# ANNUAL SURVEY OF

# TEXAS INSURANCE LAW

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## I. INTRODUCTION

This term was very active, with many significant issues.

The Texas Supreme Court held that an insurer's negligent delay in settling a liability suit is actionable under Article 21.21 of the Insurance Code, thus making *Stowers* suits statutory, with recovery of attorney's fees and the possibility of treble damages.

The court also held that an employee's intentional conduct does not flow to the employer whose negligence made the tort possible, so the employer is insured. The Fifth Circuit continued to hold there is no coverage whenever negligence is related to and dependent on intentional conduct.

Courts of appeals are split on the issue of whether the diminished value of a wrecked car is recoverable.

The United States Supreme Court held that ERISA does not preempt a state law that requires a health insurer to allow, and abide by, an independent review of medical necessity, but ERISA would continue to bar any state law that gave additional remedies.

Two courts held that persons are disabled if they cannot perform *any* significant occupational duty, rejecting the insurers' argument that the insureds had to be disabled from *all* work duties.

## II. FIRST PARTY INSURANCE POLICIES & PROVISION

### A. Automobile

The issue of whether diminished value of a repaired automobile is recoverable continued to divide the Texas Courts of Appeals.

The Beaumont Court of Appeals cited a long line of precedents to conclude that when repairs do not restore an automobile to substantially the same condition it was in prior to a collision, the insured may recover for diminished market value. *Schaefer v. American Mfrs. Mut. Ins. Co.*, 65 S.W.3d 806 (Tex. App.–Beaumont 2002, pet. filed). In reaching this conclusion, the court noted its disagreement with *Carlton v. Trinity Universal Ins. Co.*, 32 S.W.3d 454 (Tex. App.–Houston [14th Dist.] 2000, pet. denied).

In *Bailey v. Progressive Co. Mut. Ins. Co.*, ___ S.W.3d ___, 2002 WL 1263895 (Tex. App.–Dallas June 7, 2002, no pet. h.), the insureds brought an action against their insurer under their automobile insurance policy for the insurer's failure to repair or replace their damaged vehicle. In this case, the insurer initially elected to repair the vehicle. However, the insurer significantly underestimated the cost of repairs, which ultimately almost tripled the original estimate. Despite the repairs, the market value of the vehicle after repairs was less than its market value before the accident. The insurer refused to pay the insured's request for the diminution in value of the automobile. The insured then sued the insurer, asserting that it failed to repair or replace their property with other of like kind and quality as required by the policy.

The court rejected the insurer's argument that it had fully complied with the obligation under the policy because it fully repaired all damages subject to repair. The court noted that the policy language requires the insurer to "repair/replace" the property with other of like "kind and quality," and thus to restore the vehicle to its former condition. A vehicle's former condition includes some reference to its value, and is consistent with the policy language as well as the reasonable expectation of car owners.

The court reached the opposite conclusion in *Smither v. Progressive County Mut. Ins. Co.*, 76 S.W.3d 719 (Tex. App–Houston [14th Dist.] 2002, pet. filed), where an insured sued an insurer for the diminished value of her automobile after the automobile had been repaired following an accident. The insurer argued that the inherent diminished value of the vehicle was not a loss covered under the policy. The court agreed, concluding that once a damaged automobile has been restored to its pre-accident condition, the insurer is not required to also compensate the insured for any remaining inherent diminution in value. The court distinguished cases where the diminished value results from improper, faulty, or inferior repairs. The court also distinguished cases where the claims arose from the insurer's decision to repair the vehicle when it should have declared the vehicle a total loss.

In *Texas Farm Bureau Mut. Ins. Co. v. Sturrock*, 65 S.W.3d 763 (Tex. App.–Beaumont 2001, pet. filed), a driver brought an action against his automobile insurer to recover personal injury protection (PIP) benefits for injury to his neck, shoulder, and upper back that occurred while exiting his pickup truck. The insurer argued that under the plain meaning of the policy, the insured was not involved in a "motor vehicle accident," so the event was not covered. The court rejected this argument, observing that an "auto accident" does not require a collision between objects. The court noted that "collision" is defined in the property damage portion of the policy, and that the liability portion of the policy is not limited to a "collision." The court concluded that viewing the policy as a whole, the term "motor vehicle accident" does not necessitate any physical impact, provided that the facts demonstrate causation between use of the vehicle and the accidental injury incurred by the covered person.

An uninsured vehicle hit a truck owned by Sanchez, who was lying underneath working on the gas tank hose. The truck collapsed on him, causing severe injuries. His policy excluded benefits if he was "occupying" or "struck by" a vehicle he owned that was not insured under the policy. His truck was not insured. The question was whether he was occupying it or was struck by it.

The court held that Sanchez was not occupying his truck when it injured him. The common meaning of the term suggested that the vehicle would be supporting him, and it was not. *Old American County Mut. Fire Ins. Co. v. Sanchez*, ___ S.W.3d ___, 2002 WL 1377870 (Tex. App.–Austin, June 27, 2002, no pet. h.).

The court also held that Sanchez was not "struck by" his truck. The causative force was the other vehicle. His truck was passive, until it was hit.

The next issue was whether the rejection of the uninsured motorist ("UM") and PIP coverage by Sanchez's wife was valid. She signed a rejection, but she was not named as an insured. The statutes require a rejection by "any insured named in the policy." Although Mrs. Sanchez was insured as a family member, she was not actually named in the policy, so the court concluded the rejection was not valid.

**The Texas Supreme Court held that an insurer's negligent delay in settling a liability suit is actionable under Article 21.21 of the Insurance Code**

In *Garza v. State Farm Mut. Auto. Ins. Co.*, ___ F. Supp. 2d ___, 2002 WL 1285364 (S.D. Tex. Feb. 15, 2002), the surviving spouse and children of an employee brought suit against the employer's automobile insurer. The employee was killed in an automobile-train accident while riding in a vehicle owned by his employer and driven by an uninsured fellow employee. The insurer denied coverage.

The parties agreed that, by its terms, the policy excluded from coverage the company vehicle that the fellow employee was driving at the time of the accident. The plaintiffs contended that exclusion should not be enforced because it frustrated the legislative intent of the uninsured/underinsured motorist coverage statute and was contrary to public policy. The plaintiffs contended the exclusion violated public policy because there was no other provision in it for any other insurance policy to cover the plaintiffs' damages.

The court rejected the plaintiffs' argument, noting that the policy was internally consistent and clearly denied liability coverage and UM coverage to employees in the plaintiffs' circumstance. Moreover, the court observed that an earlier declaratory judgment action in state district court enforced the exclusions to protect the insurer from paying benefits outside the scope of coverage. The court found that to conclude that the UM exclusion was against public policy would frustrate

the earlier state court decision and the obvious intent of the parties to exclude work related injuries.

**B. Homeowners**

In *Parton v. State Farm Gen. Ins. Co.*, ___ F. Supp. 2d ___, 2002 WL 1343789 (E.D. Tex. June 7, 2002), the insured died in an automobile accident with an underinsured driver. The insured's estate then recovered from the at fault driver and from the insured's UIM and PIP protection portions of her automobile policy. The insured's estate then made the novel argument that they should be able to recover under the insured's mobile homeowner's policy, arguing that the policy was a "automobile liability insurance policy" as defined by the Texas Insurance Code and therefore required to offer UM/UIM and PIP motorists coverage. The court found that the language of the applicable statutes was unambiguous, and that the broad definition of motor vehicle supported the insured's interpretation. However, the court reluctantly concluded that the legislature could not have intended such a result. The court relied on another appeals court decision that held that UM/UIM statutes should not be applied to umbrella policies because those policies are by their very nature "extra" policies added on top of primary policies to provide liability coverage in excess of the minimum liability requirements of the Texas Insurance Code. Similarly, the court found that in this case the insureds were covered by a primary automobile insurance policy, and thus there was no need to extend UM/UIM statutory protections to their mobile homeowner's insurance policy.

In *Smith v. Texas Farmer's Ins. Co.*, ___ S.W.3d ___, 2002 WL 1020693 (Tex. App.–San Antonio May 22, 2002, pet. filed), the sellers of real property brought an action against the purchaser and an insurance company that had provided the purchaser with an insurance policy on the property. That policy named the sellers as mortgagees. In an underlying action, the purchasers won a secured judgment against the sellers for their failure to disclose foundation defects. The purchasers obtained a judgment in excess of the amount owed on the mortgage. After the judgment was entered in the trial court, but before appeals were resolved, the purchasers continued to file claims with their insurance company relating to plumbing leaks in the house. After the appeals were resolved in the underlying suit, the sellers brought this suit against the purchasers and the insurance company alleging that payments after the entry of the trial court judgment to the purchasers violated the terms of the insurance policy. Specifically, the sellers contended that the loss-payment checks should have been made payable to them as mortgagees under the policy, and that the insurer fraudulently concealed the check that resulted in an increase damage award to the purchasers under the 1993 judgment.

The court rejected the sellers' arguments, holding that the trial court's judgment in the earlier matter extinguished all rights that the sellers had under the policy. The court found that while the purchasers filed property loss claims before the rendition of the earlier judgment, the claims were paid after rendition of the judgment, by which time the debt owed by the purchasers to the sellers under the note had been paid. Because the note was satisfied, the sellers no longer had an interest in the insurance policy as mortgagees, and the insurer was not liable to the sellers for any claims paid after rendition of the earlier judgment.

The court also rejected the sellers' argument that the insurer fraudulently concealed the claims that were submitted after the earlier trial court judgment. The court found the insurer conclusively established that those claims were unrelated to the foundation problems that formed the basis of the earlier lawsuit. Because they were unrelated, the court concluded that the insurance company payments of the claims to the purchasers would not have affected the damages awarded to the purchasers under the earlier judgment.

**C. Commercial Property**

A commercial property policy did not cover damage to building foundations resulting from seepage or leakage from underground pipes and drains, or for the cost of accessing and repairing the underground plumbing. First, the policy excluded damage caused by or resulting from continuous or repeated seepage or leakage of water that occurred over a period of fourteen days or more. Second, the policy explicitly did not cover underground pipes or drains. Because the underground plumbing was not insured, the court deemed irrelevant the exclusion for rust, corrosion, and deterioration. Also, because there was no covered loss, the insurer did not owe "access costs" to tear out and replace the plumbing system. Finally, the court rejected the argument that the insurer's course of conduct supported coverage. The insured argued that the insurer had paid other similar claims. The court held parol evidence was not admissible to interpret the policy, which was unambiguous. *General Accident Ins. Co. v. Unity/Waterford-Fair Oaks, Ltd.*, 288 F.3d 651 (5th Cir. 2002).

In *Ghoman v. New Hampshire Ins. Co.*, 159 F. Supp. 2d 928 (N.D. Tex. 2001), the insured owned and operated a hotel that was insured under a commercial property policy. When the hotel was damaged by wind and hail, the insured submitted claims. The insured rejected the initial offer of settlement, and demanded an appraisal as provided by the policy. The appraisal award valued the replacement costs and the actual cash value of the loss. In response to the appraisal, the insurer tendered payment to the plaintiff for the cost of replacement as determined by the umpire, less depreciation, contractor's overhead and profit, sales tax on building materials, and the deductible.

The plaintiff then brought suit contending that, with the exception of the depreciation and deductible, the sums withheld by the insurer were recoverable under the policy. The court agreed. The court noted that the policy allows the plaintiff to either make a claim for replacement costs or the actual cash value of the loss supplemented by the additional replacement cost coverage. The court rejected the insurer's argument that the plaintiff made a replacement cost claim, noting that the mere fact that the plaintiff may have requested funds to repair the damage to his property was not inconsistent with making an actual cash value claim.

The court observed that the policy provides a two-step process to enable the insured to obtain funds to begin the process of repair or replacement, at which point the insured could submit claims for expenditures that went above the actual cash value of the loss. The court held that the summary judgment evidence strongly suggested that the plaintiff invoked this two-step process. The court noted that the appraisal determined both the replacement cost value as well as the actual cash value of the loss. There would be no reason for the umpire to make an actual cash value award if the plaintiff were requesting only replacement costs. Similarly, the court observed that the claim forms submitted by the plaintiff were consistent with the actual cash value of the claim. Thus, the court concluded that the evidence conclusively established that the plaintiff filed a claim for the actual cash value of the loss, supplemented by additional replacement cost coverage, rather than a replacement cost claim.

Next, the court was asked to decide whether the contractor's overhead and profit and sales tax were properly deducted from the actual value. The court concluded that "actual cash value"

under the policy means repair or replacement costs less depreciation. The contractor's overhead, profit, and sales tax, the court noted, clearly fit this definition. Thus, the court held that the previous amount should be included in the actual cash value award. The court rejected the argument that the plaintiff did not actually incur some of these costs because he completed some of the repairs himself. The court noted that while this might be true, it was legally irrelevant. What the plaintiff actually spent to repair his property – indeed, whether he repaired the property at all – did not affect his right to recover actual cash value.

**D. Life Insurance**

In *Mayo v. Hartford Life Ins. Co.*, 193 F. Supp. 2d 927 (S.D. Tex. 2002), 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. The court agreed, observing that public policy in Texas does not allow anyone who has no insurable interest to be the owner of a life insurance policy. A putative beneficiary only has an insurable interest in the life of another if the beneficiary is (1) so closely related to the person insured that they want the other to continue to live, irrespective of the monetary considerations, (2) a creditor, or (3) one possessing a reasonable expectation of advantage from the continued life of another.

The court concluded that the employer failed to demonstrate that it had any expectation of continued benefits or advantage from the former employees apart from the policies on their lives. The court rejected the employer's analogy to "key man" insurance, noting that once that "key man" leaves the company, the need for insurance disappears.

**The court rejected the employer's analogy to "key man" insurance, noting that once that "key man" leaves the company, the need for insurance disappears.**

In *Certain Underwriters at Lloyds v. Smith*, ___ S.W.3d ___, 2002 WL 730463 (Tex. App.–Houston [14th Dist.] April 25, 2002, no pet. h.), an employer obtained an accidental death policy that paid $250,000 upon the death of its employee. When the surviving spouse and child learned of the policy, they sued the employer and the insurer to recover the benefits. The court held that the employer had no insurable interest in the lives of its employees, and thus the surviving spouse was the proper beneficiary of the proceeds of the accidental death policy.

The spouse then argued that the insurer was joint and severally liable for the policy proceeds. The court rejected this argument, noting that Texas law requires only that the insurance company pay the proceeds of the insurance policy to the designated beneficiary in the policy. If the designated beneficiary is not the proper party to receive the proceeds, the payee holds them in constructive trust for the proper beneficiary. In this case, the insurer paid the policy proceeds to the employer in satisfaction of the employer's claims for benefits. The employer held the proceeds in constructive trust for the surviving spouse. Accordingly, the court concluded that the insurer discharged its responsibilities by paying the proceeds to the employer.

Moreover, the court noted that there was no contractual relationship between the spouse and the insurer. Because there was no contractual relationship the court also found that no duty of good faith or fair dealing was owed by the insurer to this surviving spouse. Without a contractual relationship or any other duty owed to the spouse, the court reasoned that the joint and several liability could not be independently imposed upon the insurer for the proceeds.

Finally, the court rejected the plaintiff's request to reform the contract to add her as a named beneficiary. The court concluded that because the constructive trust is available to plaintiffs in such cases, there is nothing that suggests that the legislature thought the plaintiffs needed the additional protection of reformation.

**E. Disability Insurance**

A doctor whose injury limited some, but not all, of the professional duties he could perform raised a fact issue on whether he suffered a "total disability" within the meaning of his policy. *Knott v. Provident Life & Accident Ins. Co.*, 70 S.W.3d 924 (Tex. App.–Eastland 2002, pet. filed). It was not necessary that the doctor be disabled from performing *all* the duties of his occupation.

Further, the doctor also raised a fact issue on whether his disability commenced after his 65th birthday, which would limit the duration of the benefits. The fact that he listed a date after his 65th birthday as the date he last worked did not conclusively establish that his disability commenced after his 65th birthday.

An ERISA case reaching a similar conclusion on the meaning of total disability is found in *Lain v. UNUM Life Ins. Co.*, 279 F.3d 337 (5th Cir. 2002).

**F. Other Policies**

In *Autobond Acceptance Corp. v. Progressive Northern Ins. Co.*, 76 S.W.3d 489 (Tex. App.–Houston [14th Dist.] 2002, pet. denied), a party that purchased automobile dealers brought an action against their insurer after the insurer cancelled a blanket vendor's single interest policy that provided coverage for property damage and deficiency balances. The court held that the policy unambiguously provided that the insurer was entitled to cancel the policy on thirty days notice and that by canceling the policy, the insurer was not liable for losses that occurred after the cancellation date. Moreover, the court found that the insurer's liability was limited to 88% of the premium paid each month. The court found that the trial court erred in submitting the issue of ambiguity to the jury, but the jury, nonetheless, found that the insurer complied with the policy. Therefore, the court concluded that despite the erroneous jury submission, the trial court did not err in granting a take nothing judgment for the insurer.

## III. FIRST PARTY THEORIES OF LIABILITY

### A. Unfair Insurance Practices, Deceptive Trade Practices, and Duty of Good Faith & Fair Dealing

In *Mid-Century Ins. Co. v. Boyte*, ___ S.W.3d ___, 45 Tex. Sup. Ct. J. 696 (May 23, 2002), the Texas Supreme Court held

that an uninsured motorist insurer's statutory duty of good faith and fair dealing ends when the insured becomes a judgment creditor.

Boyte was injured in a car wreck and sued his underinsured motorist insurer. They disagreed on the value of his claim. Boyte demanded the policy limits of $100,000. Mid-Century offered and paid only $20,000. The jury found Boyte was entitled to the remaining policy benefits. Boyte then sued Mid-Century asserting that by failing to pay after the judgment was rendered, Mid-Century failed to attempt to make a fair settlement once its liability became reasonably clear.

The Supreme Court held that once judgment was rendered against the insurer, the insurer no longer owed a duty of good faith and fair dealing to its insured, and the only remedies were based on their relationship as judgment creditor and judgment debtor.

The court rejected the argument that the insurer and insured still had a disparity in power that required continued application of the duty of good faith. The court reasoned that the insured, as a judgment creditor has remedies, just like all other judgment creditors.

The court further held that its prior decision in *Stewart Title Guaranty Company v. Aiello*, 941 S.W.2d 68 (Tex. 1987), finding no common-law duty of good faith and fair dealing once judgment was rendered, applied to statutory claims as well.

The court's reasoning is misguided. Under the common-law duty of good faith, an insurer is liable when it delays or denies a claim without a reasonable basis. Courts construed this standard to let insurers off the hook if there was any evidence of a reasonable basis. The pendency of an undecided appeal arguably could provide a reasonable basis for continuing to delay paying.

**The court addressed whether the "professional service" defense barred recovery under the DTPA.**

On the other hand, the statute imposes liability if the insurer fails to settle when its liability is reasonably clear. Under this standard, juries assess liability based on facts the insurer learns during its investigation or even during the course of the lawsuit that make liability reasonably clear. What can make the insurer's liability more reasonably clear than a judgment holding it liable?

The court does offer one intriguing suggestion. Boyte complained that he needed surgery while the appeal was pending but could not pay for it. The court noted that if superseding a judgment threatens to harm the judgment creditor, then the trial court may make any order necessary to adequately protect the judgment creditor against loss or damage that the appeal might cause. Tex. R. App. P. 24.1(e). The court did not clarify whether this could include an order requiring payment of the claim while the appeal is pending. The context of the court's decision makes this possibility reasonable.

In *Gates v. State Farm County Mutual Insurance Company of Texas*, 53 S.W.3d 826 (Tex. App.–Dallas 2001, no pet.), the insured was involved in an automobile accident with an uninsured motorist and filed a claim under the UM/UIM provision of its policy. After a settlement could not be reached, the insured filed suit against the insurer asserting claims for breach of contract and bad faith. The trial court then severed the contractual claims from the extra-contractual, bad faith claims. In the contract action, the trial court struck all of the insured's medical experts and then granted summary judgment for the insurer. The insured did not appeal this judgment and it became final.

After the judgment in the contractual suit became final, the insurer filed a motion for summary judgment on the insured's bad faith common law and statutory bad faith claims. The insurer asserted that because the contract claim failed, the insured, therefore, could not recover on any of their bad faith claims. The court agreed, holding that the final judgment against the insured on the contract claim prevented recovery as a matter of law on the bad faith claims.

The court further found that the insured presented no evidence of "extreme" conduct by the insurer that would permit recovery in those limited circumstances where there was no coverage under the policy. The court rejected the insured's contention that the post-litigation Rule 11 agreement between the parties constituted extreme conduct, holding that the insured needed to produce evidence of "extreme" conduct by the insurer occurring during the claims process.

In *Jones v. Ray Ins. Agency*, 59 S.W.3d 739 (Tex. App–Corpus Christi 2001, pet. filed), the court found unconscionable conduct by the insurance company because it simultaneously retained the premiums paid by the insurer and denied coverage.

In *Nast v. State Farm & Cas. Co.*, ___ S.W.3d ___, 2002 WL 799595 (Tex. App.–San Antonio, May 1, 2002, no pet.), the plaintiffs brought suit against their agent and the insurance company for failure to procure a flood insurance policy. In reversing summary judgment for the insurer and the agent, the court rejected the argument that the plaintiffs failed to rely on the misrepresentations of the agent.

The insurer and the agent argued that because the plaintiffs knew that their neighbors had obtained FEMA flood insurance, they should have known the agent was wrong about their inability to receive flood insurance at a lower cost than he advised. The court rejected this argument, noting that the plaintiffs sought to procure FEMA flood insurance, but their agent told them they were not eligible. The plaintiffs trusted their agent, who had been their agent for eighteen years. When the plaintiffs asked why their neighbors were eligible, the agent responded that there had been a "shyster" selling fake flood insurance policies in the neighborhood. Based on these misrepresentations, the plaintiffs did not make any further attempts to acquire insurance. Thus, the court found that a fact issue existed as to whether the plaintiffs relied on the agent's misrepresentations. For similar reasons, the court went on to find that an issue of genuine fact existed as to whether the agent's misrepresentations were a producing cause of the plaintiffs' damages.

Next, the court addressed whether the "professional service" defense barred recovery under the DTPA. The court held that the exemption does not apply to an express misrepresentation of a material fact that cannot be characterized as advice, judgment, or opinion. The court noted that the agent's statements as to the plaintiffs' eligibility for FEMA flood insurance were misrepresentations of fact, and not professional advice.

Finally, the court addressed the insurer's argument that the plaintiffs were not consumers under the DTPA because they did not purchase the flood policy. The court noted that a consumer is an individual who "seeks or acquires by purchase or lease, any goods or services." *Id.* at 4. It was not necessary

for the plaintiffs to have made an actual purchase of an insurance policy; it was sufficient for the plaintiff to acquire those services in good faith.

In *Greil v. Geico*, 184 F. Supp. 2d 541 (N.D. Tex.–2002), an insurer brought an action against her automobile insurer pursuant to her uninsured/underinsured policy. The insured argued that the insurer engaged in bad faith by: (1) offering the insured only $40,000 in settlement when the insurer was given settlement authority up to $60,000; and (2) requiring the insured to sign a release before paying the "undisputed" $40,000 portion of personal injury claim. The court rejected both arguments.

First, the court found that the insurer's settlement authority did not equate to the actual value of the insured's claim. The court observed that numerous factors other than the actual value of the claim, including the desire to avoid a trial, go into calculating a settlement amount. Second, the court concluded that the $40,000 settlement offer from the insurer was not "undisputed." The court noted that at the time the settlement offer was made, the insured stated her disagreement with the insurer's valuation of her claim. The court observed that it was clear from the correspondence between the adjuster and the insured that the valuation of the claim was disputed from the outset. The court concluded that, given the disputed nature of the claim, it was reasonable for the insurer to demand a release prior to paying the settlement.

Finally, the insured argued that the insurer's failure to "break down" the settlement offer was a violation of the insurer's duty to "provide promptly to the policyholder a reasonable explanation of the basis in the policy, in relation to facts or applicable law, for the insurer's . . . offer of a compromise settlement." *Id.* at 546. The court rejected this argument as well, concluding that the adjuster's offer to discuss the insured's claim on more than one occasion satisfied the insurer's obligation under the statute.

In a case involving fire damage to an insured building, the insured asserted various violations. *Johnson v. Essex Ins. Co.*, ___ S.W.3d ___, 2002 WL 112561 (Tex. App.–San Antonio, June 30, 2002, no pet.). The court first found that the insurer did not fail to attempt in good faith to effectuate a prompt, fair, and equitable settlement once liability had become clear. The valuation of the claim was never reasonably clear, due to conflicting estimates. The court noted that because there was a bona fide dispute between the parties, it could not be said that the insurer had no reasonable basis for delaying payment of the claim. Further, the court found that the insured failed to raise a fact issue regarding the reliability of the adjuster's report, the reasonableness of the insurer's conduct in relying on the adjuster's report in light of conflicting estimates, and the insurer's conduct in offering the insured a partial settlement offer.

Next, the insured argued that the insurer failed to pay the claim without conducting a reasonable investigation. The insured argued that the insurer's adjuster was unqualified to adjust the claims, failed to contact two other contractors to get additional estimates, refused to consider the insured's estimate prepared by another contractor, and disregarded the insured's criticisms and misgivings regarding the selection of the insurer's contractors. The court rejected these arguments and held that as a matter of law the insured failed to raise a fact issue regarding a reasonable investigation. The court observed that the evidence at most established that three contractors disagreed about the extent of soot damage and the method to repair it. While disagreeing with the insured's contractor, the adjuster did have a second estimate prepared. The fact that the adjuster used the report rather than obtaining two additional reports, as he told the insured he would, was insufficient to cast doubt on the reliability of those opinions. The court further observed that the evidence of the Gerloff Company's alleged bias was so weak that it creates only a mere suspicion.

The court also affirmed summary judgment for the insurer on the grounds that the insured presented no evidence that the insurer failed to affirm or deny the claim within a reasonable time. The court opined that, unlike Article 21.55 of the Insurance Code, which sets forth deadlines for resolving claims and contains no good faith exception to liability, Article 21.21 requires only that the insurer affirm or deny coverage within a reasonable time. Without further analysis, the court held that the insurer's delay was not unreasonable.

In a case involving payments to beneficiaries under a life insurance policy, the court found that the beneficiaries lacked standing to assert a claim for violation of Article 21.21. *Metro. Life Ins. Co. v. Barretto*, 178 F. Supp. 2d 745 (S.D. Tex. 2001). Furthermore, the court found that the beneficiaries were not "consumers" and thus lack standing to bring claims under the DTPA.

In *Kuper v. Stewart Title Guar. Co.*, 2002 WL 992566 (Tex. App.–Houston [1st Dist.] May 16, 2002, no pet.), a property owner sued his title insurance company alleging violations by the insurer's refusal to defend access rights to the property. The court of appeals found that a genuine issue of material fact existed as to whether the property owner relied on alleged misrepresentations that there was access to the property by a public road that induced him to purchase the property. The court found the title insurer knew the property owner would not buy the property without assurances of a public road access, and the title insurer arranged for an abstract company to confirm by letter that access to the property was by public road.

The court also rejected the insurer's argument that the plaintiff was not a "consumer" under the DTPA. The court found that the purchase of the title insurance policy qualified as a "service."

### B. Prompt Payment of Claims – Article 21.55

An insurer was not liable for delay penalties when it paid an underinsured motorist claim immediately after judgment was rendered establishing its liability on the claim. The court rejected the argument that the insurer was liable for failing to pay within sixty days. *Wellisch v. United Serv. Auto. Ass'n*, 75 S.W.3d 53 (Tex. App.–San Antonio 2002, pet. filed). The insured argued that the insurer should be liable for failing to pay within sixty days, under cases such as *Higginbotham v. State Farm Mutual Ins. Co.*, 103 F.3d 456, 461 (5th Cir. 1997), which hold that an insurer that denies or delays a claim and later is found liable also is automatically liable for penalties under the statute. The court of appeals reasoned that with UM coverage the insurer's liability did not arise until the insured established their "legal entitlement" to benefits.

The court's conclusion is wrong. In every other type of insurance case where delay penalties are automatically assessed, the insurer is expected to make its decision on the claim based on its investigation and then take the risk that its decision to deny the claim is wrong. When insurers in other contexts are found liable, i.e., when the insured established their "legal entitlement," the insurers then are liable for the claim and for penalties. There is no justification for treating UM coverage differently. An insurer, as in this case, makes its best determination based on its investigation. If that decision is wrong, then a UM insurer, like any other insurer, should be assessed delay penalties.

In *Wellisch*, the dispute between the parties was over the value of the claim, which determined whether the insured was underinsured. This is no different than any other type of coverage dispute where the insurer and insured disagree on the value of the claim, or disagree on any other fact affecting liability, and have it resolved by a jury. For example, two of the leading cases holding insurers automatically liable for delay penalties, involved claims for foundation damage caused by water leaks. In these cases, the insurers' liability – and the insureds' "legal entitlement" – was not established until the cause of damage was resolved by the juries. Nevertheless, penalties were properly assessed in addition to the amounts of the claims. *See Cater v. United Serv. Auto. Ass'n*, 27 S.W.3d 81, 84 (Tex. App.–San Antonio 2000, pet. denied); *Oram v. State Farm Lloyds*, 977 S.W.2d 163, 167 (Tex. App.–Austin 1998, no pet.).

**C. Negligence**

In *Nast v. State Farm & Cas. Co.*, ___ S.W.3d ___, 2002 WL 799595 (Tex. App.–San Antonio, May 1, 2002, no pet.), the plaintiffs alleged that the agent failed to exercise ordinary care by: (1) representing to the plaintiffs that their home was not in a flood zone that made it eligible for FEMA flood insurance, (2) failing to correctly advise the plaintiffs that they were eligible for FEMA flood insurance and the correct premium for such insurance, (3) discouraging the plaintiffs from obtaining FEMA flood insurance by providing them with incorrect information as to its availability for their home, and (4) failing to advise the plaintiffs at the outset that the agent refused to write FEMA flood insurance for them.

**The court characterized the plaintiffs' claim as one of negligent misrepresentation, and not negligent procurement of insurance.**

The insurer and the agent argued that the agent has no duty to obtain insurance for a client without having been asked to do so. However, the court characterized the plaintiffs' claim as one of negligent misrepresentation, and not negligent procurement of insurance. The court rejected the suggestion that the tort of negligent misrepresentation should not apply to insurance agents. Only by making an affirmative misrepresentation does the insurance agent create potential liability. In this case, not only did the agent misrepresent the plaintiffs' eligibility for flood insurance, but when asked why their neighbors had been eligible, the agent responded that those neighbors had purchased "fake" insurance from a "shyster." The court concluded that these affirmative representations could be misrepresentations. Thus, the plaintiff stated a claim for negligent misrepresentation.

In a case involving fire damage to an insured building, the insured asserted a claim of negligence per se against the insurer, arguing that one of the insurer's employees adjusted the claim without a license, in violation of the Texas Insurance Code. *Johnson v. Essex Ins. Co.*, ___ S.W.3d ___, 2002 WL 112561 (Tex. App.–San Antonio, Jan. 30, 2002, no pet.). Without deciding the issue of whether it would be appropriate to assign tort liability for violation of the licensing statute, the court held that the insured failed to produce any evidence that the employee performed any adjusting activities in handling the claim.

**D. ERISA**

The United States Supreme Court again addressed the scope of ERISA preemption and found another state law related to insurance that was not preempted in *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151 (2002). At issue was an Illinois law requiring HMOs to a submit determinations of medical necessity to a second, independent medical review, before denying the claim. The Court found the statute regulated insurance and thus was saved from preemption under the express language of ERISA.

However, the Court's further analysis bodes ill for other state laws that admittedly regulate insurance; such laws should be saved from preemption if they provide additional remedies. The Court considered the HMO's argument that even if the law regulated insurance, the statute nevertheless should be preempted because it provided a remedy in conflict with the remedial provisions of ERISA. The Court detailed at length its view that any state law providing additional remedies would be preempted, even a law regulating insurance. However, the Court concluded that the independent review statute did not provide an additional remedy. It simply provided another layer of review.

The optimism created by the Supreme Court's recent decision in *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999), has been severely blunted. While *UNUM* and *Moran* breathe life into the savings clause, the Court seems to have made it equally clear that any state law that provides additional relief, different from ERISA's enforcement scheme, will be preempted to that extent.

In granting review in *Moran*, the Supreme Court noted that the Fifth Circuit had reached a different result when examining Texas law in *Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, 215 F.3d 526 (5th Cir. 2000), *rev'd sub nom., Montemayor v. Corp. Health Ins.*, 122 S.Ct. 2617 (2002). In that case, the Fifth Circuit held that ERISA preempted the independent review provisions under the Texas Insurance Code. *Id.* at 536-39. The Supreme Court vacated this decision and remanded for consideration in light of *Moran*.

In a disability case under ERISA, the Fifth Circuit demonstrated that ERISA can sometimes provide a remedy. A lawyer was insured under a disability policy with UNUM. She developed severe, recurrent chest pains, which her doctor said disabled her from performing the tasks of her job. UNUM denied her claim. The district court found UNUM abused its discretion and awarded her benefits and attorney's fees. The Fifth Circuit affirmed. *See Lain v. UNUM Life Ins. Co.*, 279 F.3d 337 (5th Cir. 2002).

> The Fifth Circuit detailed the standards of review under ERISA. The test is whether the client administrator acted arbitrarily and capriciously, that is, whether the administrator abused its discretion. A "sliding scale" of deference is applied to the standard when the administrator has acted under a conflict of interest.

The court applied a two-prong test when reviewing an administrator's denial of benefits. First, the court determined the legally correct interpretation of the policy. Then, the court determined whether the administrator's decision was an abuse of discretion.

The policy provided that the insured was disabled if she

"cannot perform *each* of the material duties of her regular occupation." *Id.* at 343. UNUM argued that this meant she was not disabled unless she could not perform *all* of her duties. The court rejected this argument and held that the plain meaning of this language meant she was disabled if she could not perform *any* of the duties of her job.

The fact that the administrator applied the wrong interpretation did not necessarily mean the denial was an abuse of discretion. The court reviewed the evidence supporting the claim and the evidence supporting the denial. The only physician to file a statement with UNUM reported that the insured was disabled. UNUM did not present any evidence that the insured was capable of working. Because there was a complete absence of any "concrete evidence" supporting UNUM's determination that the insured was not disabled, the district court properly held that UNUM abused its discretion. The court affirmed the award of benefits and fees.

In *Erwin v. Texas Health Choice, L.C.*, 187 F. Supp. 2d 661 (N.D. Tex. 2002), a surviving spouse of an insured employee brought a state court action against the employee benefit plan's health insurer and others alleging improper delay in the payment for the insured's liver transplant. The spouse brought third-party beneficiary claims as well as claims for common law and statutory bad faith. The defendants removed the action to federal court, and then moved for judgment on the pleadings as to the spouse's claims.

The court dismissed the spouse's bad faith claims, ruling that those claims "related to" defendant's coverage decisions and were therefore preempted by ERISA. The court distinguished this case, where the plaintiff sought to recover benefits under the policy, from those cases involving a third-party service provider alleging that an ERISA plan administrator misrepresented a beneficiaries' coverage. The latter category of cases would not be pre-empted.

The court next held that ERISA's savings clause did not salvage plaintiff's claims. The savings clause excludes from ERISA preemption "any law of any state which regulates insurance." *Id.* at 664. The court concluded that Article 21.21 of the Texas Insurance Code and the Texas common law action for bad faith do not regulate insurance. Under Fifth Circuit precedent, a law regulates insurance when it transfers or spreads policyholder risk and affects an integral part of the relationship between the insurer and insured. The court concluded that Article 21.21 and the common law action for bad faith meet neither of these criteria.

After dismissing the non-ERISA claims, the court rejected the insurer's argument that the ERISA claims were not timely. The court observed that a plaintiff may bring a claim for denial of benefits up to four years after the cause of action accrued. The court concluded that the plaintiff's claim was well within this four-year limitation.

Finally, the insurer argued that a surviving spouse could not recover the full value of the liver transplant services. The insurer argued that ERISA's civil enforcement provision only permits the recovery of benefits while the beneficiary is in a position to receive the medical treatment. Because the beneficiary was deceased, the insurer argued that he was not in a position to receive the liver transplant allegedly covered by the insurance contract. The court rejected this argument, concluding that the insurer's interpretation conflicts with the public policy rationale behind the passage of the statute. The court noted that such a construction would provide an incentive for ERISA plan administrators to deny claims for expensive services, because, should the patient die, the plan administrator would escape responsibility. The poorer the patient, and the more expensive the service, the higher the incentive would be for the plan administrator to withhold benefits. As a consequence, the court observed that the people who need the benefits the most – those in serious condition and with few financial resources – would be those most harmed by insurer's interpretation of ERISA. The court held that Congress could not have intended ERISA to bring about such a result.

## IV. AGENTS, AGENCY, AND VICARIOUS LIABILITY

### A. Insurer's Vicarious Liability for Agent's Conduct

An insurance broker that had authority to issue a certificate of insurance nevertheless lacked authority to extend coverage not provided by the policy. The agency agreement with the insurer denied any such authority, and the certificate of insurance stated that it did not amend, extend, or alter the coverage afforded by the policy. *See TIG Ins. Co. v. Sedgewick James of Washington*, 276 F.3d 754 (5th Cir. 2002).

## V. THIRD PARTY INSURANCE POLICIES & PROVISIONS

### A. Automobile Liability Insurance

In *Old Am. Mut. Fire Ins. Co. v. Gulf States Fin. Co.*, 73 S.W.3d 394 (Tex. App.–Houston [1st Dist.] 2002, pet. filed), a lender sued the insurer for damage that occurred when the insured's car was driven by a driver excluded under the policy. The insurer denied coverage, claiming the loss payable clause did not protect the lender. The court agreed with the insurer, concluding that the loss payable clause in this case only protected the lender from the insured's "fraudulent acts or omission." Because there was no allegation that allowing the excluded driver access to the car constituted fraud, the court concluded that the lender could not recover.

In *Associated Int'l Ins. Co. v. Blythe*, 286 F.3d 780 (5th Cir. 2002), the insured hired a work crew to hang fiber optic television wire on utility poles in the Houston area. The insured hired a contract laborer, who in turn would recruit a four-man crew to work on the job. The insured provided a truck to be used while performing the work. The insured informed the contractor that its insurers would not permit him to operate the truck, because of his driving record. It was understood that one of the other men in the contractor's crew would actually operate the vehicle.

Blythe, the contractor, hired a crew that was hanging cable television wire using the insured's truck. Blythe gave one of the crewmembers, Eason, the keys to drive the truck. Eason was driving the truck when another member of the crew, Wood, was injured when the truck hit power lines. The accident caused a fire, which severely burned over two-thirds of Wood's body. Wood then brought suit and obtained a judgment against both Blythe and Eason.

The insurer then brought this suit alleging that Blythe was not covered under commercial automobile liability policy. In particular, the insurer argued that Blythe was not an insured under the omnibus clause of the policy because he was not present at the work site when the accident occurred and he was therefore not "using" the vehicle. The insurer further argued that the negligent entrustment theory asserted against Blythe did not establish his "use" of the truck when it injured Wood. The court rejected this argument, noting that, although Blythe was not permitted to drive the truck, his employer entrusted him with the vehicle to use it to accomplish the purposes of

the job. When Blythe entrusted the vehicle to Eason, he was putting the truck in service to perform the task assigned to him by his employer – the vehicle owner and the named insured. Thus, Blythe's entrustment of the vehicle to Eason constituted "use" of the vehicle.

**B. Comprehensive General Liability Insurance**

An employer is covered for its negligence in hiring and supervising an employee who commits an intentional tort. *King v. Dallas Fire Ins. Co.*, ___ S.W.3d ___, 45 Tex. Sup. Ct. J. 715 (May 30, 2002). King's employee assaulted Jankowiak, who then sued King under the theory of respondeat superior and for negligent hiring, training, and supervision of the employee. The lower courts held the liability insurer had no duty to defend, because the employee's intentional conduct was attributable to the employer and, therefore, there was no "occurrence."

The court relied on the plain language of the policy, which treats insureds separately and excludes bodily injury only if it is expected or intended from the standpoint of the insured. The supreme court concluded that whether the act was "intentional" had to be determined from the perspective of the insured. The employer was a separate insured and was not alleged to have acted intentionally. Therefore, the employer was entitled to coverage, even though the employee was not.

The court noted that there is a split of authorities in other jurisdictions. The court also noted that the Fifth Circuit has held under Texas law that negligence claims that are "related to and interdependent on" an intentional act are also excluded. The supreme court held this reasoning by the Fifth Circuit is erroneous.

Finally, the supreme court looked at the history of the commercial general liability policy to conclude that whether an act is intentional must be determined from the perspective of the insured. To conclude otherwise would make certain provisions of the policy superfluous.

In contrast, the Fifth Circuit held a few months before *King* that there was no coverage for an insured's negligent failure to warn of her mother's sons proclivity to sexually molest other minors. *American National General Ins. Co. v. Ryan*, 274 F.3d 319 (5th Cir. 2001). The Fifth Circuit relied on its line of cases holding that negligence that is "related to and interdependent on" intentional underlying acts is not encompassed within the definition of "occurrence." This is the rule the Texas Supreme Court held erroneous in *King*.

The Fifth Circuit rejected the argument that the severability clause required the court to consider the liability of each insured separately. This was precisely the basis for the supreme court's holding in *King*; therefore, *Ryan* is questionable.

In *Westchester Fire Ins. Co. v. Gulf Coast Rod, Reel & Gun Club*, 64 S.W.3d 609 (Tex. App.–Houston [1st Dist.] 2001, no pet.). The insureds were sued for negligence relating to their conduct in dredging part of the Bolivar peninsula to improve fishing. Certain landowners who were affected by erosion sued, contending that the insureds were negligent in several ways related to the dredging: the failure to determine the consequences of the dredging and the failure to notify the landowners of the consequences.

The insurer argued there was no "occurrence," because the dredging was intentional. The court rejected this argument. While the dredging was intentional, the "occurrence" was the repeated exposure to water currents that caused erosion, which was neither expected nor intended from the view point of the insureds.

The insurer's next argument was that the loss was excluded as a "loss in progress" or a "known loss." The court rejected this argument as well. Under these doctrines, an insured cannot insure against something that has already begun and that is known to have begun. The plaintiffs' allegations were sufficiently unclear on this point, so the court concluded the insurer had a duty to defend.

In *Hartrick v. Great American Lloyds Ins. Co.*, 62 S.W.3d 270 (Tex. App.–Houston [1st Dist.] 2001, pet. filed), homeowners brought an action against a builder's liability insurer to recover on a judgment against the builder for breach of warranty in preparing the soil and constructing a foundation.

The court concluded that the builder's breach of warranty was not an "accident" under the policy. The court held that the builder's failure to comply with its implied warranty was not accidental, but the result of its not doing what it was required to do. By not doing what it was required to do, the builder could reasonably anticipate the injury to the homeowners.

In *Fina, Inc. v. Traveler's Indemnity Company*, 184 F. Supp. 2d 547 (N.D. Tex. 2002), an employer sought to determine the obligations of its primary liability insurer and excess insurer for claims by workers exposed to asbestos. The primary insurer argued that exposure to asbestos at any of the work premises constituted a single occurrence, and thus prior settlements had exhausted the policy limits. The insured argued that each claimant's injuries constituted a separate occurrence.

The court rejected both arguments, concluding that claimants who were exposed to asbestos at the same location, at roughly the same time, were asserting one "occurrence." The court found at least three occurrences – one at each of the insured's facilities.

In *All-Tex Roofing, Inc. v. Greenwood Insurance Company Group, Inc.*, 73 S.W.3d 412 (Tex. App.–Houston [1st Dist.] 2002, pet. filed), the insurer argued that the insured's policy did not cover the underlying personal injury case, because the plaintiff was the insured's employee. In the underlying action, the court found that the insured was the plaintiff's employer under the workers compensation statute. However, the court rejected the argument that the plaintiff was the insured's employee for purposes of the insurance contract.

In *Zaiontz v. Trinity Universal Insurance Company*, ___ S.W.3d ___, 2002 WL 753815 (Tex. App.–San Antonio, June 17, 2002, no pet.), an employee brought an action against his employer's insurers to recover a judgment against the employer and president for injuries caused by spraying fire and odor eliminator in the interior of the plane. The CGL insurer first argued that the employee exclusion barred coverage. In response, the employee argued that because the policy contained a "separation of insureds" clause, the employee exclusion applied only if the insured who was actually seeking coverage under the policy was the claimant's employer. Because the executive was the insured who was actually seeking coverage, and the plaintiff was not his employee, the employee exclusion did not apply. The court agreed.

Next, the CGL insurer argued that the executive was not an insured. The policy contained a provision that stated that "no employee is an insured for bodily injury or personal injury to you or a co-employee." Based on this language, the court held that the executive was not an insured under the policy.

As for the umbrella policy, the court concluded that the plaintiff's claims were barred by the pollution exclusion. The court rejected the plaintiff's argument that the policy contained a latent ambiguity. The court relied on *National Union Fire Insurance Company v. CBI Industries, Inc.*, 907 S.W.2d 517 (Tex. 1995, no pet.), which found that a virtually identical pollution exclusion was not ambiguous.

### C. Directors & Officers Liability Insurance

An insured was not entitled to coverage under a "claims made" policy where he did not give timely notice. The suit against the insured was filed in 1998 alleging various intentional misrepresentations. In 2000, the petition was amended to assert the same facts in support of a negligent misrepresentation claim. At that time, the insured gave the insurer notice. The court concluded there was no coverage under the 1998 policy because the insured did not give notice of the claim during that policy year. The court also concluded there was no coverage under the 2000 policy, because the claim arose out of and was based on the prior pending litigation. The court rejected the insured's argument that he had no obligation to report the claim earlier because at that time it was alleged in a manner that would be excluded. The court reasoned that it is not the theories alleged that determine the insurer's duty to defend but the factual basis that might potentially give rise to coverage. *Nat'l Union Fire Ins. Co. v. Willis*, ___ F.3d ___, 2002 WL 1369092 (5th Cir., June 25, 2002).

In *Federal Insurance Company v. CompUSA, Inc.*, ___ F.Supp.2d ___, 2002 WL 1285263 (N.D. Tex., June 4, 2002), the court also held that late notice by the insured excused the insurer's duty to defend under a claims-made policy, even though the insurer had actual notice and was not prejudiced.

### D. Environment Impairment Liability

A policy did not cover the cost of cleaning up lead-contaminated battery waste that was used as fill material in residential areas near the insured's battery recycling facility. *Int'l Ins. Co. v. RSR Corp.*, ___ F. Supp. 2d ___, 2002 WL 493121 (N.D. Tex., March 27, 2002).

The policy contained an exclusion for "any commodity, article, or thing supplied, repaired, altered or treated by the insured and happening elsewhere than at the insured's premises[.]" The court found this unambiguously applied to fill material made from rubber parts of the batteries – the "thing" – supplied to nearby residents.

The court rejected the argument that an exclusion applied for costs of cleaning up "any waste disposal sites," because the residential areas were not waste disposal sites.

In dicta, the court made an error that had no impact on the case but is a common mistake. The court stated that if the contract were ambiguous the court would look to extrinsic evidence to decide the parties' intent. This is correct for most contracts but not for insurance policies. With insurance policies, the well-settled rule of *contra proferentum* – construe ambiguities in favor or coverage and against the insurer – means that if the policy is ambiguous it must be construed in favor or coverage. There is no issue of what the parties intended. *See* Mark L. Kincaid & Christopher W. Martin, *Texas Practice Guide: Insurance Litigation* §§ 4:7-4:8 (West 2000).

## VI. DUTIES OF LIABILITY INSURERS

### A. Duty to Defend

Two liability insurers had a duty to defend their insured who was sued for negligently causing pollution in the course of oil and gas exploration. *Harken Exploration Co. v. Sphere Drake Ins. PLC*, 261 F.3d 466 (5th Cir. 2001). The court reasoned that an "occurrence" is an "accident," and an accident includes deliberate acts performed negligently such that the effect is not the intended or expected result if the deliberate act was performed non-negligently. In this case, the non-negligent operation of the oil facilities would not have caused the contaminated water, dead cattle, and other injuries alleged by the plaintiffs.

The fact that the plaintiffs also alleged that the insured acted maliciously did not relieve the insurers of the duty to defend. Because the insurers had to defend the negligence part of the suit, the insurers had to defend the entire suit.

The *Harken* court also considered whether the petition in the underlying suit sufficiently alleged the dates of the occurrences. While the pleading was not specific with reference to the exact dates of occurrences, a fair reading suggested that part of the property damage occurred during one insurer's policy term. With respect to the other insurer, the lease between the insured and the landowners offered evidence that the dates of some occurrences may have been during the insurer's policy year. Although the lease date was not alleged in the petition, the court held that when the petition does not contain sufficient facts to enable a court to determine whether coverage exists, it is proper to look to extrinsic evidence to adequately address the issue.

An insured's conduct in circulating "wanted" posters of a building engineer who had been fired resulted from the insured's "business activities" in attempting to safeguard the property and thus was covered under the personal injury provision of the liability policy. Therefore, the insurer had a duty to defend the insured in the engineer's suit for wrongful termination, invasion of privacy, libel, and other claims. *St. Paul Guardian Ins. Co. v. Centrum GS Ltd.*, 283 F.3d 709 (5th Cir. 2002).

In *Admiral Insurance Company v. Rio Grande Heart Specialists of South Texas, Inc.*, 64 S.W.3d 497 (Tex. App.–Corpus Christi 2001, pet. filed), a group of cardiologists sued a clinic alleging that the clinic enticed them to abandon their successful practices and come to work there. The clinic demanded that its insurer provide a defense. The insurer refused and filed declaratory judgment action.

The court observed that the clinic's liability insurance policy obligated the insurer to pay damages for "wrongful acts" arising out of the clinic's "managed health care services." The face of the cardiologists' petition alleged facts within the scope of this policy. According to the petition, the clinic made misleading misstatements concerning the sales and marketing of health care services and the accurate and timely provision of detailed accountings to the cardiologist. The insurer had a duty to defend.

Next, the court rejected the insurer's claim that a variety of exclusions in the policy relieved its duty to defend. First, the court concluded that the contract exclusion in the policy did not apply because the cardiologists asserted claims, like a breach of the duty of good faith, that fell outside contract exclusion.

Second, the court rejected the fraudulent act exclusion, because the cardiologists asserted a negligent misrepresentation claim.

Finally, the court rejected the insurer's employment exclusion, because none of the claims asserted by the cardiologists involved employment-related practices as defined by the policy. Moreover, the record was unclear as to whether the cardiologists were employees of the clinic or in a partnership with the clinic. Thus the employment exclusion did not relieve the insurer of its duty to defend.

A homebuilder was entitled to a defense in suits alleging it built houses with defective foundations. *CU Lloyd's of Tex. v. Main Street Homes, Inc.*, ___ S.W.3d ___, 2002 WL 1289874 (Tex. App.–Austin, June 13, 2002, no pet.). While the

underlying petitions alleged that the builder knew the foundations would be inadequate, they did not allege the builder intentionally designed bad foundations.

The court distinguished *Hartrick*, *supra*, which denied coverage based on similar facts. The Austin court noted that they were deciding the broader duty to defend, not the duty to indemnify, which was the issue in *Hartrick*.

The court rejected several exclusions asserted by the insurer. One exclusion related to real property where the insured was performing operations. The insured was not alleged to be *currently* performing operations.

The exclusions for "your work" did not apply, because the work was completed, and because the work was alleged to have been done by subcontractors.

The exclusion for "your product" applied to manufactured products, not construction of a building.

An issue related to the duty to defend is whether an insurer can use salaried staff attorneys to represent insureds. The State Bar of Texas Unauthorized Practice of Law Committee sued Allstate contending that this practice is unlawful. Other insurers joined that suit. Nationwide chose to file suit in federal court seeking a declaratory judgment finding that this interpretation of Texas law is unconstitutional.

The Fifth Circuit chose to abstain, because the case involves a federal constitutional challenge to state action and an unclear issue of state law that, if resolved, would make it unnecessary for the federal court to rule. *Nationwide Mut. Ins. Co. v. Unauthor-ized Practice of Law Comm.*, 283 F.3d 650 (5th Cir. 2002). The dismissal was without prejudice, pending the outcome of the Allstate suit.

**B. Duty to Settle**

An insured under a liability policy may sue the insurer for delay in settling that results in the insured incurring additional defense costs. In *Rocor International, Inc. v. National Union Fire Insurance Company*, 77 S.W.3d 253 (Tex. 2002). Rocor was sued when one of its truck drivers was involved in a fatal collision. Rocor complained that the excess insurer delayed settle- ment, causing Rocor to incur additional defense costs.

**An insured under a liability policy may sue the insurer for delay in settling that results in the insured incurring additional defense costs.**

The court rejected the argument that Article 21.21 does not apply to liability insurers. The court found nothing in the language or purpose of the statute to distinguish between first-party and third-party claims when an insured has been directly injured as a result of the insurer's unfair claims settlement practices. The insurer therefore could be liable for failing to act in good faith to effect a prompt settlement once its liability became reasonably clear.

The court then considered what liability standard should apply. Referring to its decisions under the common-law *Stowers* duty to settle, the court imposed four elements:

(1) the policy covers the claim,
(2) the insured's liability is reasonably clear,
(3) the claimant has made a proper settlement demand within policy limits, and
(4) the demand's terms are such that an ordinarily prudent insurer would accept it.

The court found no reason to treat the statutory standard different from the common-law standard, under which a proper settlement demand must propose to release the insured fully in exchange for a stated sum or for the policy limits. The insurer was not liable because the court found there was no evidence of a proper settlement demand.

The court rejected the insurer's argument that because it had no duty to defend the insured under the excess policy it could not be liable for defense costs. The court held that the defense costs were recoverable as tort damages, even though they were not recoverable under the contract.

The court held the insurer was not liable for misrepresentations. The insured argued that the insurer falsely represented that the case would settle within a month but then made no effort to settle. The court found no evidence that this misrepresentation affected the insured's trial preparation costs and thus caused damage.

The dissent criticized the court for in engrafting onto the statute additional elements. This criticism has some validity, considering the many decisions by the supreme court holding that is improper to imply into the DTPA and Article 21.21 additional elements and obstacles to recovery.

Aside from the problematic reasoning that led to the court's conclusion, the conclusion itself is extremely significant and beneficial to insureds in future cases. By equating the common-law *Stowers* duty and the statutory standard for unfair settlement practices, the court has now made breach of the *Stowers* duty a statutory violation. Insureds now will be able to recover their attorneys' fees and may be awarded treble damages if the breach was committed knowingly.

**C. Duty to Indemnify**

An underlying tort judgment finding the insured guilty of negligence and battery related to sexual misconduct with his stepdaughter did not establish the insurer's duty to pay the claim. The underlying jury questions included damages for physical pain and mental anguish. Thus, it was not clear whether the damages were within the scope of coverage because the policy would not cover only mental anguish as "bodily injury." *State Farm Lloyds v. Borum*, 53 S.W.3d 877 (Tex. App.–Dallas 2001, pet. denied).

The *Borum* court also held that the insurer did not waive its right to dispute coverage by initially denying the claim and then later defending under a reservation of rights.

The father of a crime victim, who was shot and killed by an insured, obtained a $100,000 judgment against the insured for false imprisonment. *Williamson v. State Farm Lloyds*, 76 S.W.3d 64 (Tex. App.–Houston [14th Dist.] 2002, no pet.). The insurer refused to defend or indemnify the insured in the underlying action. The victim's father then brought an action against the insurer to collect the judgment under the insured's homeowner's policy. The victim's father then moved for summary judgment against the insurer, arguing that insurer was collaterally estopped from challenging the jury's finding of false imprisonment. The court rejected this argument, holding that a conflict of interest existed between the insured and insurer as to whether the insured's conduct amounted to "willful detention or imprisonment" covered by the policy or whether it was robbery, murder, and the willful violation of the penal statute

not covered by the policy. Because of the conflict of interest, the insured and the insurer were not in privity in the underlying action, and thus the insurer was not collaterally estopped from relitigating the existence of false imprisonment.

## VII. THIRD PARTY THEORIES OF LIABILITY

### A. Fraud & Negligent Misrepresentation

An additional insured named in a certificate of insurance who was not covered by the underlying policy could not recover based on fraud or negligent misrepresentation absent proof that in issuing the certificate of insurance the broker had an intent to defraud, or acted negligently or carelessly. The court found no explanation of why the broker, rather than the additional insured, bore the burden of reading the incorporated policy to determine that it did not provide coverage. *TIG Ins. Co. v. Sedgewick James of Washington*, 276 F.3d 754 (5th Cir. 2002).

### B. Other Theories

An additional insured named in a certificate of insurance who was not covered by the underlying policy could not recover based on mutual mistake, absent evidence that the parties reached a definite and explicit agreement understood in the same sense by both parties. *TIG Ins. Co. v. Sedgewick James of Wash.*, 276 F.3d 754 (5th Cir. 2002). While the plaintiff offered some evidence that it expected coverage, and some evidence that the insurance broker expected coverage, there was no evidence that the insurer intended to provide coverage.

In an interesting case from Washington, that state's supreme court held that an insurance adjuster engaged in the practice of law in her handling of an automobile liability claim. The court held that the adjuster went beyond the actions of a mere scrivener when she advised the claimants to sign releases and failed to advise them of the consequences or refer them to independent counsel. The court held that to safeguard the public interest when an insurance claims adjuster prepares and completes documents affecting the legal rights of third party claimants or advises third parties to sign such documents, the adjuster must comply with the standard of care of a practicing attorney. Breach of this duty would support a claim for negligence. *Jones v. Allstate Ins. Co.*, 45 P.3d 1068 (Wash. 2002).

## VIII. SUITS BY INSURERS

### A. Declaratory Relief

A liability insurer could properly challenge coverage for sexual abuse in a separate declaratory judgment action. The court held this was not an improper collateral attack. The court reasoned that a collateral attack is an attempt to avoid the effect of a judgment in another proceeding. The insurer's declaratory judgment suit would negate coverage, but would not avoid the effect of the liability findings between the parties in the underlying lawsuit. *State Farm Lloyds v. Borum*, 53 S.W.3d 877 (Tex. App.–Dallas 2001, pet. denied).

The *Borum* court also found the insurer was not barred by res judicata or collateral estoppel. Because the insurer defended under a reservation of rights, it was not in privity with the insured on issues related to coverage.

The insurer in *Borum* did not lose its right to dispute coverage by delaying the filing of its declaratory judgment suit. The insurer defended under a reservation of rights and was not required to have coverage decided before trial of the underlying suit. The court noted that the coverage issue often is not even ripe for adjudication before the underlying suit is resolved.
The court in *Certain Underwriters at Lloyds London v. A&D Interests, Inc.*, 197 F. Supp. 2d 741 (S.D. Tex. 2002), rejected the agent's argument that declaratory relief could not be granted on negligence and tort issues. The insurer sought a declaration that a policy was void because the agent and insured's misrepresentations induced the policy's issuance.

The court recognized the general rule that a prospective tort defendant could not move for declaratory relief because such relief would compel a personal injury plaintiff to litigate their claims at a time and in a forum chosen by the apparent tortfeasor. In this case, however, the court noted that the insurer was not a prospective tort defendant but a prospective tort plaintiff. Thus, the general rule restraining courts from providing declaratory relief in negligence and tort cases did not apply. The court further found that the purposes of the Declaratory Judgment Act were satisfied. By asking that the court declare the agent liable for the insurer's defense and indemnity, it allows the insurer to minimize its already accruing defense costs and likely indemnity costs in the future.

### B. Rescission

In *Certain Underwriters at Lloyds London v. A&D Interests, Inc.*, 197 F. Supp. 2d 741 (S.D. Tex. 2002), an insurance agent solicited an adult entertainment club for the purpose of selling a dram shop liability policy. The agent notified the club that the policy had been procured, and the club cancelled its other insurance policy. Soon after the club was told the policy had been procured, the club attempted to submit a claim under the policy. On the day the agent learned of the claim, he attempted to procure a retroactive policy from the insurer to cover the claim. The insurer issued the policy, without knowledge of the pending claim or the history of two other claims submitted under the prior policy.

The insurer then filed declaratory judgment action against the agent and the club, seeking a declaration that the policy was void as a result of they club's and the agent's misrepresentations. The agent then moved to have the claims against him dismissed on grounds of lack of subject matter jurisdiction and failure to state a claim.

The court found that the insurer adequately stated a claim upon which relief could be granted. The insurer alleged that the agent, in collaboration with the club, made material misrepresentations in various insurance applications submitted to the insurer, specifically with regard to the club's claims history.

The insurer further contended that it never would have issued the policy had it been aware of the three prior alcohol-related automobile accidents already associated with the establishment. Thus, the court concluded that the insurer had adequately stated a claim of negligent misrepresentation under Texas law.

### C. Interpleader

In *Metropolitan Life Insurance Company v. Barretto*, 178 F. Supp. 2d 745 (S.D. Tex. 2001), a dispute arose between a mother and a minor daughter of the insured as to the proceeds payable under a life insurance policy. The mother and daughter resolved their dispute and agreed upon a means of distributing the life insurance proceeds. Because the daughter was a minor, the insurer asked that a guardian ad litem be appointed to approve the settlement. The insurer also asked that each sign a release of liability on the policy in favor of the insurer upon the

distribution of the proceeds. When the mother and minor daughter did not comply, the insurer filed an interpleader action asking for the court to appoint a guardian ad litem to accept the policy proceeds into the registry, and release the insurer. The mother and daughter opposed the interpleader, arguing that it unreasonably delayed payment of the funds. The court found that the interpleader was properly brought, and that the insurer's demand for a guardian ad litem and court approval of the settlement were reasonable ways to protect both the proceeds and the claimants' rights. The court concluded that it was the claimants, not the insurer, who protracted the litigation. The court not only rejected the claimants' assertion of delay but also ordered that the claimants pay the insurer's fees and costs.

**D. Indemnity & Contribution**

In *American Indemnity Lloyds v. Travelers Property & Casualty Company*, 189 F. Supp. 2d 630 (S.D. Tex 2002), a subcontractor's liability insurer sued the contractor's insurer seeking a declaration that is was entitled to recover one-half the amount paid to settle a personal injury lawsuit. The underlying suit was brought by the subcontractor's employee against the subcontractor and the contractor. The contract between the subcontractor and contractor contained an indemnity clause, which the subcontractor claimed violated the express negligence and conspicuousness doctrines. The court rejected both arguments, concluding that the indemnity provision was valid and enforceable.

The subcontractor further argued that notwithstanding the indemnity provision in the subcontract, the "other insurance" clause of the policy noted that each party was responsible for an equal share of the settlement amount and defense costs incurred as a result of a personal injury lawsuit. The court rejected this argument, holding that valid indemnity agreements must be given effect over "other insurance" policy clauses. To hold otherwise, the court reasoned, would render the indemnity agreement completely ineffectual.

**E. Subrogation**

An insured was severely injured in a car wreck. An ERISA plan insurer provided a substantial amount of health insurance benefits. When the insured settled her underlying tort suit, the proceeds were allocated largely to attorney's fees and to establish a "special needs" trust for her. Only a relatively small amount was allocated for past medical expenses subject to the insurer's right of subrogation. The insurer attempted to sue under ERISA for "equitable relief" as a fiduciary, contending that it was entitled to more money from the settlement. The Supreme Court rejected this argument and held that ERISA only allows a fiduciary to seek *equitable* relief, and the claim in this case was a *legal* claim against the insured. The court left open whether there were other legal remedies the insurer could have pursued, but, in any event, concluded that even if there were no legal remedies, ERISA did not allow the fiduciary to assert a claim. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

In *Trinity Universal Insurance Company v. Bill Cox Construction, Inc.*, 75 S.W.3d 6 (Tex. App.–San Antonio, October 3, 2001 no pet.), a property owner's builders risk insurer sought subrogation from the general contractor and subcontractor after paying a claim for a fire loss. The general contractor argued that the contract between it and the insured waived the insurer's right to subrogation. The court agreed and rejected the insurer's argument that the waiver of subrogation clause was ineffective because the insurer had no notice of the clause. The court observed that the "transfer of rights" clause did not preserve the insurer's subrogation rights from being impaired after loss. The court noted that had the insurance contract prohibited the insured from impairing its subrogation rights "at any time," such a provision would have been sufficient to preserve the insurer's right of subrogation. Given that such a clause could have been inserted in the insurer's policy to protect the insurer's right of subrogation, the court rejected the invitation to rewrite the insurance contract.

Next, the court had to determine the scope of the subrogation waiver. The court concluded that waived claims were not defined by what property is harmed (i.e., "any injury to the Work"), but rather limited by the source of any insurance proceeds paying for the loss (i.e., where the loss was paid by a policy "applicable to the Work"). The court noted that the subrogation waiver clauses are intended to avoid litigation of claims for damages while also protecting the parties by simply requiring one of the parties to the contract to provide insurance for all of the parties.

**The court determined that the insurer's policy was "insurance applicable to the Work" as defined by underlying contract between the insured and the general contractor.**

Finally, the court determined that the insurer's policy was "insurance applicable to the Work" as defined by underlying contract between the insured and the general contractor. The court noted that a majority of jurisdictions interpreting similar clauses have ruled that an existing policy is broad enough to cover both Work and non-Work property that the owner waives the right to sue for any damages suffered as long as the damage is covered by the policy.

## IX. DAMAGES & OTHER ELEMENTS OF RECOVERY

**A. Mental Anguish Damages**

In *Wellisch v. United Services Automobile Association*, 75 S.W.3d 53 (Tex. App.–San Antonio 2002, pet. filed), the court considered whether the evidence was sufficient to support mental anguish claimed by two parents who pursued an uninsured motorist claim after their teenage daughter was killed in a car wreck. The court detailed the testimony from the mother and father outlining their mental suffering related to the insurer's claim handling. Ultimately, the court held that this testimony might relate to the claim denial, but not to the insurer's claim investigation. Therefore, the insurer was entitled to summary judgment rejecting liability for its failure to investigate.

The court's distinction seems arbitrary. The denial was based on the investigation, as it is in all insurance cases. What difference should it make which point in the process caused the mental anguish, if they are all part of the insurer's wrongful conduct?

**B. Statutory Additional Damages**

In a case involving a failure to procure flood insurance, the court held that the plaintiffs' testimony that the agent did not write the necessary flood insurance because he would make little or no premium on the insurance policy constituted no evidence that the agent acted "knowingly." *Nast v. State Farm & Cas. Co.*, ___ S.W.3d ___, 2002 WL 799595 (Tex. App.–San Antonio, May 1, 2002, no pet.).

**C. Prejudgment & Postjudgment Interest**

The Fifth Circuit held that prejudgment interest is proper at six percent when the parties have unambiguously and expressly established the amount owed under a contract, but is proper at ten percent when the parties have not. Thus, an insured's recovery of defense costs was subject to the ten percent rate. *Harken Exploration Co. v. Sphere Drake Ins. PLC*, 261 F.3d 466 (5th Cir. 2001).

**D. Attorney's Fees**

In a declaratory judgment suit, the trial court is not required to award fees to the prevailing party and may even award fees to the non-prevailing party. *State Farm Lloyds v. Borum*, 53 S.W.3d 877 (Tex. App.–Dallas 2001, pet. denied). Because the trial court found coverage and awarded fees to the claimant, the court of appeals remanded the case for reconsideration after finding there was no coverage.

Fees were properly awarded to the plaintiff under ERISA, when the defendant abused its discretion by denying her disability claim. *Lain v. UNUM Life Ins. Co.*, 279 F.3d 337 (5th Cir. 2002).

## X. DEFENSES & COUNTERCLAIMS

**A. Arbitration**

The Federal Arbitration Act does not provide an independent basis for federal jurisdiction. The federal court can only enforce an arbitration provision in a contract if the court would have subject matter jurisdiction over the underlying civil action. Because the Fifth Circuit concluded that the Federal Crop Insurance Act did not preempt the insured's state law claims against an agent for failing to obtain proper crop insurance, the federal court properly refuse to enforce the arbitration clause in the parties' contract. *Rio Grande Underwriters, Inc. v. Pitts Farms, Inc.*, 276 F.3d 683 (5th Cir. 2001).

**B. Capacity to Sue**

A co-debtor who was party to a credit life insurance application had capacity to sue the insurer when the other borrower died and the insurer refused to pay. *Guillory v. Serv. Life & Cas. Ins. Co.*, 52 S.W.3d 922 (Tex. App.–Beaumont 2001, no pet.).

**C. Limitations**

Limitations barred an insured's suit for misrepresentations regarding disability benefits after he became disabled, received benefits for a period of time, resumed work, and then filed suit thirteen years later after he filed another claim, which the insurer rejected. The insured alleged that the earlier termination of benefits was inconsistent with representations the agent made about coverage. Nevertheless, he could pursue his breach of contract claim. *Knott v. Provident Life & Accident Ins. Co.*, 70 S.W.3d 924 (Tex. App.–Eastland 2002, pet. filed).

The Texarkana Court of Appeals held that the discovery rule applies to a claim for negligent misrepresentation, but the court found the plaintiff's claim was barred because the misrepresentation was not inherently undiscoverable. *Sabine Towing & Transp. Co. v. Holliday Ins. Agency*, 54 S.W.3d 57 (Tex. App.–Texarkana 2001, pet. denied). Sabine required contractors to provide a certificate of insurance naming Sabine as an additional insured. After a subcontractor's employee was injured, Sabine turned to the subcontractor's insurance agency for coverage as set out in the certificate of insurance provided by the subcontractor. The insurance agency denied coverage. The trial court found the claim was barred by the two year statute of limitations.

The court of appeals affirmed, finding that the negligent misrepresentation was not inherently undiscoverable. While there was a certificate of insurance issued in favor of Sabine, the certificate stated that it was provided as a matter of information only and conferred no rights on the certificate holder. Sabine also departed from its customary practice of sending certificates of insurance to its parent company for approval. Finally, Sabine delayed nine months after asking the insurance agency to confirm coverage before the agency denied coverage. Based on these facts, the court of appeals found that the lack of coverage could have been discovered, so the discovery rule did not avoid limitations.

On rehearing, the court of appeals was careful to distinguish cases where an insured directly seeks coverage from an insurer or agent. In those cases, the court agreed that the statute of limitations begins to run when the claim is denied, not when the misrepresentation of coverage occurred.

In *Mangine v. State Farm Lloyds*, 73 S.W.3d 467 (Tex. App.–Dallas 2002, pet. filed), the insureds first made a claim under their policy for hail damage to their roof and water damage to their bathroom in December 1993. On January 15, 1994, the adjuster examined the roof and concluded that there was no hail damage. One year later, the insureds made another claim under their policy for hail damage to the roof and a leak in the bathroom. The insured's filed suit a little over a year later, alleging claims for breach of contract, breach of duty of good faith and fair dealing, and violations to the Texas Insurance Code.

The insurer argued it was entitled to summary judgment on the claim made in December 1993. The insureds responded that the claim in 1995 was a continuation of the claim made in 1993. The court rejected this argument, noting that the insurer's January 1994 response clearly stated that there was no hail damage to the roof. There was nothing tentative or conditional about the statements made by the insurer, and that although the notice did not use the word "denial," it conveyed in writing the insurer's determination with respect to the claim. Thus, the court concluded that the 1994 response was an effective denial of the insureds' claim. Furthermore, the court concluded that the hail damage to the insured's roof was not an ongoing or continuing problem. The court found no evidence that the two claims were related; State Farm investigated the claims separately and never suggested it was reconsidering withdrawing its earlier denial of the 1993 claim when an investigated the 1995 claim.

In a case involving general liability insurance, the court concluded that limitations began to run no sooner than the date that a judgment was entered in the underlying personal injury suit brought against the policyholder. *All-Tex Roofing, Inc. v. Greenwood Ins. Co. Group, Inc.*, 73 S.W.3d 412 (Tex.

App.–Houston [1st Dist.] 2002, pet. filed). The court rejected the argument that the cause of action accrued when the policyholder learned of the insurer's insolvency and cancellation of the policy. The court observed that there was no indemnity claim for the insolvent insurer to pay under the policies indemnity clause until the entry of judgment in the underlying suit.

**D. Preemption**

A doctor seeking disability benefits raised a fact issue precluding ERISA preemption. There was a fact issue on whether a "plan" subject to preemption existed because there was summary judgment evidence that the only persons covered by the disability policies were owners of the medical practice. A plan in which the only participants are the owners or partners does not constitute an ERISA benefit plan. *Knott v. Provident Life & Accident Ins. Co.*, 70 S.W.3d 924 (Tex. App.–Eastland 2002, pet. filed).

In *Reliable Home Healthcare, Inc. v. Union Central Insurance Company*, ___ F.3d ___, 2002 WL 1357826 (5th Cir. 2002), a home heath care provider filed a suit against an insurance company and insurance agent for recovery of damages and equitable relief for losses associated with the formation and cancellation of its deferred compensation plan. The court held that the fraud claims asserted by the home health care provider against the insurance agent, which were based on the agent's failure to inform the provider that the plan was not timely implemented, and use of the allegedly improper funding mechanism, required examination of the language of the plan. Thus, all claims were preempted by ERISA.

In *Foley v. Southwest Texas HMO, Inc.*, 193 F. Supp. 2d 903 (E.D. Tex. 2001), healthcare providers bought a class action in state court against managed health care insurers to recoup payments for services provided to their enrollees through a third party administrator. The defendants removed the case to federal court, and the plaintiffs moved to remand the case to state court. The court observed that the plaintiffs failed to establish the existence of any independent contractual relationship between themselves and the defendants. As such, the court noted that the plaintiffs could only recover from the defendants based on the plaintiffs' positions as assignees of the enrollee's benefits. Because a number of the defendants' enrollees were covered under employer-sponsored benefit plans, the plaintiffs/assignees' attempts to recover payments allegedly owed to them under these plans "relate to" an ERISA plan and were therefore preempted. The court further found that the saving clause may not be used to circumvent the framework established by Congress under ERISA. The court denied the plaintiffs' motion to remand.

In *St. Luke's Episcopal Hospital Corporation v. Stevens Transport, Inc.*, 172 F. Supp. 2d 837 (S.D. Tex. 2001, no pet.), a hospital brought a state court action against the patient's employer and administrator of its health insurance plan alleging that they made misrepresentations regarding the patient's health care coverage. The defendants removed the action. On motion to remand, the court noted that the Fifth Circuit has articulated a two-step analysis to determine ERISA preemption in the context of suits by third-party health care providers for coverage misrepresentations by insurance companies. First, the court determines whether the patient had any insurance coverage at all. If the patient does not have coverage, then the suit is not preempted. If however, the insured is covered by part of an ERISA plan, then the court must take the next analytical step to determine whether the claim is dependant on and derived from the benefit plan.

St. Luke's petition sought benefits under the terms of the plan and asserted that the defendants improperly and unfairly processed St. Luke's claims. Thus, St. Luke's appeared to be asserting derivative claims arising from the employees' rights under the policy. The statutory claims, as pleaded, were preempted by ERISA and thus the case could not be remanded to state court. The court noted that had St. Luke's not pled claims derivative of any employees' rights under the policy, the statutory claims would not have been preempted. The court then allowed St. Luke's the opportunity to replead its claims. If St. Luke's declined to assert an ERISA claim, the court would remand to state court.

The Federal Crop Insurance Act did not completely preempt state law claims against agents who sell federally-reinsured crop insurance. Thus, the federal court did not have jurisdiction over a claim by an onion grower who filed suit in state court alleging state law claims against an insurance broker for its failure to obtain the right crop insurance coverage. *Rio Grande Underwriters, Inc. v. Pitts Farms, Inc.*, 276 F.3d 683 (5th Cir. 2001). The court found no evidence that Congress intended to completely preempt the field.

**E. Res Judicata & Collateral Estoppel**

In *All-Tex Roofing, Inc. v. Greenwood Insurance Company Group, Inc.*, 73 S.W.3d 412 (Tex. App.–Houston [1st Dist.] 2002, pet. filed), the liability insurer argued that the insured was collaterally estopped from arguing that the plaintiff in the underlying personal injury suit was not the insured's employee. In the underlying suit, the trial court found that the insured was a "non-subscriber" under the Texas Worker's Compensation Act and the insured was the plaintiff's employer for the purposes of the Act.

The court concluded that the issue of employee status was not fully and fairly litigated in the underlying suit. The court observed that no question, definition, or instruction appeared in the charge concerning whether the plaintiff in the underlying action was an employee of the insured. The court reasoned that if the plaintiff in the underlying suit had been proved to be the insured's employee, there would have been no reason to invoke the worker's compensation statute in order to be "treated" as one. Because the insured did not prove as a matter of law that the plaintiff in the underlying action was the employee of the insured, the court reversed the summary judgment for the insurer and remanded the case to trial court.

In *Parker v. State Farm Mutual Automobile Insurance Company*, ___ S.W.3d ___, 2002 WL 1020647 (Tex. App.–San Antonio, May 22, 2002, no pet.), a passenger in a one car accident brought an action against the driver's automobile insurance company for breach of contract and bad faith against the driver for negligence. The cases were severed into three separate suits, and a take nothing judgment was entered in favor of the driver in the negligence action. Although the jury in the negligence action found that the driver was not negligent, the jury also made a damages finding. The insurer then attempted to argue that in the passenger's breach of contract and bad faith claims, they were barred from relitigating damages. The court rejected this argument and held that the jury's answer to the damages question in the negligence suit against the driver was not necessary to the judgment. Therefore, collateral estoppel did not bar relitigation of the same damages in a subsequent suit.

### F. Other Defenses

In insurance policies where the insurer is required to give a certain number of days notice prior to cancellation, it cannot be determined whether the insured was afforded the number of days as agreed unless the insured received the attempted cancellation notice. *Jones v. Ray Ins. Agency*, 59 S.W.3d 739 (Tex. App–Corpus Christi 2001, pet filed). Unless the cancellation notice is received, it is ineffective. Thus, because there was conflicting evidence relating to the receipt of the cancellation notice, summary judgment for the insurer was inappropriate. The court further found that the notice of cancellation violated provisions of the Tex. Ins. Code on grounds that it cancelled the policy for reasons other than those permitted by statute, and failed to give the required ten days notice of termination.

## XI. PRACTICE & PROCEDURE

### A. Anti-suit Injunction

A trial court did not abuse its discretion in granting an anti-suit injunction against a parallel suit in California. The insured filed a declaratory judgment suit in Texas against its insurer seeking a declaration that its policy provided coverage for a punitive damage award in an underlying suit. The insurer later filed a separate suit in California against the insured and sought accelerated rulings to decide the coverage issue.

The court of appeals held that an anti-suit injunction is appropriate in four instances: (1) to address a threat to the court's jurisdiction; (2) to prevent the evasion of important public policy; (3) to prevent a multiplicity of the suits; or (4) to protect a party from vexatious or harassing litigation. While a single suit in California did not constitute a "multiplicity," the court found the other three factors were present. The court was particularly persuaded by the "service of suit" endorsement to the policy, which provided that the insurer would submit to the jurisdiction of a court at the request of the insured and "will abide by the final decision of such court." The court reasoned that this language would be meaningless if the insurer could file a separate suit after the insured had properly joined the insurer in an existing lawsuit. *Am. Int'l Specialty Lines Ins. Co. v. Triton Energy, Ltd.*, 52 S.W.3d 337 (Tex. App.–Dallas 2001, pet. denied w.o.j.).

### B. Default Judgments

An insured defendant against whom a default judgment was rendered was not entitled to have the judgment set aside by a bill of review, where the evidence established that the insurance adjuster who was responsible for answering the lawsuit, and later for filing a motion for new trial, was negligent. *Garcia v. Tenorio*, 69 S.W.3d 309 (Tex. App.–Fort Worth 2002, pet. denied). The adjuster admitted that the insurer had received notice that the suit was filed and had received notice that a default judgment was taken. The adjuster's only excuse for failing to take action was that the she never received faxed copies of the petition and judgment from the insured. The court concluded that a reasonable insurance adjuster would have taken action.

In *Benefit Planners, L.L.P., v. RenCare, Ltd.*, ___ S.W.3d ___, 2002 WL 864268 (Tex. App.–San Antonio, May 8, 2002, pet. filed), a default judgment against a health insurance administrator was set aside because of defective service. The court held that because the return of service failed to recite that citation was delivered to the administrator by serving its registered agent, service of process was invalid. The return stated that the petition was served on the registered agent, but failed to mention the administrator. The court noted that while at times compliance with the service of process rules leads to "rather weird conclusions," public policy favors following the standard because it increases the opportunity for trial on the merits.

### C. Parties

In *Jones v. CGU Insurance Company*, ___ S.W.3d ___, 2002 WL 1025088 (Tex. App.–Austin, May 23, 2002, no pet.), a consumer who was representing herself sued a food manufacturer and its insurer for damages resulting from the consumer becoming ill after eating the manufacturer's oysters. The consumer and the manufacturer settled, and the insurer moved to dismiss. The court held that the district court correctly determined that there was no legal basis for the consumer to maintain her lawsuit against the liability insurer. The court noted that Texas is not a direct action state. The consumer was not in privity with CGU, she was simply a tort claimant with a claim against the manufacturer, who had settled with her. The court found that CGU owed the consumer no direct legal duty.

### D. Removal & Remand

In *Blanchard v. State Farm Lloyds*, 206 F. Supp. 2d 840 (S.D. Tex. 2001), the insured homeowners brought a state court suit against a property insurer and the adjuster relating to the insurer's refusal to pay the insured's claim for foundation damage resulting from plumbing leaks. The action was removed to federal court based on the alleged fraudulent joinder of the adjuster. The federal court remanded the case, holding that the adjuster had not been fraudulently joined. The court observed that by alleging that the adjuster hired a biased engineering firm, disregarded the evidence that the damage was caused by plumbing leaks, and failed to conduct a full and fair investigation of a claim, the insureds alleged facts, that if proven, would make it reasonably possible for a Texas court to find that the adjuster violated sections of the Texas Insurance Code.

In *Moody National Bank of Galveston v. St. Paul Mercury Insurance Company*, 193 F. Supp. 2d 995 (S.D. Tex. 2002), a Texas bank sued a Minnesota property insurer that refused to pay a theft claim. The insured later added a Texas insurance agency as a party. The insurer then removed the case on diversity grounds, asserting that the Texas insurance agency was fraudulently joined. The court rejected this argument, noting that the defendant has a heavy burden of proof when asserting fraudulent joinder. As an initial matter, the court found a factual dispute as to whether the insured's joinder of the agency was solely for the purpose of avoiding federal diversity jurisdiction. After examining the claims asserted by the insured, the court found that the agency was not fraudulently joined, because it was potentially liable for negligence under state law for misrepresenting the policy coverage.

### E. Choice of Law

Texas law would apply to a dispute between primary and excess insurers over allocation of defense costs. Texas had the most significant relationship to the substantive issue to be resolved, because all the litigation in the case occurred in Texas, and all the defense costs that were the subject of the suit were

incurred in Texas and involved Texas attorneys. The fact that the excess insurer was incorporated in Pennsylvania did not lead the court to believe that state had the most significant relationship. *Schneider Nat'l Transport v. Ford Motor Co.*, 280 F.3d 532 (5th Cir. 2002).

In *Mayo v. Hartford Life Insurance Company*, 193 F. Supp. 2d 927 (S.D. Tex. 2002), 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. The employer argued that Georgia law, rather than Texas law, applied in determining whether the employers had an insurable interest in the policies. The court rejected that argument, concluding that no one state clearly had the "most significant contacts" for the dispute. However, the court observed that Texas had far stronger contacts than Georgia. Texas was the place of the insured's domiciles, place of the subject matter of the policies, and the place with the most significant aspects of performance of the contract. 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 pointed to Texas as the state with the most significant interest in the application of its law and public policies to the dispute.

**F. Jurisdiction**

In *Ace Insurance Company v. Zurich American Insurance Company*, 59 S.W.3d 424 (Tex. App.–Houston [1st Dist.] 2001, pet. denied), Ace contended that the exercise of personal jurisdiction by a Texas court was improper, and thus the trial court erred in denying its special appearance. The underlying policy, however, contained a service of suit clause. That clause stated that Ace will consent to jurisdiction in a court of "competent jurisdiction." Ace argued this clause means that the court must have both subject matter and personal jurisdiction, and that Texas did not have personal jurisdiction over Ace. The court rejected this interpretation as unreasonable, noting that Ace's interpretation would render the clause meaningless. The court concluded that in agreeing to the service of suit clause, Ace consented to the jurisdiction of the court of Zurich's choice by waiving personal jurisdiction. In *Bernard v. Michelin North America, Inc.*, 193 F. Supp. 2d 908 (E.D. Tex. 2001), the estate of a former employee brought a state court action against the employer seeking life insurance benefits under a breach of contract theory. The employer removed the action to federal court on the basis of federal question jurisdiction. The employer claimed that the estate's claim was preempted by ERISA. The court agreed, holding that to determine if the estate can recover the benefits it seeks, the court will need to determine if the employer violated the terms of its benefits program, which is governed by ERISA. Because the merits of the estate's claim addresses an area of exclusive federal concern, the interpretation of the employer's ERISA plan, the court concluded that ERISA preempted the estate's state law claim and thus removal was appropriate.

**G. Discovery**

In *State Farm Fire & Casualty Company v. Rodriguez*, ___ S.W.3d ___, 2002 WL 1624680 (Tex. App.–San Antonio, July 24, 2002, no pet.), the trial court struck the insurer's expert's testimony because the insurer failed to provide the expert's Power Point presentation to the insured before trial. The insured argued that the presentation contained testimony outside the scope of what the expert had testified to during his deposition. After hearing these arguments, the trial court struck the testimony. The court of appeals observed that the record did not adequately resolve the dispute as to whether the insurer withheld the presentation before trial. Thus, the court could not conclude that the trial court abused its discretion. The court further found that the trial court's striking of the expert testimony did not amount to a death penalty sanction, because the insurer did not have the burden of proof and was not prevented from presenting the merits of its case.

**H. Experts**

In *State Farm Fire & Casualty Company v. Rodriguez*, ___ S.W.3d ___, 2002 WL 1624680 (Tex. App.–San Antonio, July 24, 2002, no pet.), homeowners sued their insurer for damage to their home caused by a plumbing leak. The insurer attempted to strike the testimony of the insureds' expert on causation, contending that the expert's opinions were unreliable. The court rejected this argument, observing that there was no dispute that a plumbing leak existed underneath the insured's home. The expert's opinions were based on the same data that the insurer used. In his report, his affidavit, and his testimony during direct examination of trial, the expert consistently stated that the plumbing leak caused 100% of the damage to the foundation. The Court concluded that the expert's references to other contributing causes were merely hypothetical. Both his testimony and affidavit indicate that from the data provided to him, the only possible causes of foundation damage were the plumbing leaks and climatic conditions. The expert's inability to apportion damages among the seven possible contributing causes went to the weight of his testimony, not its admissibility.

**I. Arbitration**

In *American National Insurance Company v. Everest Reinsurance Company*, 180 F. Supp. 2d 884 (S.D. Tex. 2002), an insurer brought an action against a reinsurer seeking to confirm an arbitration award against the reinsurer relating to a medical stop loss program. The reinsurer opposed confirmation, alleging that the award was issued without the deliberation and consideration of key evidence by the panel. The reinsurer also alleged that the award was arbitrary, capricious, and in manifest disregard of the law. The court rejected the reinsurer's arguments, noting that the district court's review of an arbitration award is extraordinarily narrow. Because none of the concerns of the reinsurer rose to the level of "injustice," the court confirmed the award.

In *American Heritage Life Insurance Company v. Orr*, 294 F.3d 702 (5th Cir. 2002), borrowers who obtained consumer loans including the purchase of credit life and credit disability insurance brought a state court action against the lender and the insurers alleging fraudulent misrepresentation and conspiracy to sell unnecessary insurance at exorbitant premiums. The lenders and insurers brought a separate action in federal court seeking to compel arbitration under the Federal Arbitration Act ("FAA") and to stay the state court proceedings. The district court entered an order compelling arbitration, stayed the state court proceedings, and ordered the case closed.

On appeal, the borrowers made a variety of arguments to avoid arbitration. First, they argued that the FAA is inapplicable to the agreements in this case because the FAA is precluded or preempted by the McCarran-Ferguson Act, which provides that no act of Congress can invalidate or impair any

law enacted in any state for the purpose of regulating the business of insurance. The court observed that the party seeking to avail itself of the act must demonstrate that the application of the FAA would invalidate, impair, or supersede a particular state law that regulates the business of insurance.

The court found that the borrowers failed to identify any such statute. The court rejected the borrower's claim that opinions by the state attorney general and the commissioner of insurance prohibit arbitrating cases relating to insurance. The court noted at least one instance where the commissioner of insurance permitted the arbitration of an insurance dispute. Thus, the court held that district court properly concluded that the McCarran-Ferguson Act did not apply and that under the FAA the agreements were valid, enforceable, and irrevocable.

Next, the borrowers maintained that they were entitled to a jury trial on the issue of arbitrability. The FAA provides that "if the making of the arbitration agreement . . . be an issue, the court shall proceed summarily to the trial thereof." In particular, the borrowers alleged that the agreements were unconscionable, were products of an equal bargaining power between the parties, were lacking mutuality of the obligation between the parties, and failed to result in the meeting of the minds. The court held that these issues related to the enforceability of the agreements, but did not affect the "making" of the arbitration agreement, and thus a jury trial was not required.

Finally, the borrowers contended that the arbitration fees were oppressive and unconscionable, thereby rendering the agreements unenforceable. As to the potentially burdensome cost of arbitration, the court noted that a party resisting arbitration has the burden to show the likelihood that "arbitration would be prohibitively expensive." The borrower's argued they would not be able to afford the fees associated with the arbitration. The court noted that to date only the lender and insurers had paid the arbitration fees. If the lenders and insurers prevailed, the borrowers must pay all costs and expenses of the arbitration. The court held that the mere fact that borrowers could face the possibility of being charged arbitration fees, including paying the arbitrator's fee if directed to do so by the arbitrator, did not render the agreement unenforceable.

### J. Appraisal

In *Gardner v. State Farm Lloyds*, 76 S.W.3d 140 (Tex. App.–Houston [1st Dist.] 2002, no pet.), the insureds sued to recover for a hail loss. Before suit was filed, an appraisal of the insured's claim was conducted and an award was entered for less than the deductible. The insureds then brought this suit to challenge the appraisal award. The court rejected the insureds' challenge, noting that an appraisal award may only be challenged when it is: (1) made without authority; (2) was the result of fraud or mistake; or (3) was not made in substantial compliance with the terms of the contract. The court rejected the insured's attempt to challenge the independence of the appraiser. The court concluded that the appraiser was independent, even though he wrote a training program used by the insurer about hail damage claims, wrote numerous publications about the hail storm evaluations, and served as a consultant for the insurer, and was paid by the insurer's companies for assignments across the United States over seven years. The court concluded that the insured's evidence might tend to show that the appraiser had expertise in the field, not that the appraiser lacked independence.

### K. Burden of proof

In *State Farm Fire & Casualty Company v. Rodriguez*, ___ S.W.3d ___, 2002 WL 1624680 (Tex. App.–San Antonio, July 24, 2002, no pet.), the insurer argued that under the doctrine of concurrent causes, when covered and non-covered perils combine to create a loss, the insured is entitled to recover only that portion of damage cause solely by the covered peril. Thus, the insured has the burden of segregating the damage attributable solely to the covered event. The insurer argued that the insured's expert failed to allocate 100% of the foundation damage to various potential contributing causes, and thus prevented the insured from proving causation. The court rejected this argument, noting that the insured's expert testified that 100% of the damage was caused by the plumbing leaks. The insurer argued that none of the damage was caused by the plumbing leaks, and the jury concluded that 25% of the damage was cause by plumbing leaks. The jury could believe all, some, or none of the evidence presented to it. Because the jury's finding of 25% was within the range presented by the evidence, the court found the evidence was sufficient to sustain the verdict.

## XII. OTHER ISSUES

### A. Excess & Primary Coverage

An excess insurer's policy clearly did not require it to pay a pro rata share of defense costs where the excess insurer was not obligated to defend the insured until all underlying coverage was exhausted. Because the contract clearly defined the excess insurer's obligation, the court declined to impose an equitable obligation to share defense costs. Further, the court declined to engraft onto the excess policy language from the primary policy that called for pro rata allocation of defense costs between the primary insurer and the insured. Nothing in the excess policy incorporated this language by reference, and the excess policy did not contain "follow form" language. *Schneider Nat'l Transport v. Ford Motor Co.*, 280 F.3d 532 (5th Cir. 2002).

### B. Subrogation

A worker's compensation insurer is entitled to subrogation against uninsured/underinsured motorist benefits to reimburse benefits paid to the claimant. *Tex. Workers' Comp. Ins. Fund v. Knight*, 61 S.W.3d 91 (Tex. App.–Amarillo 2001, no pet.). The court rejected the argument that equitable subrogation principles should limit the insurer's recovery. The court noted that the subrogation right is defined by statute.

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