Annual Survey of TEXAS Insurance Law 2011

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I. INTRODUCTION

This year's survey covers a substantially larger number of cases, almost twice the usual number. The Texas Supreme Court decided several significant cases. The court overruled a prior decision to hold that workers compensation claimants cannot sue under the Insurance Code for unfair settlement practices.[1] In the same case, four justices also voted to overrule *Aranda*[2] and eliminate claims by workers' compensation claimants for breach of the duty of good faith and fair dealing.

The court decided another workers compensation case dealing with injuries when an employee is going to or from work, or is on a trip that is part business and part personal.[3]

The supreme court also held that the Insurance Code does not allow a cause of action for unfair discrimination for race-neutral conduct – specifically, credit scoring – that has a disparate racial impact.[4]

Revisiting the issue of appraisal, the court held that mere delay will not waive the right; the other party must show prejudice, but the court said showing prejudice is unlikely.[5]

On the liability insurance side, in a case of first impression, the supreme court held there was no coverage for liability to passengers exposed to a tubercular driver, because the injuries did not result from "use" of the bus.[6]

Two potentially significant decisions from lower courts allowed use of extrinsic evidence to decide whether the insurers had a duty to defend.[7]

A couple of other cases continued to delimit an insurer's liability for interfering with the defense or with the defense lawyer.[8]

Another court upheld an insurer's agreement to "buy back" a liability policy from the defendant to eliminate coverage for a plaintiff's pending claim.[9]

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II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile

An insured was not entitled to recover under his uninsured/underinsured motorist coverage where his damages were less than the total amounts paid by the other motorist and other parties in settlement. The court found the policy language unambiguously allowed the UM insurer to take a credit for amounts

from anyone who "may" be liable, which would include all three of the settling parties. The court also held that a statute allowing the insurer to reduce its liability by the amount recoverable from the underinsured motorist's insurer did not preclude consideration of settlements from other parties because those settlements would reduce the underinsured motorist's liability as settlement credits. *Melencon v. State Farm Mut. Auto. Ins. Co.*, 343 S.W.3d 567 (Tex. App.–Houston [14th Dist.] 2011, no pet.).

A city employee was injured by a drunk driver and received worker's compensation benefits for his injuries. The employee then attempted to recover benefits under the city's UIM policy, which the city acquired for its employees. The court held that if an employee suffers work-related injuries and seeks redress from an employer that subscribes to a workers' compensation program, the only way to obtain damages is through that compensation program. The law bars the employee from forcing the employer to redress the injuries through other means. *Smith v. City of Lubbock*, No. 07-10-0466-CV, 2011 WL 4478494 (Tex. App.–Amarillo Sept. 26, 2011, no pet.).

An insured who was injured in a car accident sued the driver and his underinsured motorist insurer. The jury awarded damages that the UIM carrier would have to pay, but the appeals court reversed, holding that the plain language of Tex. Civ. Prac. & Rem. Code section 41.0105 provides that medical expenses subsequently written off by a health care provider do not constitute medical expenses actually incurred by the claimant or on his behalf where neither the claimant nor anyone acting on his behalf will ultimately be liable for pay those expenses. Therefore, because the insurer's offsets and credits subsumed the insured's collectible damages, the trial court held that the insured take nothing. *Progressive Co. Mut. Ins. Co. v. Delgado*, 335 S.W.2d 689 (Tex. App.–Amarillo 2011, pet. denied).

The Fifth Circuit held that a policy unambiguously excluded a vehicle owned by a self-insured entity from the definition of "uninsured/underinsured vehicle," so there was no coverage. Further, the court held this exclusion did not violate Texas law, because the insurance commissioner had the authority to approve policies that exclude certain motor vehicles whose operators are in fact uninsured. *McQuinnie v. Am. Home Assur. Co.*, 400 F. App'x 801 (5th Cir. 2010).

B. Homeowners

An insured's tenant sued the insurer for damages when she was injured on a riding lawn mower while mowing the lawn. The tenant was listed as an insured on the homeowner's policy. But because the policy excluded from coverage bodily injury to any insured or resident of the residence premise, the court granted the insurer's motion for summary judgment. *Rust v. Tex. Farmers Ins. Co.*, 341 S.W.3d 541 (Tex. App.–El Paso 2011, pet. denied).

After a rental home burned down, the insurer denied the claim, citing its vacancy clause, which provided that the insurer was not liable for fire perils if the building was vacant for more than sixty days before the loss. No one lived in the dwelling, but the remodeler's proposal said repairs would be completed several months before the fire occurred. The court held that there was a fact issue concerning whether the dwelling was vacant. *Columbia Lloyds Ins. Co. v. Mao*, No. 02-10-00063-CV, 2011 WL 1103814 (Tex. App.–Fort Worth Mar. 24, 2011, pet. filed) (mem. op., not designated for publication).

Insureds sued their homeowners' insurer after rain entered their roof and caused extensive damage inside the house. The insurer denied coverage. The jury found that coverage existed because the "direct force of wind or hail made an opening in [the insureds'] roof through which rain entered." The insurer appealed. Because the opening in the roof was repaired before the insurer's field adjuster could examine it, and the insureds themselves could not testify as to what caused the opening, there was no evidence that direct force of wind or hail made the opening. Consequently, there was no coverage. *Farmers Mut. Prot. Ass'n v. Rooney*, No. 11-09-00225-CV, 2011 WL 2518766 (Tex. App.–Eastland Jun. 23, 2011, no pet.) (mem. op., not designated for publication).

A homeowner whose house was damaged by a storm sued the insurer for depreciating general contractor overhead and profit and sales tax in calculating the actual cash value of the loss. The court granted the insurer's motion for summary judgment as to breach of contract and unfair insurance practices, as the insured did not show that the insurer had violated the terms of the policy. Instead, there was proof that payment was made in accordance with the policy terms. *Tolar v. Allstate Tex. Lloyd's Co.*, 772 F. Supp. 2d 825 (N.D. Tex. 2011).

C. Commercial Property

The supreme court held that a policy negotiated through Lloyds of London did not cover charges for repair vessels kept "standing by" so they could resume repairs to an offshore platform once weather permitted. *Houston Exploration Co. v. Wellington Underwriting Agencies, Ltd.*, No. 08-0890, 2011 WL 3796361, 54 Tex. Sup. Ct. J. 1683 (Tex. Aug. 26, 2011). The majority held it was proper to consider the fact that language covering standby charges included in the preprinted form contract was struck by the parties. The court held that deletions in the printed form agreement are indicative of the parties' intent. The majority further held that the language of the policy, without the deletion, did not provide coverage.[10]

Justice Johnson concurred, because he thought the policy language did not provide coverage regardless of the presence of the stricken language.

Chief Justice Jefferson, joined by two others, argued that it was improper to consider the deleted language, because it was parol evidence. Without the stricken language, the dissenters found the remaining language was sufficiently broad to cover "standby charges." The policy provided coverage for repair costs

that were "necessarily incurred and duly justified" and provided coverage for vessels "when used in or about the repair." Another clause provided coverage for boats "utilise[d] … for" repairs. The dissenters reasoned that "about" was broad enough to include vessels used "in connection with" repairs. The dissenters also reasoned that the standby charges were "duly justified" and that the standby vessels were being "utilized for" the repairs, because their use was to wait on standby so that repairs could continue with haste.

In *QB Invs., L.L.C. v. Certain Underwriters at Lloyd's London*, an insured sued its insurer after one of its commercial buildings was destroyed in a fire. No. 01-10-00718-CV, 2011 WL 3359683 (Tex. App.–Houston [1st Dist.] Aug. 4, 2011, no pet.) (mem. op., not designated for publication). The insurer argued that the policy required the insured to maintain a fire alarm system and limited any obligation of the insurer to pay for fire loss if this system was not in place. It was undisputed that there was no fire alarm system at the time of the fire. The insured argued that the relevant endorsement was not listed in the binder it received and, because it had not yet received the policy with the endorsement, the endorsement was not part of the policy at the time of the fire. The court held that the terms of the endorsement had to be complied with and, therefore, found in favor of the insurer.

D. Life insurance

A life insurer brought an interpleader action to determine how life insurance proceeds should be distributed where the insured decedent had named as beneficiaries both his mother and his out-of-wedlock child. The beneficiary child died shortly after the insured. The child's mother and the insured's mother disputed which of them was entitled the child's share of the proceeds. The insured's mother argued that the child's mother was not entitled to the proceeds because the application was ambiguous in that, on one page, the insured had listed his mother on a line that said "first" and his child on a line that said "second," but another page listed both mother and child as "first beneficiaries." The court did not agree that this amounted to an ambiguity, and concluded that, taken as a whole, the designation of beneficiaries was intended to name the mother and child equally as beneficiaries. Accordingly, the child's mother could recover the proceeds on the child's behalf. *Lopez-Franco v. Hernandez*, No. 08-08-00343-CV, 2011 WL 1492002 (Tex. App.–El Paso Apr. 20, 2011, pet. denied).

When the wife and sister of an insured disputed who was entitled to the policy proceeds, a life insurer filed an interpleader. The insured had changed the beneficiary of the policy from his wife to his sister several months before his death, during a period when, apparently, he was on medication. The wife argued that the change was invalid because the insured either lacked capacity or was subject to undue influence. She submitted several affidavits in support of her position, but the court held that these affidavits were insufficient because they stated opinions, were based on assumptions, and were inconclusive about whether the insured was actually impaired at the precise time he executed the beneficiary change. As such, the evidence did no more than create a mere suspicion that the insured lacked capacity or was subject to undue influence. The change was valid, and the sister was entitled to the proceeds. *McDaniel v. Householder*, No. 11-09-00307-CV, 2011 WL 3793326 (Tex. App.–Eastland Aug. 25, 2011, no pet.) (mem. op., not designated for publication).

A life insurer filed an interpleader action asking the court to determine who was entitled to the insurance policy proceeds: a widower named as the beneficiary or a lender to whom the deceased woman had assigned the policy as collateral to secure a small business note. The widower argued that the proceeds were owed to him because he had filed bankruptcy and discharged the lender's note. The court held that the policy was never the property of the bankruptcy estate, because the lender was the assignee of the deceased's right to the policy, effectively taking her place as owner of the policy. Therefore, the lender was entitled to the proceeds of the policy. *Mass. Mut. Life Ins. Co v. Sanders*, 787 F. Supp. 2d 628 (S.D. Tex. 2011).

A life insurance beneficiary sued after the insurer denied her claim. The insurer relied on an exclusion for injuries sustained "as a result of being legally intoxicated from the use of alcohol." The insured fell at his home after an evening of drinking. The hospital listed his cause of death as a brain injury and cardiopulmonary arrest. The court determined that the exclusion applied. The insured's blood alcohol level was very high and the medical examiner's notes stated that the injury occurred because the insured "fell at home while intoxicated." The court rejected the beneficiary's argument that "legal intoxication" meant not only that the insured be intoxicated but that he be intoxicated in a legally relevant manner, such as by operating a motor vehicle in violation of the law. The court concluded that the policy did not have such a requirement, and Texas law defines "intoxicated" in more than just a criminal context. *Likens v. Hartford Life & Accident Ins. Co.*, No. H-10-155, 2011 WL 2584803 (S.D. Tex. Jun. 29, 2011).

E. Disability insurance

The Fifth Circuit held there was no disability coverage based on an ambiguous provision in a description of coverage, which could be read to allow coverage if the person suffered certain conditions *or* if the person was permanently unable to perform his usual duties and was under the supervision of a physician. The description of coverage contained a statement that if there was any conflict between the description of coverage and the master policy, then the master policy would control. The master policy made clear that disability required that the person suffer the condition *and* be permanently unable to perform activities *and* be under the supervision of a physician. *Tolbert v. Nat'l Union Fire Ins. Co.*, 657 F.3d 262 (5th Cir. 2011).

F. Health Insurance

A health plan participant sued the plan administrator for breach of contract after it refused to pay for surgeries needed to correct skin laxity following gastric bypass surgery. The participant and administrator had previously disputed earlier skin laxity surgeries and had entered into a settlement agreement by which the administrator agreed to pay for the prior surgeries and "complications" resulting therefrom. The administrator argued that it did not have to pay for the new skin laxity surgeries because they were not due to any complications resulting from the prior

surgeries. In support of her position, the participant submitted an affidavit from her doctor, who stated that the surgeries were medically necessary. The court held that evidence that the surgeries were medically necessary was not evidence that they were due to "complications," which the administrator's expert had defined as things such as hematoma, wound breakdowns, and heart attack, among other things. Loose skin was not included within the definition of "complications." Therefore, the administrator was not liable. *Contreras v. Clint I.S.D.*, 347 S.W.3d 413 (Tex. App.–El Paso 2011, no pet.).

G. Worker's Compensation

The supreme court held that a worker who was in a wreck while driving from a business-related dinner to a business-provided storage unit and then home was in the "course and scope of employment" so that her injuries were covered. *Leordeanu v. Am. Prot. Ins. Co.*, 330 S.W.3d 239 (Tex. 2010). The court noted that the Workers' Compensation Act excludes two types of travel: (a) "to and from" the place of employment, unless transportation is furnished by the employer, the means of transportation are under the employer's control, or the employee is directed to proceed from one place to another; or (b) travel for the "dual purpose" of business and personal reasons, unless the travel would not have occurred without the business purpose. In this case, the worker had the business purpose of going to a storage unit to store work-related products, but also had the personal purpose of going home after a work-related dinner. The court of appeals held there was no coverage because of this "dual purpose" and that the worker would have made the trip anyway because she was going home. The supreme court disagreed, relying on the history of the statute to note that the "to and from" provisions and "dual purpose" provision had always been considered separate. Construing the statute as the court of appeals did would mean that traveling home would always be excluded, because the person would always have a personal reason.

III. FIRST PARTY THEORIES OF LIABILITY

A. Breach of Contract

An insured's failure to pay premiums for an insurance binder barred any claim for breach of contract. The court held that the binder was not ambiguous and clearly made payment of the premium a condition precedent for the insurance contact to go into effect. The court rejected the insured's argument that the policy was ambiguous and could reasonably be read to require payment of the premium for the binder only once a replacement policy was issued. *Becerra v. Ball*, No. 13-10-00361-CV, 2011 WL 3366361 (Tex. App.–Corpus Christi Aug. 4, 2011, no pet.) (mem. op., not designated for publication).

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

The supreme court held that a workers' compensation claimant cannot sue for unfair settlement practices under the Texas Insurance Code. *Tex. Mut. Ins. Co. v. Ruttiger*, No. 08-0751, 2011 WL 3796353, 54 Tex. Sup. Ct. J. 1642 (Aug. 26, 2011). Ruttiger was hurt on the job. The insurer denied the claim, contending he was really hurt in a softball game. Eventually, the parties settled, agreeing that his injury was work-related. Ruttiger sued the insurance company for unfair insurance practices, deceptive trade practices, and breach of the duty of good faith and fair dealing, and won at trial.

The supreme court agreed with the insurer that the Workers' Compensation Act provides the exclusive remedy for unfair settlement practices. The court noted that in its prior decision in *Aetna Cas. & Sur. Co. v. Marshall*, 724 S.W.2d 770 (Tex. 1987), the court had rejected this very argument. But now the court concluded that the Workers' Compensation Act had changed. The majority reasoned that when *Marshall* was decided the Workers' Compensation Act provided no meaningful remedies and allowed de novo judicial review. In contrast, the Workers' Compensation Act was substantially amended after that to provide detailed procedures for handling and paying claims and for resolving any disputes that arose. The court concluded that permitting a workers' compensation claimant to also recover for unfair settlement practices under the Insurance Code would be inconsistent.

The court did, however, find no inconsistency in allowing a workers' compensation claimant to sue under the Insurance Code for misrepresentations. While such a cause of action would be allowed, in this case the court found legally insufficient evi-

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dence to support a finding of misrepresentation.

The court also dismissed Ruttiger's DTPA claims, because they were based on the same violations as the unfair settlement practice claim under the Insurance Code.

Chief Justice Jefferson, joined by two others, dissented. The dissenters felt it was clear that the Workers' Compensation Act changes were not intended to overrule *Marshall*, so they would not hold that unfair insurance claims were precluded.

The court also addressed the common law cause of action for breach of the duty of good faith and fair dealing, which is addressed *post*.

The San Antonio Court of Appeals reaffirmed its prior holdings that DTPA claims do not survive the insured's death, so that heirs of a deceased insured could not recover on a claim that the insurer misrepresented benefits. *Tex. Farm Bureau Mut. Ins. Co. v. Rogers*, No. 04-10-00546-CV, 2011 WL 3120645 (Tex. App.–San Antonio July 27, 2011, pet. filed).

A trial court properly rendered summary judgment on claims under the DTPA against an insurer that denied a permanent disability claim based on language in the description of coverage that appeared ambiguous and potentially provided coverage. The description of coverage appeared to define permanent disability as meaning that the person suffered a listed condition *or* the person was permanently unable to perform activities and was under the supervision of a physician. However, the description of coverage said that, in the event of any conflict, the policy would control. The policy had language making clear that permanent disability required that the person have a listed condition *and* be permanently unable to perform activities. The Fifth Circuit concluded that DTPA liability for misrepresentation could not be based on a disagreement over the meaning of uncertain terms. *Tolbert v. Nat'l Union Fire Ins. Co.*, No. 09-10739, 657 F.3d 262 (5th Cir. 2011).

The *Tolbert* court noted that there could be liability under the Insurance Code for failing to state facts necessary to make other statements not misleading or making statements in a manner that would mislead a reasonably prudent person. The court noted it was not being asked to decide whether the ambiguous description, standing alone, could violate either of these provisions. Instead, the court found no violation where the ambiguous provision was accompanied by a notice that the master policy would control.

The *Tolbert* court also concluded that the plaintiff failed to state a claim for unconscionable conduct, because the conduct had to occur "at the time of the sale," and plaintiff's unconscionability claim was premised on conduct that occurred after his injury and after the inception of coverage under the policies.

On this last point, it appears the court may have erred. The court said that the plaintiff alleged that the insurer took advantage of the plaintiff's lack of knowledge to a grossly unfair degree by attempting to absolve the insurer of liability based on language in the master policy "when National Union never offered or provided any such 'Master Policy' to plaintiff prior to the filing of this lawsuit." That language seems to refer to the time of sale, which would satisfy the court's requirement.

A medical service provider sued ERISA insurers under the DTPA, seeking reimbursement for services it provided relating to insureds' surgical procedures. *Encompass Office Solutions, Inc. v. Ingenix, Inc.*, 775 F. Supp. 2d 938 (E.D. Tex. 2011). The district court held that the provider was not a consumer under the DTPA. The only relation the provider had to the policy was to seek the proceeds of the plan. The assignments the provider received from its patients did not allow it to bring DTPA claims because those types of claims generally cannot be assigned.

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

The Texas Supreme Court revisited the issue of whether a worker's compensation claimant should have a right to sue for breach of the common law duty of good faith and fair dealing, as established by *Aranda v. Ins. Co. of N. Am.*, 748 S.W.2d 210 (Tex. 1988). As noted above, the court held that the changes to the Workers' Compensation Act made it inconsistent to allow an injured worker to also sue for unfair settlement practices under the Texas Insurance Code. *Tex. Mut. Ins. Co. v. Ruttiger*, No. 08-0751, 2011 WL 3796353, 54 Tex. Sup. Ct. J. 1642 (Aug. 26, 2011). Four of the justices announced that they would overrule *Aranda*, because they think the amended Workers' Compensation Act addresses the concerns that led to creation of the common law remedy. Two justices chose not to address the issue, because it had not been decided by the court of appeals in the first instance, so they favored a remand. Three justices would hold that the common law duty of good faith and fair dealing in *Aranda* should be preserved, because nothing in the legislative amendments indicated any intent for *Aranda* to be overruled.

An insurer did not violate its duty of good faith by relying on experts it hired to investigate the insured's hail claim, even though the three experts' estimates varied significantly. The court held that the insurer's reliance on the expert with the least expensive estimate did not in and of itself support a finding of bad faith. *Southland Lloyds Ins. Co. v. Cantu,* No. 04-09-00705-CV, 2011 WL 1158244 (Tex. App.–San Antonio Mar. 30, 2011).

A homeowner sued its insurer after his home was damaged by Hurricane Ike and the insurer offered minimal payment. The court dismissed the homeowner's extracontractual claims, holding that the homeowner failed to meet the pleading standards of Rule 12(b)(6) for a common law breach of duty of good faith and fair dealing. The court stated the homeowner did not provide any facts that showed the insurer's liability was reasonably clear, that his claims were covered under particular provisions of the policy, what the insurer knew at the time it denied his claims, any proposed settlements within policy limits that the insurer failed to effectuate, why and how the insurer's payments were unreasonably delayed, or where the insurer's investigation was not reasonable. *Luna v. Nationwide Prop. & Cas. Ins. Co.*, No. H-10-2918, 2011 WL 2565354 (S.D. Tex. June 27, 2011).

D. Unfair discrimination

The Texas Supreme Court held that the Insurance Code prohibits discrimination "because of" or "based on" race, but that does not provide a cause of action for practices like credit rating that are race-neutral but have a disparate impact on racial minorities. *Ojo v. Farmers Group, Inc.*, No. 10-0245, 2011 WL 2112778, 54 Tex. Sup. Ct. J. 1068 (Tex. May 27, 2011). The court compared language in the Labor Code that does give a cause of action based on disparate impact and noted such language was not used in the Insurance Code. The court also distinguished the Federal Fair Housing Act and the Civil Rights Act, both of which use language prohibiting discrimination "because of" race and nevertheless allow causes of action for disparate impact. The court held that the policy reasons behind those statutes were different. Finally, in a holding that led to a lengthy concurrence and an even longer dissent, the court held that the legislative history of the Insurance Code showed the legislature was aware of concerns about disparate impact but chose not to prohibit race-neutral use of credit scoring for insurance.

E. Negligence

An insurance agency could not be liable for professional negligence in failing to obtain liability coverage that would allow a landlord to sue its tenant for fire damage. *W. Houston Airport, Inc. v. Millennium Ins. Agency, Inc.*, 349 S.W.3d 748 (Tex. App.–Houston [14th Dist.] 2011, no pet.). The court found that in general there is no duty where there is no privity, and there was no privity between the landlord and the insurance agency. Although the tenant was required to get liability insurance naming the landlord as an additional insured, the court found that was irrelevant. The landlord's claim was as an injured third party, not as an additional insured. Finally, the court held that the foreseeability of damages to the landlord caused by a $50,000 limit on fire coverage was too remote to create a duty, considering the lack of any direct communications or relationship between the insurance agency and the landlord.

F. Prompt Payment of Claims – Physicians & Providers

A group of hospitals sued an HMO, arguing that it was liable under the prompt pay statute, now Tex. Ins. Code § 843.336-.353, for failing to timely pay claims for healthcare services provided to HMO enrollees under agreements between the hospitals and an intermediary. The hospitals had hired the intermediary to provide hospital services to the HMO enrollees and, while the HMO contracted with the intermediary, the hospitals had no contracts directly with the HMO. The court held that the plain language of the statute required contractual privity with the HMO. The hospitals could sue the intermediary under the prompt pay statute, but not the HMO. The court concluded that providers can sue through an assignment to stand in the shoes of a patient beneficiary or on their own provider contracts. Neither situation applied in this case. *Christus Health Gulf Coast v. Aetna, Inc.*, 347 S.W.3d 726 (Tex. App.–Houston [14th Dist.] 2011, pet. granted).

G. ERISA

A man who had two ERISA-governed group accident policies through his employer died in a single vehicle crash. He was intoxicated at the time of death. The claims administrator of the policies refused to pay his beneficiary the death benefit, arguing that the claim was not covered because it was not an "accident," since the deceased would have been aware of the risks of operating his vehicle while under the influence, making his death foreseeable. Neither of the policies defined the term "accident,"

or excluded coverage for injury when driving an automobile while intoxicated. The court held that the definition of accident should focus on what is actually expected or foreseen by the insured, not what is capable of being foreseen, looking instead to the issue of whether the insured had the subjective expectation of survival and whether that expectation was objectively reasonable from the perspective of the insured. The court found in favor of the beneficiary and ordered the administrator to pay the benefits. *Firman v. Becon Constr. Co.*, 789 F. Supp. 2d 732 (S.D. Tex. 2011).

A life insurance beneficiary sued the insurer/plan administrator under ERISA for wrongfully denying her life insurance benefits. The insurer had erroneously placed the plan participant in the wrong plan and policy and accepted premiums for over two years. After his death, the insurer informed the beneficiary that the participant was not eligible for the coverage and reimbursed the premiums paid for the policy, but denied the beneficiary's claim for life insurance benefits. The beneficiary argued that the insurer was estopped from denying coverage. The court, however, granted the insurer's motion for summary judgment. The participant did not qualify for the coverage, and any conflict in the dual role the insurer played as insurer and administrator of the plan was minimal. Equitable estoppel did not apply, according to the court, because the insurer's assurance that the participant was covered by the policy "was not reasonable because such 'statements' were contrary to the terms of the plan and policy." The beneficiary also failed to submit evidence of "extraordinary circumstances" such as bad faith or fraud. *Sanborn-Alder v. Cigna Group Ins.*, 771 F. Supp. 2d 713 (S.D. Tex. 2011).

A hospital sued an insurer for ERISA violations, breach of contract, and violations of the Texas Insurance Code, after the insurer failed to pay for services the hospital provided to the insurer's plan subscribers. The insurer moved to dismiss all of the claims for lack of standing. The court held that the hospital had standing because its pleadings stated that it had obtained an assignment of benefits and rights from the plan subscribers, making it a beneficiary of the ERISA plan. The hospital also sufficiently pled an injury-in-fact by stating that its patients were legally responsible for any charges the insurer failed to reimburse in full. The court also rejected the insurer's argument that the hospital lacked standing for failure to exhaust administrative remedies because, based on the pleadings, the insurer had withheld information required for the hospital to pursue an administrative appeal. Thus, the hospital was excused from the requirement of exhausting administrative remedies and had standing to sue. *North Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 782 F. Supp. 2d 294 (S.D. Tex. 2011).

A medical service provider sued insurers for reimbursement for services it provided relating to insureds' surgical procedures, in *Encompass Office Solutions, Inc. v. Ingenix, Inc.*, 775 F. Supp. 2d 938 (E.D. Tex. 2011). The insurers argued that the provider lacked standing because the assignments it received from its patients did not expressly give the provider the right to bring a lawsuit. The court held that the provider had derivative standing to bring the suit, finding that the provider's assignment of the right to payment was enough to create standing.

An ERISA plan administrator refused to pay bills for services provided by a medical service provider, which was located on the second floor of a hospital. The plan covered hospital care but not services by a "skilled nursing facility." The plan administrator concluded that the provider was a skilled nursing facility rather than a hospital. The provider sued the administrator under ERISA for payment of its bills. The court determined that the provider was not a skilled nursing facility within the meaning of the plan. The plan definition included seven elements, but the administrator made no findings regarding six of those elements and so its conclusion was inconsistent with a fair reading of the plan in light of the relevant facts. Further, the administrator abused its discretion by determining that the provider was a skilled nursing facility without investigating six of the seven necessary elements. *Lifecare Mgmt. Servs., LLC v. Ins. Mgmt. Adm'rs, Inc.*, 761 F. Supp. 2d 426 (N.D. Tex. 2011).

IV. AGENTS, AGENCY, AND VICARIOUS LIABILITY

A. Individual liability of agents, adjusters, and others

After a fire occurred at an airport hangar, the lessor of the hangar sued the lessee's insurance broker for failing to obtain the proper amount of coverage required under the lease. The court held that the insurance broker for the lessee did not owe a professional duty to the lessor with whom the broker never communicated regarding insurance coverage, even though the lessor was named as an additional insured under the policy. *W. Houston Airport, Inc. v. Millennium Ins. Agency, Inc.*, 349 S.W.3d 748 (Tex. App.–Houston [14th Dist.] 2011, no pet.).

An agent did not owe any special duty to inform an insured that the policy had been cancelled. The policy was written as a direct bill, such that the agent was not involved in the invoicing, receipt, or processing of any premium payments. The insurer billed the insured directly for monthly premiums, and the insured made all premium payments directly to the insurer. There were no facts indicating that the agent owed any special duty to the insured based on custom or practice. Accordingly, the agent was entitled to summary judgment on the insured's claim of negligent failure to notify him of cancellation. *Penn-America Ins. Co. v. Zertuche*, 770 F. Supp. 2d 832 (W.D. Tex. 2011).

B. Insurer's vicarious liability for agent's conduct

After an automotive repair shop caught fire, the insured discovered that the agent had only obtained third-party liability coverage, not first-party property coverage, which the insured had requested. The court held that the insured had a duty to read and be familiar with the terms of his policy and also held that the agent was not the surplus lines insurance company's agent, because he only delivered the quote and collected the initial premium. He did not have the authority to issue the policy; therefore, the insurer was not responsible for any of his alleged misrepresentations. *Howard v. Burlington Ins. Co.*, 347 S.W.3d 783 (Tex. App.–Dallas 2011, no pet. h.).

An insurer was not vicariously liable for the conduct of an agent who defrauded an insured by taking $200,000 for an annuity, keeping $75,000 for himself and forwarding only $125,000 to the insurer. The court reasoned that the authority of the agent did not extend to the conduct in question, and the mere existence of an agency relationship was not sufficient to hold the insurer liable. *Nat'l W. Life Ins. Co. v. Newman*, No. 02-10-00133-CV, 2011 WL 4916434 (Tex. App.–Fort Worth Oct. 27, 2011, pet. denied) (mem. op., not designated for publication).

A moving truck containing an insured's personal property was stolen. The insured filed a claim with his insurer, which contacted an appraiser and replacement service to appraise the property and, at the insured's option, replace it. The insured initially wanted the appraiser to replace the stolen property and asked the insurer to pay the settlement funds directly to the appraiser, which was done. Later, the insured canceled his order with the appraiser and sought a refund from the appraiser. The refund check bounced, and the insured did not receive all of the settlement funds. The insured then sued both the insurer and the appraiser. The jury found that the appraiser had engaged in false, misleading, or deceptive acts. It also determined that the appraiser was the agent of the insurer, but, in a question condi-

tioned upon that finding, did not find that the insurer had engaged in any false, misleading, or deceptive acts. The court of appeals affirmed the trial court's take-nothing judgment in favor of the insurer, explaining that the insured failed to meet his burden of obtaining a finding to hold the insurer liable for the appraiser's acts. While he established an agency relationship between them, he did not link this relationship to the conduct of the appraiser that the jury found false, misleading, or deceptive. *Jaster v. Shelter Mut. Ins. Co*., No. 05-08-01441-CV, 2011WL 386856 (Tex. App.–Dallas Feb. 8, 2011, no pet.) (mem. op., not designated for publication).

C. Ratification

Evidence was insufficient to support a finding that an insurer ratified the conduct of its agent who took $200,000 from an insured and kept $75,000 for himself. Ratification requires that the insurer, although it had no knowledge of the unauthorized act of the agent, retained the benefits of the transaction after acquiring full knowledge. The court found that the insurer only received $125,000 and issued an annuity for that amount and did not have "full knowledge" of any wrongdoing by the agent. *Nat'l W. Life Ins. Co. v. Newman*, No. 02-10-00133-CV, 2011 WL 4916434 (Tex. App.–Fort Worth, Oct. 27, 2011, pet. denied) (mem. op., not designated for publication).

V. THIRD PARTY INSURANCE POLICIES & PROVISIONS

A. Commercial general liability insurance

Frito-Lay sued Adampac, a food packaging company, for contaminating its product. Adampac's insurer argued that the loss was not covered due to exclusions for damage to property in the "care, custody, or control" of the insured and for "work incorrectly performed" by the insured. The court agreed. Frito-Lay and Adampac had stipulated that the damage occurred while the product was within Adampac's exclusive possession and control. The exclusion for "work incorrectly performed" also applied, because Adampac failed to prevent the product from being adulterated, which was directly related to the repackaging job for which Adampac was hired. *Frito-Lay, Inc. v. Trinity Universal Ins. Co.*, No. 05-08-01263, 2010 WL 4705526 (Tex. App.–Dallas Nov. 22, 2010, pet. denied) (mem. op., not designated for publication).

An "absolute pollution exclusion" endorsement unambiguously excluded any duty to defend or indemnify a claim based on a worker's death from silicosis caused by prolonged inhalation of silica dust.

A masonry company was covered for damage it caused to window frames. An exclusion for damage to property upon which the insured performed its work did not apply. The insured was hired to do masonry work, not window frame work. The insured's contact with the window frames came about only as a precaution to prevent damage. *Evanston Ins. Co. v. D&L Masonry of Lubbock, Inc.*, No. 07-10-00259-CV, 2011 WL 1465776 (Tex. App.–Amarillo Apr. 18, 2011, no pet.) (mem. op., not designated for publication).

An "absolute pollution exclusion" endorsement unambiguously excluded any duty to defend or indemnify a claim based on a worker's death from silicosis caused by prolonged inhalation of silica dust. *RLI Ins. Co. v. Gonzalez*, 411 F. App'x 696 (5th Cir. 2011) (per curiam). The court found that silica dust was an "irritant" or "contaminant" under the policy endorsement. The court rejected the arguments that the policy was ambiguous if the exclusion was read this broadly, that the policy was ambiguous because another exclusion also applied and that there was an ambiguity created between the policy and the endorsement. On the last point, the court concluded that in a conflict between the policy and the endorsement, the endorsement would control.

An exclusion for "ongoing damages" did not apply to damage to a swimming pool that first occurred during the insurer's policy period, even though the insured's negligence may have happened earlier. The court held it was proper to focus on the time of the "actual physical damage," not the time of the "negligent conduct" that resulted in the damage. *Md. Cas. Co. v. Acceptance Indem. Ins. Co.*, 639 F.3d 701 (5th Cir. 2011). The court also found evidence sufficient to support the jury's answer that the "subsidence of earth" exclusion did not apply. There was evidence from which the jury could find that damage to the swimming pool was caused by structural movement, which was different and distinct from soil movement.

The "your work" exclusion precluded coverage for property damage to parts of a reactor upon which the insured performed defective work, and precluded coverage for property damage to parts of the reactor where the insured performed non-defective work, but it did not preclude coverage for damage to other parts of the reactor upon which the insured did not perform work. *Am. Home Assur. Co. v. CAT Tech, L.L.C.*, 660 F.3d 216 (5th Cir. 2011).

B. Commercial Automobile Liability Insurance

In a case of first impression, the supreme court held that a business auto policy did not cover claims by passengers infected with tuberculosis after riding on a bus driven by a diseased employee. The policy provided that covered injuries had to "result from" the "use" of the covered auto. The court concluded that the bus was merely the situs of the infection and did not have a sufficient causal nexus to the injuries. *Lancer Ins. Co. v. Garcia Holiday Tours*, 345 S.W.3d 50 (Tex. 2011).

The Fort Worth Court of Appeals, sitting en banc, held that the term "domestic employee" in an exception to an exclusion was not ambiguous and only provided coverage to persons engaged in employment incidental to their personal residents, not persons who were in the United States. *Robertson v. Home State County Mut. Ins. Co.*, 348 S.W.3d 273 (Tex. App.–Fort Worth 2011, pet. denied) (en banc). The court recognized the dictionary definitions of the term "domestic" supported both arguments; however, the court reasoned that the exception was based on provisions of the Labor Code and the Transportation Code that intended to allow liability coverage only for "domestic employees" who were engaged in employment incidental to a personal residence. To read the phrase broadly, the court concluded, would render meaningless language requiring that the "domestic employees" were "not entitled to worker's compensation benefits." In reaching its conclusion, the court declined to follow a contrary decision from the Corpus Christi Court of Appeals and instead followed several federal court decisions.

A driver was not an "insured" under his parents' liability policy, because their home was not his "primary residence." Although the driver listed his parents' home as his address on several documents and kept valuables there, the court concluded that his apartment in another town was his primary residence, because he spent most of his time there, had several months remaining on his lease, and listed that address on his bank and

truck title documents. *State Farm Fire & Cas. Co. v. Lange*, No. H-09-2011, 2011 WL 149482 (S.D. Tex. Jan. 18, 2011).

C. Construction liability insurance

A commercial umbrella insurer had no duty to indemnify its insured homebuilder for amounts paid to settle with homeowners whose homes were built with defective imitation stucco siding. The builder had used the defective material on a large number of homes and then voluntarily undertook to remove that material, repair water damage, and reapply a different type of stucco. The court agreed with the insurer's argument that the builder failed to show a covered "ultimate net loss" under the policy. There had been no finding through adjudication or arbitration that the builder was legally liable. Further, the policy provided coverage for a compromised settlement, if the insurer agreed in writing, but there was no evidence that the insurer ever agreed. *Markel Am. Ins. Co. v. Lennar Corp.*, 342 S.W.3d 704 (Tex. App.–Houston [14th Dist.] 2011, pet. filed).

The *Markel* court rejected the builder's argument that the insurer could not show prejudice from the settlements without the insurer's consent. The court distinguished cases where insurers were not allowed to enforce settlement-without-consent clauses unless they could show prejudice. In this case, the court reasoned that the language defined the scope of coverage, so that the insurer did not have to show prejudice. For the same reason, the court also concluded that the insurer did not waive its right to insist on consent to any settlement. The court relied on the principle that an insured cannot assert waiver to create coverage that otherwise would not exist.

D. Excess insurance

Excess insurers had no liability where the insured settled with the primary insurer for $15 million of its $50 million limits in exchange for a release. *Citi Group, Inc. v. Fed. Ins. Co.*, 649 F.3d 367 (5th Cir. 2011). The Fifth Circuit found the excess policies unambiguously required full payment of the primary limit. The court declined to follow the rule established in *Zeig v. Mass. Bonding & Ins. Co.*, 23 F.2d 665 (2nd Cir. 1928), which says that if an excess insurance policy ambiguously defines "exhaustion," then settlement with an underlying insurer constitutes exhaustion of the underlying policy for purposes of determining when the excess coverage attaches.

VI. DUTIES OF LIABILITY INSURERS

A. Duty to defend

The supreme court held that injured plaintiffs have no standing to sue a liability insurer for breach of its duty to defend, even though as judgment creditors they could seek judgment on the insurer's duty to indemnify. The court reasoned that the duty to defend is owed to the insured, not third party judgment creditors, so the plaintiffs had no justiciable interest in any breach of the duty to defend. *Lancer Ins. Co. v. Garcia Holiday Tours*, 345 S.W.3d 50 (Tex. 2011).

An insured who was involved in a car accident case settled at mediation for an amount he would pay personally in addition to the policy limits. The insured then sued his insurer based on complaints about how the underlying case was handled. The court held that, under these circumstances, Texas law does not recognize a cause of action by an insured against his insurer for tortious interference with the insured's relationship with his attorney arising out of the insurer's handling of the defense of a third party claim. However, the court also held in favor of the insured that a breach of contract claim can exist against an insurer for its conduct in handling the defense of a third party claim against the insured. The court also held that Texas law does not prohibit an insured from bringing valid statutory claims against an insurer. *Taylor v. Allstate Ins. Co.*, No. 01-09-00457-CV, 2011 WL 1233331 (Tex. App.–Houston [1st Dist.] Mar. 31, 2011, pet. filed).

In two potentially significant cases, courts recognized exceptions to the "eight corners" rule and allowed extrinsic evidence to determine the duty to defend.

First, the Houston Fourteenth Court of Appeals recognized a narrow exception to the "eight corners" rule and held it is proper to consider extrinsic evidence when the insurer can establish that a party seeking a defense is a stranger to the policy and could not be entitled to a defense under any set of facts. The court further held that the extrinsic evidence must go strictly to an issue of coverage without contradicting any allegation in the third party claimant's pleadings that is material to the merits of the underlying claim. *Weingarten Realty Mgmt. Co. v. Liberty Mut. Fire Ins. Co.*, 343 S.W.3d 859 (Tex. App.–Houston [14th Dist.] 2011, pet. denied).

In the *Weingarten* case, Johnson was assaulted by an unknown assailant at the store where she worked. She sued her employer, Norstand and Weingarten Realty Management Co., which she alleged was the lessor of the space. Norstand had an insurance policy with Liberty Mutual that included any lessor of premises leased to Norstand as an additional insured. The problem was that Weingarten Management was not really the lessor. Instead, a separate entity, Weingarten Investors, was the actual lessor. Liberty Mutual refused to defend Weingarten Management. After a successful defense, Weingarten Management and its own insurer sued Liberty Mutual to recoup defense costs, arguing that Liberty Mutual owed a duty to defend because Johnson named Weingarten Management as a lessor in her underlying petition.

After citing a number of cases discussing a possible exception to the eight corners rule allowing extrinsic evidence that only goes to coverage issues, the *Weingarten* court decided this was the case to recognize such an exception.

One justice dissented, because he felt the court should not recognize such an exception. Further, the dissenting Justice felt the majority had misapplied the exception recognized. In this case, the plaintiff alleged Weingarten Management was a lessor. Liberty Mutual's extrinsic evidence offered to show no coverage contradicted that allegation.

It seems the dissent has the better of the argument in this case. As the majority recognized, one benefit provided by a liability policy is a defense of allegations, even if they are false, fraudulent, and groundless. Instead of proving Weingarten Management was not a lessor to defeat *coverage*, the insurer properly should prove Weingarten Management was not a lessor to defeat

liability. While there is some sympathy for the idea that the insurer has to defend someone who isn't "really" its insured, allowing the exception as the court has done, where the coverage facts contradict the liability facts, creates a very dangerous situation because a liability insurer may devote its resources to establishing facts to negate coverage that also would be harmful to the potentially insured party in the underlying case. The majority seems to gloss over this concern by stating that Liberty Mutual's interest in contradicting the lessor allegation was confined to disputing Weingarten Management's status as an insured.

A federal district court held that the "eight corners" rule did not apply to determine the duty to defend under an automobile liability policy.

In the second case, a federal district court held that the "eight corners" rule did not apply to determine the duty to defend under an automobile liability policy. The policy in question did not have the usual language requiring a defense "even if the allegations of the suit are groundless, false, or fraudulent." Instead, the policy said that the insurer had no duty to defend against any suit to which the insurance does not apply. Because the duty to defend was coextensive with the duty to indemnify, the court found it proper to consider evidence and determine whether the claim was covered and then determine whether there was a duty to defend. *Guideone Specialty Mut. In. Co. v. Missionary Church of Disciples of Jesus Christ,* No. 4:11-CV-009-A, 2011 WL 3805463 (N.D. Tex. Aug. 16, 2011).

In *Guideone,* the accident occurred while some church members were using a van owned by the pastor, but without his knowledge or his permission. The court found no coverage, because there was no evidence that the van was being used with the permission of the church, which was necessary to bring it within the scope of an endorsement, and there was no evidence that the van was a covered auto or that the pastor, who was an "insured," had any legal obligation to pay damages. The court concluded that summary judgment was proper on both the duty to defend and duty to indemnify, in advance of the underlying suit being resolved, because all parties, including the injured plaintiff, were before the court.

In *Taylor v. Allstate Ins. Co.*, No. 01-09-00457-CV, 2011 WL 1233331 (Tex. App.–Houston [1st Dist.] Mar. 31, 2011, pet. filed), the court considered whether and to what extent a liability insurer could be sued for its conduct in connection with the defense of a claim, or for the conduct of the defense lawyer it hired. The insured asserted various theories against the insurer based on complaints about the way the case was handled, resulting in a settlement for greater than the policy limits. The court first rejected the insured's attempt to hold the insurer vicariously liable for the defense lawyer's conduct, under the authority of *State Farm Mut. Auto Ins. Co. v. Traver*, 980 S.W.2d 625 (Tex. 1998). The court further held that the insurer could not be sued for negligence in failing to exercise ordinary care by failing to conduct an adequate investigation and failing to provide an adequate defense. The court relied on a number of prior decisions rejecting such a theory and specifically relied on the decision in *Maryland Ins. Co. v. Head Indus. Co. & Servs., Inc.*, 938 S.W.2d 27 (Tex. 1996), where the supreme court held that the exclusive common law remedies against a liability insurer are breach of contract and a claim for breaching the *Stowers* duty to settle.

Based on the same analysis, the *Taylor* court refused to recognize a claim for tortious interference with the attorney's fiduciary duties or tortious interference with the contractual relationship. The court noted that no court had recognized such theories in this context, and the *Traver* decision suggested that the insurer could not exercise enough influence to interfere with the attorney's duty of absolute loyalty. Nevertheless, the *Taylor* court did conclude that the insured potentially stated claims against the insurer for breach of contract and for violations of the DTPA and Insurance Code. Those causes of action were potentially available, and the insurer had failed to negate them.

An insurer had a duty to defend even though some of claims were excluded, because other claims might be covered. *Dallas Nat'l Ins. Co. v. Sabic Americas, Inc.*, No. 01-08-00758-CV, 2011 WL 862049 (Tex. App.–Houston [1st Dist.] Mar. 10, 2011, pet. denied).

An insurer had a duty to defend where the plaintiff sought damages, not only for damage and repair to the insured's products, but also for lost income and damages while its oil wells "were forced to stop operations while being repaired" and "other incidental and inconsequential damages." The policy covered property damage arising out of the insured's products, including loss of use but excluding damage to the insured's products and repairs to the insured's products. The pleading showed that the plaintiff's manufacturing process involved more than the insured's product, and the "other incidental and consequential damages" could reasonably be construed as referring to damages beyond those requiring repair and replacement of the insured's product itself. *Lexington Ins. Co. v. Nat'l Oilwell NOV, Inc.*, No. 01-10-00711-CV, 2011 WL 1835308 (Tex. App.–Houston [1st Dist.] May 12, 2011, no pet.).

The *Lexington* court also held that failure to notify the insurer when the insured reached its self-insured retention limit did not relieve the insurer of its duty to pay defense costs. The insured timely reported the claim, and a unilateral request in a reservation of rights letter could not create duties beyond those set forth in the policy.

A liability insurer had no duty to defend claims against a builder for a retaining wall that collapsed and caused damage to adjacent property, where the collapse occurred after the policy period. Damage to the retaining wall itself was excluded as part of the builder's work under the "your work" exclusion, and the damage to the plaintiffs' property occurred after the policy year. The court rejected the argument that coverage could be based on the negligent construction of the wall occurring during the policy period, because no damage occurred then. *VRV Dev., L.P. v. Mid-Continent Cas. Co.*, 630 F.3d 451 (5th Cir. 2011). The court then concluded that the same factual allegations that negated the duty to defend also negated the duty to indemnify.

A liability insurer had no duty to defend under "advertising injury" coverage for claims that the insured misappropriated trade secrets, including price information and other data. The court held that, even if these activities could be considered "advertising injury," they were not committed in the course of the insured's advertising of its own goods, products, or services as required by the policy. Applying Texas law, the Fifth Circuit construed "advertising" to require some sort of public dissemination, which was not alleged. *Cont'l Cas. Co. v. Consol. Graphics, Inc.*, 646 F.3d 210 (5th Cir. 2011).

An employee of an insured company injured a person while driving the company's truck, rendering the injured person a paraplegic. The company had a primary liability insurer, with $1,000,000 in coverage, and an excess insurer with $4,000,000 in coverage, both of which listed the employee as an additional insured. Both policies provided that the insurer's duty to defend or settle ended once the limit of insurance was paid. The injured party sent a *Stowers* letter that offered to release the em-

ployee from liability for $5,000,000. The offer did not include a release of the insured company. The primary insurer's limits had been tendered to the excess insurer, which accepted the offer and withdrew from further defense of the insured company. The company then sued both insurers, arguing that the insurers breached their contract with the insured by failing to provide a full defense for the company. The court granted the insurers' motions for summary judgment, holding that the insurers acted reasonably in accepting the demand, despite the fact that the insured company remained exposed. *Pride Transp. v. Cont'l Cas. Co.*, No. 4:08-CV-007-Y, 2011 WL 1197306 (N.D. Tex. Mar. 31, 2011).

An elevator technician was injured while repairing an elevator at a mall. Prior to his injuries, an inspector had cited the freight elevator for broken welds on the hatch that the technician fell through. The technician sued his employer, the mall, and the management corporation, which filed a declaratory judgment action against their insurer. The court held that the petition stated a claim within the policy's scope of coverage. However, the court found that an exclusion applied. The policy did not cover bodily injury arising out of an employee's acts or omissions, other than general supervision of work performed for the insured by the contractor. The technician alleged that his injuries were caused by the negligence of the insureds in failing to repair the elevator, but there were no allegations that the technician's injuries arose from the insured's general supervision of his work. Therefore, the insurer had no duty to defend. *Town Center Mall v. Zurich Am. Ins. Co.*, No. H-10-1913, 2011 WL 2532911 (S.D. Tex. June 24, 2011).

In a case between liability insurers regarding coverage obligations to defendants in an underlying personal injury suit, the court held that the policy did not require that there be a written contract directly between the insured and the developer to allow the developer to be an additional insured under the policy. Because the contract with the contractor agreed to make the developer an additional insured, this was enough to make the developer an additional insured. The court also held that because the original petition, combined with readily ascertainable facts going solely to the issue of coverage, presented a claim that was within coverage under the insurance policies, the insurers had a duty to defend both the contractor and developer beginning with the date of the original petition. *Millis Dev. & Constr., Inc. v. Am. First Lloyd's Ins. Co.*, No. H-10-3260, 2011 WL 3567331 (S.D. Tex. Aug. 12, 2011).

An insurer had to defend a jewelry appraiser sued for failing to exercise reasonable care in preparing a diamond ring appraisal. The intentional misrepresentation exclusion was ambiguous and did not apply to a negligent misrepresentation. *Elliott Appraisers, L.L.C. v. JM Ins. Servs., L.L.C.*, No. H-10-2231, 2011 WL 722186 (S.D. Tex. Feb. 22, 2011).

An insurer had to defend an insured in the business of providing temporary workers, whose employee died while working for a client and riding in the client's garbage truck. The policy's automobile exclusion stated that there was no coverage for bodily injury arising from use of any auto owned or operated by any "insured." The pleadings stated that the client suffered damages for which the insured was responsible and which would be covered by the policy, but made no mention of the truck or the details of how the employee died, referring only to an "accident." *Liberty Surplus Ins. Corp. v. Allied Waste Sys., Inc.*, 758 F. Supp. 2d 414 (S.D. Tex. 2010). However, the court concluded that the insurer owed no duty to indemnify, because the client was an "insured," triggering the automobile exclusion, and the client had admitted that the employee was injured in an accident involving a truck owned and/or operated by the client in which he was a passenger and that the employee was on the truck for a work-related purpose.

An insurer did not owe a duty to defend its insured for deficient construction of a tennis facility. *Ewing Constr. Co. v. Amerisure Ins. Co.*, No. C-10-256, 2011 WL 1627047 (S.D. Tex. Apr. 28, 2011). The policy's contractual liability exclusion applied because the underlying petition was for breach of contract and alleged that the insured breached various implied and express warranties all stemming from failure to construct the tennis facility properly. According to the court, the underlying suit was directly related to the insured's assumed liability with respect to its own construction work pursuant to its contract. An exception for liability that the insured would have had in the absence of the contract did not apply, because the claims sounded solely in contract. The damage alleged was to the subject matter of the contract – the tennis courts.

B. Duty to settle

A plaintiff who was hit by a drunk driver obtained an excess judgment after the insurer failed to timely accept a settlement demand. The plaintiff then got a turnover order giving him the right to assert the defendant's claims against the insurer. The court held that the demand letter was defective because it did not specifically contain an offer to release a hospital lien. The court held there was no implied offer to release liens in a *Stowers* demand and the offer to release a lien must be specifically stated to trigger the insurer's duty to settle. The court also held that the validity of the lien was irrelevant. *McDonald v. Home State County Mut. Ins. Co.*, No. 01-09-00838-CV, 2011 WL 1103116 (Tex. App.–Houston [1st Dist.] Mar. 24, 2011, pet. denied).

C. Duty to indemnify

The supreme court held it was error to decide whether an insurer had a duty to indemnify without considering extrinsic evidence. The insured had a contract to maintain vegetation at a railway crossing and was sued for failing to do so, which resulted in a fatal collision. The policy had an exclusion for "completed operations." The court held that, while the duty to defend is based on the allegations of the pleadings, the duty to indemnify is determined by the facts actually established. The court of appeals erred by not considering extrinsic evidence of whether the insured's work was completed, considering that the accident occurred in 1995 and the insured's contract extended from 1994 through 1996. *Burlington N. & Santa Fe Ry. Co. v. Nat'l Union Fire Ins. Co.*, 334 S.W.3d 217 (Tex. 2011).

A claims-made policy did not cover a claim against a county and sheriff that was similar to a prior claim for violating the plaintiff's civil rights. The later claim was not covered, because it fell within policy language providing that "interrelated acts" would be deemed made when the first such claim was made. The court concluded that the claim was made in a prior policy year when the first related claim was made. The court did not find any prior Texas or Fifth Circuit cases interpreting the term "interrelated wrongful act," but the court found the phrase had the same meaning as "related," which meant "having a logical or causal connection." The court concluded that the two claims were related and thus constituted a single claim. *Reeves County v. Houston Cas. Co.*, No. 08-09-00256-CV, 2011 WL 4062479 (Tex. App.–El Paso Sept. 14, 2011, no pet.).

An insured failed to notify the insurer of a suit pending against it for injuries sustained in an automobile accident. The injured parties notified the insurer of the suit prior to taking a default. However, the court held that the insured's failure to cooperate in the investigation, defense, and settlement of the claim supported summary judgment for the insurer. Therefore,

the insurer did not have a duty to defend or indemnify. *Martinez v. ACCC Ins. Co.*, 343 S.W.3d 924, 929-30 (Tex. App.–Dallas 2011, no pet.).

An insured homebuilder sued its excess liability insurer, seeking coverage for costs incurred in repairing defective imitation stucco siding on homes it had built. *Markel Am. Ins. Co. v. Lennar Corp.*, 342 S.W.3d 704 (Tex. App.–Houston [14th Dist.] 2011, pet. filed). The homebuilder voluntarily undertook the repairs. The insurer argued that the homebuilder failed to apportion its covered losses from its uncovered losses, thereby precluding recovery, and that the homebuilder did not establish that it was "legally liable" to the homeowners as required for coverage. The court of appeals agreed with the insurer. Regarding the failure to segregate covered and uncovered losses, the court noted that the homebuilder asked the jury to state the total amount it had paid for "property damage," defining that term in a manner that would include removing and replacing the defective siding as a preventative measure (which was not covered by the policy) regardless whether there was property damage (the costs of which were covered). Because the builder did not apportion the damage between its preventative costs and its costs to repair damage, the court concluded that there was no evidence of the homebuilder's covered-loss damages.

The *Markel* court also held that the homebuilder was not "legally liable" to pay the homeowners and thus had no coverage. The policy covered damages the insured was legally liable for and which may be established "by adjudication, arbitration, or a compromise settlement to which [the insurer has] previously agreed in writing." The homebuilder argued that it was legally liable under the Residential Construction Liability Act, but the court disagreed because there was no adjudication. The settlements did not create legal liability under the policy, because the insurer had not agreed to the settlements in writing.

After finding no duty to defend under "advertising injury" coverage, in *Cont'l Cas. Co. v. Consol. Graphics, Inc.*, 646 F.3d 210 (5th Cir. 2011), the Fifth Circuit also concluded that there was no duty to indemnify. The underlying case had already been resolved, and the insured presented no evidence that its conduct occurred in the course of its own "advertising," which was required to prove coverage.

An employer argued that its insurer should indemnify it for payments made to an injured employee. The insurer had issued a group policy that provided occupational accident insurance to the employer's employees. The court held that the policy language clearly excluded either in the form of benefits, defense, or indemnity, any claims brought by employees against the insured employer. Therefore, the court concluded that the policy did not insure any casualty or general liability risks, did not require the insurer to indemnify or protect the employer from losses, and did not provide the employer with any defense relating to the employee's claims. *Ortiz v. A.N.P., Inc.*, 768 F. Supp. 2d 896 (S.D. Tex. 2011).

An insured nightclub sought coverage for a suit arising after a patron was struck in the insured's parking lot by a vehicle driven by a third party. The policy excluded coverage for bodily injury arising out of or resulting from the use of any automobile. The district court held that the policy excluded coverage for claims that arise out of incidents involving automobiles, and was not limited to vehicles driven by employees or agents of the insured. *Colony Ins. Co. v. ACREM, Inc.*, No. H-10-1137, 2011 WL 744744 (S.D. Tex. Feb. 23, 2011).

An injured worker, as an insured's assignee, sued a commercial general liability insurer for recovery under the policy for the amount of the worker's judgment against the insured for injuries the worker sustained when a pump valve on the insured's towable asphalt plant ruptured while unloading hot oil from a tanker truck. *Salcedo v. Evanston Ins. Co.*, No. EP-10-CV-363-KC, 2011 WL 2532847 (W.D. Tex. Jun. 24, 2011). The insurer argued that the judgment fell within the exclusion for damages from accidents arising from the use of an auto, since the accident happened while the oil truck was being unloaded. The worker argued that if the auto exclusion applied, then an exception to the exclusion for damages from use of mobile equipment brought the judgment back into coverage. The court concluded that the worker's injuries arose out of the unloading of the truck, which was being used for its inherent purpose of transporting and unloading hot oil. The accident also occurred in close physical proximity to the truck and was therefore within the territorial limits of the vehicle. The use of the truck had not ended when the accident occurred, since the accident happened soon after the pump first started to run. Finally, because the pumping process itself produced the worker's injuries, the use of the truck produced the worker's injuries and did not merely contribute to cause conditions that produced them. As such, the auto exclusion applied. The mobile equipment exception did not apply, however, because the asphalt plant was not "mobile equipment," which the policy defined as a self-propelled vehicle with a permanently attached pump. The asphalt plant was not a self-propelled vehicle and did not fall within the definition. Because the auto exclusion applied and the mobile equipment exception did not, the insurer had no duty to indemnify.

VII. THIRD PARTY THEORIES OF LIABILITY

A. Unfair insurance practices, and breach of the duty of good faith and fair dealing

Following Hurricane Katrina and Rita, an insured sued its insurer for coverage of damage caused by the escape of crude oil from storage tanks at the insured's facility. The insurer was defending under a reservation of rights letter, so the insured insisted on separate counsel due to the conflict of interest. However, after separate counsel was obtained, the insurer continued to have the original law firm it hired investigate certain claims and even offer settlement to one claimant, without consulting with or informing the insured. The insured argued that the settlement offer to the one claimant, which it made the insurer withdraw, resulted in a higher settlement than if the insurer had not wrongfully made the offer. The court held that Texas law does not provide a cause of action for breach of the duty of good faith and fair dealing in the context of an insurer's handling of a third-party claim. The court held that even if there was sufficient evidence to show that the insurer engaged in unfair insurance practices, the evidence was legally insufficient to show that the failure was a producing cause of the increased settlement. The court also held that even if Texas law recognized a cause of action for breach of the duty of good faith and fair dealing in the third-party claims handling context, and even if the court assumed the insurer committed an extreme act, the insurer was not liable because there was legally insufficient evidence to show that the insured suffered an injury independent of the policy claim. *Mid-Continent Cas. Co. v. Eland Energy, Inc.*, No. 3:06-CV-1576-D, 2011 WL 2417158 (N.D. Tex. June 14, 2011).

An insurer had issued a general liability policy covering an apartment building. The premiums on the policy were due monthly. One of the insured's premium checks was returned for insufficient funds, and the underwriter on the policy mailed a cancellation notice to the insured. The insured contacted the underwriter about reinstatement and was told that the policy would be reinstated if the insured sent a cashier's check by overnight mail along with a statement verifying no loss in the interim. The

insured did this, but the underwriter sent another notice stating that the policy remained cancelled. The insured did not receive this second notice, but did not make any premium payments in the following two months. Later, a fire destroyed the apartment building. The insurer then filed a declaratory action that it had no duty to indemnify because the policy was cancelled for non-payment of premium, and the insurer brought counterclaims for misrepresentation, negligence, and violations of the Insurance Code and DTPA. The parties filed cross-motions for summary judgment. *Penn-America Ins. Co. v. Zertuche*, 770 F. Supp. 2d 832 (W.D. Tex. 2011).

The court found that questions of material fact existed on whether the insurer misrepresented whether the policy would be reinstated and so denied the insurer's summary judgment. The underwriter was the insurer's agent as a matter of law and could be held responsible for the underwriter's misrepresentations about reinstatement of the policy.

The court also denied the insurer's motion for summary judgment regarding whether the insured had an insurable interest in the property. The court concluded that he did, even though he was not the owner, because he had a pecuniary interest in the property. Further, there were questions of material fact regarding whether the insurer made misrepresentations regarding whether the insured had an insurable interest in the property. However, while the misrepresentation claims remained viable, the court granted the insurer's motion for summary judgment as to its duty to indemnify. The court concluded that the policy was properly cancelled in accordance with the law and the terms of the policy. Moreover, the insured did not make any attempt to pay premiums for the following two months. Because the insurer had no duty to indemnify, it did not breach the contract.

VIII. SUITS BY INSURERS

A. Subrogation

A contract requiring a waiver of subrogation rights against an insured third party company did not include employees of that company, where the waiver did not expressly refer to employees. *Reliance Ins. Co. v. Hibdon*, 333 S.W.3d 364 (Tex. App.–Houston [14th Dist.] 2011, pet. denied).

The Fifth Circuit held that one liability insurer that defended claims against a swimming pool contractor had a right of subrogation against a second liability insurer that had coverage but refused to defend. *Md. Cas. Co. v. Acceptance Indem. Ins. Co.*, 639 F.3d 701 (5th Cir. 2011). The Fifth Circuit continued to limit *Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co.*, 236 S.W.3d 765 (Tex. 2007), which held that a liability insurer that believed it overpaid in settlement did not have a right of subrogation against another liability insurer that underpaid. The Fifth Circuit distinguished *Mid-Continent* because, in this case the second insurer violated its duty to defend the insured, which gave the insured a right of recovery to which the first insurer was subrogated.

A defendant argued that a trial court erred in recognizing an insurer as subrogee of an insured and awarding damages to the insurer in that capacity. The court of appeals, however, concluded that the insurer was a proper subrogee. The insurer sued from the outset as subrogee and asserted its right to recover in that capacity. The insurer's capacity was not challenged in the trial court. Because the defendants made no complaint in the trial court, the issue was tried by consent, and the trial court did not err in recognizing the insurer as subrogee. *Tex. Delta Mech., Inc. v. Republic Underwriter's Ins. Co.*, No. 05-09-00940-CV, 2011 WL 2572492 (Tex. App.–Dallas Jun. 30, 2011, no pet.) (mem. op., not designated for publication).

B. Allocation

Where there were two insurers for the same loss whose insurance provisions conflicted, the court concluded that it should disregard the conflicting provisions and apportion liability between both insurers on a pro rata basis. The court also held that one insurer was entitled to reimbursement from the other under a theory of contractual subrogation for the amounts it paid over its pro rata share of the defense or indemnity costs. *Millis Dev. & Constr., Inc. v. Am. First Lloyd's Ins. Co.*, No. H-10-3260, 2011 WL 3567331 (S.D. Tex. Aug. 12, 2011).

IX. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Attorney's fees

The court held that an attorney fee award by a jury of $0 in a case where the plaintiff was only awarded $100 for the cost to tow the insurer's damaged car and $0 for the car repairs, was not so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. The court noted that the coverage for towing was separate from the repairs under the policy, and the plaintiff never previously submitted the towing bill to the insurer. *Crounse v. State Farm Mut. Auto. Ins. Co.*, 336 S.W.3d 717 (Tex. App.–Houston [1st Dist.] 2010, pet. denied).

A title insurer proved that property sellers committed fraud by failing to disclose an existing mechanic's and materialmen's lien for $55,000, causing the title insurer to incur damages and to have the lien removed. *Windsor Village, Ltd. v. Stewart Title Ins. Co.*, No. 10-20298, 2011 WL 61848 (Tex. App.–Houston [14th Dist.] Jan. 6, 2011, no pet.) (mem. op., not designated for publication). However, the insurer was not entitled to attorney's fees for statutory fraud, because the fraud related to real estate but did not relate to a contract that actually effected a conveyance of real estate between the parties.

B. Mental anguish

Evidence was insufficient to support an award of mental anguish damages against a home warranty provider for failing to disclose information about the condition of the house. The homeowner testified that he was angry, that living in the damaged house was difficult, that he felt he had not protected his wife, that the past few years had been a nightmare, and the couple did not entertain family in the home, were embarrassed, and there was no joy. The court concluded this testimony fell short of the high degree of mental pain and distress necessary to allow recovery for mental anguish. *Barnett v. Home of Tex.*, Nos. 14-09-01005-CV, 14-10-00197-CV, 2011 WL 665309 (Tex. App.–Houston [14th Dist.] Feb. 24, 2011, no pet.) (mem. op., not designated for publication).

C. Statutory additional damages

Sufficient evidence supported the jury's finding that the defendant homeowner warranty provider acted "knowingly" by providing minor details from an inspector's report, but omitting

more important details about serious problems with the foundation. The court found that the jury reasonably could have determined that the defendant intentionally provided and emphasized certain information while omitting more important information. The trial court therefore erred in disregarding the jury's award of additional damages. *Barnett v. Home of Tex.*, Nos. 14-09-01005-CV, 14-10-00197-CV, 2011 WL 665309 (Tex. App.–Houston [14th Dist.] Feb. 24, 2011, no pet.) (mem. op., not designated for publication).

The subcontractors' insurers argued that the assignment of the contractor's claims was invalid under the anti-assignment provisions of the relevant insurance policies.

X. DEFENSES & COUNTERCLAIMS

A. Anti-assignment clause

A district court considered whether insurers' breaches of their duty to defend estopped them from asserting an anti-assignment provision in connection with their duty to indemnify. After settling a suit against it regarding deficiencies in a skilled nursing facility it had built, a contractor assigned to its insurer its claims against its subcontractors and their insurers. The contractor's insurer, as assignee, sued the subcontractors and their insurers for indemnity. The subcontractors' insurers argued that the assignment of the contractor's claims was invalid under the anti-assignment provisions of the relevant insurance policies. The contractor's insurer argued that the subcontractor's insurers were estopped to assert the anti-assignment provision by breaching their duty to defend. The district court concluded that, as a matter of law, an estoppel defense based on an insurer's alleged breach of the duty to defend the assignor cannot defeat enforcement of an anti-assignment clause in an insurance policy. The court found that Texas law favors enforcement of such clauses except when they interfere with the operation of statute, and distinguished them from "no action" clauses. *Nautilus Ins. Co. v. Conceirge Care Nursing Ctrs., Inc.*, No. H-10-2243, 2011 WL 1363815 (S.D. Tex. Apr. 8, 2011).

B. "Buyback" of insurance policy

A "buyback" agreement between an insured defendant and its insurer was upheld in *General Agents Ins. Co. of Am. v. El Naggar*, 340 S.W.3d 552 (Tex. App.–Houston [14th Dist.] 2011, no. pet. h.). A customer sued its contractor's insurer to collect on a judgment against the contractor. The underlying suit between the customer and the contractor required two trials because the first trial ended in a mistrial. Just after the mistrial, the contractor and the insurer entered into a "buy-back agreement" under which the insurer repurchased the contractor's policy, and the contractor released the insurer from any and all claims arising out of the policy. The plaintiff sought and was granted declaratory judgment that the buy-back agreement was void as against public policy, and the insurer appealed. The plaintiff argued that the agreement was void because the parties knew of the plaintiff's claims when the entered into the agreement and left the plaintiff without a remedy, and because the policy was a prerequisite to the contractor being hired. The court of appeals disagreed, however, because there was no statute requiring that the policy be in place. "Without strong public-policy reasons against enforcement," the court refused to declare the buy-back agreement as void.

C. ERISA Preemption

In *North Cypress Medical Ctr. Operating Co. v. Cigna Healthcare*, 782 F. Supp. 2d 294 (S.D. Tex. 2011), the court found that a hospital's breach of contract claim was not preempted by ERISA, because the hospital's claim was based on the insurer's breach of certain "Discount Agreements" the insurer allegedly entered into with the hospital, and thus implicated a legal duty independent of the ERISA plans. However, the hospital's claims for violations of the prompt payment statute under Texas Insurance Code sections 843.338 and 843.351 were preempted by ERISA. The statutes were explicitly directed toward health maintenance organization (entities engaged in insurance) and were remedial in nature, intending to create a deterrent against delaying reimbursement of claims, and did not affect risk allocation.

D. Late notice

In a case where a hospital was sued for medical malpractice and later settled with the injured party, the court held that the insurer was not prejudiced by late notice given to the insurer eight months after the lawsuit was filed. The hospital was self-insured up to $2 million, but gave the insurer the right to participate in the defense of any lawsuit that might implicate the insurer's coverage. The court held that depositions of nurses, where they admitted negligence, taken prior to the insurer being given notice of suit, did not prejudice the insurer because the insurer did not show how the case would have turned out differently had the insurer been able to prepare the nurses before their depositions. *E. Tex. Med. Ctr. Reg'l Healthcare Sys. v. Lexington Ins. Co.*, No. 6:04-CV-165, 2011 WL 773452 (E.D. Tex. Feb. 25, 2011).

E. Limitations

In *Citi Group, Inc. v. Federal Ins. Co.*, 649 F.3d 367 (5th Cir. 2011), the court held that limitations began to run on the date the insurer sent a letter saying that the insurer "cannot extend coverage" and "no coverage is afforded." The letter did not have to use the word "denial" to constitute a denial sufficient to trigger limitations. The insured's claim was therefore barred by the four year statute of limitations.

F. Misrepresentation or fraud by insured

Where the jury found the insured guilty of misrepresentation and voided the policy, there could be no ratification of that policy by the insurer. *Tex. Farm Bureau Mut. Ins. Co. v. Rogers*, No. 04-10-00546-CV, 2011 WL 3120645 (Tex. App.–San Antonio July 27, 2011, pet. filed).

A title insurance company met its burden of proof to show that an insured property owner committed fraud against it. In its affidavit of debts and liens, the insured failed to disclose a mechanic's and materialman's lien on the property, even though it knew of the lien because its representative had discussed it with the lienholder. In executing the affidavit, the insured had undertaken a duty to disclose the existence of the lien, and the title insurance company relied on the affidavit in issuing the policy. *Windsor Village, Ltd. v. Stewart Title Ins. Co.*, No. 14-09-00721-CV, 2011 WL 61848 (Tex. App.–Houston [14th Dist.] Jan. 6, 2011, no pet.) (mem. op., not designated for publication).

G. Res judicata & collateral estoppel

A pedestrian sued the insurer of an insured driver for damages after the insured struck the pedestrian. The court of appeals agreed that res judicata barred the pedestrian's suit against the insurer because the pedestrian had previously sued the insurer in connection with the same accident, only to have those claims disposed of by summary judgment. The fact that the pedestrian added new causes of action did not prevent res judicata from bar-

ring her second suit. *Lynch v. State Farm Mut. Auto. Ins. Co.*, No. 03-10-00477-CV, 2011 WL 2162877 (Tex. App.–Austin, Jun. 2, 2011, no pet.) (mem. op., not designated for publication).

H. Waiver of, or estoppel to assert, defenses by insurer

An insurer did not waive its right not to defend a corporate insured's owner when it defended the corporation and its owner, and then continued to represent the corporation's owner once the corporation was nonsuited prior to trial. The policy did not provide coverage for the corporation's owner and was not expanded to cover risk simply because the insurer assumed control of the defense. However, the court denied the insurer's motion for summary judgment, finding that a fact question existed as to whether the insurer was equitably estopped from declining to defend and indemnify the corporation's owner, as the attorney provided for the insurer failed to provide adequate representation, depriving the owner of the opportunity to provide a more forceful defense. *Canal Indem. Co. v. Palmview Fast Freight Transp., Inc.*, 750 F. Supp. 2d 743 (N.D. Tex. 2010).

XI. PRACTICE & PROCEDURE

A. Pre-suit Notice and Abatement

An insured homeowner sued her insurer after the insurer paid too little for damages to her roof caused by Hurricane Dolly. The insurer moved to abate the suit because the insured had not provided sufficient written notice prior to the suit and had not submitted to an examination under oath as required by the policy. The court of appeals held that the insurer was not entitled to abatement. Although the insured failed to provide notice sixty days before filing suit, more than sixty days had passed by the time the insurer moved to abate. Furthermore, the notice provided sufficiently identified the insured's causes of actions and her alleged damages. And because the insurer had previously investigated and paid the insured's claim, it could have no doubt as to her specific claim. The court also held that the insured did not need to submit to examination under oath before bringing her suit because her duties under the contract existed during the investigation of the claim, which had concluded, and these duties did not continue after disposition of the claim. Therefore, the insurer was not entitled to an abatement. *In re Cypress Tex. Lloyds*, No. 13-11-00070-CV, 2011 WL 3630515 (Tex. App.–Corpus Christi Aug. 15, 2011, orig. proc.).

B. Service of process

Service of process on an insurance company was invalid where the plaintiff attempted to serve the company's president but another person instead signed the green card. There was no evidence in the record to show that the signer was authorized to accept service. *United Servs. Auto. Ass'n v. McGuire*, No. 09-10-00256-CV, 2011 WL 2420988 (Tex. App.–Beaumont June 16, 2011, no pet.) (mem. op., not designated for publication).

C. Standing

An insured homeowner sued her insurer when it refused to pay for the loss of her home after a fire. The insurer showed that the insured had lied about her criminal record. During the suit, the insured died, but her children continued to pursue the claim. The court held DTPA claims do not survive the death of the consumer and cannot be pursued by the consumer's estate who are not themselves "consumers." Therefore, the children did not have standing to pursue the insured's DTPA cause of action. Additionally, because the jury found the insured made a material misrepresentation in her policy application, the policy was void and could not be ratified. *Tex. Farm Bureau Mut. Ins. Co. v. Rogers*, No. 04-10-00546-CV, 2011 WL 3120645 (Tex. App.–San Antonio July 27, 2011, pet. filed).

In a case where an injured party was bitten by the dog of an insured, the court held that the injured party lacked standing to sue the insured's insurance company as a third-party beneficiary of the policy between the insured and his insurance company. Because the insured's liability had not been finally determined by agreement or judgment and because the language of the "medical payments coverage" clause did not overcome the strong presumption against conferring third-party beneficiary status, the court concluded that the injured party lacked standing. The court also held that the issue of standing cannot be waived, so it rejected the injured party's argument that the insurer waived the issue of standing by failing to plead it in its answer. *Farias v. Allstate Ins. Co.*, No. 13-10-00071-CV, 2011 WL 2175220 (Tex. App.–Corpus Christi June 2, 2011, no pet.) (mem. op., not designated for publication).

D. Removal and remand – fraudulent joinder

An adjuster was not fraudulently joined as a defendant in an insured's lawsuit to defeat diversity jurisdiction. The insured's claims against the adjuster and the insurer raised common questions of fact, such as the types of damage covered by the policy and the types and amounts of damage the insured's property sustained. *Centaurus Unity, LP v. Lexington Ins. Co.*, 766 F. Supp. 2d 780 (S.D. Tex. 2011). The court held that independent adjusters can be found liable under the Texas Insurance Code. Therefore, the in-state adjusters who were parties to this case were properly joined, and because they resided in Texas, complete diversity of citizenship was absent. Therefore, the court lacked subject matter jurisdiction and remanded the case.

E. Forum Non Conveniens

A trial court did not abuse its discretion by denying a motion to dismiss based on forum non conveniens so a suit could be refiled in Florida, where the suit had been pending in Texas for almost three years, the motion to dismiss was filed within a week of trial, granting the motion would result in unnecessary delay, and witnesses would be from several jurisdictions. *In re Old Republic Nat'l Title Ins. Co.*, No. 14-10-01219-CV, 2011 WL 345676 (Tex. App.–Houston [14th Dist.] Feb. 1, 2011, orig. proc., no pet.) (mem. op., not designated for publication) (per curiam).

F. Forum selection clause

When an insurer refused to pay the full amount of an insured's claim, the insured sued the insurer in Montgomery County for fraudulent inducement, negligent misrepresentation, and violations of the Insurance Code and the DTPA. The insurer moved to dismiss the suit based on a mandatory forum selection clause in the contract, which said that Utah was the exclusive forum for claims or disputes related to "any insurance coverage issues and any payments due" under the policy. The insured argued that his claims were not related to coverage or payments under the policy because they related to pre-contractual misrepresentations that fell outside the scope of the forum selection clause. The court disagreed. The insured alleged that he did not receive the coverage represented to him and did not receive a payment he would have received if he had the coverage represented to him. The dispute thus related to coverage and payment of a policy that the insured contended the insurer induced him to enter into through fraudulent misrepresentations and, as such, fell within the scope of the forum-selection clause. *In re Prime Ins. Co.*, No. 09-11-00349-CV, 2011 WL 3505143 (Tex. App.–Beaumont

Aug. 11, 2011, orig. proc.) (mem. op., not designated for publication).

G. Arbitration

The court held in *Ranchers & Farmers Mut. Ins. Co. v. Stahlecker* that the trial court had improperly denied the appellant's motion to compel arbitration. The insurance policy included an arbitration agreement, and the court held that the insured's home damage claim related to and was intertwined with the insurance policy; therefore, the arbitration agreement applied to the claim. No. 09-11-00054-CV, 2010 WL 4354020 (Tex. App.–Beaumont Nov. 4, 2010, no pet.) (mem. op., not designated for publication).

H. Appraisal

The supreme court held that mere delay does not waive an insurer's right to demand appraisal. The delay that matters is after the parties reach an impasse. The court held that an impasse occurs when the parties have a mutual understanding that neither will negotiate further. Then, appraisal must be invoked within a reasonable time. The court further held that delay will not waive appraisal unless the insured can show prejudice. While the court

recognized prejudice was shown in arbitration cases by the other party substantially invoking the judicial process, the court stated that it was difficult to see how prejudice could ever be shown for appraisal when the policy gives both sides the same opportunity to demand appraisal. The court reasoned that when an impasse has been reached the party can avoid prejudice by demanding an appraisal itself. *In re Universal Underwriters of Tex. Ins. Co.*, 345 S.W.3d 404 (Tex. 2011).

The court then concluded that mandamus was appropriate to enforce the insurer's right to appraisal, but mandamus would not be granted based on the trial court's failure to grant a motion to abate, and the proceedings need not be abated while the appraisal goes forward.

In a subsequent case a court of appeals declined to grant a writ of mandamus to cause the trial court to abate the suit while appraisal proceeded. *In re Liberty Mut. Group, Inc.*, No. 14-11-00310-CV, 2011 WL 2149482 (Tex. App.–Houston [14th Dist.] May 26, 2011, orig. proc., no pet.) (mem. op., not designated for publication) (per curiam); *see also In re Cypress Tex. Lloyds*, No. 14-11-00726-CV, 2011 WL 4367140 (Tex. App.–Houston [14th Dist.] Sept. 20, 2011, orig. proc.) (mem. op., not designated for publication).

Insured homeowners sued their insurer for breach of contract and bad faith after the insurer paid approximately $2,000 for hail damage that was later estimated to be $65,000. The insurer sought appraisal, but the trial court denied it. The court of appeals affirmed that the insurer had waived appraisal. A year before filing suit, the insureds wrote to the insurer requesting appraisal, but the insurer never responded. The insurer waited another sixteen months after suit was filed to invoke appraisal. Under these circumstances, the trial court correctly denied the insurer's motion for appraisal. *Southland Lloyds Ins. Co. v. Cantu*, No. 04-09-00705-CV, 2011 WL 1158244 (Tex. App.–San Antonio, Mar. 30, 2011, no pet.).

A trial court denied an insurer's motion to compel an appraisal. The insured argued that the insurer waived its rights to appraisal by denying all liability on her home damage claim. The court of appeals disagreed and conditionally granted mandamus relief to compel appraisal. Although causation was at issue, the court found that the appraisal should be determined as an initial mater to assess damages, leaving the parties to then litigate causation questions. Further, the insurer did not waive its rights to appraisal. The policy stated that no provision is waived unless the terms of the policy allow it, and the appraisal clause did not provide for a forfeiture of that right. The policy also did not require an admission of liability to invoke the appraisal clause. *In re Southern Ins. Co.*, No. 09-11-00022-CV, 2011 WL 846205 (Tex. App.–Beaumont, Mar. 10, 2011, orig. proceeding) (mem. op., not designated for publication).

The court in *Glenbrook Patiohome, Owners Ass'n v. Lexington Ins. Co.*, held that the insurer's denial of payment did not in itself waive the insurer's right to appraisal. The court went on to state that an insured cannot avoid appraisal because there might be a coverage or causation question that exceeds the scope of appraisal. Therefore, the court granted the insurer's motion to compel appraisal. No. H-10-2929, 2011 WL 666517 (S.D. Tex. Feb. 14, 2011).

A property insurer moved to compel appraisal of hurricane damage to an insured's property. The insured opposed the motion on grounds that the insurer failed to conduct a reasonable investigation of his claims and thus had not complied with the conditions precedent for appraisal. He also argued that the insurer waived its right to appraisal and that the appraisal clause was unconscionable. *Dike v. Valley Forge Ins. Co.*, No. H-11-376, 2011 WL 2517270 (S.D. Tex. Jun. 23, 2011). The district court granted the motion to compel appraisal. Compliance with the claims handling provisions of the policy and the Texas Insurance Code were not conditions precedent to exercising appraisal rights. The appraisal clause did not use conditional language, and no other policy language made the compliance with the claims handling provisions a condition precedent. The insurer did not waive its right to appraisal, regardless of the length of its delay, because the insured was not prejudiced by the delay. Finally, the appraisal clause was not unconscionable, because it was not the product of fraud, accident, or mistake.

I. Pleadings

A federal district court considered whether a pleading alleging unfair insurance practices, deceptive trade practices, prompt payment violations, and breach of the duty of good faith and fair dealing was sufficiently specific to withstand a motion to dismiss under Fed. R. Civ. P. 12(b)(6) for failure to state a claim. The court held the pleading was not sufficiently specific but allowed the plaintiff an opportunity to amend. *SHS Investment v. Nationwide Mut. Ins. Co.*, No. H-10-4004, 2011 WL 2551036 (S.D. Tex. June 27, 2011). The district court considered the recent supreme court decisions in *Bell Atl. Corp. v. Twombly*, 550 U.S. 544 (2007), and *Ashcroft v. Iqbal*, 129 S.Ct. 1937 (2009), to state that the plaintiff must allege enough facts to state a claim to relief that is plausible on its face, and a claim has facial plausibility

when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.

The district court noted that pleadings of Insurance Code violations and deceptive trade practices are subject to the requirements of Fed. R. Civ. P. 9(b), which requires the allegations of fraud state with particularity the circumstances constituting fraud.

The court found that the plaintiff's lengthy allegations of different violations were largely composed of legal conclusions couched as factual allegations, formulaic recitations of the elements of a cause of action, generic paraphrases of statutory language, and conclusory statements without supporting facts.

As examples of deficiencies, the court asked: Why did the insurer issue supplemental payments; how and when did the plaintiff know repairs would cost more than it was paid; what did an engineer's report and estimate state; what were plaintiff's other claim loses and their value as estimated by the insurer and by plaintiff's expert; what provision in the policy covered what particular loses; which damages did the insurer undervalue and underpay and in what amount; which elements of damages did the insurer misrepresent and where in the policy were they covered; what conduct by the insurer misrepresented what; what attempts to settle were made and why were they unfair; how was the insurer aware of its liability and what provisions in the policy made it liable; what were examples of settlement offers and how was the payment inadequate; what was the reasonable time to pay the claim; and what made the insurer's liability reasonably clear?

J. Discovery

A trial court abused its discretion by limiting an UIM insurer's deposition of the insured to only conditions that happened since the date of the prior deposition in the underlying lawsuit, which had settled. The insured failed to make any showing of undue burden, harassment, or duplication. Further, the trial court abused its discretion by ordering an advanced sanction of $100 for any question asked in violation of its protective order. *In re State Auto Prop. Cas. Ins. Co.*, 348 S.W.3d 499 (Tex. App.–Dallas 2011, orig, proc., pet. denied).

An insured's internal communications were privileged. *In re Energy XXI Gulf Coast, Inc.*, No. 01-10-00371-CV, 2010 WL 5187730 (Tex. App.–Houston [1st Dist.] Dec. 23, 2010, orig. proc.) (mem. op., not designated for publication). A suit arose between an insured's oil and gas company and its insurance broker regarding the amount of coverage the insured had for one of its wells and whether the insured had asked for an increase in coverage. After the well suffered a blowout, the broker sent an e-mail to the insured, in which the broker denied that the insured had requested an increase in coverage and confirmed that the insured had only half the coverage it thought it had. The court concluded that the insured's internal communications following the broker's email were privileged as work product because, at that point, the insured and the broker were taking directly adverse positions as to which one was at fault for failing to secure additional coverage. A reasonable person would thus conclude there was a substantial chance that litigation would ensue.

An insurer sought mandamus relief to obtain documents and depose the general partner of its insured, which had previously assigned to a tort victim its right to bring a *Stowers* action against the insurer. The insurer argued that the deposition was necessary for it to prove its *Gandy* defense and show that the underlying judgment from the suit between the insured and the tort victim was the result of a fully adversarial trial. The court of appeals denied the insurer's request for mandamus relief, finding that the insurance company had an adequate remedy on appeal. In a prior interlocutory appeal, the court of appeals had already found that the evidence raised a genuine issue of material fact regarding whether the judgment from the underlying suit was the result of a fully adversarial trial. As such, while the documents and deposition testimony sought might bolster the insurer's *Gandy* defense, it was not so vital as to justify mandamus relief. *In re Yorkshire Ins. Co.*, 337 S.W.3d 361 (Tex. App.–Amarillo 2011, orig. proc.).

K. Severance & separate trials

A trial court did not abuse its discretion by ordering severance of contract claims against an uninsured motorist carrier and extracontractual claims. *In re State Auto Property Cas. Ins. Co.*, 348 S.W.3d 499 (Tex. App.–Dallas 2011, orig. proc., pet. denied).

A court held that the insured's extracontractual claims and statutory claims for prompt payment should be severed from the breach of contract claim, after the insurer offered to settle the breach of contract claim. The insured rejected the insurer's offer. The court stated the claims must be severed to avoid prejudice to the insurer in its defense of the coverage dispute. *In re Loya Ins. Co.*, No. 01-10-01054-CV, 2011 WL 3505434 (Tex. App.–Houston [1st Dist.] Aug. 11, 2011, no pet.) (mem. op., not designated for publication).

L. Experts

A trial court did not err by allowing expert testimony from an insurance adjuster who gave his opinion that hail damage did not cause interior water damage to a motel and that the water damage was preexisting. The testimony was not speculative on its face because the adjuster testified based on his training and inspecting roofs and 28 years of experience, and supported his opinions with objective data by referring to photographic evidence regarding the condition at the motel. Further, to the extent the plaintiffs were challenging the expert's qualifications or the reliability of his testimony, the court held those objections were waived. *Patel v. Nautilus Ins. Co.*, No. 13-08-00735-CV, 2011 WL 345967 (Tex. App.–Corpus Christi Jan. 28, 2011, pet. denied) (mem. op., not designated for publication).

The court in *Dickerson v. State Farm Lloyd's, Inc.*, held that three experts were properly struck, which then left the injured party with no causation evidence. A man was killed in a car accident, and his estate brought suit against the driver and the decedent's underinsured motorist insurer. The court held that a doctor could not testify regarding accident reconstruction as it was not within his "knowledge, skill, experience, training, or education." The court also held that the injured party had not qualified the EMT as an accident reconstructionist and that the accident reconstructionist's opinions were unreliable because there were too many analytical gaps. Therefore, the court affirmed the trial court's summary judgment in favor of the alleged tortfeasor. As a result, the underinsurance issue was moot. No. 10-11-00071-CV, 2011 WL 3334964 (Tex. App.–Waco, Aug. 3, 2011, pet. filed) (mem. op., not designated for publication).

In a case involving hail damage to an insured's home, the insureds did not call the expert who had actually inspected and appraised the damage to their home, but instead called an expert who had adopted the prior expert's estimate and report. The insurer complained that the testifying expert's testimony was irrelevant and unreliable because he did not review the policy or opine on whether the damage was covered, his estimate exceeded the house's value, and he did not verify whether the items listed as damages in the report were actually damaged. The court of appeals rejected these arguments and found the testimony relevant. The expert was called to opine only on the estimated cost to re-

pair damage caused by the hailstorm, which only required him to determine what damage was attributable to hail. It was not necessary for him to review the policy or opine whether the damage was covered. The court also concluded that the estimate was economically feasible, even though it exceeded the value of the home, because he adequately explained that the amount of work to repair a house has nothing to do with the amount of insurance available to pay for those repairs. The court further found that the expert's alleged failure to verify the items of damage went to the weight of evidence, and not its relevance or reliability. The insurer also argued that the testifying expert's testimony was irrelevant and unreliable because he merely "parroted" the prior expert's report. The court disagreed, finding that the prior expert's professional judgment was within the testifying expert's knowledge: both were experienced adjusters; the testifying expert was familiar with the software used by the prior expert to prepare his report; the manner in which the prior expert prepared the estimate was no different than the way the testifying expert would have done it; the two experts had adjusted many claims together; and the testifying expert independently inspected and verified the damage to the house as represented in the report. Accordingly, the court held that the testifying expert's testimony was relevant and reliable. *Southland Lloyds Ins. Co. v. Cantu*, No. 04-09-00705-CV, 2011 WL 1158244 (Tex. App.–San Antonio Mar. 30, 2011, no pet.).

After the insured's building was damaged during Hurricane Ike, the insurer refused to pay, asserting that the damage was normal wear and weathering. The insurer relied on its expert in maintaining its position. The court granted summary judgment in favor of the insurer on an insured's claims for bad faith, unfair settlement practices under the Texas Insurance Code, prompt payment of claims, deceptive trade practice violations, and fraud. Although reliance on expert reports does not preclude a bad faith claim if there is evidence that the reports were not objectively prepared or that the insurer's reliance was unreasonable, the court held in this case that there was nothing in the record to show that the insurer's decision to believe its own experts was unreasonable. *Lee v. Catlin Specialty Ins. Co.*, 766 F. Supp. 2d 812 (S.D. Tex. 2011).

M. Burden of proof

A court reversed and rendered judgment against a builder that recovered repair costs against its insurer, where the builder failed to segregate covered amounts from uncovered amounts. *Markel Am. Ins. Co. v. Lennar Corp.*, 342 S.W.3d 704 (Tex. App.–Houston [14th Dist.] 2011, pet. filed). The builder had voluntarily removed defective artificial stucco from a number of homes. The builder incurred costs in removing stucco to repair water damage and in removing stucco to determine whether there was water damage. The court found the former was covered but the latter was not. Because the builder failed to offer proof segregating these damages, the court held that failure to segregate covered and uncovered perils was fatal to recovery.

N. Court's charge

In *Maryland Cas. Co. v. Acceptance Indem. Ins. Co.*, 639 F.3d 701 (5th Cir. 2011), the court approved the following definition of "occurrence":

> "Occurrence" means an accident, including continuous or repeated exposure to substantially the same general harmful conditions. A deliberate act, performed negligently, is an accident if the effect is not the intended or expected result.

Id. at 706. The court found the first sentence was quoted from the insurance policy, and the second sentence came from the Texas Supreme Court's opinion in *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1 (Tex. 2007). The court found the district court did not err by declining to include another sentence from *Lamar Homes* stating, "an occurrence is not an accident if circumstances confirm that the resulting damage was the natural and expected result of the insured's action, that is, was highly probable whether the insured was negligent or not." Even though this language also came from Lamar Homes, the Fifth Circuit held this was fairly close to the converse of the instruction that was already given and the insurer did not show how it would have argued the case any differently with the requested instruction.

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1 *Tex. Mut. Ins. Co. v. Ruttiger*, No. 08-0751, 2011 WL 3796353, 54 Tex. Sup. Ct. J. 1642 (Aug. 26, 2011) (overruling *Aetna Cas. & Sur. Co. v. Marshall*, 724 S.W.2d 770 (Tex. 1987)).

2 *Aranda v. Ins. Co. of N. Am.*, 748 S.W.2d 210 (Tex. 1988).

3 *Leordeanu v. Am. Prot. Ins. Co.*, 330 S.W.3d 239 (Tex. 2010).

4 *Ojo v. Farmers Group, Inc.*, No. 10-0245, 2011 WL 2112778, 54 Tex. Sup. Ct. J. 1068 (May 27, 2011).

5 *In re Universal Underwriters of Tex. Ins. Co.*, 345 S.W.3d 404 (Tex. 2011).

6 *Lancer Ins. Co. v. Garcia Holiday Tours*, 345 S.W.3d 50 (Tex. 2011).

7 See *Weingarten Realty Mgmt. Co. v. Liberty Mut. Fire Ins. Co.*, 343 S.W.3d 859 (Tex. App.–Houston [14th Dist.] 2011, pet. denied) and *Guideone Specialty Mut. In. Co. v. Missionary Church of Disciples of Jesus Christ,* No. 4:11-CV-009-A, 2011 WL 3805463 (N.D. Tex. Aug. 16, 2011).

8 *Taylor v. Allstate Ins. Co.*, No. 01-09-00457-CV, 2011 WL 1233331 (Tex. App.–Houston [1st Dist.] Mar. 31, 2011, pet. filed); *Mid-Continent Cas. Co. v. Eland Energy, Inc.*, No. 3:06-CV-1576-D, 2011 WL 2417158 (N.D. Tex. June 14, 2011).

9 *General Agents Ins. Co. of Am. v. El Naggar*, 340 S.W.3d 552 (Tex. App.–Houston [14th Dist.] 2011, no. pet. h.).

10 The majority opinion contains a lengthy description of the negotiation process for a Lloyds of London policy, quoting from *Houston Cas. Co. v. Certain Underwriters at Lloyd's London*, 51 F. Supp. 2d 789, 791-92 (S.D. Tex. 1999).