was broad enough to include a comparable roof. Further, the extra cost was due to the speed with which the insured had the roof replaced to avoid further damage, which was required by the policy. *Republic Underwriters Ins. Co. v. Mex-Tex, Inc.*, 106 S.W.3d 174 (Tex. App.–Amarillo 2003, no pet. h.).

A business insurance policy covered the cost to replace lost computer data, the cost of replacement software and hardware, and lost income resulting from a computer virus. The loss was "accidental" from the perspective of the insured, even though it was intended by the hacker. Further, the loss was a "direct physical loss." *Lambrecht & Assoc. v. State Farm Lloyds*, 119 S.W.3d 16 (Tex. App.–Tyler 2003, no pet. h.).

A commercial property policy that covered theft of property from a vehicle within 100 ft. of the described premises did not cover a loss that occurred within 100 ft. of the shopping center, but more than that distance from the insured's suite. *Evergreen Nat'l Indem. Co. v. Tan It All, Inc.*, 111 S.W.3d 669 (Tex. App.–Austin 2003, no pet. h.).

G. Other policies

In *Northfield Ins. Co. v. Tri My Way, Inc.*, __ F. Supp.2d __, 2003 WL 21854424 (N.D. Tex., Jan. 27, 2003), an insurer sought a declaration that it had no further liability under a policy covering a sailing vessel for losses incurred in a hurricane. The court concluded that the unpaid losses fell within the exclusion for losses due to ordinary wear and tear, gradual deterioration, and lack of maintenance, or were items that should have been submitted as a second claim separate from the hurricane damage.

The insured sought coverage for a shipper's fraudulent collection on a letter of credit issued by the insured's bank. *Parkans Int'l, LLC v. Zurich Ins. Co.*, 299 F.3d 514 (5th Cir. 2002). The shipper presented forged documents to secure payment for a shipment that was never made. The court held that the crime coverage provision applicable to forged documents "made or drawn upon [the insured]" or its agent did not cover the shipper's presentation of forged documents to a bank to obtain payment on a letter of credit issued by the insured's bank. Neither the letter of credit nor

the forged documents were "made or drawn by or drawn upon" the insured, and the insured's bank was acting as a principal for itself rather than as an agent of the insured in the transaction.

In coverages for a similar case, the court held that losses resulting from the "forgery" or alteration of "covered instruments" did not apply when the insured paid fraudulent invoices submitted by a vendor. *Travelers Cas. & Sur. Co. v. Baptist Health Sys.*, 313 F.3d 295 (5th Cir. 2002). The court held the invoices were not "made or drawn by or drawn upon" the insured, as those terms were used in the commercial paper context. The court rejected the argument that the checks issued on the invoice should be considered as one instrument.

In *Performance Autoplex II, Ltd. v. Mid-Continent Cas. Co.*, 322 F.3d 847 (5th Cir. 2003), two vehicle dealerships asserted claims under their commercial crime coverage policies. The court found one of the dealerships failed to establish a covered claim for inventory losses caused by its parts manager. The dealership failed to show that the parts manager, who admitted stealing cash and parts from the dealership, caused all the inventory losses. The court also found that unauthorized pay increases secured by the controller and another employee were not covered under the policy, which excluded salaries from covered employee dishonesty losses.

An apartment complex owner sued its commercial property and excess insurers seeking coverage for water damage to each of nineteen apartment buildings for defects traceable to installation of the plumbing system. *U.S. Texas One Barrington, Ltd. v. General Star Indem. Co.*, 332 F.3d 274 (5th Cir. 2003). The court held that costs incurred in accessing the plumbing system for repair are not covered under the policy. The court further concluded that damage to each of the apartment buildings was a separate occurrence under the excess policy; therefore, the insured had to pay nineteen deductibles. Because the net loss attributable to each apartment was less than each deductible, summary judgment for the excess insurer was appropriate.

IV. FIRST PARTY THEORIES OF LIABILITY

A. Breach of Contract

A life insurer was not liable for additional benefits where it never approved the requested increase, and the policy unambiguously required written approval. The court held that by accepting premiums for over four years the insurer still did not waive, and was not estopped to assert, the requirement of written approval. The court relied on cases holding that waiver and estoppel may operate to prevent an insurance company from avoiding payment because of a failure on the part of the insured to comply with a procedural requirement, but cannot enlarge the risk covered by the policy. *Royal Maccabees Life Ins. Co. v. James*, __ S.W.3d __, 2003 WL 1848601 (Tex. App.–Dallas, April 10, 2003, no pet. h.). One judge dissented.

It seems the dissent has the better of this argument. Numerous cases hold that waiver and estoppel cannot create coverage that would not otherwise exist. These involve issues where the loss or risk would not have been covered by the language of the policy. Waiver and estoppel can apply to policy requirements, such as filing a proof of loss, that do not affect whether the loss would have been within the scope of the policy. The requirement of written approval affected the process by which insurance was issued, not whether the risk would have been covered.

A borrower was not a third party beneficiary of private mortgage insurance required by her lender. There was no showing that she directly benefited, nor was she trying to enforce a PMI contract provision. *Bennett v. Bank United*, 114 S.W.3d 75 (Tex. App.–Austin 2003, no pet. h.). The court distinguished *Palma v. Verex Assurance, Inc.*, 79 F.3d 1453 (5th Cir. 1996), which held a borrower did have standing as a third party beneficiary of a PMI contract. Unlike the *Palma* court, the *Bennett* court did not have the insurance contract language before it.

In a case involving a misrepresentation to the insured that premiums would vanish on the insured's life insurance policy, the court held that the policy unambiguously provided that premiums were payable for life unless dividend performance was sufficient to cover the premium payments. *Hunton v. Guardian Life Ins. Co.*, 243 F. Supp.2d 686 (S.D. Tex. 2002). The court noted that the insurance agent did not have authority to alter the terms of the policy, and that parol evidence could not be relied upon to alter the terms of the parties' written agreement. The court held that the illustrations used by the agent to sell the policy were not incorporated into the final contract, because the illustrations were not signed, and the policy did not expressly incorporate them. The court refused to reform the policy to include the illustrations, absent a showing that the insurer initially agreed to the terms of the illustrations as a contract.

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

The court upheld a $4 million verdict for unfair settlement practices and breach of the duty of good faith and fair dealing based on an insurer's conduct in handling a claim for mold damage resulting from plumbing leaks, in *Allison v. Fire Ins. Exch.*, 98 S.W.3d 227 (Tex. App.–Austin 2002, pet. filed). The claim was delayed because the adjuster lacked authority and experience. There was evidence that the adjuster misrepresented the reason she needed more time to pay the claim; that the adjuster misrepresented that a "complete plumbing test" had been done; that the homeowner was told she could not remove a damaged wood floor because that would jeopardize coverage; that the insurer required a large number of inspections that were designed to harass and cause further delay; that the insurer delayed for three weeks paying a claim for damage to a hardwood floor, after receiving all the information that was needed; and that, despite having all the information needed to pay for remediation of the house, the insurer invoked the appraisal provision of policy, causing eighteen months more delay, during which time mold continued to grow in the house. The court also found sufficient evidence of misrepresentations in violation of the DTPA, but not sufficient evidence that the insurer acted unconscionably.

The *Allison* court also found there was no evidence that the insurer acted "knowingly." Although the insurer acted unreasonably in handling the claims, the court found no evidence that the insurer had subjective awareness of the falsity, deception, or unfairness of its conduct. The court therefore reversed the awards for punitive damages and mental anguish.

There was some evidence of a misrepresentation by a life insurer that it accepted premiums from the insured for four years, but failed to approve the policy, and thus denied coverage. However, because the jury did not find the agent made any misrepresentation, and there was no other evidence of a misrepresentation by the company, the

evidence was factually insufficient. Also, because the policy expressly required written approval, and there had been no written approval, there is no evidence to support the jury finding of unconscionability. *Royal Maccabees Life Ins. Co. v. James*, __ S.W.3d __, 2003 WL 1848601 (Tex. App.–Dallas, April 10, 2003, no pet. h.).

A borrower was a "consumer" as to a subsequent noteholder who required private mortgage insurance, because her objective in the original transaction was to acquire real estate. However, the subsequent noteholder did not act unconscionably by continuing to require private mortgage insurance even after the loan to value ratio dropped below 80%, despite the practice of the initial lender to drop the PMI requirement. The original loan documents required PMI until the note was paid in full. *Bennett v. Bank United*, 114 S.W.3d 75 (Tex. App.–Austin 2003, no pet. h.). The borrower also could not show any damages from any misrepresentation because the lender was not obligated to cancel the insurance.

The court found issues of material fact precluded summary judgment for a broker of a commercial crime policy. *Performance Autoplex II, Ltd. v. MidContinent Cas. Co.*, 322 F.3d 847 (5th Cir. 2003). The court found issues of fact remained on the insured's claim that the broker misrepresented the scope of coverage. The broker represented that the employee dishonesty policy would cover inventory losses when there was evidence of criminal activity by the employee. (In an earlier part of the opinion, the court concluded that the inventory losses were not a covered claim.) The court rejected the argument that the representations were too broad or general to be actionable.

C. Prompt Payment of Claims – Article 21.55

A life insurer was liable for penalties when it failed to timely acknowledge a claim after its agent received notice. The court held that notice to the agent counted as notice to the company and was sufficient to start the time for acknowledgement. *Protective Life Ins. Co. v. Russell*, S.W.3d 274 (Tex. App.–Tyler 2003, pet. denied).

A commercial property insurer was liable when it failed to timely pay a claim. The 18% penalty was calculated on the entire amount of the claim submitted by the insured, not just the difference between the amount claimed and the amount offered by the insurer. *Republic Underwriters Ins. Co. v. Mex-Tex, Inc.*, 106 S.W.3d 174 (Tex. App.–Amarillo 2003, pet. filed).

In *Allison v. Fire Ins. Exch.*, 98 S.W.3d 227 (Tex. App.–Austin 2002, pet. filed), the insurer was liable for the 18% penalty under article 21.55 because it did not pay the claim within sixty days after receiving all the information it needed; however, the insurer was not liable for the period of time when the insured caused the delay.

The court held that the insurer's wrongful rejection of the insureds' claim, even if made in good faith, could be considered a delay in payment for the purposes of the sixty-day rule and statutory damages under article 21.55. *Keeling v. State Farm Lloyds*, __ F. Supp.2d __, 2002 WL 31230804 (N.D. Tex., Sept. 30, 2002).

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

In *Vandeventer v. All American Life & Cas. Co.*, 101 S.W.3d 703 (Tex. App.–Fort Worth 2003, no pet. h.), the court held the insureds did not state a claim for breach of the duty of good faith and fair dealing based on a subsequent insurer canceling their disability policies. The insureds sued their prior insurer arguing that it dumped the unprofitable policies on a less solvent company. The court found no such cause of action under the law of the insureds' home states, and the court also found no such cause of action under Texas law.

It seems the court erred in finding no such cause of action under Texas law. In *Union Bankers Ins. Co. v. Shelton*, 889 S.W.2d 278 (Tex. 1994), the supreme court recognized that the duty of good faith and fair dealing is breached by canceling a policy without a reasonable basis. The court stated:

> The insured is not merely at the mercy of the insurer to treat him fairly in the processing of a single claim, but must rely on the insurer's good faith for the continued existence of any coverage. The insurer's ability to cancel unilaterally an insurance policy and the insured's inability to prevent cancellation demonstrates a great disparity in bargaining power between the two parties. Furthermore, a failure to extend the duty of good faith and fair dealing to the cancellation of an insurance policy would allow insurers to avoid bad faith liability by canceling the entire policy rather than denying a single claim.

Id. at 283.

Where a life insurer did not owe a claim, because it had never given the required written approval to issue the policy, there was also no basis for finding the insurer breached its duty of good faith and fair dealing. *Royal Maccabees Life Ins. Co. v. James*, __ S.W.3d __, 2003 WL 1848601 (Tex. App.–Dallas, April 10, 2003, no pet. h.).

E. Unfair discrimination

A borrower could not sue for unfair discrimination for the lender's failure to cancel private mortgage insurance, because she was not the policyholder. *Bennett v. Bank United*, 114 S.W.3d 75 (Tex. App.–Austin 2003, no pet. h.).

F. Fraud

Although the evidence supported the jury's findings that the insurer committed unfair settlement practices and made misrepresentations, the evidence was not sufficient to find the insurer guilty of fraud in the handling of a mold damage claim in *Allison v. Fire Ins. Exchange*, 98 S.W.3d 227 (Tex. App.–Austin 2002, pet. filed), noted above.

G. ERISA

A twenty-seven month limitations period in an ERISA plan was reasonable and would be enforced, despite the insurer's failure to give notice of the denial that complied with ERISA. The court found that the insureds were given reasonable notice of the denial, even though the denial did not provide the specific reason, as required by ERISA. *Hand v. Stevens Transport, Inc. Employee Benefit Plan*, 83 S.W.3d 286 (Tex. App.–Dallas 2002, no pet.).

In *Blum v. Spectrum Restaurant Group, Inc.*, 261 F. Supp.2d 697 (E.D. Tex. 2003), the beneficiary of decedent's group supplemental life insurance plan brought suit against the plan, plan sponsor and plan administrator/insurer. In granting the defendants' motion for summary judgment, the court held that the plan sponsor was not a proper party in a suit for the wrongful denial of ERISA benefits. When turning its attention to the plan administrator's denial of the claim, the court noted that its review of the administrator's decision was limited to the administrative record. The proper remedy for an incomplete record was to remand the case to the plan administrator; this remedy was not sought by the plan participant. Finally, when reviewing the plan administrator's decision, the court concluded that the administrator's interpretation of the terms of the plan to require that the participant submit evidence of good health in order to qualify

for coverage beyond the plans guaranteed amount was consistent with a fair reading of the plan.

In *Musmeci v. Shwegmann Giant Super Markets, Inc.*, 332 F.3d 339 (5th Cir. 2003), retirees brought a class action against their employer and the employer's excess liability insurer after termination of the voucher plan designed to provide retirees with a portion of their monthly food needs. The court concluded that the voucher plan provided retirement income and was therefore governed by ERISA. Monetary damages were an appropriate remedy for retirees denied benefits by the plan, and the retirees were not limited to the recovery of the vouchers themselves, which had become worthless following the sale of the employer's business. Because the employer was both the plan administrator and plan sponsor, the employer (and not just the plan itself) could be held liable under ERISA. While the decision to terminate the plan did not constitute a breach of fiduciary duty under ERISA, both the employer and the employer's executive could be held liable for acts before termination, such as the failure to fund the plan, failure to hold plan assets in trust and failure to fulfill statutory disclosure and reporting requirements.

V. AGENTS, AGENCY & VICARIOUS LIABILITY

A. Insurer's own liability

A life insurer was not liable for breach of contract or negligent misrepresentation, based on its decision to give commissions to one agent instead of another, where the contracts between the agents and the company gave the company that authority. Furthermore, the agent who got the commissions was not liable for tortiously interfering with the other agent's contract with the company, because the company fulfilled its contractual obligation to consider and resolve the dispute. *New York Life Ins. Co. v. Miller*, 114 S.W.3d 114 (Tex. App.–Austin 2003, no pet. h.).

B. Individual liability of agents, adjusters, and others

In a dispute between an insurance agency and a former agent, the agent could not be ordered to turn over his commissions to the unlicensed agency, because that would violate statutory provisions against sharing commissions with an unlicensed person. *Ahmed v. Shimi Ventures, L.P.*, 99 S.W.3d 682 (Tex. App.–Houston [1st Dist.] 2003, no pet. h.).

An insurer paid a noncovered claim because the agent represented it would obtain coverage. The insurer then sought common law indemnity from the agent. The court held that common law indemnity would be available if the agent was guilty of a tort for which the insurer was vicariously liable. However, the jury question was defective because it merely asked if the agent was guilty of undefined "misconduct." The court, therefore, rendered judgment for the agent. *Vecellio Ins. Agency, Inc. v. Vanguard Underwriters Ins. Co.*, ___ S.W.3d ___, 2003 WL 21197188 (Tex. App.–Houston [1st Dist.], May 22, 2003, no pet.). This case has since been overruled. The opinion was withdrawn and superceded by *Vecellio Ins. Agency, Inc. v. Vanguard Underwriters Ins. Co.*, ___ S.W.3d ___, 2003 WL 22382553 (Tex. App.–Houston [1st Dist.], Oct. 16,2003, no pet. h.), holding the proper remedy for an erroneous jury question was to reverse and remand rather than to reverse and render.

It looks like the court erred by finding the question was immaterial, instead of just defective, and by rendering judgment, instead of remanding. *See Spencer v. Eagle Star Ins. Co. of America*, 876 S.W.2d 154, 157 (Tex. 1994) (the question that plainly attempted to submit liability theory was defective, not immaterial).

When an insurer alleged that an adjuster had been fraudulently joined, the court rejected that argument and reasoned that an adjuster was engaged in the "business of insurance" by investigating, processing, evaluating, approving, and denying claims. *Vargas v. State Farm Lloyds*, 216 F. Supp.2d 643 (S.D. Tex. 2002).

In another case involving the alleged fraudulent joinder of an agent, the court noted that numerous courts have held that violations of article 21.21 of the Texas Insurance Code are actionable against individual adjusters. *Hornbuckle v. State Farm Lloyds*, __ F. Supp.2d __, 2003 WL 21955864 (N.D. Tex., Aug. 14, 2003).

VI. THIRD PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile liability insurance

There was a fact issue on whether an employee's personal use of a company vehicle was a "minor" or "material" deviation, which had to be resolved to determine whether the employer's commercial automobile policy covered the employee's wreck while he was on a personal trip. The employer allowed an employee to take a vehicle home when the employee had to be at the job site early the next morning. However, the employee was using the company truck for another personal reason at the time of the wreck. The court considered it important that the employee repeatedly had used the vehicle for personal trips, including social visits to his immediate supervisor. *Old American County Mut. Fire Ins. Co. v. Renfrow*, 90 S.W.3d 810 (Tex. App.–Fort Worth 2002, no pet.).

A listed driver on an automobile policy was not entitled to coverage for a vehicle that was owned by a family member but was not insured at the time she ran over a family member. The court held that the "owned by uninsured" exclusion applied and did not conflict with the mandatory liability insurance statute. *Armendariz v. Progressive County Mut. Ins. Co.*, 112 S.W.3d 736 (Tex. App.–Houston [14th Dist.] 2003, no pet. h.).

B. Homeowners liability insurance

A homeowner was entitled to a defense of a suit against her for damage caused by a limestone mining company to which she leased the property. Her alleged negligence in leasing the property was an "occurrence" potentially within coverage. The "business pursuits" exclusion did not apply, absent evidence that she regularly leased her property. *Hallman v. Allstate Ins. Co.*, 114 S.W.3d 656 (Tex. App.–Dallas 2003, pet. filed).

C. Comprehensive general liability insurance

The Fort Worth court of appeals held that punitive damages for gross negligence are covered and that such coverage is not against public policy. *Westchester Fire Ins. Co. v. Admiral Ins. Co.*, ___ S.W.3d ___, 2003 WL 21475423 (Tex. App.–Fort Worth, June 26, 2003) (rehearing en banc granted). The court reviewed various cases from Texas and other jurisdictions considering whether punitive damages are insurable. On the one hand, some courts hold it is against public policy to insure punitive damages, because they are intended to punish the wrongdoer, and shifting the award interferes with that purpose. On the other hand, the insurer accepted a premium for coverage broad enough to cover punitive damages and should be held to its bargain. Further, the insured still may be punished if the punitive damage award makes it more difficult or expensive to get liability

insurance. The court noted that in Texas, neither the legislature nor the supreme court has determined it is against public policy to insure punitive damages. In fact, the legislature has provided by statute that punitive damages coverage for certain health care providers may be obtained by a separate policy endorsement. *See also Fairfield Ins. Co. v. Stephens Martin Paving, L.P.*, ___ F. Supp.2d ___, 2003 WL 22005877 (N.D. Tex., Aug. 25, 2003).

The *Westchester* court also held that liability for gross negligence – that is, conduct involving an extreme degree of risk of which the actor has actual, subjective awareness but proceeds anyway – nevertheless fits within policy language providing coverage for injuries that are "neither expected nor intended by the insured." However, an award of treble damages under the DTPA for conduct committed "knowingly" was not covered.

A comprehensive general liability (CGL) policy required the insurer to defend and indemnify an insured who defamed a former employee for the purpose of trying to keep her from enticing other employees to work for a competitor. The court concluded that this conduct did not arise out of the employment relationship and thus did not fit within an exclusion. The insurer owed coverage for lost profits, mental anguish, and punitive damages awarded against the insured. The court also held that the policy covered intentional conduct. *Waffle House, Inc. v. Travelers Indem. Co. of Ill.*, 114 S.W.3d 601 (Tex. App.–Fort Worth 2003, no pet. h.).

The *Waffle House* court did not elaborate on its holding that punitive damages were covered, other than finding they fit within the policy language providing coverage for damages that "arose out of" or "resulted from" defamatory statements.

A company should have been an additional insured under its subcontractor's liability policies, and the coverage was not limited to the subcontractor's indemnity obligations. Further, the subcontractor's employee's death occurred "with respect to operations performed" by the subcontractor, so that the loss fell within coverage. The subcontractor's insurer could not challenge the amount of the settlement between the company and the plaintiffs, absent fraud or other illegality. Because the settlement expressly stated that it did not include punitive damages, the insurer also could not deny liability on that basis. *Atofina Petrochemicals, Inc. v. Evanston Ins. Co.*, 104 S.W.3d 247 (Tex. App.–Beaumont 2003, pet. filed).

A general liability policy excluded liability for an accident that occurred while one company's employee was operating a truck owned by the company. Although the truck was owned and operated by two companies that were named insureds, the exclusion applied to "any insured." The court declined to read the "separation of insureds" clause to provide separate coverage. *Bituminous Cas. Corp v. Maxey*, 110 S.W.3d 203 (Tex. App.–Houston [1st Dist.] 2003, pet. denied).

A liability insurer had no duty to indemnify its insured homebuilder for economic losses suffered by homebuyers when their home was built over an easement. There was no physical damage to the house, and the easement did not result in any loss of use. *Great American Lloyds Ins. Co. v. Mittlestadt*, 109 S.W.3d 784 (Tex. App.–Fort Worth 2003, no pet. h.).

A company was not an additional insured on a subcontractor's liability policy where the bid only referred to furnishing insurance, but did not provide other details. In addition, the company would not have been covered for its own negligence anyway, because the policy excluded liability arising out of acts or omissions by an additional insured. *Continental Cas. Co. v. Fina Oil & Chem. Co.*, ___ S.W.3d ___, 2003 WL 21470362 (Tex. App.–Houston [1st Dist.] June 26, 2003, no pet. h.).

When a declaratory judgment action was brought by a CGL insurer, the court found an issue of fact as to the deceased's employment status, precluding summary judgment on the exclusion for work-related bodily injuries to employees. *St. Paul Surplus Lines Ins. Co. v. Clyde Bros. Johnson Circus Corp.*, ___ F. Supp.2d ___, 2002 WL 2030857 (N.D. Tex., Sept. 4, 2002). The court further found that the insured was a "corporation" within the executive officer exemption, despite the insurer's contention that the insured's status as a corporation had lapsed.

A CGL insurer sought a declaration that it had no duty to defend or indemnify the insured homebuilder in *Great Am. Ins. Co. v. Calli Homes, Inc.*, 236 F. Supp.2d 693 (S.D. Tex. 2002). The court observed that in determining whether an incident involved an accidental occurrence within coverage of the policy, it must examine whether the conduct complained of was intentional and whether the resulting damage was the natural and probable result of an intentional act. The court concluded that the allegations that the insured negligently constructed the home or supervised the subcontractors stated an accidental "occurrence" within the terms of the policy, absent any claim that the homebuilder intentionally failed to follow specifications or had actual knowledge of improper installation.

A LIABILITY INSURER HAD NO DUTY TO INDEMNIFY ITS INSURED HOME-BUILDER FOR ECONOMIC LOSSES SUFFERED BY HOMEBUYERS WHEN THEIR HOME WAS BUILT OVER AN EASEMENT.

The faulty workmanship exclusion in a CGL policy issued to a tank repairer precluded coverage in a lawsuit brought by a plaintiff who hired the insured to modify its tank. *Southwest Tank & Treater Mfg. Co. v. MidContinent Cas. Co.*, 243 F. Supp.2d 597 (E.D. Tex. 2003). Plaintiff brought suit claiming that the insured's negligence in performing the modifications to the tank caused it to explode resulting in the loss of the tank. The exclusion denied coverage to the "particular part of any property" that was required to be restored, repaired, or replaced because "your work" was incorrectly performed on it. The court concluded that the "particular part of any property" applied to the entire tank, and the damages sought were replacement of the entire tank.

In *Jim Johnson Homes, Inc. v. MidContinent Cas. Co.*, 244 F. Supp.2d 706 (N.D. Tex. 2003), an

insured homebuilder sued its CGL insurer seeking defense and indemnity in an underlying arbitration with a homeowner. Noting that a CGL policy was not intended to serve as a performance bond, the court held that the policy did not provide coverage for construction deficiencies or guarantee that the contractor would perform in a workmanlike manner. The mere characterization of the contractor's performance as negligent was not sufficient to convert claims based on a breach of contract into a claim for recovery of property damages caused by an accident within the meaning of the policy. The court noted that even if the contractor's conduct constituted an "occurrence" under the policy, the exclusion for damage to property on which the insured was performing work applied.

In *Investors Ins. Co. v. Breck Operating Corp.*, __ F. Supp.2d __, 2003 WL 21056849 (N.D. Tex., May 8, 2003), the court concluded that an underground resources and equipment coverage endorsement superseded a pollution exclusion in a CGL policy and thus triggered the duty to defend and indemnify the insured in the underlying action alleging saltwater contamination of an oil and gas lease.

In *American Equity Ins. Co. v. Castlemane Farms, Inc.*, 220 F. Supp.2d 809 (S.D. Tex. 2002), the court held that damages caused by the insured's rupturing of a salt water disposal pipeline fell within the policy's total pollution exclusion.

In *Consumers County Mut. Ins. Co. v. P.W. & Sons Trucking, Inc.*, 307 F.3d 362 (5th Cir. 2002), a commercial auto insurer sued its insured, a small trucking company, seeking a declaration that injuries to the driver who worked for the insured were excluded under the policy's employee exclusion. The court applied the exclusion, rejecting the insured's argument that the driver was an independent contractor under Texas common law. The court observed that the policy was drafted to comply with the Motor Carrier Safety Act; therefore, the Department of Transportation's definition of employee applied. That definition eliminated the distinction between an employee and independent contractor.

D. Personal injury & advertising injury liability insurance

The "advertising injury" language in a CGL policy did not cover a claim against an insured for misappropriation of trade secrets that did not allege any misappropriation of advertising ideas or style of doing business. Further, the claims were excluded because they arose from an alleged breach of contract by the insured. The policy also did not cover a counterclaim for a groundless suit under the DTPA as "malicious prosecution." The court found this was an issue of first impression. While the dictionary definition of malicious prosecution includes a suit brought without reasonable cause, the term historically had a technical meaning that tracked the common law elements. *Pennsylvania Pulp & Paper Co. v. Nationwide Mut. Ins. Co.*, 100 S.W.3d 566 (Tex. App.–Houston [14th Dist.] 2003, pet. denied).

An insured business sought reimbursement of defense for a trademark infringement suit. *Sport Supply Group, Inc. v. Columbia Cas. Co.*, 335 F.3d 453 (5th Cir. 2003). The court first held that coverage was barred based on an exclusion for an advertising injury arising out of a breach of contract. The underlying infringement claim alleged that the insured breached a licensing agreement by advertising and selling products using the licensor's trademark. The court rejected the insured's argument that an exception to the exclusion applied, holding that the insured's conduct did not constitute a "misappropriation of an advertising idea."

Real estate investment company sought a declaratory judgment that their CGL insurer owed a duty to defend a Telephone Consumer Protection Act suit arising from the insureds' sending unsolicited fax advertisements. *Western Rim Inv. Advisors, Inc. v. Gulf Ins. Co.*, 269 F. Supp.2d 836 (N.D. Tex. 2003). The court concluded sending the faxes was not an accident, and thus did not qualify as an occurrence. However, the court found that the faxes were potentially within the "advertising injury" coverage. The court rejected the insurer's argument that the exclusion for violation of a penal statute or ordinance barred coverage, concluding that the TCPA is not a penal statute and that no facts were alleged to show a willful violation of the Texas Fax Law, which the court concluded was a penal statute.

E. Workers' compensation

A workers' compensation insurer was not liable to the employer for unreasonably settling claims that should not have been covered by the policy, even though that raised the employer's premiums under a retrospective premium payment plan. There was nothing in the contract limiting the insurer's discretion in investigating and settling claims. There was no evidence of a misrepresentation apart from the contract. The court found the insurer did not owe a fiduciary duty, and the court found no general cause of action for negligent claims handling. *Wayne Duddlesten, Inc. v. Highland Ins. Co.*, 110 S.W.3d 85 (Tex. App.–Houston [1st Dist.] 2003, pet. denied).

F. Construction liability insurance

In *Federal Ins. Co. v. CompUSA, Inc.*, 319 F.3d 746 (5th Cir. 2003), an insurer sought a declaratory judgment that it was not obligated to indemnify an insured business and its chief executive officer under a claims-made executive liability policy. The court concluded the insured did not provide notice of the claim "as soon as practicable" under the policy; formal notification of the claim was not sent until eleven months after the insureds had been served in the underlying action and six days after a multi-million dollar verdict against the insureds. The court rejected the insureds' argument that the insurer was required to show prejudice from the lack of notice. The court observed that the effect of the insured's noncompliance with the notice provision depends on whether the policy is a "claims-made" or "occurrence" policy. Under a "claims-made" policy, notice is the event that triggers coverage. Thus, an insurance company may deny coverage under a "claims-made" policy because of an absence of notice, without a showing prejudice.

G. Directors & officers liability insurance

An insured sued for coverage of the settlement of a securities fraud class action in *Medical Care America, Inc. v. Nat'l Union Fire Ins. Co.*, 341 F.3d 415 (5th Cir. 2003). The court observed that an insurance binder provides coverage according to the terms of the ordinary form of the contemplated policy. Consequently, the court held a "related acts" exclusion (barring coverage for acts related to acts prior to the inception of the policy) in a prior acts endorsement of the policy followed the ordinary form for such policies, and thus the earlier binder provided coverage subject to the same exclusion. The court further held that the policy's definition of "loss" to mean "settlements" did not by itself require coverage of the insured's underlying settlement. The definition did not preclude the operation of

other policy exclusions, one of which was for acts "related to" noncovered prior acts.

An insurer sought a declaration that it had no duty to defend or indemnify an insured corporation or its officer or directors in a stock fraud suit. *Admiral Ins. Co. v. Briggs*, 264 F. Supp.2d 460 (N.D. Tex. 2003). In the underlying case, the landlord claimed that the insured's officers and directors misrepresented the future success of the insured to convince the landlord to accept stock instead of cash for payment of a lease and security deposit. The court concluded that the insurer's interpretation of the contract exclusion was overly broad, potentially excluding all stock fraud claims. Moreover, the court noted that the breach of the lease was immaterial to the landlord's claim, because the harm occurred at the time an agreement to accept stock was made. Because the lease contract did not cause the stock fraud claim, the contract exclusion did not apply. Finally, the court held that claims of stock fraud involving different misstatements occurring on different days did not constitute a single "claim" for purposes of policy limits.

An insurer had no duty to defend or indemnify a securities fraud action against an insured waste management company and its executives alleging losses from nondisclosure of polluting activities. *Nat'l Union Fire Ins. Co. v. U.S. Liquids, Inc.*, 271 F. Supp.2d 926 (S.D. Tex. 2003). The court held that the activity was within a broad pollution exclusion.

H. Professional liability insurance

A professional malpractice insurer argued that it did not have a duty to defend a law firm, based on an exclusion in the claims-made policy that precluded coverage if the claim arose before the policy period. *Westport Ins. Corp. v. Atchley, Russell, Waldrop & Hlavinka, L.L.P.*, 267 F. Supp.2d 601 (E.D. Tex. 2003). A claim arose prior the policy period if the attorney had subjective knowledge of the claim or could have reasonably foreseen the likelihood the claim. The court concluded that the exclusion did not apply, because the petition in the underlying malpractice action did not allege that any member of the firm had subjective knowledge of the claim, or that any of the attorney's alleged wrongs were so blatant that any lawyer would have expected to foresee a claim against them.

I. Errors & omissions coverage

A printer's E&O policy covered the cost of reprinting coupon books that were printed with incorrect information. The loss was not "property damage" within an exclusion. *Venture Encoding Serv., Inc. v. Atlantic Mut. Ins. Co.*, 107 S.W.3d 729 (Tex. App.–Fort Worth 2003, pet. denied).

VII. DUTIES OF LIABILITY INSURERS

A. Duty to defend

An insurer had a duty to defend a physicians' professional association sued by patients who received anesthesia drugs that were contaminated by an employee who was stealing the drugs. The court rejected the insurer's argument that the professional services exclusion applied. While administration of anesthesia was a professional service, the act of securing the drugs against theft was not. The plaintiffs' petition alleged both types of negligence, so the insurer's duty to defend was triggered. In contrast, the court could not determine whether the insurer had to pay the claim, until fact issues were resolved on which acts of negligence actually caused the harm. *Utica National Ins. Co. v. American Indem. Co.*, ___ S.W.3d ___, 2003 WL 21468776 (Tex., June 26, 2003)(petition for rehearing filed).

An automobile liability insurer breached its contractual duty to defend where it insisted that the insured drop a motion to transfer venue, which his personal counsel had filed. The court reasoned that this conflict between the insurer and insured caused the insurer to forfeit its ability to control the defense and settlement of the case. *Northern County Mut. Ins. Co. v. Davalos*, 84 S.W.3d 314 (Tex. App.–Corpus Christi 2002, pet. granted).

An insurer had a duty to defend an employer who was sued for giving inaccurate information about a former employee, which was alleged to have contributed to the former employee's sexual assault on a third party. Relying on the supreme court's decision in *King v. Dallas Fire Insurance Co.*, 85 S.W.3d 185 (Tex. 2002), the court rejected the argument that the employer's negligence was not an "occurrence" because it was related to and interdependent on the employee's intentional conduct. *Acceptance Ins. Co. v. Lifecare Corp.*, 89 S.W.3d 773 (Tex. App.–Corpus Christi 2002, no pet.). The court also rejected the argument that the "employment related practices" exclusion applied. There was no allegation that the employer defamed the former employee, and the incorrect information was not given in the employment context.

A liability insurer did not have a duty to defend its insured who was sued for selling a house with mold, which was alleged to have caused personal injuries and property damage to the buyers. The policy was in effect only four months, and the court found no specific allegation that the injuries occurred during that time. *Allstate Ins. Co. v. Hicks*, ___ S.W.3d ___, 2003 WL 22096500 (Tex. App.–Amarillo, Sept. 10, 2003, no pet. h.). It seems the court got it backwards. If the petition alleged claims that could have arisen during the policy term, the absence of a specific date would invoke a duty to defend, not negate it. *See Gulf Chemical & Metallurgical Corp. v. Associated Metals & Minerals Corp.*, 1 F.3d 365 (5th Cir. 1993).

An insurer had a duty to defend a homebuilder against underlying claims of negligent construction and supervision of subcontractors, even though some of the allegations regarding the homebuilder's installation of stucco fell within an exclusion. *Great American Ins. Co. v. Calli Homes, Inc.*, 236 F. Supp.2d 693 (S.D. Tex. 2002). The court noted that an insurer's duty to defend is triggered if at least one of several claims in the plaintiff's complaint falls within coverage, even if other claims do not.

An insurer had no duty defend a tax and investment consulting firm under a claims-made professional liability errors and omissions policy, because the suit in which coverage was sought was related to two other lawsuits commenced before the effective date of the policy. *Tri Core Inc. v. Northland Ins. Co.*, __ F. Supp.2d __, 2002 WL 31548754 (N.D. Tex., Nov. 12, 2002).

An insurer had a duty to defend a retailer in an action involving a fallen display rack, because that the display rack was a "product" within the vendor's endorsement to the manufacturer's policy. *Home Depot v. Federal Ins. Co.*, 241 F. Supp.2d 702 (E.D. Tex. 2003). The exclusion in the policy for failure to make inspections, adjustments or servicing that the vendor agreed to make did not preclude coverage, because there was no evidence that the retailer ever agreed to make inspections of the rug display cabinets.

In *Southwest Tank & Treater Mfg. Co. v. Mid-Continent Cas. Co.*, 243 F. Supp.2d 597 (E.D. Tex. 2003), an insured tank repairer sought a declaration that the insurer

had a duty to defend in lawsuit arising from a tank explosion. The court held that extrinsic evidence beyond the pleadings in the underlying lawsuit was permissible when the insurer denied coverage on grounds that facts giving rise to the lawsuit were excluded from coverage, and the allegations in the pleadings did not describe the facts surrounding the incident for which plaintiff claimed damages.

In *Westport Insurance Corp. v. Atchley, Russell, Waldrop & Hlavinka, L.L.P.*, 267 F. Supp.2d 601 (E.D. Tex. 2003), a malpractice insurer and the insured both offered stipulations for the court's consideration. However, because none of the stipulated facts went to the fundamental coverage issues, the court concluded that it could not consider any extrinsic evidence in deciding the duty to defend or indemnify before the conclusion of the state court malpractice action. The court limited its examination to fact alleged in the claimant's petition for malpractice, and would not consider any facts to create coverage or trigger an exclusion to defeat coverage outside of the petition. Ultimately, the court held that the underlying petition did not allege facts that would preclude coverage of a claims-made policy based on the insured's knowledge of the claim prior to the inception of the policy. Furthermore, the court noted that because the claimants in the underlying action alleged wrongdoing both before and after the inception of the policy, the duty to defend was triggered.

Following a state court negligence judgment against a hospital management company, the company sued the hospital and the hospital's insurer seeking a declaration as to the insurer's duty to defend and indemnify. *Quorum Health Resources, LLC v. Maverick County Hospital District*, 308 F.3d 451 (5th Cir. 2002). The district court granted summary judgment for the insurer, concluding that the insurer had not breached its duty to defend and indemnify. The Fifth Circuit reversed and remanded, holding that an issue of fact existed as to whether the insurer met its duty to defend and whether the insured met its duty to cooperate. In that case, the insurer provided an attorney to represent the insured. A conflict of interest arose between that attorney and a second attorney hired by the insured. The insurer then provided substitute counsel, but that counsel declined the assignment. The insured demanded that the insurer pay the cost of the second attorney, who was not on the insurer's list of approved counsel. The insured allegedly told the insurer it would reject any other lawyer the insurer offered.

B. Duty to indemnify

In *Home Depot v. Federal Ins. Co.*, 241 F. Supp.2d 702 (E.D. Tex. 2003), the court held that the manufacturer's liability insurer had a duty to indemnify the retailer for the settlement of an underlying personal injury suit by a customer injured when a manufacturer's display rack fell. The court found that the incident fell within the vendor's endorsement because it arose out of the sale of the manufacturer's rugs, and the retailer was entitled to coverage as an insured designated by the policy. Moreover, in settling the underlying case, the insurer agreed it would not contend that the amounts awarded in the settlement were excessive or unreasonable, or did not constitute damages under the policy. Thus, the court concluded that the retailer was entitled to indemnity.

In *Westport Ins. Corp. v. Atchley, Russell, Waldrop & Hlavinka*, L.L.P., 267 F. Supp.2d 601 (E.D. Tex. 2003), after finding that a professional liability insurer had a duty to defend, the court held that Texas law generally prohibits determination of the insurer's duty to indemnify prior to the conclusion of the underlying litigation against the insured. Even if state law would not reach such a conclusion, in its discretion under the Federal Declaratory Judgment Act, 28 U.S.C. § 2201, the court would decline to grant relief on the duty to pay prior to the conclusion of the underlying action.

C. Settlements, assignments & covenants not to execute

Several hundred plaintiffs who suffered health problems when their apartments were treated for termites by spraying chlordane sued the Kings Park apartment complex and other related entities. National Union had a $5 million excess policy. Before the first trial, Kings Park settled with the plaintiffs and agreed not to contest liability; assigned to the plaintiffs any extracontractual claims against the insurers; received a covenant not to execute from the plaintiffs; and retained a percentage interest in any recovery the plaintiffs received from the insurers. In the subsequent "bad faith" litigation, National Union and the plaintiffs from the underlying case entered into a settlement agreement whereby National Union would pay the full $5 million policy limits and would receive a covenant not to execute in favor of Kings Park. Kings Park then sued National Union, contending the National Union "misappropriated" the policy proceeds to settle its own bad faith liability, and that Kings Park did not benefit. *Kings Park Apartments, Ltd. v. Nat'l Union Fire Ins. Co.*, 101 S.W.3d 525 (Tex. App.–Houston [1st Dist.] 2003, pet. denied).

The court of appeals found no evidence to support liability under this theory. The court concluded that the payment was for the plaintiffs' bodily injury claims, not for National Union's bad faith; and that Kings Park benefited by receiving a covenant not to execute, by triggering the next level of coverage, and by receiving half of the settlement proceeds.

The court also held that the prior releases released any claim for bad faith in the underlying litigation, and the insurer could not be liable for bad faith in several other cases, because its policy limits had been exhausted.

A doctor stated a claim for unfair and deceptive practices based on the insurer's agent telling him he should settle a liability claim and that would not affect his relationship with the insurer, and the insurer then refusing to renew his professional liability policy. *Herrin v. Medical Protective Co.*, 89 S.W.3d 301 (Tex.App.—Texarkana 2002, pet. denied).

VIII. THIRD PARTY THEORIES OF LIABILITY

A. *Stowers* duty & negligent failure to settle

In an equitable subrogation suit by an excess carrier alleging the primary carrier negligently failed to settle, the court found a fact issue on whether there was a proper policy limits demand. The court relied on oral communications between the parties, as well as letters that indicated an intent to make an offer to settle within policy limits, and a willingness by the insured to accept that offer. *Westchester Fire Ins. Co. v. Admiral Ins. Co.*, ___ S.W.3d ___, 2003 WL 21475423 (Tex. App.–Fort Worth, June 26, 2003) (rehearing en banc granted). The court also found a fact issue on whether the insured would have authorized a policy limits settlement. Finally, the court found sufficient evidence that the insurer was negligent in failing to accept the policy limits demand, based on expert testimony that the case value exceeded the demand, despite evidence that a prudent insurer might choose to negotiate instead of taking the initial offer.

B. Unfair & Deceptive Practices

A doctor stated a claim for breach of the duty of good faith and fair dealing based on the insurer's agent telling him he should settle a liability claim and that would not affect his relationship with the insurer, and the insurer then refusing to renew his professional liability policy. *Herrin v. Med. Protective Co.*, 89 S.W.3d 301 (Tex. App.–Texarkana 2002, pet. denied).

C. Prompt Payment of Claims Statute – Article 21.55

The Austin court reasoned that one insurer's claim against another insurer to recoup defense costs was a "third party" claim that did not fall within the statute, which defines "claim" as a "first party claim made by an insured or a policyholder." *Utica Nat'l Ins. Co. v. Tex. Prop. & Cas. Ins. Guar. Ass'n*, 110 S.W.3d 450 (Tex. App.–Austin 2001) (released for publication Aug. 14, 2003), *aff'd in part, rev'd in part, on other grounds*, ___ S.W.3d ___, 2003 WL 21468776 (Tex., June 26, 2003, pet. filed).

An automobile liability insurer that failed to timely accept or reject a claim for a defense of its insured was liable for attorney's fees, penalties, and interest under the statute. *Northern County Mutual Ins. Co. v. Davalos*, 84 S.W.3d 314 (Tex. App.–Corpus Christi 2002, pet. granted).

Similarly, a liability insurer that failed to defend an additional insured was liable for penalties, even if the delay was in good faith. *Atofina Petrochemicals, Inc. v. Evanston Ins. Co.*, 104 S.W.3d 247 (Tex. App.–Beaumont 2003, pet. filed).

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

A corporation sued for coverage of the settlement of a securities fraud class action. *Med. Care Am., Inc. v. Nat'l Union Fire Ins. Co.*, 341 F.3d 415 (5th Cir. 2003). The court held that the insurer did not breach its duty of good faith and fair dealing by denying coverage where there was a bona fide dispute, which the insurer eventually won. The court observed that there can be no claim for bad faith when the insurer has promptly denied a claim that is in fact not covered.

E. Breach of fiduciary duty

A doctor stated a claim for breach of an informal fiduciary relationship based on the insurer's agent telling him he should settle a liability claim and that would not affect his relationship with the insurer, and the insurer then refusing to renew his professional liability policy. *Herrin v. Med. Protective Co.*, 89 S.W.3d 301 (Tex. App.–Texarkana 2002, pet. denied). The court noted there had been a thirty-one year relationship of trust between the doctor and the insurance company.

A doctor stated a claim for fraud based on the insurer's agent telling him he should settle a liability claim and that would not affect his relationship with the insurer, and the insurer then refusing to renew his professional liability policy. *Herrin v. Med. Protective Co.*, 89 S.W.3d 301 (Tex. App.–Texarkana 2002, pet. denied).

F. Other theories

A railroad brought suit against an insured logging company after one of the company's drivers collided with a train. The court held that the insured's failure to obtain an endorsement required by the Motor Carrier Act, which would require the insurer to pay a judgment whether or not the vehicle involved in the accident was specifically described in the policy, did not justify reformation of the contract. *Illinois Cent. R.R. Co. v. Dupont*, 326 F.3d 665 (5th Cir. 2003).

IX. SUITS BY INSURERS

A. Declaratory relief

The court in *London Mkt. Insurers v. Am. Assurance Co.*, 95 S.W.3d 702 (Tex. App.–Corpus Christi 2003, no pet. h.), held that the trial court properly issued an anti-suit injunction preventing the insurer from maintaining its declaratory judgment suit in New York. The insured had filed an earlier declaratory judgment suit in Texas to determine premises liability coverage for asbestos. The court found that the later New York suit to determine product liability coverage for asbestos was a threat to the Texas court's jurisdiction. The court further found that the existence of a "service of suits" provision in the policy, by which the insurer agreed to submit to the jurisdiction of any court of competent jurisdiction, was a "special circumstance" sufficient to cause the potential for an "irreparable miscarriage of justice" that warranted issuance of the anti-suit junction.

B. Indemnity & contribution

A contractor's insurer did not waive its right to further contribution by accepting $150,000 from a coinsurer as its share of the settlement amount. *Liberty Mut. Ins. Co. v. Mid-Continent Ins. Co.*, 266 F. Supp.2d 533 (N.D. Tex. 2003). When accepting the contribution, the contractor's insurer stated it would not be bound by any arbitrary limitation established by the co-insurer of its share of the settlement, and reserved all rights of recovery against the co-insurer.

In *American Indem. Lloyds v. Travelers Prop. & Cas. Ins. Co.*, 335 F.3d 429 (5th Cir. 2003), a subcontractor's insurer sued the contractor's insurer seeking to recover half the amount paid to settle a personal injury lawsuit brought by the subcontractor's employee. The court held that the subcontractor's insurer was liable for the full amount it paid in settling the claim, notwithstanding "other insurance" language in the policy purporting to make it excess over the contractor's insurer. The court focused on the indemnity agreement between the parties, noting that the subcontractor contractually agreed to indemnify the contractor and the contractor, was an additional insured on the subcontractor's policy.

C. Subrogation

A highway construction contractor's liability insurer was entitled to further contribution from a co-insurer for $1.5 million settlement of a negligence suit. *Liberty Mut. Ins. Co. v. Mid-Continent Ins. Co.*, 266 F. Supp.2d 533 (N.D. Tex. 2003). The court concluded that the co-insurer was objectively unreasonable in refusing to change its estimate of the insured's potential exposure of only 10-15%, while the insurer remained flexible as the circumstances of the case changed and reasonably determined that the insured could be found as much as 60% responsible.

X. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Mental anguish damages

In *Allison v. Fire Ins. Exchange*, 98 S.W.3d 227 (Tex. App.–Austin 2002, pet. filed), noted above, evidence of the toxic effects of mold was properly admitted to show the plaintiff's mental anguish from the insurer's delay in handling her claim, even though the trial court disallowed it to prove that the toxic mold caused any personal injuries.

B. Exemplary damages

In *State Farm Mutual Automobile Insurance Co. v. Campbell*, 123 S. Ct. 1513 (2003), the insureds sued their insurer for its bad faith failure to settle within policy limits.

The jury awarded the insureds $2.6 million in compensatory damages and $145 million in punitive damages. The trial court reduced the award to $1 million in compensatory damages and $25 million in punitive damages. The Utah Supreme Court reinstated the punitive damage award, and the Untied States Supreme Court reversed. The Court held that a punitive damages award of $145 million, where full compensatory damages are $1 million, is excessive and violates the Due Process Clause of the Fourteenth Amendment. Relying on the reasonableness factors laid out in *BMW of North America, Inc. v. Gore*, 116 S. Ct. 1589 (1996), the Court concluded that "State Farm's handling of the claims against the Campbells merits no praise," but a more modest punishment could have satisfied the State's legitimate objectives. The Court criticized the use of evidence from other jurisdictions demonstrating State Farm's misconduct, holding that a state does not have a legitimate interest in punishing a defendant for unlawful acts committed outside its jurisdiction. More fundamentally, the Court observed that the evidence from other jurisdictions bore no relation to the insured's harm. While conceding that evidence of other acts need not be identical to have relevance to the calculation of punitive damages, the Court found that the Utah court erred "because evidence pertaining to claims that had nothing to do with a third-party lawsuit was introduced at length." *Campbell,* 123 S. Ct. at 1523.

While suggesting it was reluctant to identify concrete constitutional limits on the ratio between the harm to the plaintiff and punitive damages, the Court stated that few awards should exceed a single digit ratio between punitive and compensatory damages. When compensatory damages are significant, the Court observed that a ratio of one-to-one may reach the outermost limit of due process. In this case, the Court concluded that given the substantial compensatory damages award, punitive damages would be justified at or near the compensatory damage amount.

C. Prejudgment & postjudgment interest

An uninsured motorist insurer owed prejudgment interest as part of the damages owed by the uninsured driver. *Menix v. Allstate Indemnity Co.*, 83 S.W.3d 877 (Tex. App.– Eastland 2002, pet. filed).

A life insurer owed prejudgment interest accruing thirty days after the insured's death, and not accruing 180 days after notice of the claim, which is the common law standard. *Protective Life Ins. Co. v. Russell*, ___ S.W.3d ___, 2003 WL 203240 (Tex. App.–Tyler, Jan. 31, 2003, pet. denied).

A property insurer was liable for prejudgment interest on the entire amount of the claim, not just the difference between the amount claimed and the amount it had offered. *Republic Underwriters Ins. Co. v. Mex-Tex, Inc.*, 106 S.W.3d 174 (Tex. App.–Amarillo 2003, pet. filed).

D. Attorney's fees

An award of attorney's fees based on a contingent fee stated as a dollar amount was supported by testimony applying the eight *Arthur Andersen* factors, even without proof of the actual time spent. *Allison v. Fire Ins. Exch.*, 98 S.W.3d 227 (Tex. App.–Austin 2002, pet. filed). However, because the court reduced the damage awards, they remanded for a determination of fees based on the lower awards.

An uninsured motorist insurer was not liable for attorney's fees for breach of contract or for failing to promptly pay, where the insurer paid after the verdict establishing the uninsured motorist's liability. The court reasoned that the insurer was entitled to wait. *Menix v. Allstate Indemnity Co.*, 83 S.W.3d 877 (Tex. App.– Eastland 2002, no pet.).

An insured could sue its liability insurer to recover attorney's fees for its defense even though the fees were incurred but not paid by the insured. The court rejected the insurer's argument that the insured had to actually pay the fees before suing. *Vansteen Marine Supply, Inc. v. Twin City Fire Ins. Co.*, 93 S.W.3d 516 (Tex. App.–Houston [14th Dist.] 2002, pet. denied).

Where the receiver of an impaired insurer approved an attorney's fees as a "covered claim" but then failed to pay, the attorney was entitled to recover for breach of contract, and to receive additional fees and prejudgment interest. *Berkel v. Texas Prop. & Cas. Ins. Guar. Ass'n*, 92 S.W.3d 584 (Tex. App.–Austin 2002, pet. denied).

In *Beacon Nat'l Ins. Co. v. Glaze*, 114 S.W.3d 1 (Tex. App.–Tyler 2003, pet. denied), the homeowners claimed $12,500 for additional living expenses, the insurer offered $2,400, and the trial court awarded $5,875. The court of appeals held the homeowners were not entitled to recover attorney's fees for breach of contract, because their demand was not for "the just amount owed." The court reasoned that until a duty to pay under an insurance policy has been established there is no just amount owed.

The *Beacon* court erred in this holding. As the supreme court recognized, Texas appellate courts have consistently held for nearly twenty years that attorney's fees are allowed against insurers in breach of contract suits. *Grapevine Excavation Inc. v. Maryland Lloyds*, 35 S.W.3d 1, 5 (Tex. 2000).

A group insurer filed an interpleader action against the deceased insured's former husband and against her surviving husband to resolve a dispute over policy proceeds. *Metropolitan Life Ins. Co. v. Palmer*, 238 F. Supp.2d 831 (E. D. Tex. 2002). The surviving husband counter-claimed for negligence and breach of contract. The court held that ERISA preempted the surviving spouse's counterclaim against the plan's group insurer and awarded attorney's fees to the insurer. The court ordered an accounting of the amount of attorney's fees, segregating the amount arising from the defense of the preempted counterclaim from the amount incurred litigating the interpleader action.

XI. DEFENSES & COUNTERCLAIMS

A. Accord & satisfaction

The insured brought suit against his underinsured motorist carrier after signing a release and receiving payment of the claim from the carrier. *Vaughan v. Hartford Cas. Ins. Co.*, 277 F. Supp.2d 682 (N.D. Tex. 2003). The insured argued that the scope of the release did not include all claims the insured might have against the carrier. The court held that the release was broad enough to include violations of article 21.55 of the Texas Insurance Code, because the failure to comply with the prompt pay statute was intimately related to the insurer's obligation to perform under the contract. The court refused to hold that the other theories of the insured (including the duty of good faith and violations of the DTPA and article 21.21) were barred by the release. However, the court granted summary judgment on the extracontractual theories because the insured failed to show actual damages.

B. Examination under oath

Policy language requiring that "a person" cooperate with the insurer and that "a person" submit to an examination under oath, allowed the insurer to take separate examinations of a husband and wife who were making a

claim under their automobile policy. *Lidawi v. Progressive County Mut. Ins. Co.*, 112 S.W.3d 725 (Tex. App.–Houston [14th Dist.] 2003, no pet. h.).

C. Insured's conduct

The court in *Allison v. Fire Ins. Exch.*, 98 S.W.3d 227 (Tex. App.–Austin 2002, pet. filed), noted above, considered whether the trial court erred by excluding evidence of the plaintiff's conduct, which the insurer offered to show caused the delay in paying the claims. The court of appeals held that the trial court properly excluded evidence of the plaintiff's conduct during mediation. The court held that a "cloak of confidentiality" surrounds mediation and should be breached only sparingly. The trial court acted within its discretion in concluding that the danger of unfair prejudice justified excluding evidence of the insurer's offer and the plaintiff's demands at mediation.

The court also upheld the trial court's exclusion of evidence of other conduct by the plaintiff, such as her threat to use her $44 million trust fund to fight the insurer and to snort toxic mold if necessary to hurt the insurer. The court found there was ample other evidence in letters by the insured to give the jury an idea of her conduct and to let the jury determine whether it hampered the insurer's efforts.

D. Limitations

When an insurance adjuster orally denied a homeowner's claim for water damage and confirmed that with a letter, and then two months later another adjuster met with the insured and sent another letter denying the claim, there was a fact issue on whether the first denial was an "outright denial" sufficient to commence limitations. *Ehrig v. Germania Farm Mutual Ins. Ass'n*, 84 S.W.3d 320 (Tex. App.–Corpus Christi 2002 , pet. denied).

A doctor's suit against an insurer for refusing to renew his professional liability policy after assuring him that a settlement would not affect their relationship was timely when it was brought within the statutory period after the insurance company refused to renew his policy. *Herrin v. Medical Protective Co.*, 89 S.W.3d 301 (Tex. App.–Texarkana 2002, pet. denied).

The discovery rule applied to a claim by the executor of an estate to impose a constructive trust on life insurance proceeds held by a beneficiary that lacked an insurable interest. *Torrez v. Winn-Dixie Stores, Inc.*, 118 S.W.3d 817 (Tex. App.–Ft. Worth 2003, pet. filed).

In a case involving the insured's allegation that premiums on a life insurance policy would vanish, the court held that the discovery rule did not did not toll limitations, because the misrepresentations were not inherently undiscoverable. *Hunton v. Guardian Life Ins. Co. of Am.*, 243 F. Supp.2d 686 (S.D. Tex. 2002). The court concluded that because the representations were contrary to the language in the policy, the insured could have discovered the misrepresentation. The court further rejected the insured's argument that the cause of actions for fraud and fraudulent inducement did not accrue until the insured suffered damages by paying premiums past the point at which they were promised the premium would vanish. The court held that fraud itself is "an actionable legal injury" and that the limitations period begins to run when the fraud is perpetrated. *Id.* at 702.

In *Med. Care Am., Inc. v. Nat'l Union Fire Ins. Co.*, 341 F.3d 415 (5th Cir. 2003), an insured corporation sued an insurer under its directors and officers liability policy seeking coverage of the insured's settlement of a securities fraud class action. The court held that the insured's claims for violations of the Texas Insurance Code should have been discovered at least as of the date the insurer denied coverage; thus, the filing of suit over three years after the denial barred the statutory claims.

E. Preemption

An insured brought an action against private insurance adjusters alleging state law violations in connection with its attempts to file claims with the Federal Emergency Management Agency under its standard flood insurance policy (SFIP). *Richmond Printing LLC v. Director of Fed. Emergency Mgmt.*, 72 Fed. Appx. 92, 2003 WL 21697457 (5th Cir., July 21, 2003) (not designated for publication). Following *Spence v. Omaha Indem. Ins. Co.*, 996 F.2d 793 (5th Cir. 1993), the court concluded that extracontractual claims were not preempted under the National Flood Insurance Program (NFIP).

In *Dehoyos v. Allstate Corp.*, 345 F.3d 290 (5th Cir. 2003), non-Caucasian policyholders brought a civil rights action against their insurers on the theory that the credit scoring system utilized by their insurers resulted in more expensive policies being sold to them. The insurers argued that the insureds' claims were preempted under the McCarran-Ferguson Act. The court rejected the preemption argument, first noting that the insurers failed to point to any state law with which the federal civil rights laws conflict. Consequently, the court noted that the insurers could not show how state law or policy would be impaired by application of federal law. The court rejected the argument that federal law interfered with state law merely by its presence in the regulatory field.

The Supreme Court held that California's Holocaust Victim Insurance Relief Act was preempted because it impermissibly interfered with the President's conduct of foreign affairs. *American Ins. Assoc. v. Garamendi*, 123 S. Ct. 2374 (2003). The Court further struck down a California statute that required any insurer that did business in California and sold insurance policies in Europe that were in effect during the Holocaust-era to disclose certain information to the California Insurance Commissioner or risk losing its license.

A claim by the estate of a deceased employee for benefits under a corporate owned life insurance policy was not related to an ERISA plan. *Mayo v. Hartford Life Ins. Co.*, 220 F.Supp.2d 714 (S.D. Tex. 2002). The court reasoned that the employees were seeking benefits of a policy purchased by their employer, not benefits from an ERISA plan.

In *Metropolitan Life Ins. Co. v. Palmer*, 238 F. Supp.2d 831 (E. D. Tex. 2002), a group insurer filed an interpleader action against the deceased insured's former husband and against her surviving husband to resolve a dispute over policy proceeds. The surviving husband counterclaimed for negligence and breach of contract. The court held that ERISA preempted the surviving spouse's counterclaim. The court further concluded that the surviving spouse's ERISA claim could only be brought against the plan itself, and not its insurer.

A participant in a group long-term disability plan, who had fibromyalgia and chronic pain syndrome, brought a state court action against the insurer after it denied her claim for benefits. *Magee v. Life Ins. Co.*, 261 F. Supp.2d 738 (S. D. Tex. 2003). The insurer removed the action. The court granted summary judgment for the insurer, holding that the plan was covered by ERISA and did not fall within the safe harbor provision of the Act. In particular, the court concluded employer's role was not limited to collecting

premiums and remitting them to the insurer. The employer endorsed the plan and notified the participants that the plan was subject to ERISA. Moreover, the court concluded that the employer was granted authority to control and manage the operation of the plan.

After finding that the insured's state law claims were preempted by ERISA, the court reviewed the determination of the plan administrator denying benefits. The court concluded that the administrator did not abuse its discretion based on a determination that the participant could perform sedentary work. The physical ability assessment filled out by a physician supported that position. The treating physician did not state a firm opinion as to whether the participant could perform sedentary work, while a physician hired to conduct a peer review of the medial record concluded that she could perform sedentary work.

HMOs sought a determination that "Any Willing Provider" (AWP) provisions of the Kentucky Health Care Reform Act were preempted by ERISA. *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471 (2003). The court held that the statute was a law regulating insurance, and thus saved from preemption. For laws to be saved from preemption, the statute must be "law[s] . . . which regulat[e] insurance" and must be "specifically directed toward" the insurance industry; laws of general application which have some bearing on insurers do not qualify. The court rejected the argument that the statute was not "specifically directed" towards the insurance industry, noting that the law is violated when a "health insurer" excludes from its network a provider who is willing and able to meet its terms.

The court also rejected the argument that the AWP laws do not regulate an insurance practice, but focus upon insurers relationships with third party providers. The court distinguished cases relying on the McCarran-Ferguson Act by defining the "business of insurance." To come within ERISA's savings clause, the court is not concerned with how to characterize the conduct of private actors, but with how to characterize state laws with regard to what they "regulate." Kentucky's laws "regulate" insurance by imposing conditions on the right to engage in the business of insurance. To come within ERISA's savings clause, those conditions must also substantially affect the risk pooling arrangement between an insurer and insured. Kentucky's laws pass this test by altering the scope of permissible bargains between insurers and insureds.

An insured sued his HMO for negligence, alleging that its delay in referring the diabetic insured to a hospital resulted in the amputation of his leg. *Haynes v. Prudential Health Care*, 313 F.3d 330 (5th Cir. 2002). The HMO moved to dismiss, contending the action was expressly preempted by ERISA. The court agreed, holding that the HMO's decision that the insured's physician was not a primary care physician (and thus could not refer the patient to a hospital) was an administrative decision. Accordingly, the court concluded that the patient's state law negligence claim was expressly preempted by ERISA because it did not involve a medical decision.

An HMO and seller of health insurance brought an action challenging the Texas law that created a statutory cause of action against managed care entities that failed to meet an ordinary care standard for health care treatment decisions, claiming that the statute was preempted by ERISA. *Corporate Health Ins., Inc. v. Tex. Dept. of Ins.*, 314 F.3d 784 (5th Cir. 2002). The Fifth Circuit originally held that the statute was preempted. On appeal, the Supreme Court vacated and remanded the case for further consideration in light of *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S. Ct. 2151 (2002). On remand, the Fifth Circuit held that sections of the Texas law that provided for independent review of determinations by health care entities were not preempted by ERISA, because they are within the saving clause of ERISA and do not offer an additional remedy in conflict with ERISA's exclusive remedy. Because self-funded ERISA plans are not covered by ERISA's saving clause, ERISA preempts any application of the statute to those plans.

F. Release

In *Barker v. Roelke*, 105 S.W.3d 75 (Tex.App.—Eastland 2003, pet. denied), Barker sued after his daughter was killed in a car wreck. He eventually settled for $500,000, which was his agreed share of the policy limits divided with the father of another child who was injured in the wreck. His ex-wife also was injured in the wreck but did not timely file suit. The insurer insisted that she agree to the settlement as well. The ex-wife later brought her own suit, contending she lacked capacity earlier, and she ultimately received $5.5 million. That prompted Barker to try to set aside his release and get part of his ex-wife's money. He asserted various theories based on the premise that if his ex-wife lacked capacity to approve the prior settlement, then his settlement was invalid. The court held that the ex-wife was not a party to the contract, because she was not named. The court rejected Barker's theories of mutual mistake, fraud, quasi-estoppel, and conspiracy. The court also held that by waiting two years after he learned his ex-wife might have lacked mental capacity, Barker had ratified his contract. Finally, the court held that the release included an affiliated insurer that was not specifically named, because the release applied to a named insurer and each of its affiliates.

An agreement between a liability insurer and the insured to retroactively cancel a policy after they learned of a significant claim was void as against public policy. A statute required the crop duster insured to maintain liability coverage for the express purpose of protecting third parties who might suffer damages. *Ranger Ins. Co. v. Ward*, 107 S.W.3d 820 (Tex. App.–Texarkana 2003, pet. denied).

A prior settlement that related to a claim for fracturing or otherwise servicing wells did not release the insurer from liability for a later claim based on asbestos. *Dresser Indus., Inc. v. Underwriters At Lloyd's*, 106 S.W.3d 767 (Tex. App.–Texarkana 2003, pet. filed).

G. Res judicata & collateral estoppel

The fact that a company's excess insurer paid a prior settlement, which would only happen if the underlying policy limits had been exhausted, was some evidence that the policy limits were exhausted, so that the excess insurer owed a subsequent claim. However, the prior settlement was not res judicata, and did not collaterally estop the insurer on that issue, because the issue of whether the limits were exhausted was not actually litigated in the prior claim. *Dresser Indus., Inc. v. Underwriters At Lloyd's*, 106 S.W.3d 767 (Tex. App.– Texarkana 2003, pet. filed).

H. Other defenses

An insurer sought a declaration that it had no duty to defend or indemnify an insured construction products dealer against an antitrust action brought by the insured's competitor. *RLI Ins. Co. v. Maxxon Southwest, Inc.*, 265 F. Supp.2d 727 (N.D. Tex. 2003). In concluding that no coverage existed, the court invoked the fortuity doctrine. The court observed that the fortuity doctrine precludes

coverage if the insured is aware of an ongoing or progressive loss at the time the policy is purchased. The court concluded that the insured was aware that it was engaged in a discriminatory pricing scheme for several years prior to purchasing the policy. It was irrelevant, the court opined, whether the insured had actual knowledge of the specific loss claimed by the competitor. The key was whether the insured was engaged in activities for which they could possibly be found liable.

In *Flores v. Allstate Texas Lloyd's Co.*, 278 F. Supp.2d 810 (S.D. Tex. 2003), the court observed that whether notice of a mold claim is deemed reasonably prompt under a home-owner's insurance policy will ordinarily be a question of fact for the jury. Notice may be considered unreasonable as a matter of law if the facts are undisputed and the delay is not excused. The court concluded that questions of fact as to the insured's notice existed with respect to the bathroom toilet overflow, bathroom sink leak, water stains around the skylight, air conditioning system leaks, and water heater leaks. The court granted summary judgment for the insurer as to mold on the bedroom ceiling.

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

In a case involving a misrepresentation to the insured that premiums would vanish on a life insurance policy, the court rejected the insured's promissory estoppel claim and held that the insured could not have reasonably relied on the misrepresentation when it varied from the terms of the written policy. *Hunton v. Guardian Life Ins. Co.*, 243 F. Supp.2d 686 (S.D. Tex. 2002).

In *Blum v. Spectrum Restaurant Group, Inc.*, 261 F. Supp.2d 697 (E.D. Tex. 2003), the court held that the administrator of a supplemental group life insurance plan governed by ERISA was not estopped from denying benefits. The court concluded that the participant could not show reasonable reliance on a misrepresentation where the plan documents unambiguously required evidence of good health. Alternatively, the court held that the administrator did not knowingly and intentionally waive the requirement that the participant provide evidence of good health in order to qualify for additional insurance. The participant was reminded that he needed to submit evidence of good health on at least four occasions. Evidence of an increased premium deducted from the participant's paycheck was the result of a mistake and was refunded, and did not constitute evidence of waiver.

A joint venturer was not estopped from asserting a breach of contract claim against a subcontractor that failed to secure insurance for the venture. *Bott v. J.F. Shea Co.*, 299 F.3d 508 (5th Cir. 2002). The conduct of the joint venturer, which the subcontractor claimed invoked estoppel, included sending a letter instructing the subcontractor to add one of the joint venturers to the policy but not the other, and allowing the subcontractor to perform work on the project, absent proof of insurance for the venture. The court reasoned that this was not inconsistent positions so as to permit a claim of estoppel. The court left open the possibility that those facts might establish a claim of waiver.

In *Medical Care America, Inc. v. Nat'l Union Fire Ins. Co.*, 341 F.3d 415 (5th Cir. 2003), an insured corporation sued for coverage of the insured's settlement of a securities fraud class action. The court held that the insurer was not estopped from relying on the "related acts" exclusion of a prior acts endorsement. The court noted that the insurance binder's silence as to coverage for related acts did not constitute a misrepresentation, and the insured could have inquired as to the scope or effect of the endorsement.

XII. PRACTICE & PROCEDURE

A. Choice of law

Texas law properly applied to the conduct of a Colorado insurer whose offices and principal place of business were located in Texas. All contacts with policyholders came from the insurer's Texas offices, and the disputed insurance policy forms were designed in Texas. *Nat'l Western Life Ins. Co. v. Rowe*, 86 S.W.3d 285 (Tex. App.–Austin 2002, pet. filed).

In *Vandeventer v. All American Life & Cas. Co.*, 101 S.W.3d 703 (Tex. App.–Fort Worth 2003, no pet. h.), the court applied Indiana and South Carolina law to claims against an out-of-state insurer who transferred disability policies to a Texas insurer then canceled them. The court reasoned that because the summary judgment was filed by the foreign insurer, the law of the claimants' states would apply. The court also noted that the parties had not identified any conflict between the law of those states and the law of Texas.

As noted above, it seems the court erred in holding there was no cause of action for breach of the duty of good faith and fair dealing against the insurer for canceling the policies. If there is such a cause of action, then there would be a conflict, because Texas law should apply, and the insureds' home states would have no reason to protect the insurer from such liability.

TEXAS LAW PROPERLY APPLIED TO THE CONDUCT OF A COLORADO INSURER WHOSE OFFICES AND PRINCIPAL PLACE OF BUSINESS WERE LOCATED IN TEXAS.

In a class action by agents against Farmers for failing to pay bonus commissions, California law applied. All drafting, mailing, calculating, and awarding of bonuses originated from California, and the entity responsible for the bonuses had its primary office in California. The court rejected the argument that the law on parol evidence varied so much that the law of the twenty-nine states where each group of agents resided should apply. *Farmers Ins. Exch. v. Leonard*, __ S.W.3d __, 2003 WL 1831928 (Tex. App.–Austin April 10, 2003, pet. filed).

Employees sued their employers seeking a declaration that the employers did not have an insurable interest in the corporate life insurance policies on the lives of their employees. *Mayo v. Hartford Life Ins. Co.*, 220 F. Supp.2d 714 (S.D. Tex. 2002). While the employers urged the law of Georgia, the court concluded that Texas law. Texas was the place of the insureds' domicile, the place of the

subject matter of the policies, and the place of the most significant aspects of performance of the contracts. The court rejected evidence of the places of contracting and negotiation as inconclusive. The court observed that the purpose of insurance, and the need for certainty, predictability and uniformity of result, all point to Texas as the state with the most significant interest in the application of its law and public policies to the dispute.

B. Venue

Venue in an insurer's declaratory judgment suit was proper in the county where the accident that gave rise to the claim occurred, not in the county where the insurance contract was issued. *Old American County Mut. Fire Ins. Co. v. Renfrow*, 90 S.W.3d 810 (Tex. App.–Fort Worth 2002 , pet. denied).

Similarly, the court in *Chiriboga v. State Farm Mut. Auto. Ins. Co.*, 96 S.W.3d 673 (Tex. App.–Austin 2003, no pet. h.), held, in an insurer's declaratory judgment suit to determine its duty to defend its insured, that venue was proper in the county where the insured was involved in the accident and resided at the time of the wreck. The court rejected the insurer's argument that a "substantial part" of the cause of action accrued in the county where the insurance policy was issued, even though the basis for the insurer denying the duty to defend or indemnify was that the agent who was responsible for scheduling the vehicle was located in that county, and the insurer contended that the vehicle was owned but not insured. The court found the connection to this county was tangential and insubstantial.

The *Chiriboga* court also held that the insurer, as plaintiff, could not rely on the statute allowing transfer for the convenience of the parties, because that provision applies only upon the motion of a defendant.

A suit for unfair claims handling related to mold damage resulting from plumbing leaks was properly filed in Travis county where part of the action accrued and where the insurer had its home office. The mandatory venue provision applicable to suits for damage to real property did not apply. *Allison v. Fire Ins. Exch.*, 98 S.W.3d 227 (Tex. App.–Austin 2002 , pet. filed).

C. Pleadings

A trial court did not abuse its discretion by refusing to allow a plaintiff to amend her pleading postverdict to include a request for attorney's fees. *Menix v. Allstate Indem. Co.*, 83 S.W.3d 877 (Tex. App.– Eastland 2002, pet. filed).

D. Discovery

A trial court abused its discretion by ordering an engineer to produce unredacted reports that had been prepared for other insurers who were not parties to the suit. The plaintiffs sued their insurer for failure to pay a foundation claim, and they sued the engineers hired by the insurer alleging that the engineers conspired to "lowball" their estimates. The trial court granted the engineers' motion for summary judgment, dismissing the plaintiffs' claims. The plaintiffs then sought discovery of reports from the engineers to defend against the engineers' counterclaim against plaintiffs for filing a groundless claim. The court of appeals held that other insureds have privacy rights and that the burden was on the party seeking production of the reports to show they were relevant. The court of appeals concluded that the unredacted reports, which included the names of the other insureds, were not relevant to determine whether the plaintiffs had a proper basis at the time they filed their claim against the engineers. Therefore, the trial court abused its discretion by ordering production of the unredacted reports prepared for the nonparty insurers. *In re United Servs. Auto. Ass'n*, 76 S.W.3d 112 (Tex. App.–San Antonio 2002, no pet.).

Another trial court abused its discretion by refusing to compel insureds to answer questions about their prior illegal drug use. The insureds sued their health insurer for its delay in issuing their policy, resulting in them having uninsured expenses. The insurer alleged that they misrepresented their prior drug abuse and they would not have been insured at all if they had told the truth. The court of appeals held the insurer was entitled to discovery to support this defense. *In re Nat'l Health Ins. Co.*, 109 S.W.3d 607 (Tex. App.–Corpus Christi 2003, no pet. h.).

A trial court could not order a liability insurer to submit its adjusters for depositions in a suit to determine liability for negligent failure to settle. *In re Hochheim Prairie Farm Mut. Ins. Ass'n*, ___ S.W.3d ___, 2003 WL 22024269 (Tex. App.–Beaumont, Aug. 29, 2003, no pet. h.). The underlying tort suit against the insured was still pending and the plaintiff, who hoped to become a judgment creditor, sought the depositions solely to preserve the testimony before it was diminished by the passage of time or the witnesses became unavailable.

A trial court's discovery order was upheld in part, and was overly broad in part, in *In re American Home Assurance Co.*, 88 S.W.3d 370 (Tex. App.–Texarkana 2002, no pet. h.). The trial court ordered environmental liability insurers to produce documents related to: their communications regarding the insureds; their deliberations in drafting the policy forms that were used; their handling of environmental claims; their setting of reserves; their policies, procedures, and guidelines concerning processing of claims against their insureds; and communications with Texas regulators about pollution coverage and forms. The court of appeals held that it could not determine whether documents related to the drafting process were or were not relevant until the trial court first determined whether the policies were ambiguous. If the policies were unambiguous, then documents to contradict the policy language would not be discoverable. The court also held that discovery of reserve information was not proper because it would not lead to the discovery of admissible evidence. Communications regarding the insureds, and the policies and procedures, were discoverable. Also, the court concluded that discovery regarding the insurers' handling of other third party claims was proper if clarified to state whether it applied to Texas corporations or corporations authorized to do business in Texas, and whether it applied only to Texas residents or to Texans who resided outside the state at the time of the claims.

An insurer could not undesignate as experts two investigators after the trial court ordered production of their investigative file. This attempted dedesignation was intended to conceal facts and was therefore improper. *In re State Farm Mut. Auto. Ins. Co.*, 100 S.W.3d 338 (Tex. App.–San Antonio 2002, no pet.). However, the trial court erred by ordering production of privileged parts of the claim file. The documents were generated in anticipation of litigation by the plaintiff against the insured driver. The documents were therefore not discoverable in the subsequent lawsuit against the insurer. The court of appeals held that the investigative file was not discoverable as part of the "facts known" to the experts.

E. Discovery Sanctions

In *Kings Park Apartments, Ltd. v. Nat'l Union Fire*

Ins. Co., 101 S.W.3d 525 (Tex. App.–Houston [1st Dist.] 2003, pet. denied), noted above, the insured alleged that the insurer and its counsel had engaged in massive discovery abuses, including concealing discoverable documents, filing a false affidavit, instructing a deposition witness to remain unavailable, and instructing a paralegal to steal documents from the chambers of the special trial judge. The trial court relied on its inherent power and sanctioned National Union by: requiring that the insurer implement a policy that would include the Lawyers Creed in any Texas litigation file, and to educate every supervisor about the content of the Lawyers Creed; ordering that a particular representative of the insurer not participate in any Texas case without permission from the court, until he explained his prior affidavit; and ordering the insurer to sponsor three years of ethics courses and make a financial contribution for ethics. The insured appealed, arguing that these sanctions were inadequate, and that the trial court should have awarded the insured $500,000 in attorney's fees. The court of appeals concluded that the trial court properly relied on its inherent authority and did not abuse its discretion by declining to grant other sanctions. The trial court found the insured's fees were selfinflicted as Kings Park tried to gain information to use in other cases, and that the sanction was properly crafted to punish the conduct.

F. Experts

In *United Servs. Auto. Ass'n v. Gordon*, 103 S.W.3d 436 (Tex. App.–San Antonio 2002, no pet.), the San Antonio court of appeals held that the testimony of an engineer, James Andrews, was sufficiently reliable to support a jury verdict finding that plumbing leaks caused foundation movement. The expert relied on the same data the insurer had relied on. He gave several reasons for ruling out other causes of movement, such as seasonal weather changes and the homeowners' use of a soaker hose. He also relied on his experience in conducting over 1,000 foundation investigations, and he relied on a published treatise relied upon by other engineers.

The *Gordon* court also found the trial court erred by allowing into evidence another engineer's report, where that engineer did not testify, and his report was not relied on by a testifying engineer. Because the report was cumulative of evidence presented by an engineer who did testify, the error was harmless.

Another court, in *Nordstrud v.Trinity Universal Ins. Co.*, 97 S.W.3d 749 (Tex. App.–Fort Worth 2003, no pet. h.), upheld a jury verdict that found an insureds' foundation damage was not caused by a sprinkler leak, based on expert testimony. The insureds complained that the expert relied on a scientifically unreliable test called "resistivity imaging testing." The court rejected this argument because, even though the technique was new, it was only part of what the expert based his conclusions on. The court also rejected a challenge that the testimony of another expert for the insurer suffered from a number of analytical gaps, because the insureds did not object at trial.

The Austin court, in contrast, held that a doctor was not qualified to testify that toxic mold resulting from a plumbing leak caused the plaintiff's illness. *Allison v. Fire Ins. Exch.*, 98 S.W.3d 227 (Tex. App.–Austin 2002, pet. filed). Under the *Havner* standard, for an epidemiological study to be a reliable foundation for an expert's opinion, the study must show that exposure to a substance doubles the risk of injury, and the study must have a 95% confidence interval. Because the doctor relied on a study that did not meet these criteria, his opinions were properly excluded. Without this evidence of causation, the trial court properly rendered summary judgment against the plaintiff's claim.

In a class certification hearing, the trial court could consider expert testimony without undergoing *Robinson/Daubert* analysis. *Nat'l Western Life Ins. Co. v. Rowe*, 86 S.W.3d 285 (Tex. App.–Austin 2002, pet. filed). Those standards were created based on the possibility that jurors might give undue weight and credibility to unreliable expert testimony. The same concerns are not present in a class certification hearing before a trial court.

A homeowner's expert's testimony created an issue of fact as to whether foundation damage to the insured's home was caused by a plumbing leak, and therefore outside the scope of the policy exclusion. *Keeling v. State Farm Lloyds*, __ F. Supp.2d __, 2002 WL 31230804 (N.D. Tex., Sept. 30, 2002). The court further found that the expert's testimony provided a reasonable basis for the jury to conclude that 100% of the foundation damage was caused by a "covered peril," thus precluding summary judgment for the insurer on concurrent causation.

In *Flores v. Allstate Texas Lloyd's Co.*, 229 F. Supp.2d 697 (S.D. Tex. 2002), the insurer moved to exclude the insured's medical expert testimony regarding the health effects of household mold. The court excluded the expert's testimony, holding that the medical expert's theory that the homeowner's allergies were caused by the existence of mold in their home was not tested, had a great potential for error, was not subjected to peer review or publication, and was not generally accepted within the relevant scientific community.

In *Hussey v. State Farm Lloyds Ins. Co.*, 216 F.R.D. 591 (E.D. Tex. 2003), the insureds sought the discovery of the insurer's engineering expert's reports prepared for the insurer dealing with plumbing leaks in the past five years. The court held that those reports were discoverable, concluding that the reports might allow the factfinder to infer that the reports were not prepared objectively, that the insurer was aware of the expert's lack of objectivity, and that the insurer's reliance on the report was a pretextual excuse to deny the claims.

G. Class actions

A trial court properly certified a class and approved a trial plan in a suit against a life insurer for breach of contract, fraud, deceptive trade practices, and unfair insurance practices. The plaintiffs sued the insurer for selling life insurance riders that covered children and then continuing to collect premiums after the children turned twenty-five and coverage ended. The court of appeals found the trial court had a sufficient record before it, and that the trial plan adequately addressed discovery issues, the costs associated with notice to the class, and how the issue of reliance and the defendant's limitations defense would be submitted. The trial plan also suitably focused on the common issue of the defendant's conduct in billing and collecting premiums on the riders. The trial court properly required the insurer to bear some of the costs of identifying class members, to give the plaintiffs access to its computer system and records, to cooperate with plaintiffs' counsel, and to compile a database of policyholders within the class. *Nat'l W. Life Ins. Co. v. Rowe*, 86 S.W.3d 285 (Tex. App.–Austin 2002, pet. filed); *see also Farmers Ins. Exch. v. Leonard*, __ S.W.3d __, 2003 WL 1831928 (Tex. App.–Austin, May 23, 2003, pet filed).

There was no conflict with the class representatives representing different subclasses in a suit brought by agents

for unpaid commissions. The court rejected the argument that the subclasses would be competing with each other for a limited fund. No settlement was agreed to before class certification, and the amounts owed to each subclass could be determined mathematically, based on the bonuses owed to each class member. *Farmers Ins. Exch. v. Leonard*, __ S.W.3d __, 2003 WL 1831928 (Tex. App.–Austin, May 23, 2003, pet. filed).

An insured employer brought suit under the RICO Act alleging that casualty insurance companies charged excessive premiums on retrospectively-rated workers' compensation policies. *Sandwich Chef of Tex. v. Reliance Nat'l Indem. Ins. Co.*, 319 F.3d 205 (5th Cir. 2003). The district court granted the employer's motion for class certification, and the insurers appealed. On appeal, the court held that the class could not be certified, because individual issues of reliance and causation would predominate. The court held that the insurers were entitled to defend themselves by offering evidence that an individual plaintiff negotiated a premium that varied from the filed rate and was aware that the insurer was charging more than what the regulators approved, and therefore was not a victim of fraud.

H. Arbitration

A suit by physicians against several managed health care organizations under the Racketeer Influenced and Corrupt Organizations Act (RICO) for failing to pay the doctors was subject to arbitration. The contracts between the doctors and the organizations required arbitration, but would not allow punitive damages. The doctors argued that their RICO claims were not subject to arbitration, because the arbitrator lacked authority to award treble damages. The Supreme Court held that treble damages have been considered both remedial and punitive, so it was not clear whether the arbitration agreement's prohibition on "punitive damages" would limit the arbitrator's authority to award statutory treble damages. The Court held this was an issue for the arbitrator to decide in the first instance. *Pacificare Health Sys., Inc. v. Book*, 123 S.Ct. 1531 (2003).

A trial court abused its discretion by appointing an arbitrator, when the health insurance policy contained an arbitration clause that specified that AAA rules would apply to selection of the arbitrator. *In re Nat'l Health Ins. Co.*, 109 S.W.3d 552 (Tex. App.–Tyler 2002, no pet.).

When a reinsurer allegedly interfered with the process of selection of an arbitrator, the insurer brought suit alleging the reinsurer waived its right to arbitrate. *Gulf Guar. Life Ins. Co. v. Conn. Gen. Life Ins. Co.*, 304 F.3d 476 (5th Cir. 2002). The court rejected that argument, concluding that the reinsurer's alleged participation in a dispute over the composition of the panel, even if protracted and deliberately causing delay in arbitration, did not rise to the level of waiver of its contractual right to arbitrate. The court further held that the district court, prior to the issuance of an arbitral award, had no authority to entertain a challenge that went to the arbitral process itself, and specifically to the arbitrator selection process.

In *Pedcor Mgmt. Co. Welfare Benefit Plan v. Nations Pers. of Tex., Inc.*, 343 F.3d 355 (5th Cir. 2003), employer funded ERISA plans sued an insurer alleging it breached its reinsurance contracts with the plans by defaulting on payment of claims. The district court entered an order certifying a class for arbitration proceedings against the insurer. Relying on the recent United States Supreme Court decision in *Green Tree*, the court held that if an arbitration agreement is governed by the Federal Arbitration Act and state law does not clearly forbid class arbitration, then arbitrators (and not courts) are to decide whether the agreement allows class arbitration.

I. Appraisal

In *Allison v. Fire Ins. Exch.*, 98 S.W.3d 227 (Tex. App.–Austin 2002, pet. filed), the court considered the binding effect of an appraisal decision in a case seeking damages for mold caused by plumbing leaks. The jury found the appraisal award was the result of fraud, accident, or mistake, and that the appraiser was not competent and independent. The court found no evidence to support these findings. The court found that the appraisal award was comprehensive and did not improperly exclude any items. The court held that a mistaken reference to "alternative living expenses" instead of "additional living expenses" was not the kind of mistake that affected the validity of the award. Further, the prior business relationship between the appraiser and insurer did not establish lack of independence. The court also found the appraiser was sufficiently competent based on his engineering background and his experience building houses, even though he had to rely on others for expertise regarding mold remediation.

The court concluded that the appraisal award was binding on the insured; therefore, she could not recover for the cost of the appraisal process, because the insurance policy required each party to pay its own appraiser. The court concluded that because the insurance claim for breach of the duty of good faith and fair dealing was based on a statute and was extracontractual, it was outside of the scope of the appraisal decision, and the insured's damages were not limited to the amount of the appraisal decision.

THE DOCTORS ARGUED THAT THEIR RICO CLAIMS WERE NOT SUBJECT TO ARBITRATION, BECAUSE THE ARBITRATOR LACKED AUTHORITY TO AWARD TREBLE DAMAGES.

J. Severance & separate trials

A trial court abused its discretion by denying a motion to sever the plaintiffs' claim against the negligent driver from the plaintiffs' claim against their underinsured motorist insurer. The court of appeals reasoned that, without the insurer's consent, the judgment against the driver would not be binding against the insurer. Because the issues of liability and damages would have to be litigated twice, the claims were not sufficiently interwoven and should have been severed. *In*

re Koehn, 86 S.W.3d 363 (Tex. App.–Texarkana 2002, no pet.). It seems the court's analysis is flawed. With both the driver and insurer in the same suit, findings on liability or damages should bind both.

Where there was no clear evidence that the insurer made a settlement offer on the entire claim, the trial court did not err by refusing to sever the homeowners' contract claim from their extracontractual claims. The court found that the proof of loss and the insurer's check did not conclusively apply to the entire claim. *In re Republic Lloyds*, 104 S.W.3d 354 (Tex. App.–Houston [14th Dist.] 2003, no pet. h.).

K. Burden of proof

In *Allison v. Fire Ins. Exch.*, 98 S.W.3d 227 (Tex. App.–Austin 2002, pet. filed), the insurer argued that the insured had the burden of segregating damages between covered and non-covered losses, under the doctrine of concurrent causation. The court recognized that concurrent causation is not an affirmative defense but instead is part of the insured's burden of proof. The insured must present some evidence by which the jury can allocate damages attributable to the covered peril. However, the court found the doctrine inapplicable because the insurer never denied any claim as being not covered, and all of the plaintiff's theories of recovery were extracontractual, and beyond recovery under the contract.

The court in *Bituminous Cas. Corp. v. Maxey*, 110 S.W.3d 203 (Tex. App.–Houston [1st Dist.] 2003, pet. denied), considered whether the doctrine of concurrent causation would allow coverage of a loss caused in part by the company's negligent maintenance of a vehicle (which was covered) and in part by the negligent driving of an employee (which was not covered). The court held these were not separate and independent causes of the accident, so there was no coverage.

XIII. OTHER ISSUES

A. Criminal fraud by insured

The "value of the claim" within the criminal statute referred to the fraudulent portion of the claim, not the entire amount. Thus, the insured was guilty of a misdemeanor, not a felony, for filing a partially false claim for personal property destroyed in a house fire. *Logan v. State*, 89 S.W.3d 619 (Tex. Crim. App. 2002).

B. Excess & primary coverage

A liability insurer's umbrella policy was not triggered by a $1.5 million settlement, where the combined coverage of the insurer's policy and the co-insurer's policy was sufficient to cover the settlement. *Liberty Mut. Ins. Co. v. Mid-Continent Ins. Co.*, 266 F. Supp.2d 533 (N.D. Tex. 2003). The court rejected the co-insurer's argument that both CGL policies were excess over any other insurance, and thus all policies were triggered because there was no primary insurance.

In *Parkans Int'l, LLC v. Zurich Ins. Co.*, 299 F.3d 514 (5th Cir. 2002), the court held that an excess insurance policy was secondary to crime coverage in a commercial policy and did not provide "drop-down" or gap-filling coverage. The excess policy did not specify drop-down coverage and contained a maintenance provision requiring that primary insurance continuously provide no less coverage than that specified in the coverage schedule. Furthermore, the court observed that the policy provided that if primary coverage was not maintained, excess coverage "will apply in the same manner as if the primary insurance were still in effect."

C. Subrogation

A contractor's bid that merely mentioned furnishing insurance was not sufficient to make another company an additional insured, so the contractor's insurer did not waive its rights of subrogation against the company. *Continental Cas. Co. v. Fina Oil & Chem. Co.*, ___ S.W.3d ___, 2003 WL 21470362 (Tex. App.–Houston [1st Dist.] June 26, 2003, no pet. h.). Also, the insurance that was to be provided did not include workers compensation. Thus, the insurer could seek subrogation against the company for money paid on a worker's compensation claim.

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