# ANNUAL SURVEY OF Texas INSURANCE Law

By Mark L. Kincaid* & Trevor A. Taylor**

## I. INTRODUCTION

This year's survey covers the period from September 2003 to December 2004. One of the marquee issues for the Texas Supreme Court during this period is whether it is against public policy to insure punitive damages. The court has a certified question from the Fifth Circuit raising the issue, and an en banc decision from the Fort Worth Court of Appeals is headed to the court.

Another issue with far-reaching implications is whether, and to what extent, courts may consider extrinsic evidence when deciding whether a liability insurer has a duty to defend. The prevailing view is that courts may consider only the text of the plaintiff's complaint and the text of the insurance policy, but some courts have suggested there may be exceptions. Here are the highlights of this year's cases:

- The Texas Supreme Court gave further definition to the types of conflicts of interest that will let an insured reject a qualified defense. Other courts addressed the ability of the insured to recover fees in these cases.
- The Texas Supreme Court and the Fifth Circuit both decided that total disability means the insured can't do anything, not that the insured can't do any one thing.
- Several cases outlined the principle that if you are outside of your vehicle when you are hurt, there is no coverage, but you may be covered if you are injured while exiting the vehicle.
- The federal courts revisited ERISA preemption, in light of recent United States Supreme Court authority, and found everything is pretty much still preempted.
- Parties continued to litigate mold and foundation movement claims, and the courts addressed the sufficiency of evidence to allocate between covered and excluded damages.
- Litigants started to appreciate that applying the law of a state other than Texas might make a difference–positive or negative – so several cases decided choice of law questions.
- Uninsured motorist cases continued to be a problem, with insurers arguing they can never be liable for delay in paying a UM claim until the underlying liability is established. Courts treated UM insurers' bad faith liability like scientists view quarks – they exist in theory, but nobody has seen one.
- Whether delay penalties under article 21.55 are proper in duty to defend cases is still being debated. One court of appeals said the statute doesn't apply; two more federal district courts said it does; and the Texas Supreme Court noted the issue but wouldn't say.
- The Fifth Circuit ratcheted up the requirements for suing an individual for unfair insurance practices, by requiring proof – not just pleadings – to support the allegations, in order to defeat removal based on fraudulent joinder.

• Finally, in a non-insurance case, the Texas Supreme Court foreshadowed issues that may affect the ability of an insured to assign "bad faith" claims to a plaintiff.

## II. FIRST PARTY INSURANCE POLICIES

### A. Automobile

The Texas Supreme Court held that the named insured's wife could waive underinsured motorists coverage, even though she was not named in the policy.[1] Mrs. Sanchez obtained insurance for two vehicles belonging to herself and her husband. She rejected uninsured motorist coverage, and they never paid premiums for it. Later, Mr. Sanchez was severely injured by an uninsured motorist. Even though Mrs. Sanchez was covered under policy language defining "insured" to include the spouse of the named insured, she was not listed as a "named insured" on the declarations page. The Sanchezs' argued that the waiver of UM coverage was ineffective, based on statutory language requiring such coverage unless "any insured named in the policy shall reject the coverage in writing."

The supreme court held that Mrs. Sanchez was a "named insured" within the meaning of the statute and thus could waive UM coverage, even though she was not a "named insured" shown on the declarations page. The court looked at the legislative history of article 5.06 and concluded that the legislature must have intended for the words "named insured" in the statute to include an insured's spouse, because the statute incorporated the policy language in effect at the time it was enacted. The court found this conclusion was consistent with the authority of Mrs. Sanchez, since she was able to purchase coverage. As a result, the court found there was no UM coverage.

The supreme court also held that a driver's injuries when he tripped on the edge of his truck's door while exiting resulted from a "motor vehicle accident" within his personal injury protection coverage.[2] The court held that a "motor vehicle accident" occurs when: "(1) one or more vehicles are involved with another vehicle, an object, or a person; (2) the vehicle is being used, including exit or entry, as a motor vehicle; and (3) a causal connection exists between the vehicle's use and the injury-producing event." The four dissenters felt there was no coverage because the average person would not think tripping on a truck's door edge was a motor vehicle accident.

A driver and passenger who were struck while walking on the side of the road as they went to get help to repair a flat, however, were not entitled to receive uninsured motorists benefits. They were not designated persons in the policy, so the policy extended coverage to them only if they were "occupying" the vehicle. The court concluded that because they had left the vehicle for some period of time, they were no longer occupying it. The plaintiffs also argued that UM coverage should be broadly construed to include liability arising out of the maintenance or use of any vehicle, either their vehicle or the uninsured driver's vehicle. However, the court concluded that their injuries as pedestrians did not arise out of the use or maintenance of their truck.[3]

A passenger who was struck by a speeding car brought an action to recover on his underinsured motorist policy. Upholding summary judgment for the insurer, the court first noted that the passenger had exited the vehicle at the time he was injured. Therefore, he was not "occupying" the vehicle as required by the policy. The court rejected the passenger's argument that it was sufficient that he be in "contact" with the vehicle, noting that no evidence was presented to the court supporting that contention. The court looked to cases involving an injury that occurred outside of the covered vehicle, and whether there was a causal connection between the incident that caused the injury and the covered vehicle. The court found there was no causal connection in this case. The court noted that the passenger produced no evidence showing how long he had been out of the covered vehicle before being struck by another car, and produced no evidence showing that these injuries were related to any impact with the covered vehicle. Finally, the court rejected the passenger's claim that the term "occupying" as used in the policy was ambiguous.[4]

An automobile insurer could not lawfully collect a dollar per policy anti-theft fee, in addition to premiums. The insured brought a class action challenging this fee. The court of appeals held that the Insurance Code provides a comprehensive scheme for establishing automobile insurance rates, which precludes additional charges. Further, to the extent a rule by the commissioner could be interpreted to allow this fee to be collected in addition to the premiums, that rule was void.[5]

In a Corpus Christi case, the court held that the family exclusionary clause a business automobile policy issued to a corporation did not apply to an accident involving the corporation's president's wife.[6] The only named insured in the policy was the corporation, which could have no family members, and thus the exclusionary clause would only apply if the named insured was an individual.

In a case involving an automobile policy issued by an insurer's affiliated company, the court held that the policy qualified as a renewal rather than an initial policy and therefore the insured's written waiver rejecting personal injury protection (PIP) benefits under the initial policy remained in effect.[7]

A court also held that hired and non-owned auto liability insurance was not "automobile liability insurance" within the meaning of the statutes mandating personal injury protection coverage and uninsured motorists coverage.[8] And in a case where an insured brought an action challenging the insurer's right to require the insured to assign title of the "totaled" vehicle to the insurer, the court concluded that the payment of loss clause, stating that the insurer may keep all or part of the property at the agreed or appraised price, applied to stolen vehicles and to damaged vehicles. Thus, the insurer's requirement did not amount to a breach of contract.[9]

A court dismissed a class action brought against automobile insurers to recover the diminished value of repaired vehicles. Noting that the Texas Supreme Court recently resolved this issue, the court reaffirmed that the Texas Standard Personal Auto Policy affords no coverage for the diminished value of an adequately repaired vehicle.[10]

### B. Homeowners

The Fifth Circuit held that insureds presented sufficient evidence to allow a jury to segregate excluded flood damage resulting in mold from water damage resulting in mold, assuming there was coverage for the latter. The insureds presented expert testimony that, in addition to the excluded flood, the home had suffered water intrusion on several other occasions, resulting in mold higher than the flood level, and resulting in mold more densely located in the area of other leaks. The court held this was enough evidence to give the jury a basis to allocate damages, and that was all the doctrine of concurrent causation required.[11] The court chose not to decide the coverage question and, noting a split of authorities, certified to the Texas Supreme Court the question whether the ensuing loss provision contained in a Homeowners B insurance policy, when read in conjunction with the remainder of the policy, provides coverage for mold contamination caused by water damage that is otherwise covered under the policy. The

district court had found no coverage.

An innocent co-insured sued her insurer to recover for a fire loss after the insurer declared the policy void due to arson by the insured's husband. The court affirmed summary judgment for the insurer, holding that the "concealment or fraud" clause provides that the policy is void as to both insureds if either engaged in fraud.[12]

An insured sought compensation for lost cars and related equipment. The court held the race cars were recreational vehicles, an exception to the motor vehicle exclusion. The court concluded that the insured's failure to record the purchase of the race cars did not amount to an intentional concealment, misrepresentation, or fraud.[13]

Mold damage caused by a leaking air conditioner was within coverage for physical loss caused by the named peril of leakage from within an air-conditioning system. Because the mold could be damage from the named peril, the court reversed the summary judgment for the insurer.[14]

In a case involving foundation damage to a house, there was sufficient evidence to support the jury's finding that the damage was caused by a plumbing leak. The homeowner's expert testified that the plumbing leaks caused 100% of the damage, which negated the possibility of other causes, including soil movement. The court noted that with competing contentions supported by expert witnesses on both sides, the burden fell on the jury to determine which was more reliable. The court concluded that the evidence supporting the finding that a plumbing leak caused the foundation damage was not so weak, or the evidence to the contrary so overwhelming as to require that the jury's verdict be set aside.[15]

**C. Life**

A policy unambiguously covered only the unpaid mortgage amount, not the higher maximum of $100,000. While the policy stated that the maximum amount of life insurance was $100,000, it also expressly stated that the only insurance in effect was that for which a premium was paid. A premium was paid only for $22,000 of insurance, which was the amount of the mortgage.[16]

The Fifth Circuit held that Wal-Mart did not have an insurable interest in the lives of its regular employees, so a deceased employee's estate was entitled to receive the insurance proceeds. Under Texas law, a beneficiary has an insurable interest when they are closely related to the insured, are a creditor, or have a reasonable expectation of pecuniary benefit or advantage from the continued life of the insured. The court rejected Wal-Mart's argument that it had a sufficient expectation of pecuniary benefit with respect to its regular employees.[17]

A daughter, as the administrator of the insured's estate, brought an action against the insured father's lover seeking to recover or impose a trust on the life insurance proceeds paid to the lover-beneficiary upon the father's death. The lover-beneficiary had been dating the insured for approximately three months. The insured died of a heart attack during sexual intercourse. Prior to his death, the insured told the lover-beneficiary he was removing his ex-wife as beneficiary on the policy and substituting her because he wanted her to take care of the college expenses of his two-year-old daughter.

The court affirmed summary judgment for the lover-beneficiary, concluding that a bargained for exchange had not occurred, thus no valid contract was created between the insured and the beneficiary requiring that the policy proceeds be used for the education of the insured's two-year-old daughter. The court also rejected the promissory estoppel argument advanced by the daughter, noting that the insured voluntarily chose to change the beneficiary designation without any promise in exchange. The court further found the use of the proceeds for personal expenses was not actual fraud, and that the romantic relationship between the insured and the lover-beneficiary did not establish a fiduciary relationship that would support a claim of constructive fraud.[18]

**The Texas Supreme Court held that a doctor who could perform some, but not all, of the duties of his practice was not "totally disabled.**

Life insurance companies interpleaded proceeds following an insured's murder, where two putative wives resolved all issues except who was the surviving spouse. Following a trial that determined that the surviving spouse of the insured was the first wife, the second wife appealed. The court held the evidence was sufficient to show that the insured and his first wife did not dissolve their marriage relationship, and thus the presumption of the validity of the insured's subsequent marriage to the second wife was rebutted.[19]

In another case, the former wife and surviving spouse claimed to be beneficiaries of the deceased's policy. The court found that the insured did not sign a "beneficiary designation form" naming the surviving spouse beneficiary. The former wife testified that the signature on the form was not her husband's signature, and the daughter testified that the father was incapable of signing the form on the date the surviving spouse claimed it was signed. The court further found the evidence was factually insufficient to establish the former wife waived her status as the designated beneficiary, noting that the surviving spouse failed to introduce a copy of her deceased husbands divorce decree.[20]

Relatives of the deceased husband sued the widow alleging that she caused her husband's death. The insurer intervened and filed an interpleader, depositing the proceeds of the life insurance policy in the registry of the trial court. The widow filed a no-evidence motion for summary judgment, asserting there was no evidence she caused the death. The court affirmed the summary judgment for the widow, holding that even though there was evidence of infidelity, and there were inconsistencies in the widow's account of events prior to her husband's death, any inference that the widow caused the husband's death from such evidence was speculative.[21]

**D. Health**

A policy unambiguously excluded the insured's broken spine and severed spinal cord between two thoracic vertebrae, where it excluded injury to "the cervicothoracic regions of the spine." The injury was in the area within medical and general dictionary definitions of the term "cervicothoracic." The court rejected expert testimony offered by the insured that another definition limited the region to the transition between the neck and thorax.[22]

**E. Disability**

The Texas Supreme Court held that a doctor who could perform some, but not all, of the duties of his practice was not "totally disabled."[23] The court found it significant that the policy defined total disability as meaning "you are unable to perform the duties of your occupation." In contrast, the policy defined partial disability to mean "inability to perform

one or more of your important daily business duties." Because the doctor could perform some of his duties but not others, he was not totally disabled.

### F. Commercial Property

A commercial property insurer breached its contract to replace a damaged roof with one of "like kind and quality," where it refused to pay the higher cost of a comparable roof and only tendered the amount it estimated was necessary to pay for an identical roof. The court held that the contract language allowed more leeway than just replacement with an identical roof, so the insurer breached its obligation to pay.[24]

### G. Other Policies

The Austin Court of Appeals held that a credit life, accident and health insurer could not charge a $50 policy fee in addition to the premium approved by the commissioner of insurance.[25] This decision came on the same day as the court's decision in Griesing, noted above, holding that an insurer could not collect a $1 theft prevention fee in addition to premiums.

A Houston law firm's business interruption policy did not cover loss of income when their office building was closed after the floods of 2001. The exclusion for flood water applied, even though the water had broken through an interior basement wall of the building, flowed through a downtown parking garage, and then through a pedestrian tunnel system, before finally knocking out the power to their building. The court rejected the argument that the water had lost its character as "flood water" by that point.[26]

## III. FIRST PARTY THEORIES OF LIABILITY

### A. Breach of Contract

A life insurance policy and related schedule of benefits were ambiguous and could reasonably be read to allow an employee to get $100,000 of coverage, instead of just $50,000, without proof of insurability or approval by the insurer. Thus, the insurer breached its contract by only paying $50,000.[27]

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

The Texas Supreme Court reaffirmed its prior holding that the business of suretyship is not part of the "business of insurance." The court therefore concluded that agents could not sue the surety company they sold for to recover damages under article 21.21.[28]

The Fifth Circuit declined to hold that an automobile insurer's liability for uninsured motorist benefits can never be reasonably clear, to support a finding of unfair refusal to pay, unless and until a jury establishes the extent of the uninsured driver's liability. The court reasoned that if it accepted this argument, an insured could never successfully assert a bad faith claim against his insurer for failing to attempt a fair settlement of a UM claim. If the court accepted the insurer's argument, then prejudgment liability would not be reasonably clear, and there would be no postjudgment duty of good faith.[29] Nevertheless, the court found the insurer was entitled to summary judgment, dismissing the unfair settlement claim, because the evidence showed there was a "bona fide dispute." The insured claimed he suffered a herniated disk in his neck in an auto accident. The other driver's insurer paid $25,000, and Hamburger's insurer paid $10,000 in PIP benefits. The combined amount was $16,000 more than Hamburger's medical expenses. The court reasoned that even if all of the injuries resulted from the wreck, which the insurer disputed, it could not constitute bad faith per se for the insurer to view the $16,000 as sufficient compensation for the insured's subjective pain and suffering.

On this point, it appears the court erred. While it might not be bad faith per se to offer only $16,000, that would preclude summary judgment for Hamburger. That does not justify summary judgment against him. As a factual matter, it is by no means clear, as a matter of law, that offering $16,000 for pain and suffering is a "prompt, fair, and equitable settlement." It seems the jury should have decided this.

The trial court properly granted summary judgment for the insurer where the insured's only evidence in support of their extra-contractual claims was that the adjuster did not know the specific provisions of article 21.21, that the insurer "took forever" to name its appraiser, and that the policy covered damage for plumbing leaks (which apparently turned out to be true). Further, the court found no evidence of damages resulting from any unfair insurance practice, where the only evidence was that the insureds took out a loan from their attorney, which the court found was unrelated to any of the article 21.21 claims.[30]

In a case involving death benefits under a life insurance policy, the court held the beneficiary was not entitled to extra-contractual damages for the insurer's alleged bad faith in denying the claim in the absence of policy coverage. The court concluded that there was no evidence that the insurer committed acts so extreme they would cause injury independent of the policy claim so as to allow recovery despite the absence of coverage.[31]

In *E.R. Dupuis Concrete Co. v. Penn Mut. Life Ins. Co.*,[32] a company brought claims against its insurance agents and insurer who sold a variable life insurance policy on the life of the company's president. The company alleged that the agent used information gathered during meetings for estate planning to sell the life insurance, then falsely represented that the plaintiff could expect a ten to twenty-four percent return on its investment. The company alleged that the insurer invested the company's money in risky funds without consulting the company. The company also alleged that the insurer falsely represented that the profits from the investments would cover the premiums.

Upholding summary judgment for the agent and the insurer, the court held that the company could not rely upon the projections by the agent or the insurer because the policy specifically warned the insured that the value was not guaranteed and that the agents were not authorized to make any promise as to future payment of dividends or interest. The court relied on the Texas Supreme Court opinion in *Schlumberger*, a case decided outside the insurance context, which held that a disclaimer of reliance in a contract conclusively negated the element of reliance. The court also held that because the company should have been on notice that the policy's accumulation value would decrease based upon its investment experience, the court held that it lacked reliance as a matter of law.

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

The Texas Supreme Court held a property insurer that tendered partial payment was only liable for penalties calculated on the difference between the amount it owed and the amount it tendered.[33] The court relied on the language of article 21.55 defining "claim" as a claim "that must be paid by the insured directly to the insured or beneficiary." The court reasoned that the amount of the "claim" subject to the 18% penalty under the statute would be net of any partial payment. The court reasoned this would encourage insurers to pay the undisputed portion of a claim early. The court also held, however, that a penalty would be assessed on the entire amount, if the insurer's tender of the partial payment was not unconditional. Otherwise, an insurer could delay payment by insisting on a release to which it was not entitled. However, the court found insufficient

evidence that the insurer's tender was conditional.

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

In *DeLaurentis v. United Servs. Auto. Ass'n*,[34] the insurer contended that its interpretation of a homeowner's policy, even if erroneous, served as a reasonable basis to deny the insured's claim and thus there was a bona fide dispute regarding coverage. In reversing summary judgment for the insurer, the court observed that a simple misconstruction of the policy provision alone cannot serve as the basis for a bad faith claim. But the court found the relevant provisions of the homeowner's policy unambiguous and that the policy language was susceptible to only one reasonable interpretation. The insured also offered evidence that the insurer represented that mold was specifically excluded under the policy, when it was not. Thus, the record showed an issue of fact sufficient to preclude summary judgment with respect to the reasonableness of the insurer's conduct.

In a case of foundation damage caused by a plumbing leak, the court held the evidence was legally insufficient to support a finding that the insurer breached its duty of good faith and fair dealing. The court observed that the evidence merely showed a bona fide dispute about the insurer's liability on the contract, and such a dispute did not rise to the level of bad faith. The court stated that the evidence showed a simple disagreement among experts, which would not support a judgment for bad faith. The court held there was no evidence suggesting that the insurer's expert's investigation was unreliable and that the insurer acted unreasonably in its reliance on his investigation. The court rejected the homeowner's efforts to discredit the insurer's expert. The expert testified that he received a significant amount of income from insurers. The court noted that the expert also worked for homeowners and had recently concluded that a plumbing leak in another case had caused foundation damage. The fact that the expert wanted to obtain more business from Allstate, the court concluded, did not show the expert was necessarily biased against insureds.[35]

A workers compensation claimant sued her employer's insurer challenging the insurer's failure to pay for additional weekly indemnity benefits for a work-related injury. The trial court severed the extra-contractual claims from the contract claims, and rendered judgment awarding the claimant an additional $46,002 in benefits. The trial court later granted summary judgment for the insurer on the extra-contractual claims, and the insured appealed. In reversing summary judgment for the insurer, the court noted that whether an insurer acted in bad faith because a denied or delayed payment of the claim was ordinarily a question of fact. The court recognized an exception to that rule, where the insurance company could "conclusively establish" that there was no more than a good faith dispute between the parties concerning the insurer's liability on the contract. The court found there was no such conclusive evidence presented by the insurer.[36]

**E. Unfair discrimination**

A son sued his mother's health insurer asserting the insurer discriminated against him because he had Down Syndrome. The court rejected the claim that the insurer violated article 21.21-8, concluding that Blue Cross's policy of declining to insure all persons with Down Syndrome did not unfairly discriminate between persons of the same class and of the same hazard. The court reasoned that if the relevant class is all persons, both parties presented sufficient proof that persons with Down Syndrome have greater medical risks than the average person and therefore are not of the same hazard. If the relevant class is all persons with Down Syndrome, however, Blue Cross did not unfairly discriminate because it treated all persons in that class and hazard in the same manner.

Plaintiff further asserted that insurer's conduct violated article 21.21-6, which prohibits unfair discrimination against persons with disabilities. The court concluded that this section of the insurance code did not provide a private cause of action, and allowed only for certain administrative remedies that the insurance commissioner could pursue under other portions of the Texas Insurance Code.[37]

**F. ERISA**

The United State Supreme Court held that ERISA preempts a claim by beneficiaries for damages due to injuries they suffered after the administrator rejected coverage for treatment recommended by their physicians. The claims were brought under the Texas Healthcare Liability Act, which requires an HMO to exercise ordinary care when making treatment decisions. The Court concluded that the claims necessarily derived from the plaintiffs' rights under their employee benefit plans. The statute was preempted because the Court has construed ERISA to completely preempt any state law that provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme.[38]

Two concurring justices, while agreeing that the claims were preempted, called on Congress or the court itself to "revisit what is an unjust and increasingly tangled ERISA regime." The concurring justices noted the problem between broad preemption of state law, and narrow remedies under ERISA, creating a "regulatory vacuum." The concurring justices favored a suggestion by the United States, as amicus, that some plaintiffs with claims like these could receive consequential damages as some form of "make-whole relief" under ERISA. However, because these plaintiffs specifically chose not to assert any claims under ERISA, that issue would await another day.

An employee who was on short term disability and was not actively at work was not entitled to increase his life insurance benefits, so the insurer was correct to deny his claim, even though the employer as plan administrator deemed him to be actively at work and had approved the claim.[39] The court reasoned that the determination by the plan administrator clearly contradicted the plan language, so that determination was not entitled to any deference, and the insurer's legally correct determination was not an abuse of its discretion. A concurring justice pointed out that when there is a conflict between a discretionary decision by a plan administrator and a discretionary decision by an insurer, both of whom are plan fiduciaries, the court should side with the administrator, not the insurer. In this case, the administrator's determination went beyond its authority and conflicted with the plain language of the plan.

In *Ellis v. Liberty Life Co.*,[40] a panel of the Fifth Circuit held that an employee is not totally disabled unless she is unable to perform each and every job duty, and rejected the argument that the employee was disabled if she was unable to perform any one of the job duties. A majority of the panel held this was the plain meaning of the phrase "unable to perform all of the material and substantial duties," and that reading it the other way would conflict with the definition of partial disability in the policy. One justice dissented because he considered the policy to be ambiguous and found it reasonably could be interpreted to mean that if there were several duties of an occupation and the employee could perform only some of them, then the employee was "unable to perform all of the

material and substantial duties." inexplicably, neither the majority nor dissenting opinions refer to the earlier decision in Lain v. UNUM Life Ins. Co.,[41] where another panel of the court reached the opposite conclusion.

The majority in *Ellis* also held that the insurer's decision that the employee was not totally disabled was not arbitrary and capricious, even though the insurer had previously found she was totally disabled. The dissenting justice would require the insurer to show evidence that its initial decision was wrong, or evidence of a change in the employee's condition.

### G.Other Theories

The only cause of action available for a flood insurance policy under the National Flood Insurance Act was for breach of contract. The court declined to imply a federal cause of action for negligence and consequential damages, and found state law claims were preempted. The court found no congressional intent to imply additional causes of action or to allow additional claims to be paid from treasury funds.[42]

A healthcare provider sued a self-insured employer to recover the value of kidney dialysis treatments on the theory of quantum meruit. The court held that payments to the provider under this theory entitled the employer to a set off. The jury found the reasonable value of the provider Serv.s was less than the set off, and the court rendered judgment for the employer.[43]

An insured sued his life insurer to recover the unearned portion of the first annual premium paid after the policy date. The court rejected the insured's argument that quantum meruit was applicable to the dispute, holding the policy provided it was not in force until the first premium was paid. The court held that it did not matter that the entire premium was earned as the insured agreed to pay it.[44]

## IV. AGENTS, AGENCY & VICARIOUS LIABILITY

### A. Individual Liability of Agents, Adjusters, and Others

A third party administrator owed a fiduciary duty to the health insurer for which it administered policies, and it breached that duty by revealing confidential information to another insurer that then replaced the policies. The insurer could recover damages measured by the net loss on the book of business, as shown by the amount by which past and future claims exceeded premiums. Further, the evidence supported a finding that the third party administrator and its parent corporation operated as a single business entity so that both would be liable for actual damages and for punitive damages based on evidence and a jury finding that the administrator acted with "malice."[45]

The Unauthorized Practice of Law Committee sued Public Adjusters and received an injunction against certain practices. At the time the injunction was issued, there was no licensing provision for public adjusters in Texas. Since then, the legislature passed an act to regulate "public insurance adjusters." The question for the court was the impact of the newly-enacted legislation on individuals who are not licensed public adjusters. The court affirmed the injunction, based on the law as it existed at the time. The court recognized, however, that either party could immediately ask the trial court to reconsider based on changing facts or the change in controlling law.[46]

In *Critchfield v. Smith*,[47] insureds sued their agent to recover for his negligence and breach of contact by failing to offer uninsured motorist coverage equal to the amount of their $5,000 liability coverage. The court affirmed summary judgment for the agent, noting that no legal duty exists on a part of the agent to extend the insurance protection of his customer merely because the agent has knowledge of the need for additional insurance, especially in the absence of prior dealings where the agent customarily has taken care of the customer's needs without consulting him. The insureds also argued that the agent's failure to offer higher limits constituted negligence per se in violation of article 5.06-1. The court noted that the contention was rejected in *Geisler v. Mid-Century Ins. Co.*,[48] and affirmed summary judgment for the agent.

Finally, the court found the insureds raised an issue of fact on each of the elements of a valid oral contract. The agent offered his Serv.s to advise the insureds on their insurance coverage, and the insureds accepted this offer. The agent acknowledged that a contractual relationship existed between him and the insureds where he provided advice and counsel.

An insured real-estate broker sued his insurance company for failing to provide coverage for one of the companies he owned. The court upheld summary judgment for the agent and insurer, holding that the realtor presented no evidence of any misrepresentation on the part of the agent. The court rejected the argument that the agent violated a duty to the insured broker, holding that while the agent may have known of the existence of the uninsured company, that did not give rise to a legal duty to extend coverage or cause a new policy to be created for that company.[49]

## V. THIRD PARTY INSURANCE POLICIES & PROVISIONS

### A. Automobile Liability Insurance

An employee who materially deviated from the scope of his express and implied permission to use a company truck was not covered under the company's liability policy.[50] The court held that even if the employee had express permission to take the company truck home, and had implied permission to drive it to a friend's house, his personal trip to a town forty miles away was a material diversion that took his accident out of the scope of coverage under the commercial auto liability policy language, which provided coverage for anyone using the auto with the employer's permission.

A commercial automobile liability insurer was not liable for an accident caused by an employee of its insured who was not acting within the course and scope of her employment at the time of the wreck. She was not a "permissive user" within the scope of coverage. The evidence showed that, in violation of company policy, the employee was driving the car while intoxicated, with her boyfriend as a passenger, on the way to visit a friend.[51]

A truck transporting paper intra-state was not engaged in interstate commerce at the time

of the accident, and thus the MCS-90 endorsement (and its requirement of liability coverage) did not apply.[52]

**B. Comprehensive General Liability Insurance**

The Texas Supreme Court held that a CGL insurer would be liable to indemnify a doctors association if the jury found ordinary negligence in failing to secure drugs that were stolen and contaminated by an employee, resulting in harm to several patients. On the other hand, if the jury found the harm to the patients resulted from professional negligence, or a combination of professional and ordinary negligence, then the loss would be excluded by the policy exclusion for "bodily injury . . . due to rendering or failing to render any professional service."[53]

In *Westchester Fire Ins. Co. v. Admiral Ins. Co.*,[54] the court of appeals, en banc, held it was not against public policy for an insurer to cover punitive damages, at least not in 1993. The insured was found grossly negligent with respect to its care of a nursing home patient. Before the amount of exemplary damages was decided, the insured settled the underlying suit for an amount exceeding the compensatory damages, and exceeding the primary policy limits. The excess insurer then sued the primary insurer for negligently failing to settle within the primary limits.

The issues on appeal were whether punitive damages were covered by the primary policy, and if such coverage was void as against public policy. The court found punitive damages were covered and concluded that, at least in 1993, it was not against public policy to insure punitive damages. The court recognized a number of lower court decisions have held it is not against public policy to insure punitive damages.

The court noted the public policy of not allowing insurance for punitive damages so that the wrongdoer is punished versus the competing public policy of requiring an insurer to honor its contractual obligation. The court also noted that the legislature has specifically allowed nursing homes to obtain insurance for punitive damages.

Prior to the supreme court's decision in *Transportation Ins. Co. v. Moriel*,[55] "punitive" damages served both to punish and to set an example to others. After Moriel, and the 1995 amendments to chapter 41, the "exemplary" factor was deleted, leaving only punishment. The court did not have to decide whether this constituted a change in public policy that would prohibit insuring punitive damages, because at the time this claim arose, punitive damages served in part to set an example, and that purpose was fulfilled whether the insured or insurer paid them.

A policy did not provide coverage where the jury found the insured acted with "malice." The court concluded that this finding meant there was no "occurrence," because the injuries were not unexpected, and it also placed the conduct within the exclusion for bodily injury "expected or intended from the standpoint of the insured."[56] Furthermore, the insured was a not for profit nursing home, and a provision of the insurance code, article 5.15-1, in effect at the time, precluded professional liability insurance for punitive damages absent a specific endorsement, which was lacking in this case.

The court in also held that two policies could not be "stacked" to provide coverage for related Med. incidents or related occurrences. The claims against the nursing home did not allege discrete, divisible injuries as a result of discrete and divisible acts. Instead, the plaintiff's claimed knee injuries were caused by a pattern of ongoing neglect.

In *Valmount Energy Steel, Inc. v. Commercial Union Ins. Co.*,[57] a policy did not provide coverage for an insured's steel flanges that did not meet the specifications of a customer. Coverage was excluded by the exclusion for "your product," which included "any goods or products manufactured, sold, handled, distributed, or disposed of by" the insured. The court found that a separate limit for "products-completed operations hazard" did not make the policy ambiguous so as to provide coverage. The latter clause simply limited the amount of coverage, and did not extend coverage.

A policy did not cover fire damage to trailers that were in the care, custody, or control of the insured, because of a specific exclusion. Further, the court would not construe "damages" to include the cost of fighting the fire, or cleaning up afterwards to avoid environmental damage. The court found these expenses did not fit within "damages," and the pollution exclusion in the policy expressly excluded such clean up costs.[58]

A sole proprietor's insurer sought a declaratory judgment that the motor vehicle exclusion applied to the liability of the proprietor's son for an automobile accident by using the proprietor's car. The court held that the sole proprietorship and its proprietor were the same so the exclusion for vehicles owned by the named insured applied.[59]

**C. Directors & Officers Liability Insurance**

An insurance binder did not provide coverage for acts that were related to prior acts, because the policy that was issued contained a related acts exclusion, which was customary.[60] Two companies merged and sought coverage for post-merger claims. They understood that the policy would exclude prior acts, which is also what the binder stated. Later, the company was sued for acts that did not necessarily occur before the merger date, but related to prior acts. The court held that an insurance binder provides coverage according to the terms and provisions of the ordinary form of the contemplated policy. The evidence established as a matter of law that the normal policy of the insurer always included an exclusion for liability related to prior acts.

The personal property exclusion in the securities claims endorsement of a policy excluded coverage for a director's statutory fraud violation. The director as majority shareholder of a startup company obtained personal gain by the possibility of owning a successful business when the company was infused with capital as a result of his fraud. In addition, a majority of the court held the exclusion was broad enough to preclude claims against other directors, even though they had not profited. Finally, the majority held that the policy exclusion also precluded coverage for a claim against the company itself, even though it was not an insured within the exclusion, because the "limits of liability" provision treated all interrelated claims as a single claim.[61] A concurring justice agreed with the first holding, but not the latter two. He felt the exclusion should be narrowly construed and thus would only preclude coverage for the insured who actually profited.

**D. Professional Liability Insurance**

An insurance broker was sued for negligence and deceptive trade practices related to its procurement of coverage for a client from an insurer that later became insolvent. The broker's liability insurer denied it had any duty to defend or indemnify, based on an "insolvency exclusion," which provided that the policy did not apply to any claim "arising out of, directly or indirectly resulting from, based upon, or in any way involving . . . placement of a risk . . . with any insurance company . . . that is not rated B+ or higher . . . and becomes insolvent or bankrupt." It was undisputed that the broker had placed coverage with an insurer that was not rated B+ or higher and that became insolvent. Therefore, the exclusion applied. The court also found the exclusion was worded so broadly as

to preclude all claims, not just those directly related to the insolvency.[62]

Notice of a potential claim against a doctor that did not mention a claim against his clinic only triggered liability under the doctor's policy. A subsequent letter mentioning the clinic triggered coverage under a subsequent insurer's policy. The court rejected the argument that notice to the doctor was effectively notice to the clinic as well.[63]

A "claims-made medical practitioner policy" had a single limit of $1 million for claims against two doctors and two entities. The plaintiffs alleged that the doctors misdiagnosed the decedent by misinterpreting an x-ray taken in the emergency room. The court found these allegations were part of "the same or related medical incident," within the policy language limiting related claims to a single limit. All of the conduct constituted a single "loss event" under policy language applying a single limit.[64]

A marketing licensee for a viatical settlement broker sued its professional liability insurer requesting coverage for its investors' claims against the licensee. The court held the marketing licensee's acts of representing and assisting the broker in the sale of viatical settlement to individual investors would not be the "business of insurance," and thus the liability policy did not cover the alleged liability to investors.[65]

A bank that sold certificates of deposit to a con man who bought them with funds he obtained by defrauding investors was entitled to coverage when it ultimately paid the investors.

**E. Other Policies**

An insured contractor brought an action against its liability insurer to recover on an errors and omissions policy after settling his customer's claims. The court concluded that the policy excluded claims against the insured for overcharging, loss of good will, knowing DTPA violations, and punitive damages awarded with a showing of malice. The court found no exclusions for claims arising from a breach of express or implied warranties. The court further found that the burden of identifying the portions of the settlement attributable to various claims fell upon the insureds, and they presented some evidence on this question, creating a fact issue that precluded summary judgment.[66]

**F. Excess Insurance**

An insured's failure to defend itself relieved an excess insurer of any liability. The insured company filed bankruptcy and informed the excess insurer that it was not going to defend itself and allowed a default judgment to be entered. The excess policy gave the insurer the right, but not the duty, to defend the insured. The court held that the insured had a duty to take reasonable steps to mitigate damages arising from the tort suit against it and breached that duty by failing to defend itself, which relieved the excess insurer of any obligation to pay.[67]

**G. Fidelity Bond**

A bank that sold certificates of deposit to a con man who bought them with funds he obtained by defrauding investors was entitled to coverage when it ultimately paid the investors. The fidelity bond provided coverage for a loss resulting directly from selling or extending credit based on stolen CDs. The court held that the term "stolen" was ambiguous and was broad enough to include certificates purchased with stolen funds. Also, the bank's loss arose from the stolen certificates, even though the loss occurred when the bank paid to settle the claims of the investors.[68]

## VI. DUTIES OF LIABILITY INSURERS

**A. Duty to Defend**

In *Northfield Ins. Co. v. Loving Home Care, Inc.*,[69] the Fifth Circuit considered whether under Texas Law it is ever proper to consider extrinsic evidence in deciding the duty to defend. The court made its "Erie-guess," that the Texas Supreme Court would not recognize any exception to the strict eight corners rule that allows a court only to compare the allegations in the complaint and the language of insurance policy. In the underlying suit, the plaintiff sued the defendant/insured under theories based on negligence for injuries to their infant caused by a nanny provided by the defendant. The insurer wanted to show extrinsic evidence that the nanny was convicted of a crime in causing the child's injury and death, so that the conduct was excluded. The court refused to consider such extrinsic evidence. Alternatively, the court held that even if the Texas Supreme Court were to allow an exception to the general rule barring consideration of extrinsic evidence, any exception would apply only in very limited circumstances: "when it is initially impossible to discern whether coverage is potentially implicated and when the extrinsic evidence goes solely to a fundamental issue of coverage which does not overlap with the merits of or engage the truth or falsity of any facts alleged in the underlying case."

Applying this rule, the court found there was a duty to defend. Under the eight corners rule, the complaint alleged accident coverage and did not allege acts that clearly fit within the exclusions. Any exception would not apply, because the petition alleged facts where it was not impossible to discern whether coverage was potentially implicated. Finally, the extrinsic evidence did not go to a fundamental issue of coverage, and the issue it did relate to overlapped with the merits of the case and would also engage the truth and falsity of the facts alleged. As examples of "fundamental issues of coverage," the court listed: "(1) whether the person sued has been specifically excluded by name or description from any coverage, (2) whether the property in suit is included in or has been expressly excluded from any coverage, and (3) whether the policy exists." The exclusions relied on by the insurer did not fit these categories.

The Texas Supreme Court held that an insurer did not breach its duty to defend by conditioning its offer of a defense on the insured agreeing to waive his motion to transfer venue filed by attorneys who were already representing him.[70] Davalos was involved in a wreck in Dallas County. He sued the other driver in Matagorda County, and the other driver sued him in Dallas County. The lawyers representing Davalos as plaintiff in the Matagorda County suit filed an answer for him in the Dallas suit and a motion to transfer venue to Matagorda County. The insurer for Davalos informed him that it did not wish to hire the attorneys he had selected and that it opposed his motion to transfer venue and would not provide coverage unless he agreed to substitute counsel and to drop his motion.

The supreme court held the insurer did not breach its duty to defend, because the conditions the insurer tried to impose did not create a sufficient conflict of interest. The court recognized that under certain circumstances there will be a conflict of interest that prevents the insurer from conducting the defense; however, the court found this was not such a case. The court reasoned that Davalos could have accepted the defense and then submitted the issue of venue to the defense counsel for an independent examination. The court suggested that the defense lawyer then could have rejected the insurer's

request to transfer venue if the insured's interests would be compromised by the insurer's instructions.

The court's reasoning seems a bit strained. Davalos already had defense lawyers who owed their unqualified loyalty and they had determined that the motion to transfer venue was in his best interest. It is artificial for the court to suggest that it made a difference whether this decision was made by those lawyers, or whether Davalos had to agree to transfer venue, only to ask the new defense lawyers to countermand that decision. Nevertheless, there is much in the court's opinion that may offer protection to other insureds in future cases. The court recognized a number of circumstances where a conflict of interests may prevent the insurer from controlling the defense. The court cited authority for the proposition that defending under a reservation of rights letter will create a conflict of interest, and when the facts to be adjudicated in the liability lawsuit are the same facts upon which coverage depends, that conflict will prevent the insurer from conducting the defense.

The court also listed four other circumstances when the insured may rightfully refuse the insurer's defense: (1) when the tendered defense is not a complete defense under circumstances in which it should have been; (2) when the attorney hired by the carrier acts unethically, and at the insurer's direction advances the insurer's interests at the expense of the insured's; (3) when the defense would not, under the governing law, satisfy the insurer's duty to defend; and (4) when, although the defense is otherwise proper, the insurer attempts to obtain some type of concession from the insured before it will defend.

Citing other authorities, the *Davalos* court noted that a party paying for another's legal services – such as an insurer – must allow for reasonable representation, and any directives must be reasonable in scope and character. The defense lawyer owes unqualified loyalty to the insured and "must at all times protect the interests of the insured if those interests would be compromised by the insurer's instructions."

The supreme court also held that a liability insurer had a duty to defend a doctors' professional association that was sued by patients who were infected by drugs that had been contaminated by a thieving employee. The suit against that association alleged professional negligence by the doctors in administering the drugs and ordinary negligence in failing to keep the drugs secure. The court concluded that the exclusion for "bodily injury . . . due to rendering or failure to render any professional services" did not apply to the claims of ordinary negligence, so those claims would be covered. The court found the words "due to" required more of a connection than "but for" causation and thus required breach of a professional standard.[71]

A pollution endorsement and a saline endorsement potentially provided coverage for an insured oil and gas operator, so the insurer breached its duty to defend.[72] The court held that the underlying petition did not contain sufficient facts to let the court determine if coverage existed, so it was proper to look at extrinsic evidence. Having done so, the court found liability could arise from pollution incidents that were "sudden and accidental." The court also found the policy would provide coverage for a separate incident, even if that incident contributed to an indivisible injury along with incidents outside the coverage.

An insurer had a duty to defend its insured, a professional employer organization that provided personnel management and human resources services, against a counterclaim for misrepresentations related to the provision of health insurance to the insured's employees. A claim was potentially covered by policy language insuring against wrongful acts of the insured, including misrepresentations occurring solely in the conduct of the insured's profession, which included benefit management.[73]

A suit including allegations tending to show that the insured disparaged another company's technical quality, reputation, and viability, stated a claim within the "personal injury" coverage and it required the insurer to defend, even though other claims were also alleged. Moreover, the insured could be held liable without proof that it had knowledge of the falsity, so that exclusion would not apply to preclude coverage.[74]

In other decisions, the Fifth Circuit held an insured's breach of his agreement to get permits to erect a billboard did not constitute "property damage," so the insured had no duty to defend,[75] and allegations that an insured knowingly engaged in price fixing sufficiently alleged an awareness that the insured was engaged in conduct reasonably expected to expose it to legal liability, so that the "fortuity doctrine" precluded any obligation of the insurer to defend.[76] It also found that an insurer does not have a duty to defend until a petition alleging a potentially covered claim is tendered to it; therefore, an insurer could not be required to pay any part of the defense cost incurred before the insured tendered the complaint.[77]

An insurer had to defend a religious organization in suits alleging that the plaintiffs, while children, suffered from sexual, physical, and emotional abuse in the care of schools run by the organization. While some of the allegations could refer to intentional conduct, others only alleged negligence by the organization and were potentially within the scope of coverage. The court found the "vague, broadly-worded" pleadings containing a "mishmash of legal theories and factual allegations" stated causes of actions that were potentially covered by the policy.[78]

There was no duty to defend against libel and slander claims because they were either malicious or employment-related.[79] However, the insurer did have to defend the claim of wrongful termination, which was potentially covered under the employee benefit liability endorsement, which was not limited to negligent acts.

Physicians who used breast implants were additional insureds under a product manufacturer's vendor endorsement and were entitled to a defense.[80]

An insurer had no duty to defend or indemnify a claim for trademark infringement arising from the insured's operation of an assisted living care center, where the policy designated four acres of vacant land as the insured premises.[81]

A CGL insurer owed a defense to a homebuilder who was sued for property damage, physical pain, and mental suffering, arising from, in part, the builder's negligence in constructing a house.[82] The court noted a split of authorities, but concluded that allegations of negligence in building a home constituted an "occurrence" sufficient to trigger the duty to defend and were not intentional acts.

The court also refused to re-characterize these claims as essentially claims for breach of contract, because that would imply into the complaint and policy words that did not appear. The plaintiffs alleged loss of use of the home, which was property damage potentially within the scope of coverage. They also alleged mental anguish, including "great physical and mental pain," which the court found stated a claim for "bodily injury," even though a claim merely for mental anguish would not. These claims for negligence and for bodily injury also did not clearly fall within exclusions related to property damage, or for intentional conduct or liability under a contract.

A CGL insurer had a duty to defend a general contractor sued for the negligence of its subcontractors resulting in defects in, and loss of use of, a municipal complex they were hired to build. The exclusion for "your work" did not apply to subcontractors, and the negligence claims alleged an occurrence.[83] The court declined to re-characterize the negligence claims as contractual claims that were not covered. In contrast, this argument was accepted by the court in *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*.[84] The *Lamar* court held it was necessary to look to the gravamen of the complaint and that broad allegations of negligence would not change the nature of claims for defective construction, which were really contract-based.

An insurer did not have to defend a law firm sued for its alleged fee splitting and kickback arrangements with real-estate lenders because these were not "professional services" within the policy's coverage.[85] The court cited a number of cases for the proposition that billing is an administrative task, not a professional service. It appears the court read the policy too narrowly. The policy provided coverage for claims "arising out of your acts, errors or omissions in providing professional services." Whether the billing itself was a professional service, it did arise out of such services, or at least the policy reasonably could be construed that way.

An insured was given an "opportunity to confer" as required by the policy where it was allowed to discuss the choice of defense counsel, even though the insurer had already made that choice. However, because the insurer offered its defense under a reservation of rights, and the coverage defense involved the same facts as the underlying suit, the insured was entitled to reject the defense and be defended by its own counsel.[86]

An injured property owner brought suit against a business that contracted to build an above-ground swimming pool, when the owner leaned against part of the deck railing and it collapsed. The business had contracted with a builder for construction of the pool, and it tendered the lawsuit to the insurer of the builder. The builder had named the business as an additional insured. In reversing summary judgment for the insurer, the court held the language of the property owner's petition alleging that the business contracted to build an above-ground swimming pool, combined with the policy naming the business as an additional insured, presented the potential for a covered claim. While the petition did not state that any party other than the business performed the pool construction, the petition alleged that the property owner contracted with the business to construct the pool and deck, and that injuries were suffered when the owner leaned against part of the deck railing and it collapsed.[87]

A professional basketball team sued its insurer for wrongfully refusing to defend it in a Telephone Consumer Protection Act action. The court concluded that in the underlying actions the plaintiff's alleged that the team distributed written advertising material to them without their approval, in violation of the Act. The distribution of the advertising to the telephone facsimile machines was a "publication" of the offending material. The court also upheld the trial court's conclusion that the petitions in the underlying litigation set forth claims that, if proved, were covered by the policy.[88]

An insurer had a duty to defend insured church in the underlying sexual misconduct lawsuit. The court held that extrinsic evidence that the employee of the insured church stopped working for the insured before the policy went into effect could not be considered. The court observed that even when extrinsic evidence is allowed, the court may consider only evidence pertaining to coverage and not facts pertaining to liability. The court held that the insurer was seeking to use the stipulation as to the dates of employment to show that the allegations were false, which it could not do. While the allegations concerning the dates of employment might not be true, the pleading clearly alleged a cause of action during the policy period.[89] The insurer further alleged it had no duty to defend because the underlying pleading did not allege "bodily injury." The sexual misconduct clause provided coverage for "bodily injury" but did not define that term. The plaintiff alleged that she was "sexually assaulted" and as a result suffered "emotional distress" and "bodily injury." The court distinguished the supreme court decision in *Trinity Universal Ins. Co. v. Cowan*,[90] which held that the policy's definition of "bodily injury" did not include purely emotional injuries. In this case, the policy did not define bodily injury. Moreover, the offense of sexual assault may consist of penetration of the body, and the plaintiff alleged that she suffered bodily injury and physical pain as a result. Giving the term "bodily injury" its plain meaning, the court concluded that the plaintiff alleged a claim within the policy's coverage.[91]

An errors and omissions insurer brought an action against the insured automobile dealerships for declaratory judgment that it had owed no duty to defend them in suits brought by former customers alleging that the dealerships charged a customer service fee in return for a worthless coupon book. The court affirmed summary judgment for the insurer, noting that the petitions in the underlying action did not allege violations of the Texas Deceptive Trade Practices Act and fraud. The petitions did not include any allegation that the dealerships extended credit in connection with any of the automobile purchases, nor allege any violations of state or federal truth and lending laws. In holding that the insurer owed no duty to defend under a policy covering liability for violation of the truth and leasing laws, the court observed that the complaints did not allege that the dealerships were creditors, that the automobile purchases were made on credit, or that the cash value of the automobiles was to be paid in deferred installments. The court further refused to consider extrinsic evidence that the automobile sales were made on credit, noting that the Texas Supreme Court has never recognized an exception to the "eight corners rule" to permit the introduction of extrinsic evidence. While noting that some intermediate appellate courts have allowed extrinsic evidence in limited circumstances, none of those circumstances were applicable in this case.[92]

An insurer was not obligated to defend or indemnify its insured property owners who were sued by tenants who alleged they suffered injuries due to their exposure to chemical fumes that were present in the building because of remodeling. The court found these claims fit within the pollution exclusion, which excluded coverage for bodily injury arising out of the actual, alleged, or threatened discharge, dispersal, seepage, migration, release, or escape of pollutants at or from the insured's premises. The court recognized a split of authorities, but noted that a prior Fifth Circuit case had denied coverage based on similar facts.[93]

**B. Duty to Settle**

In *Westchester Fire Ins. Co. v. Admiral Ins. Co.*,[94] the court held that disputed evidence raised a fact issue on whether the liability insurer received a policy limits demand sufficient to trigger its Stowers duty to settle. The policy had a $1 million limit, but was reduced by defense costs and expenses, so that over time the amount remaining was less than the $1 million.

Because there was conflicting testimony on whether the plaintiffs made a demand to settle for whatever policy limits remained, or only made a demand to settle for the full $1 million, the insurer failed to establish conclusively that it never received a policy limits demand.

The Westchester court also held that the insurer failed to conclusively establish that it could not settle because it lacked the insured's consent and that it was not negligent because a prudent insurer would not have tendered his policy limits. There was disputed evidence on both of these points.

**C. Duty to Indemnify**

A professional liability insurer and a CGL insurer were both required to defend and indemnify a nursing home, and both policies were primary, despite "other insurance" clauses in each policy. One policy had an escape clause, and the other had a pro rata clause. The court held these provisions were in conflict and thus the insurers would be required to share the loss.[95]

Texas liability insurers brought an action against church diocese for declaratory judgment that its policies provided no coverage for sexual molestation by a priest. The insurers alleged that the policies did not provide coverage for intentional, knowing, or grossly negligent torts. The insurers also argued that claims in the underlying molestation suit were "inextricably intertwined" with the intentional tort claims, and thus none of the claims constituted an "occurrence" under the policies. The insurers contended that the policies did not provide coverage for any acts of sexual molestation occurring before the policies went into effect. The trial court granted summary judgment for the insurers, and the diocese appealed.[96]

The court of appeals first concluded that the determination of an occurrence under a liability policy is made from the viewpoint of the insured, unless the policy terms provide otherwise. Thus, the court was to view the existence of an occurrence from the diocese's viewpoint. In the underlying suit, the diocese's alleged knowledge of the pedophilia and prior molestation was not the only basis for the suit. The plaintiffs in the underlying case also alleged the diocese was negligent in hiring and retaining the priest, and failed to provide reasonable supervision of the priest. Neither of these claims required that the diocese know about the priest's sexual propensities. If the plaintiffs in the underlying case failed to prove that the diocese was aware of the priest's pedophilia, the trier of fact could still find the diocese was negligent. From the diocese's viewpoint, if it did not know of the priest's sexual propensities, the conduct was both unexpected and unintentional. The insureds argued that the doctrine of fortuity precludes coverage for intentional actions designed to cause injury. To prevail on this theory, the insurers had to establish that the diocese knew or should have known of the priest's sexual propensities when it purchased their policies. The court concluded the insurer's proof did not meet this standard.

Finally, the insurers argued there was no coverage because some of the abuse predated the policies. The court noted that it was undisputed that some of the abuse occurred after the policies went into effect. Thus, to be entitled to summary judgment on this ground, the insurers had to establish as a matter of law that the sexual abuse that occurred during the policy periods, either did not injure the plaintiffs or for other reasons was not covered. The insurers failed to meet this burden.

**The court of appeals first concluded that in the determination of an occurrence under a liability policy is made from the viewpoint of the insured, unless the policy terms provide otherwise.**

**D. Settlements, Assignments & Covenants Not to Execute**

A non-insurance decision by the Texas Supreme Court may foreshadow how the court will decide whether, and to what extent, an insured may assign to a third-party claimant the insured's claims against an insurer. In *PPG Indus., Inc. v. JMB/Houston Centers Partners Ltd.*,[97] a buyer of a commercial building sued the manufacturer of defective windows under the DTPA for breach of warranty. The buyer asserted its right to sue based on a general assignment by the original owner of all warranties. The court held that the DTPA claim was not assignable.

The court first noted that the statute does not say claims are assignable, in contrast to the UCC, which says they are. Second, the court found that assigning DTPA claims would not be consistent with the purpose of the statute. The court reasoned that the statute was intended to let consumers bring their own claims, and an assignment would not further that goal. Also, the court expressed its concern that consumers might be misled by more sophisticated assignees, resulting in the consumer getting nothing of value for the claim, and being duped a second time. Third, the court looked to common-law analogies. While most claims are assignable, all are not. The court found that DTPA claims were punitive – as they allowed for mandatory treble damages under the older version of the statute – and were personal – allowing for mental anguish damages. Personal and punitive claims, the court reasoned, are not assignable. In contrast, property-based claims, such as breach of a warranty outside the DTPA, are assignable, the court concluded.

Relying on its decision in *State Farm Fire & Cas. Co. v. Gandy*,[98] the court held that a more important reason not to allow assignment of the DTPA claim was because an assignment might "increase or distort litigation." The court stated that it had "prohibited assignments that may skew the trial process, confuse or mislead the jury, promote collusion among nominal adversaries, or misdirect damages from more culpable to less culpable defendants." The court reasoned that juries would be confused by assessing the mental anguish suffered by the consumer and the punitive damages based on the situation and sensibilities of the parties, only to have that money go to an assignee. The court also feared that an assignment would give the seller and purchaser "a strong incentive to direct the suit elsewhere for relief" and would cause the litigation to continue with the parties in different roles – "precisely the results that have led us to prohibit assignments in other contexts." Assignability, the court opined, "may encourage some buyers to cooperate – if not collude – with a seller who may have been the one that actually misled them." Therefore, because of concerns about naïve consumers being misled into assigning their claims, and then cunningly colluding with their assignees to confusingly obtain mental anguish and punitive damages against less culpable product sellers, the court held DTPA claims aren't assignable – in a case where the sophisticated consumer was not duped into making the assignment, did not and could not seek mental anguish damages, and recovered treble damages under a version of the statute repealed twenty

years ago, all with no evidence of any collusion.

The four dissenting justices would have held the DTPA claim was assignable, for the most part, because the assignment did not present the concerns that led to voiding assignments in other cases. The dissenters distilled these concerns as: first, prolonging the suit rather than resolving the litigation; and, second, distorting the litigation by causing the parties to take positions that appeared contrary to their natural interests.

While *PPG* is not an insurance case, the analysis of both the majority and the dissenters appears certain to fuel arguments in future insurance cases about whether, and to what extent, an insured defendant can assign to a plaintiff his claims under Texas Insurance Code article 21.21 (a companion to the DTPA) and other claims against his insurer. *Gandy* voided the assignment based on the circumstances in that case. The present case broadly prohibits assignment of DTPA claims. Nevertheless, claims generally are assignable, so unless the court is in full retreat from this position, there must be circumstances where assignments – that carefully navigate the court's evolving policy concerns – are valid.

In a case involving two plaintiffs injured in a collision with a trucking company's vehicle, when the defendant's insurer refused to defend, the plaintiffs and defendants settled. The plaintiffs received certain amounts of money, an agreed judgment, and an assignment of the defendant's rights against the insurer. In return, the defendant received a release and covenant not to execute. The plaintiffs later got a turnover order that gave them the defendant's rights against the insurer. They later sued the insurer and obtained a jury verdict. However, the court held the plaintiffs could not recover from the insurer because there was no "fully adversarial trial."[99]

The court relied on the Supreme Court's decision in *State Farm Fire & Cas. Co. v. Gandy*, and held that the settlement had distorted the positions of the parties to the point where the resulting verdict was not the result of a "fully adversarial trial." For example, no live witnesses were called on behalf of the defendant trucking company, and the court found the attempt to reconstruct a defense of the trucking company was ineffective. The court also held that the turnover order did not change the result. The turnover order was simply a vehicle by which the plaintiffs acquired the defendant's rights against the insurer. It did not make the verdict a fully adversarial trial.

Finally, the court held that the prior releases precluded recovery. The way the settlement agreement and assignment were written, they clearly released the defendant from further liability and were not conditioned on the plaintiffs being able to recover from the insurer under the assignment. The court reasoned that under the insurance policy, the insurer was only obligated to pay sums the defendant had to pay, but the release meant the defendant could not incur any further liability.

An insured sued its life insurer seeking to enforce a settlement agreement. The court concluded no settlement was reached, saying that the letter by the insured's counsel that it would accept the insurer's offer if the insurer would reimburse court costs was a counter-offer that had the effect of rejecting the insurer's offer.[100]

## VII. THIRD PARTY THEORIES OF LIABILITY

### A. *Stowers* Duty & Negligent Failure to Settle

An insurer effectively cut off its *Stowers* liability after an excess verdict by paying the remaining policy benefits to the claimant and paying its insured $75,000 to release any claims with respect to the handling of the claim. The claimant thus could not assert any Stowers claim that had been available to the insured. That claim belonged to the insured and was never assigned to the claimant and would not be subject to a turnover order, because the insured never attempted to assert the claim and had released it. The court reasoned that the only claim the claimant might bring directly was for the balance remaining under the policy limits, as a third party beneficiary. But that amount had been paid.[101]

### B. Unfair Insurance Practices

An insurer that breached its duty to defend could be sued for unfair insurance practices under Article 21.21. The federal court extended the reasoning of the Texas Supreme Court in *Rocor Int'l, Inc. v. Nation Union Fire Ins. Co.*,[102] and held that a failure to settle was actionable under the statute.[103]

Former tenants and apartment complex employees brought an action against the landlord and its liability insurers to recover for breach of an agreement to settle a lawsuit and fraudulent inducement by misrepresenting the amount of available insurance. In upholding summary judgment for the insurers, the court first noted that the plaintiffs did not purchase an insurance policy from the insurer, but were third party claimants who asserted claims against the underlying insurance policies. The court held there was no direct cause of action against the insurer under section 4(11) of article 21.21, which deals with the misrepresentation of an insurance policy. The court reasoned that to create such a direct cause of action would expose an insured to potentially conflicting duties.[104]

The plaintiffs further argued that after the settlement was reached in the underlying lawsuit, they became third party beneficiaries of the insurance policies and acquired standing to bring suit for violations of the contractual and extra-contractual obligations owed by the insurers. The court rejected this argument, concluding that, even if the plaintiffs obtained the status of third party beneficiaries, the insurers owed the plaintiffs no extra-contractual duty of good faith and fair dealing after the settlement agreement was reached. Any claims that the plaintiffs may have had regarding the conduct of the insurers following the settlement, the court reasoned, would sound only in contract.

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

In *North County Mutual Ins. Co. v. Davalos*,[105] the court held that the insurer did not breach its duty to defend, so the court did not rule on whether a failure to defend would give rise to a claim for penalties under article 21.55. The insurer argued that article 21.55 only applies to first party claims and that a request for a defense is a third party claim. The insured cited the Texas Supreme Court's decision in *State Farm & Cas. Co. v. Gandy*, and other authorities for the proposition that an insured's claim for defense costs under a liability policy is really no different than any other first party claim and thus fits within the statute.[106] The court concluded that the insurer did not violate article 21.55, whether or not the statute applied. While the court's discussion was dicta, the fact that it recognized the competing authorities offers some support for the idea that article 21.55 does apply to an insured's claim for defense costs under a liability policy.

More federal courts joined the list of courts holding that the duty to defend is considered a first party claim under article 21.55, so that an insurer can be sued under the statute for breaching its duty to defend.[107] In contrast, in *TIG Ins. Co. v. Dallas Basketball, Ltd.*,[108] the court concluded that article 21.55 only applies to a first party claim for money to be paid directly to the insured. Claims by an insured for reimbursement of defense costs is not a claim under the policy, but rather a common-law claim for breach of contract. The court concluded

that the wrongful failure to defend the insured *did* not subject the insurer to the statutory 18% per annum penalty.

**D. Fraud**

Plaintiffs contended that they were fraudulently induced into a settlement agreement by the opposing insurance company. Among other things, the plaintiffs contended that the insurance company misrepresented the amount of coverage available in the underlying suit. The court rejected the plaintiff's claim, holding that the underlying settlement agreement contained a disclaimer of any reliance on representations made by the insurance company. The court concluded that one of the matters in dispute in the underlying litigation was the amount of coverage available. The court cited a demand letter from claimants' counsel in the underlying suit, which claimed the settlement should be entered to avoid the expense of trial and "having to fight about the coverage." The court reasoned that the parties in the underlying litigation entered into the settlement agreement to resolve, in part, their disagreement about available coverage.[109]

**E. Other Theories**

An insurer that issued a binder excluding liability for prior acts was not equitably estopped to deny coverage under the actual policy for claims based on acts related to prior acts, even though the binder did not expressly exclude those related acts.[110] There was no evidence that the insurer misrepresented or concealed coverage terms, which was a necessary element of equitable estoppel. Also, the insured failed to show that it lacked knowledge or the means of obtaining knowledge of the scope of coverage, which was another element.

**F. Breach of the Duty of Good Faith and Fair Dealing**

The Fifth Circuit held that an insured under a liability policy could sue for breach of the duty of good faith and fair dealing in a suit based on the insurer's handling of the insurer's own claim for reimbursement of amounts the insured paid to settle claims. The court treated this as a "first party" claim to which the duty applied, even though an insured cannot sue for the insurer's breach of this duty based on how the insurer handled a third party liability claim.[111] However, the court found there was evidence of a bona fide coverage dispute, which the insurer won, so the insurer was not liable for breaching its duty of good faith and fair dealing.

A federal district court held insurer could not be sued for breach of its duty of good faith and fair dealing for breaching its duty to defend. The court relied on the Texas Supreme Court's decision in Maryland Ins. Co. v. Head Ind. Coatings & Servs., Inc.,[112] and held there is no common law duty of good faith and fair dealing to an insured in the third party liability context.[113]

## VIII. SUITS BY INSURERS

**A. Interpleader**

A life insurer that promptly admitted liability and interpleaded the insurance proceeds avoided liability for penalties under article 21.55. Further, the trial court did not abuse its discretion by refusing to award the claimant prejudgment interest. The claimant did not win on any claim that required prejudgment interest, and the trial court was not required to award interest on equitable grounds. Finally, the trial court also did not abuse its discretion by denying appellate fees to the insurer, even though the trial court awarded the insurer fees for filing the interpleader.[114]

An insurer interpleaded the proceeds of a life insurance policy subject to conflicting claims. The trial court awarded attorneys fees to the insurer to be paid from the interpleaded funds. The court further assessed the amount of the insurer's attorney's fees to be recovered by successful claimants from the unsuccessful claimant as costs. The unsuccessful claimant appealed. The court held the trial court did not abuse its discretion by permitting the insured to recoup its attorney's fees out of the interpleaded funds, and in assessing those fees as costs against the unsuccessful claimant.[115]

**B. Indemnity & Contribution**

A liability insurer for an oil and gas lease operator brought an action against the operator's contractor for a declaratory judgment that the insurer was not required to reimburse the contractor after it indemnified the operator for its liability for the death of a contractor's employee. The court concluded that the contractor that indemnified the oil and gas lease operator after the contractor's liability insurer became insolvent had no cause of action against the operator based on its failure to request its insurer's compliance with the Property & Casualty Insurance Guarantee Act. The court noted that even if the legislature intended to make the operator's liability insurer responsible for the payment by the contractor, the contractor was contractually obligated to indemnify the operator. The court found no language in the IGA that relieved the contractor of its obligation.[116]

A homeowner's insurer sued an insurance agency under the theory of common law indemnity for damages the insurer paid one of its insureds. The insurer contended that the agency was liable due to the agency's misrepresentation to the insured regarding coverage. The court found the jury questions were defective because they only asked about undefined "misconduct," and did not establish that the agent committed a tort for which the insurer was held vicariously liable.[117]

**C. Other Theories**

A commercial automobile liability insurer was not liable to another underinsured motorists insurer for negligently misrepresenting that the insurer had plenty of coverage, so that the UM insurer would not have to pay. The court found the representations were not representations of existing fact, but instead were promises of future conduct.[118] It seems the court erred on this point. Within the context of adjusting the claim, the first insurer's statements would reasonably be understood to mean that they had coverage and did not have a coverage defense. That counts as an existing fact.

A factoring company that sought to purchase a structured settlement from the beneficiary at a discounted rate could sue the annuity owner for filing a notice with the court making a competing offer at a better rate. The factoring company stated a cause of action for tortious interference with its contract and potentially a claim for unfair competition. The court rejected the argument that the annuity owner had a legal justification to make such an offer, by virtue of a statute requiring court approval and a determination that the transfer was in the beneficiary's best interest, which allowed any interested party to support, oppose, or otherwise respond to the proposed transfer. The court reasoned that the defendant could explain why the proposed transfer was not in the beneficiary's best interest, without making a competing offer.[119]

The court's reasoning is hard to follow. It seems that one reason a transfer is not in the beneficiary's best interest is because there is a better offer available; therefore, it seems a party would be within its rights to make that fact known to the court. Further, if the beneficiary chooses the better offer because it got such information, this seems like fair competition not a tort.

## IX. DAMAGES & OTHER ELEMENTS OF RE COVERY

### A. Mental Anguish Damages

Because mental anguish damages are not recoverable for breach of contract, a trial court erred by submitting a mental anguish damage question that was conditioned on a "yes" answer to several theories of recovery, including breach of contract. The court held this was reversible error, because there was no way to determine whether the jury's award of mental anguish damages was based on its finding that the insurer breached its contract. Therefore, the court reversed the award of mental anguish damages and also reversed and remanded for a new trial on the tort and statutory theories for unfair insurance practices.[120]

The beneficiary of an accidental death policy sued the insurer to recover for bad faith delay in payment. The jury found for the insured, which included an award of $60,000 in damages for mental anguish. The court upheld the jury's award, noting that the beneficiary testified that during the time the insurer was delaying payment of the death claim, she could not sleep due to the stress from the uncertainty of her financial situation. Worried about the effect of the delayed payment on her mortgage, she felt that her "whole world" had caved in. The beneficiary was also diabetic, and she testified that during this waiting period, she experienced an increase in the blood sugar level, which her doctor attributed to her stress levels.[121] The court found that her testimony as to her blood sugar level, which was based on her regular at-home monitoring of various medical regimens, was based on her personal experience. She also testified that her doctor told her, as part of her treatment and management of her diabetes disorder, to reduce her stress levels. No objection was made to the admission of her doctor's statements. Moreover, her medical records were properly admitted into evidence. The court noted that testimony that establishes a sequence of events which provides a strong, logically traceable connection between the event and the condition is sufficient proof of causation. The court found it was sufficient for the beneficiary to testify that the delay was stressful, that several stressful things happened simultaneously, and that her blood sugar levels spiked, reportedly in response to the stress, and that such changes necessitated a change in her medication. The jury was able to evaluate all this information and draw its own conclusion regarding the cause and effect.

### B. Cost to Purchase Replacement Insurance

In *Scottsdale Ins. Co. v. Nat'l Emergency Servs., Inc.*, the court held there was sufficient evidence to support the jury's award of $642,585 as the cost for the plaintiff to obtain replacement coverage after the defendant wrongfully cancelled plaintiff's malpractice insurance.[122] A representative of the plaintiff testified that this was the cost of replacement coverage. The court rejected the defendant's argument that the plaintiff had to show the replacement policy was substantially similar to the cancelled coverage. The defendant failed to object to the jury charge on this basis.

### C. Statutory Additional Damages

In a case where a beneficiary of an accidental death policy sued the insurer for delay in payment, the court found that the evidence was legally sufficient to support the jury's finding of a knowing violation. The insurer had a policy of paying claims within ten days, but the company delayed payment for six months. The court rejected the insurer's argument that the liability did not become "reasonably clear" until it actually received additional hospital records for the decedent, observing that the insurer was asking the court to adopt a rule that allowed insurance companies to delay settlement of a claim until liability was absolutely established, not just "reasonably clear." The court stated that an insurance company is ultimately responsible for the actions of its contractors and employees and has a nondelegable duty to act on claims. If the insurer was finding a delay in recovering the records from the hospital, it could have gotten the same information from another source, such as the decedent's doctor or the medical examiner. The hospital's responsiveness did not excuse the insurer from its responsibility to settle claims promptly, especially as it was not without other options.[123]

### D. Punitive Damages

The Fifth Circuit certified to the Texas Supreme Court the question whether Texas public policy prohibits a liability insurer from indemnifying an award for punitive damages imposed on its insured because of gross negligence.[124] In *Fairfield Ins. Co. v. Stephens Martin Paving, L.P.*, the family of a deceased employee sued the employer alleging only gross negligence and seeking only punitive damages. The employer had an employer liability policy, but its insurer filed a declaratory judgment seeking a determination that it had no duty to defend or indemnify the employer, arguing that Texas public policy, as a matter of law, precludes indemnification for punitive damages.

### E. Prejudgment & Postjudgment Interest

The Fifth Circuit predicted that under Texas law prejudgment interest for attorney's fees as damages for an insurer's breach of its duty to defend would accrue from the date of each bill paid by the insured, not the date the insurer refused to defend. The court found this was more consistent with the purpose to compensate the plaintiff without punishing the defendant.[125]

An insured's surviving spouse and children were not entitled to pre-judgment interest on their recovery from their underinsured motorists carrier. The court rejected the argument that pre-judgment interest should be awarded on damages before offsetting prior settlements and PIP benefits. The court reasoned that this conclusion was consistent with the result in *Stracener*, which held that the setoff should be subtracted from the amount of "actual damages" as a result of the negligence of the underinsured motorist.[126]

An insured brought a successful action against his insurer to collect under the underinsured motorist provision of his automobile policy. The issue before the court was whether to have pre-judgment interest added to his damages before deducting any settlement credits. The court distinguished between the two types of prejudgment interest that may be involved in a UIM case: *Cavnar*-type Interest and *Henson*-type Interest. *Cavnar*-type prejudgment interest is the amount awarded as damages in a personal injury action, and *Henson*-type prejudgment interest was the amount that could be awarded against an insurer for breach of contract. The court concluded that *Cavnar* prejudgment interest should be added before deducting any settlement credits. The court further found that the insured was entitled to attorney's fees.[127]

### F. Attorney's Fees

When an insurer breached its duty to defend, the insured could recover as damages the reasonable and necessary fees incurred in defending the underlying lawsuit, and could recover attorney's fees for prosecuting the breach of contract suit.[128] The insured was required to offer proof that the fees in the underlying case were reasonable and necessary. This generally is satisfied by testimony from a designated expert witness.

With respect to the insured's fees for prosecuting a breach of contract claim, the court held these fees were recoverable under Tex. Civ. Prac. & Rem. Code section

38.0001, even though the insured did not specifically plead that section. The statute gives a presumption that usual and customary fees are reasonable, but the insured had to meet the threshold requirement of showing the fees were usual and customary. On remand, the insured would have to offer such proof. The insured, however, would have to either segregate attorney's fees (presumably on claims against another insurer that did not breach its contract), or establish that segregation was not required because the services related to multiple claims arising out of the same facts or transactions, and the prosecution entails proof or denial of the same facts.

Where an insurer breached its duty to defend, the insured could recover attorney's fees for hiring additional counsel, even though other insurers paid for the defense by another lawyer.[129] The court held that whether it was reasonable to hire another firm was a fact question. The jury verdict was supported by evidence that the insured hired additional counsel because of its uninsured exposure resulting from the insurer's refusal to defend or indemnify. The court also considered the sufficiency of the expert testimony supporting the fee award. The insurer attacked the testimony because the attorney testifying as an expert witness did not know to what extent the fees were duplicative of work performed by the other firm, which had been paid by other insurers. The court of appeals concluded that the district court, itself an expert on reasonable and necessary attorney's fees, could properly conclude that the attorney was qualified to testify as an expert based on his review of the bills from the additional law firm. Further, the complaints went to the weight of the evidence, and were properly considered by the jury.

The court also held that the attorney was qualified to give his opinion regarding the value of the services rendered, both from his general knowledge in the practice area, being board-certified in oil and gas law, as well as from his personal experience relating to the nature and extent of the services rendered in the particular litigation. Finally, the court held that the failure to produce an expert report for the lawyer was harmless, because the bases for his opinion were adequately disclosed.

A court rejected the argument in a default judgment proceeding that the affidavit of the plaintiff's attorney was incomplete because it did not delineate the number of hours worked, his hourly rate, or state that the work was necessary. The court held that the trial court had discretion to fix the amount of reasonable attorney's fees.[130]

A suit was brought to recover underinsured motorists benefits after the liability insurer settled without admitting liability. The court concluded that attorney's fees were not recoverable before there was a determination of fault against the underinsured motorist and the amount of damages. The court further reasoned that this result was consistent with the record in the case in the absence of a finding of breach of contract against the insurer.[131]

In a case involving an underinsured motorist's claim, the insurer contended that the trial court erred by rendering a judgment for the insured that included attorney's fees. State Farm argued there was no breach of contract until there was a determination by the jury. After the verdict, the insurer paid the claim. The insurer argued that no amount was owed until a judicial determination of liability was made. The court rejected this argument, noting that this case was no different from any other contractual dispute in which liability was at issue. The court noted that where a valid claim existed, and proper presentment was made, there was no reason to treat the claim any differently than any other contract claim.[132]

An employee injured in a hit-and-run accident while operating her employer's vehicle sued her employer's uninsured motorist carrier. The carrier brought a third party action against her employer's workers compensation carrier, which potentially was entitled to assert a statutory lien for recovery of benefits paid to the employee. The insurers entered into a settlement as to the statutory lien asserted. The workers compensation carrier assigned all its right to recovery on the lien and released the UM carrier from any other claims it could have asserted. After the jury verdict for the employee, the carrier asserted it was entitled to a credit for the subrogation lien it purchased from the worker's compensation carrier. The employee argued that she was entitled to reduction of the lien by the amount of her reasonable attorney's fees. The court held that the trial court abused its discretion in refusing to award attorney's fees, noting that the workers compensation statute provides that the "first money" owed to the workers compensation carrier is reduced by the amount of the allowable attorney's fees. The UM carrier, as assignee, was not entitled to an offset until the statutory provisions were satisfied.[133]

## X. DEFENSES & COUNTERCLAIMS

### A. Appraisal Award

An appraisal award was not invalid based on bias of the insurer's appraiser, merely because he had been hired by the insurer to examine the insured's home and determine the cause of damage from a plumbing leak. The court found no evidence that the engineer's conclusions regarding the cause of leak were not his own, or that the insurer influenced him, or that the engineer had a financial interest in the claim. Further, because the insurer paid the full amount of the appraisal award, the award estopped the insureds from maintaining a breach of contract claim.[134]

### B. Breach of Policy Condition by Insured

An insured that delayed reporting a hail damage claim for over six years breached a condition precedent in the policy requiring "prompt" notice "as soon as possible." The federal district court predicted the Texas Supreme Court would hold that Tex. Civ. Prac. & Rem. Code section 16.071, which renders void an unreasonably short notice provision requiring "notice of a claim for damages," did not apply. The court reasoned that a notice of a "loss" is different from a notice of "damages," with the latter being applicable once there has been a breach of contract. The court also held the insurer was not required to show prejudice from breach of the notice condition precedent.[135]

Another federal court held that a liability policy covering defense costs "when authorized and approved by the company," required prior approval, so that fees incurred by the insured without the insurer's approval were not covered. The court rejected the argument that these did not have to be authorized "prior" to being incurred, because other provisions in the policy specifically require prior approval. The court reasoned that prior approval is necessary; otherwise, the insurer would lose its right to authorize and approve the expenses. Further, the insurer did not need to show prejudice. However, the court found prejudice was shown, because, by the defense lawyers obtaining summary judgment in favor of the insured before tendering the defense to the insurer, the insurer lost the ability to control the defense.[136]

It appears the court got it wrong on both counts. Giving the insurer the right to authorize and approve expenses does not necessarily require prior approval. For example, the insurer could always review the bills and disallow any parts that were excessive or unnecessary, or that would not have

been given prior approval. While the word "authorized" does suggest prior approval, the terms could be considered ambiguous, when compared to express provisions requiring prior approval. Also, it does not seem clear that the insurer was prejudiced by the insured getting a good result, unless the insurer can show it would have done something differently. The insurer should be allowed to show it would have incurred less expense, or perhaps could have gotten a better hourly rate, to show it was prejudiced, but the mere failure to be given the chance to participate in a successful defense seems to suggest the absence of prejudice.

An insured that gave notice of a claim fifteen months after the customer who ultimately sued the insured had refused to pay for the insured's services, failed to give notice as soon as possible, as required by the claims-made policy.[137]

An insurer sought summary judgment on the grounds that the insured forfeited its rights to recover under the policy when it settled the underlying lawsuit without the insurer's consent. The court reversed, concluding that the consent provision did not discharge the insurer's obligations unless the insurer was prejudiced or deprived. The mere fact that the insurer owes money it did not wish to pay did not constitute prejudice. The court concluded that a liability insurer that had the right, but not the duty, to defend could not obstruct the settlement by refusing to attend the mediation conference and then contend that the settlement was obtained without consent.[138]

**C. Groundless or Bad Faith Suit Brought for Harassment**

Although the court granted summary judgment for the insurer on the insured's breach of contract claim, the court declined to award the insurer attorney's fees under article 21.21 for defending the statutory claim. The court could not conclude that any significant time had been devoted by the insurer for defense of the statutory claim, as distinguished from the claim for recovery under the policy.[139]

**D. Limitations**

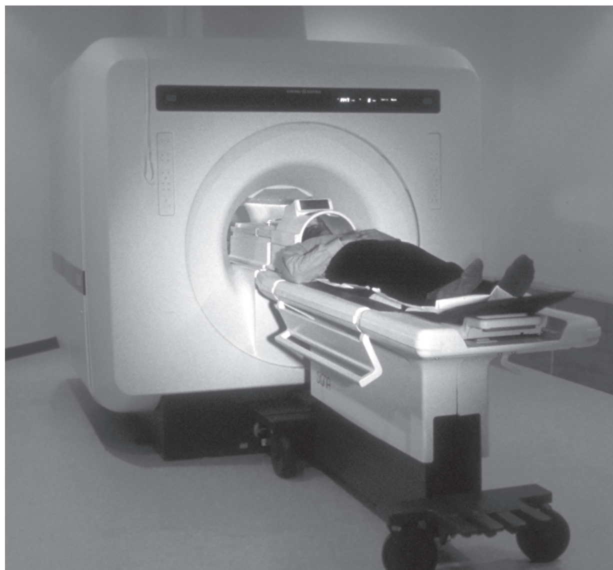
In *Provident Life & Accident Ins. Co. v. Knott,*[140] the court considered when limitations begin to run on extracontractual claims arising from the denial of a disability claim. A doctor was disabled for a period in 1985 and then was able to perform some of his duties until he retired in 1995. In 1985, the insurer initially paid for total disability but then sent a letter asking for repayment of part of the benefits because the doctor was not totally disabled. After that the parties reached a compromise, and the insurer paid partial disability benefits for the next ten years. After the doctor retired, he wanted lifetime benefits for total disability, which the insurer declined to pay, so he sued in 1998.

The Texas Supreme Court held that all of the doctor's claims for violations of article 21.21 of the Texas Insurance Code, the DTPA, and breach of the duty of good faith and fair dealing were governed by two-year limitations, and they accrued when the insurer sent its letter in 1985, and thus were time-barred. The court recognized that there may be a fact question on when limitations begins if there is no outright denial of the claim, but the court concluded that the 1985 letter clearly conveyed the insurer's position that the doctor was not totally disabled.

The court was correct that the statutory causes of action have two-year limitations periods. However, the court perpetuated an error by holding that the common-law cause of action for breach of the duty of good faith and fair dealing has a two year limitations period. The court repeated the error it made in *Murray v. San Jacinto Agency, Inc.*,[141] by holding that a cause of action for breach of the duty of good faith and fair dealing is governed by the two year limitations period in Tex. Civ. Prac. & Rem. Code section 16.003(a). Historically, there was distinction between actions for debt not evidenced by a writing, which were governed by a two-year limitations period, and actions for debt that were evidenced by a writing, which were governed by the four year statute of limitations.[142] Because of this distinction, many tort actions fell by default under the two year statute as actions for "debt" that were not evidenced by a writing. This distinction disappeared in 1979 when all actions for debt were consolidated under the four-year statute, without regard whether they were evidenced by a writing. The two-year statute, section 16.003, no longer contains any reference to actions for debt. Only the four-year statute in section 16.004 refers to "debt."

Even if the court were to ignore the history of actions for debt, the cause of action for breach of the duty of good faith and fair dealing would fit in the residual four-year statute of limitations provided by section 16.051. Oddly, the supreme court embraced this very same analysis in *Williams v. Khalaf*, which was decided around the same time as *Murray*, but nevertheless made this mistake in applying the two-year statute. The court was wrong in *Murray* to apply the two year statute and was wrong again in *Knott*. Unfortunately, a four year statute would not have helped the plaintiff in *Knott*, though.

Another court held that an insured's causes of action for fraud, negligent misrepresentation, DTPA violations, and article 21.21 violations stemming from misrepresentations made when the policy was purchased in 1996 were barred by the applicable two and four-year statutes of limitations, because the suit was filed five-years later. The court reasoned that a cause of action accrues when a wrongful act causes an injury, regardless of when the plaintiff learns of the injury. The court pointed out that the insured did not allege the discovery rule, so the insurer was not required to negate the applicability of the discovery rule.[143] It appears the court erred on this point. Normally, a claim for misrepresentation of coverage does not accrue until the insurer refuses to pay. That is the "injury" that triggers the cause of action. This is true, independent of the discovery rule, simply because there is no injury before that date.[144]



A liability insured's claims under article 21.21 were barred where suit was filed more than two-years after the insurer denied coverage under a directors and officers liability policy, even though suit was filed within two-years after the insureds paid to settle the claims, which the insurer had denied.[145]

A suit by an employee's estate for unjust enrichment or conversion to collect life insurance proceeds based on the argument that the employer lacked an insurable interest was governed by the two-year statute of limitations. However, the employer failed to show when it received the benefits, which was the wrongful act that triggered limitations, so the suit was not barred.[146]

**E. Preemption**

In *Ellis v. Liberty Life Assurance Co.*, the Fifth Circuit held that an employee's claims for breach of the duty of good faith and fair dealing, and violations of article 21.21 and 21.55 of the Texas Insurance Code, were preempted by ERISA.[147] The court revisited this issue, in light of the Supreme Court's decision in *Kentucky Ass'n of Health Claims, Inc. v. Miller*, which adopted a simplified test for deciding whether a claim survived preemption under ERISA's saving clause for laws regulating insurance.[148] The new test requires that a law: (1) be directed toward entities engaged in insurance; and (2) essentially affect the risk pooling arrangement between the insurer and the insured. The court found that claims for breach of the duty of good faith and fair dealing failed the first criteria, and the statutory claims failed the second.

The court's analysis on the statutory claims is flawed. The court stated that because the two statutes are remedial, "these two articles cannot possibly affect the bargain that an insurer makes with its insured ab initio." This is wrong, at least with respect to article 21.21. Various provisions of article 21.21 expressly govern representations, discrimination, and other activities that do affect the "bargain," if that is to be the test. This error, however, ultimately may not matter. In *Rush Prudential HMO, Inc. v. Moran*,[149] the United States Supreme Court held that even if a law fits within the savings clause, it will still be preempted if it provides an additional remedy. Although the *Ellis* court cited *Rush*, it did not cite it for this point.

A former employee's individual disability policy, which he acquired after leaving his employment, was not an ERISA plan and therefore his breach of contract suit against the insurer was not preempted. The court noted a split of authorities, but concluded that a single policy paid for by the individual who was no longer an employee did not establish an ERISA plan.[150]

ERISA, however, did not preempt claims by a healthcare provider for breach of contract and statutory violations for an insurer's failure to promptly pay claims for services provided to patients. The court reasoned that the provider's claims were based on its own contractual rights, not an assignment from the patient, and the provider was not a traditional ERISA entity. Moreover, the prompt payment statutes did not require the insurer to pay the claim, only to promptly pay a claim that was owed.[151]

**F. Res Judicata & Collateral Estoppel**

A prior action resolved coverage issues between insurance companies arising from a mid-air collision of two aircraft. A second action was brought regarding reimbursement. The court held that the reimbursement claim arose out of the same transaction as the previous litigation between the insurers, and could have been litigated in the first suit. Thus, *res judicata* precluded litigation of those issues in the second suit.[152]

**G. Waiver**

A general contractor that mistakenly instructed a subcontractor to get insurance for the wrong entity waived the contract's requirement that the subcontractor provide coverage.[153] The court held the general contractor waived the insurance requirement by intentional conduct inconsistent with claiming its right, and by silence and inaction for so long a period as to show an intention to yield the right.

**H. Other Defenses**

A claimant failed to establish the insured trucking company's legal liability for a stolen truckload of clothing. The policy provided that the insurer would cover the insured's "legal liability" for third party loss "in accordance with the Tariff, Bill of Lading, or Shipping Receipt." The record contained no tariff, bill of lading, shipping receipt, or other documents showing the insured's legal liability, the value of the cargo, or the owner of the cargo.[154]

**I. Insurer's Waiver of, or Estoppel to Assert, Defenses**

A commercial automobile liability insurer was not estopped to deny coverage where the employee who caused the wreck was not a "permissive user" of the vehicle, even though the insurer did not undertake the defense of the employee, and even though the insurer paid the property damage claim.[155] The court recognized the general rule that an insurer is not estopped to, and does not waive the right to, deny whether a claim is not covered. The court also recognized the "*Wilkinson*" exception, which holds an insurer that defends without an effective reservation of rights, aware of facts giving rise to a coverage defense, may waive the right to deny the claim. However, in this case the insurer never undertook the employee's defense. The court also cited cases for the proposition that paying part of the claim does not waive the argument that the claim is not covered.

An insured sued his homeowner's insurer to recover for mold damage caused by the air conditioner. The insurer argued that the insured failed to comply with the duties after loss by failing to provide a personal property inventory. The court rejected the insurer's argument, holding that the insurer waived the requirement for an inventory when it told the insured that the mold was specifically excluded by the policy and that the insurer would only pay for items that got wet. The court concluded that the policyholder reasonably would have considered the filing of an inventory an exercise in futility. Moreover, the court concluded the inventory the insurer sought was not a complete inventory of the damaged property, but an inventory of personal items that actually got wet, which logically would have excluded the property the insured claimed was damaged by the mold.[156]

An insurer that initially denied a claim based on an exclusion in the policy, did not waive the right to assert as a defense that the claimant failed to comply with the policy provisions for establishing the loss. The insurer's denial letter relying on the exclusion also reserved the right to assert other defenses, and this other defense was promptly asserted when the insurer was sued.[157]

**J. "Pass-on" defense**

In *Scottsdale Ins. Co. v. Nation Emergency Servs.*, the court rejected the defendant's "pass-on" damages defense.[158] The plaintiff sued the defendant for improperly canceling malpractice insurance. The plaintiff then incurred additional expense to obtain replacement coverage to insure the doctors for whom the plaintiff provided coverage. The defendant argued that the plaintiff suffered no damages because the plaintiff was able to "pass-on" this cost to the doctors. The court rejected this argument, holding that under the collateral source rule, even if the plaintiff could shift the costs to the doctors, it would not provide a basis for the defendant to avoid its liability.

## XI. PRACTICE & PROCEDURE

### A. Parties

An injured plaintiff lacks standing to sue the defendant/insured's insurer. Because a prior court determined there was no coverage under the policy, the plaintiff could not acquire any rights under the policy from the insured. Further, the court held that a third party claimant lacks standing to assert direct claims against an insurer for violations of article 21.21 and the DTPA, and for negligent mishandling of the claim.[159]

### B. Choice of Law

The Fifth Circuit held that Texas law would apply to a claim by the estate of a deceased employee asserting that the employer lacked an insurable interest in the employee's life. The court focused on the fact that the insured lived in Texas and was employed in Texas, and Texas has an interest enforcing the rule requiring an insurable interest.[160]

A suit involving claims for unfair insurance practices, breach of contact, and breach of the duty of good faith and fair dealing, based on an insurer's cancellation of malpractice insurance was properly governed by Texas law, not by Virginia law. The broker for the insured was located in Texas, and that is where the proposal was solicited, delivered, and paid for, even though the other party had contacts with other states. The court found Texas had the most significant relationship. The court also found the regulation of deceptive insurance practices, in part through private lawsuits, is an integral part of Texas's regulation of the insurance business. In contrast, Virginia lacks a private cause of action for unfair insurance practices. The court was unwilling to thwart the express policy of the Texas legislature to protect its citizens from unfair insurance practices.[161]

The court also held that because Texas law properly applied, the trial court did not error by excluding testimony that a representative of the plaintiff allegedly admitted that the cancellation was proper under Virginia law. The trial court did not abuse its discretion by concluding this evidence would be confusing to the jury.

In another case, applying Texas law instead of Louisiana law meant the insurer did not have a duty to defend or indemnify.[162] The issue was whether suits for injuries caused when refrigeration units leaked were covered or excluded by a policy that had a pollution exclusion. The parties agreed that under Texas law they would be excluded, but they would be covered under Louisiana law. The insured, Reddy Ice, was a Nevada corporation, with its principal place of business in Texas. The insurers were Texas companies, and the policies were negotiated and issued in Texas. The injuries occurred in Louisiana. The court concluded that article 21.42 of the Insurance Code did not make Texas law applicable, because Reddy was not an "inhabitant" of the state. Nevertheless, Texas had the most significant relationship to the insurance coverage issues, so Texas law would apply.

### C. Removal

Even though an insurance claims adjuster is a "person" who may be sued for unfair insurance practices, thus destroying diversity jurisdiction, the defendant is fraudulently joined if by piercing the pleadings the court finds no evidence that would support a claim against the individual. In *Hornbuckle v. State Farm Lloyds*,[163] the insured sued State Farm and its adjuster for conduct related to the handling of her foundation claim. The insurer did not initially remove the case but did so after the insured's deposition where she, according to the court, did not give meaningful answers when asked what the adjuster did to warrant being personally sued. The district court remanded the case, citing numerous cases where State Farm's argument that its adjusters were fraudulently joined had been rejected. In addition, the district court awarded $750 in attorney's fees to the insured. It was this award that gave the Fifth Circuit an opportunity to review the decision.

The court held a fee award was proper only if State Farm had no objectively reasonable grounds to believe there was no arguably reasonable basis to conclude the insured's claim against the adjuster was valid in fact and law. Under this standard, the court found a lack of evidence that State Farm did have an objectively reasonable basis. The court distinguished other cases where removal was based solely on the pleadings, not lack of evidence. The court expressed no opinion on whether the removal was proper. Instead, the court concluded that the fee award was improper.

This decision is very likely to prompt a spate of removals after plaintiffs are deposed, as insurers argue there is not sufficient evidence against the individual, non-diverse defendant. In addressing these future cases two points may be important. First, it was the fee award that was reviewed. Absent a fee award, a remand decision is not reviewable by appeal. Further, in *Hornbuckle*, the plaintiff offered no evidence, other than her own deposition, which the court found insufficient. In many cases, the insurer's claims file, or the deposition of the adjuster, may provide a factual basis for a claim against the individual.

### D. Forum Selection Clause

The Texas Supreme Court held that a forum selection clause in an insurance policy, which required that all litigation take place in the State of New York and be subject to New York law was enforceable. The provision was contained in a $70 million pollution liability policy issued to a corporation. The court held that forum selection clauses, while once disfavored, are now presumptively valid, absent a showing of fraud in obtaining the agreement, or great difficulty and inconvenience as a result of enforcing the agreement. The court also held the insurer was entitled to a writ of mandamus to enforce the clause. Finally, the court held the insurer did not waive the provision by filing a general appearance, demanding a jury trial, and waiting five months before raising the issue.[164]

### E. Jurisdiction

A corporation that purchased the stock of an insurer based in Texas, entered into a number of leases performable in Texas, and then had other contacts with Texas, had enough minimum contacts to support specific jurisdiction in a class action based on the insurer's failure to pay claims for accidental death and dismemberment benefits.[165]

A Canadian broker and its principal had sufficient contacts to support personal jurisdiction in Texas where they misrepresented coverage, induced an agency to forward premiums, and converted those funds, through various contacts with entities in Texas.[166]

The Fifth Circuit concluded that in a suit brought by a single underwriter, or a "name" of a Lloyds policy, brought by the underwriter individually and not as representative of the other names, only that underwriter's citizenship mattered for determining diversity jurisdiction. The court distinguished cases where an unincorporated association sues, and the citizenship of each member of the association must be considered.[167]

### F. Venue

An insured sued the Windstorm Insurance Association and his homeowner's insurer in the county of his residence. The trial court denied the Association's motion for

a change of venue. The court of appeals held that the venue statute applicable to an action against the Association contains a mandatory venue provision, which required that suit be filed in Jefferson County.[168]

### G. Pleadings

Before ruling that the insurer was right and the employee lost, the Fifth Circuit did hold that it was not error to let the employee amend her pleadings to allege ERISA claims. The court reasoned that since the insurer removed the case to federal court on the basis of ERISA preemption, the insurer could not complain when the employee was allowed to amend to assert an ERISA claim.[169]

### H. Service of Process

An insured brought a breach of contract and deceptive trade practices action against a health insurer, arising out of the insurer's denial of benefits for injuries sustained in an automobile accident. The trial court entered a default judgment against the insurer, and the insurer filed a restricted appeal. The court reversed the default judgment noting that strict compliance with the citation rules requires that the name of the party in the return of service essentially match the name of the party in the citation or petition. The court concluded that this was not a simple misnomer case. The insurer's name was properly alleged in the petition and citation, but the return showed a different name. There was no showing that the different names were not separate companies or that no confusion occurred because of the mistake in the return. The court noted that the return of service did not show the insurer was properly served, because the name of the company on the return was missing a word in the insurer's name. The court found the omission significant because companies sometimes use slight variations on the word combinations to name distinct entities. The court concluded that the omission of the word "life" from the insurance company's name was significant, absent the contrary showing.[170]

### I. Discovery

A trial court abused its discretion by allowing an insurer to withhold documents under a claim of work-product, where the insurer failed to sufficiently identify the documents in its privilege log and failed to offer any proof that the documents were prepared in anticipation of litigation.[171]

### J. Experts

Testimony from an experienced claims adjuster explaining the industry meaning of the term "non-Med." insurance to mean life insurance was proper to demonstrate that the policy was ambiguous. The expert, Joe Wilkerson, was properly allowed to testify that the insurer's conduct constituted bad faith, unfair dealing, and fraud, and violated various provisions of the Insurance Code and the DTPA.[172]

A trial court did not abuse its discretion by granting summary judgment dismissing the insured's unfair settlement claims, without allowing depositions of the claims adjusters. In *Hamburger v. State Farm Mut. Auto. Ins. Co.*, the court held that the insurer's offer of $16,000 for pain and suffering was reasonable as a matter of law; therefore, the court concluded that nothing the insured could have obtained from the depositions would have been material to the summary judgment motion.[173]

It appears the court erred. As noted above, the offer of $16,000 should not be conclusive proof that the insurer acted reasonably. In addition, it would seem that if the adjuster subjectively felt the amount was too low, and that was admitted in the deposition, then the testimony would be very material.

A federal court did not abuse its discretion by barring testimony from an insured's treating physician, where the doctor was not timely disclosed as an expert witness. While the doctor was not the type of expert from whom a written report was required, the court found the testimony was important and there was not a sufficient reason for the late disclosure.[174]

A court rejected expert testimony stating that there was one accepted medical definition of the term "cervicothoracic," because the court found this testimony that policy language was a "misnomer," was "not proper English" and was an improper attempt to rewrite the key language of the contract.[175]

Homeowners brought suit against their insurer for foundation damage to their house as a result of a plumbing leak. The insurer alleged the trial court erred by failing to strike the expert testimony offered by the homeowners. The court rejected the insurer's contention that the expert's testimony was unreliable because it failed to rule out other plausible causes of the foundation damage. The court observed that the expert had testified that he excluded the possibility the problems that caused earlier damage were the cause of the current damage. The expert also testified that he did not believe that seasonal moisture caused the current damage. While the insurer never specifically asked the expert whether he excluded the possibility that subsurface drainage caused the soil to move, the evidence showed that he discounted that possibility as well. Accordingly, the court held that the trial court did not abuse its discretion in denying the insurers motion to strike the expert testimony.[176]

### K. Declaratory Judgment

A court held that the insured was entitled to bring a declaratory judgment action against the insurer to determine the legality of issuing an automobile liability insurance policy without providing personal injury protection benefits or uninsured motorists coverage, even though the insured had not filed a claim against the insurer. Moreover, the court held the insured did not need to exhaust her administrative remedies prior to bringing the declaratory judgment action.[177]

### L. Class Actions

Plaintiffs failed to satisfy the predominance requirement necessary to maintain a class action against an insurer they alleged charged credit card accounts for accidental death and dismemberment insurance without consent. The trial court certified a nationwide class, reasoning that the defendant failed to show there were any significant differences in the laws of other jurisdictions. The court of appeals held it was the plaintiffs' burden to show that Texas law was similar, so that common issues predominate, and it was the plaintiffs' burden to show Texas had the most "substantial relationship" to justify applying Texas law. The mere fact that the defendant was headquartered in Texas and its acts originated in Texas were not enough. The case was remanded to determine whether a class was appropriate under these standards.[178]

An insured under a group health policy filed suit alleging that the insurer breached the underlying policy by charging an unauthorized monthly administrative fee. The insured proposed that two multi-state classes be created, one comprised of policyholders who were charged the administrative fee, and the second comprised of a "cancellation class" seeking only attorney's fee for an agreed temporary injunction. With respect to the first class, the court held that the insured failed to satisfy the typicality requirement, where the record consisted only of policy applications from ten of eighteen states where the insurer offered the policy, and the application varied from state to state.

The predominance requirement was not met, where the trial court failed to analyze whether each state permitted the insured to charge a premium that included the administrative

fee, and the insured failed to demonstrate that Texas law should apply to many of those claims so that common legal issues would predominate.

The insured also failed to establish the superiority requirement. The court rejected the trial court's analysis that the small economic value of the claims justified certification. The court observed that the certification is not "merely a vehicle to make sure no claim goes untried." For similar reasons, the court concluded the insured failed to present sufficient evidence that the "cancellation class" should be certified.[179]

**M. Arbitration**

An insurer's delay in demanding arbitration and its filing of numerous motions and participation in extensive discovery waived its right to seek arbitration, even though the contract contained provisions saying that participation in judicial activities would not waive the right to seek arbitration. The court found the extensive delay and discovery into issues beyond the enforcement of the arbitration clause prejudical to the other party. Also, the district court's inherent power to control its docket trumped the contractual no-waiver provision.[180]

**N. Appraisal**

A trial court did not abuse its discretion by refusing to enforce the appraisal clause in a policy where the plaintiff only sued under the DTPA and article 21.21, and for fraud, but did not assert any claims under the insurance contract.[181]

**O. Motions for Summary Judgment**

The court reversed summary judgment for the insurer on all of the extra-contractual claims as the insurer failed to address each discrete cause of action. The insurer argued because it had a defense to the bad faith claim, all other extra-contractual causes of action were defeated as a matter of law because they basically re-characterized the bad faith claim. The court expressly rejected this argument, noting that the causes of action for conversion and violation of article 21.55 of the Texas Insurance Code are not re-characterizations of a bad faith claim. On the insured's claims under the DTPA and violations of article 21.21, the court found that issues of fact precluded summary judgment for the insurer.[182]

**P. Burden of Proof**

The Texas Supreme Court considered the difference between "concurrent" causation and "separate and independent" causation in *Utica Nat. Ins. Co. v. Am. Indem. Co.*.[183] A doctors' association was sued for professional negligence in administering contaminated drugs, and for ordinary negligence in failing to secure the drugs, which allowed them to be contaminated by a thieving employee. The court found the policy excluded professional negligence, but not ordinary negligence. The court concluded that a jury would have to decide what type of negligence caused the injuries. The court also held that if the professional and ordinary negligence combined to cause the plaintiffs' injuries, then they would be "concurrent" causes and the loss would be excluded. On the other hand, if the covered negligence and excluded professional negligence each independently caused the plaintiffs' injuries, then they would be "separate and independent" causes, and the loss would be covered.

**Q. Severance & Separate Trials**

In a case involving extra-contractual claims under an automobile policy, the court concluded that the trial court did not abuse its discretion in severing the extra-contractual claims. The court opined that severance is required in those bad faith cases in which the insurer made a settlement offer on a disputed contract claim. Because such a settlement offer was made in this case, the court concluded that severance was required.[184]

**R. Court's Charge**

A federal court properly instructed the jury in a suit under a homeowner's policy for foundation damage allegedly caused by plumbing leaks. The court instructed the jury that the plaintiff had the burden to prove the damage was caused by plumbing leaks and that would be covered, and the insurer had the burden to prove the damage was caused by something else, which would not be covered. Also, the jury finding that plumbing leaks did not cause the damage was not inconsistent with the jury finding that $5,000 would compensate the insured for the cost of tearing out and replacing the parts of the home necessary to repair his plumbing system.[185]

**S. Default Judgment**

The lack of a reporter's record of a default judgment hearing was not error for the purposes of a restricted appeal, as the pleadings and affidavits constituted a sufficient record.[186]

## XII. OTHER ISSUES

**A. Subrogation**

An employee who was injured in a hit-and-run accident while operating her employer's vehicle brought an action against her employer's uninsured insurance carrier. The UM carrier filed a third party action against the employer's workers compensation carrier, arguing it was potentially entitled to recover the workers compensation benefits. The court held the employer's compensation carrier had a right to subrogation with respect to the damage award the employee recovered from UM insurance carrier. The court distinguished cases that rejected the subrogation right, noting the subrogation right may not exist when the UM/UIM policy is purchased by the employee and not her employer.[187]

In contrast, a workers' compensation insurance carrier did not have a subrogation right to benefits paid to an injured employee under the employee's own uninsured motorists policy.[188] The court distinguished cases where the employer paid for the UM policy.

**B. Unauthorized Insurance Business**

American Home and Travelers Indemnity Company sought a declaratory judgment against the Unauthorized Practice of Law Committee that using lawyers who are employees of an insurance company to defend insureds under their liability policies was not the unauthorized practice of law by insurer. Noting that its holding is consistent with the majority of state courts that have addressed the issue, the court concluded that insurance companies do not engage in the unauthorized practice of law by using staff counsel to represent their insureds.[189]

*__Mark L. Kincaid__ is a partner with Kincaid & Horton in Austin. He graduated with honors from the University of Texas Law School and teaches Texas Insurance Litigation there as an adjunct professor. He is board certified in Consumer Law, Civil Trial Law , and Civil Appellate Law. He is co-author of West's Texas Practice Guide on Insurance Litigation, and has written and spoken frequently on insurance and consumer issues.

** __Trevor A. Taylor__ is an associate with Kincaid & Horton. He received his bachelor's and law degrees from the University of Texas, and received a master's degree in public policy from Harvard University, John. F. Kennedy School of Government.

1. Old Am. County Mut. Fire Ins. Co. v. Sanchez, 149 S.W.3d 111 (Tex. 2004).

2. Texas Farm Bureau Mut. Ins. Co. v. Sturrock, 146 S.W.3d 123 (Tex. 2004).

3. McDonald v. S. County Mut. Ins. Co., ___ S.W.3d ___, 2004 WL

2677151 (Tex. App.–Houston [1st Dist.] 2004, no pet. h.).
4. McKiddy v. Trinity Lloyds Ins. Co., 155 S.W.3d 307 (Tex. App.–Dallas, 2004, pet. denied).
5. Liberty Mut. Ins. Co. v. Griesing, 150 S.W.3d 640 (Tex. App.–Austin 2004, pet. filed); see also Mid-Century Ins. Co. v. Ademaj, 150 S.W.3d 640, 2004 WL 2694475 (Tex. App.–Tyler, Nov. 24, 2004, pet. filed).
6. Guerra v. Am. Employers Ins. Co., 2003 WL 22025871 (Tex. App.–Corpus Christi 2003, pet. denied).
7. Payne v. Mid-Century Ins. Co., 2003 WL 22024458 (Tex. App.–Austin 2003, no pet.).
8. Taylor v. State Farm Lloyds, Inc., 124 S.W.3d 665 (Tex. App.–Austin 2003, pet. denied).
9. Hamby v. State Farm Mut. Auto Ins. Co., 137 S.W.3d 834 (Tex. App.–Houston [1st Dist.] 2004, pet. denied).
10. Hassler v. United Serv. Auto. Ass'n, 2004 WL 170014 (Tex. App.–Houston [1st Dist.] 2004, no pet.).
11. Fiess v. State Farm Lloyds, 392 F.3d 802 (5th Cir. 2004).
12. McEwin v. Allstate Texas Lloyds, 118 S.W.3d 811 (Tex. App.–Amarillo 2003, no pet.).
13. Farmers Ins. Exch. v. Neal, 120 S.W.3d 493 (Tex. App.–Texarkana 2003, no pet.).
14. DeLaurentis v. United Servs. Auto. Ass'n, ___ S.W.3d ___, 2004 WL 349922 (Tex. App.–Houston [14th Dist.] 2004, no pet.) opinion withdrawn and supeseded on rehearing by 2004 WL 2186753 (Tex. App.—Houston [14th Dist.] 2004).
15. Allstate Texas Lloyds v. Mason, 123 S.W.3d 690 (Tex. App.–Fort Worth 2003, no pet.).
16. Pena v. Assoc. Fin. Life Ins. Co., 77 Fed. App. 259 (5th Cir. 2003) (per curiam).
17. Mayo v. Hartford Life Ins. Co., 354 F.3d 400 (5th Cir. 2004).
18. Hubbard v. Shankle, 138 S.W.3d 474 (Tex. App.–Fort Worth 2004, pet. denied).
19. Bailey-Mason v. Mason, 122 S.W.3d 894 (Tex. App.–Dallas 2003, pet. denied).
20. Frazier v. Frazier, 2003 WL 23000031 (Tex. App.–Houston [1st Dist.] 2003, pet. denied).
21. Johnson v. Felts, 140 S.W.3d 702 (Tex. App.–Houston [14th Dist.] 2004, pet. denied).
22. Burford v. Great-West Life & Annuity Ins. Co., 95 Fed. Appx. 539 (5th Cir. 2004) (per curiam).
23. Provident Life & Accident Ins. Co. v. Knott, 128 S.W.3d 211 (Tex. 2003).
24. Republic Underwriters Ins. Co. v. Mex-Tex, Inc., 150 S.W.3d 423 (Tex. 2004).
25. Serv. Life & Cas. Ins. Co. v. Montemayor, 150 S.W.3d 649 (Tex. App.–Austin 2004, pet. filed).
26. Valley Forge Ins. Co. v. Hicks Thomas & Lilienstern, L.L.P., ___ S.W.3d ___, 2004 WL 2903521 (Tex. App.–Houston [1st Dist.], pet. filed).
27. Royal Maccabees Life Ins. Co. v. James, 146 S.W.3d 340 (Tex. App.–Dallas 2004, pet. filed).
28. Dallas Fire Ins. v. Texas Contractors Surety & Cas. Agency, ___ S.W.3d ___, 2004 WL 2913657 (Tex. 2004) (per curiam).
29. Hamburger v. State Farm Mut. Auto. Ins. Co., 361 F.3d 875 (5th Cir. 2004).
30. Franco v. Slavonic Mut. Fire Ins. Ass'n, 154 S.W.3d 777 (Tex. App.–Houston [14th Dist.] 2004, no pet. h.).
31. Staglik v. Gov't Pers. Mut. Life Ins. Co., 2003 WL 22300006 (Tex. App.–San Antonio 2003, pet. denied).
32. E.R. Dupuis Concrete Co. v. Penn Mut. Life Ins. Co., 137 S.W.3d 311 (Tex. App.–Beaumont 2004, no pet.).
33. Republic Underwriters Ins. Co. v. Mex-Tex, Inc., 150 S.W.3d 423 (Tex. 2004).
34. DeLaurentis v. United Servs. Auto. Ass'n, ___ S.W.3d ___, 2004 WL 349922 (Tex. App.–Houston [14th Dist.] 2004, no pet.) opinion withdrawn and supeseded on rehearing by 2004 WL 2186753 (Tex.App.—Houston [14th Dist.] 2004) Opinion withdrawn and superseded on overruling of rehearing by 2005 WL 724893 )Tex. App.-Houston [14th Dist.] 2005).
35. Allstate Tex. Lloyds v. Mason, 123 S.W.3d 690 (Tex. App.–Fort Worth 2003, no pet.).
36. Covington v. Travelers Indem. Co., 122 S.W.3d 330 (Tex. App.–Fort Worth 2003, no pet.).
37. Perez v. Blue Cross Blue Shield, Inc., 127 S.W.3d 826 (Tex. App.–Austin 2003, pet. denied).
38. Aetna Health, Inc. v. Davila, 542 U.S. 200 (2004).
39. Baker v. Metro. Life Ins. Co., 364 F.3d 624 (5th Cir. 2004).
40. Ellis v. Liberty Life Ass. Co., 394 F.3d 262 (5th Cir. 2004).
41. Lain v. UNUM Life Ins. Co., 279 F.3d 337, 345-46 (5th Cir. 2002).
42. Scritchfield v. Mutual of Omaha Ins. Co., 341 F. Supp.2d 675 (E.D. Tex. 2004).
43. HEB Grocery Co. v. Rencare, Ltd., ___ S.W.3d ___, 2004 WL 199272 (Tex. App.–San Antonio, 2004, pet. denied).
44. Hawa v. Metro. Life Ins. Co., ___ S.W.3d ___, 2004 WL 231020 (Tex. App.–Amarillo, Feb. 6, 2004, no pet.).
45. Nat'l Plan Admin., Inc. v. Nat'l Health Ins. Co., 150 S.W.3d 718 (Tex. App.–Austin, 2004, pet. filed).
46. Kabula Public Adjusters, Inc. v. Unauthorized Practice of Law Comm. for the Supreme Court of Texas, 133 S.W.3d 790 (Tex. App.–Texarkana 2004, no pet.).
47. Critchfield v. Smith, 151 S.W. 3d 225 (Tex. App.–Tyler 2004, pet. denied).
48. Geisler v. Mid-Century Ins. Co., 712 S.W.2d 184 (Tex. App.–Houston [14th Dist.] 1986, writ ref'd, n.r.e.).
49. Stroman Realty, Inc. v. State Farm Lloyds, 2003 WL 22672223 (Tex. App.–Beaumont 2003, pet. denied).
50. Old Am. County Mut. Fire Ins. Co. v. Renfro, 130 S.W.3d 70 (Tex. 2004) (per curiam).
51. Tull v. Chubb Group of Ins. Cos., 146 S.W.3d 689 (Tex. App.–Amarillo 2004, no pet.).
52. Thompson v. Harco Nat'l. Ins. Co., 120 S.W.3d 511 (Tex. App.–Dallas 2003, pet. denied).
53. Utica Nat'l Ins. Co. v. Am. Indem. Co., 141 S.W.3d 198 (Tex. 2004).
54. Westchester Fire Ins. Co. v. Admiral Ins. Co., 152 S.W.3d 172 (Tex. App.–Fort Worth 2004, pet. filed).
55. Transp. Ins. Co. v. Moriel, 879 S.W.2d 10 (Tex. 1994).
56. Commercial Underwriters Ins. Co. v. Royal Surplus Lines Ins. Co., 345 F. Supp.2d 652 (S.D. Tex., 2004).
57. Valmount Energy Steel, Inc. v. Commercial Union Ins. Co., 359 F.3d 770 (5th Cir. 2004).
58. Mid-Continent Cas. Co. v. Third Coast Pkg. Co., 342 F. Supp.2d 626 (S.D. Tex. 2004).
59. CU Lloyds v. Hatfield, 126 S.W.3d 679 (Tex. App.–Houston [14th Dist.] 2004, pet. denied).
60. Med. Care Am., Inc. v. Nat'l Union Fire Ins. Co., 341 F.3d 415 (5th Cir. 2003).
61. TIG Specialty v. Pinkmonkey.com, Inc., 375 F.3d 365 (5th Cir. 2004).
62. Greenwood Ins. Group, Inc. v. United States Liab. Ins. Co., 157 S.W.3d 444 (Tex. App.–Houston [1st Dist.] 2004, no pet.).
63. Texas Med. Liab. Trust v. Transp. Ins. Co., 143 S.W.3d 335 (Tex. App.–Dallas 2004, pet. filed).
64. Columbia Cas. Co. v. CP Nat'l, Inc., ___ S.W.3d ___, 2004 WL 2066247 (Tex. App.–Houston [1st Dist.] 2004, no pet.).
65. Employers Reinsurance Corp. v. Threlkeld & Co. Ins. Agency, 152 S.W.3d 595 (Tex. App.–Tyler, 2003, pet. denied).
66. Comsys Info. Tech. Servs., v. Twin City Fire Ins. Co., 130 S.W.3d

181 (Tex. App.–Houston [14th Dist.] 2003, pet. granted).
67. Ace Prop. & Cas. Ins. Co. v. Dorismond, 88 Fed. Appx. 695 (5th Cir. 2004).
68. Brady Nat'l Bank v. Gulf Ins. Co., 94 Fed. Appx. 197 (5th Cir. 2004).
69. Northfield Ins. Co. v. Loving Home Care, Inc., 363 F.3d 523 (5th Cir. 2004).
70. N. County Mut. Ins. Co. v. Davalos, 140 S.W.3d 685 (Tex. 2004).
71. Utica Nat'l Ins. Co. v. Am. Indem. Co., 141 S.W.3d 198 (Tex. 2004).
72. Primrose Oper. Co. v. Nat'l Am. Ins. Co., 382 F.3d 546 (5th Cir. 2004).
73. Administaff, Inc. v. Am. Int'l Specialty Lines Ins. Co., 75 Fed. Appx. 239 (5th Cir. 2003).
74. Am. Home Assurance. Co. v. United Space Alliance, Inc., L.L.C., 378 F.3d 482 (5th Cir. 2004).
75. Nautilus Ins. Co. v. John Gannon, Inc., 103 Fed. Appx. 534 (5th Cir. 2004).
76. RLI Ins. Co. v. Maxxon Southwest, Inc., 108 Fed. Appx. 194 (5th Cir. 2004).
77. Royal Ins. Co. v. Hartford Underwriters Ins. Co., 391 F.3d 639 (5th Cir. 2004).
78. Burlington Ins. Co. v. Texas Krishnas, Inc., 143 S.W.3d 226 (Tex. App.–Eastland, 2004, no pet.).
79. Altivia Corp. v. Greenwich Ins. Co., ___ S.W.3d ___, 2004 WL 1898717 (Tex. App.–Houston [14th Dist.] 2004, pet. granted).
80. Texas Med. Liab. Trust v. Hartford Acc. & Indem. Co., 2004 WL 2474859 (Tex. App.–Waco 2004, no pet. h.), withdrawn and superceded by 151 S.W.3d 706 (Tex.App.—Waco 2004).
81. Founders Commercial Ltd. v. Trinity Universe Ins. Co., ___ S.W.3d ___, 2004 WL 2677097 (Tex. App.–Houston [1st Dist., Nov. 24, 2004, no pet. h.).
82. Gehan Homes Ltd. v. Employers Mut. Cas. Co., 146 S.W.3d 833 (Tex. App.–Dallas, 2004, pet. granted).
83. In re ML & Assocs., Inc., 302 B.R. 857 (N.D. Tex. 2003).
84. Lamar Homes, Inc. v. Mid-Continent Cas. Co., 335 F. Supp.2d 754 (W.D. Tex. 2004).
85. Gregg & Valby, L.L.P. v. Great Am. Ins. Co., 316 F. Supp.2d 505 (S.D. Tex. 2004).
86. Housing Auth. of the City of Dallas v. Northland Ins. Co., 333 F. Supp.2d 595 (N.D. Tex. 2004).
87. Global Sun Pools, Inc. v. Burlington Ins. Co., 2004 WL 878283 (Tex. App.–Dallas 2004, no pet.).
88. TIG Ins. Co. v. Dallas Basketball, Ltd., 129 S.W.3d 232 (Tex. App.–Dallas 2004, pet filed).
89. Fielder Road Baptist Church v. Guideone Elite Ins. Co., 139 S.W.3d 384 (Tex. App.–Fort Worth, 2004, pet. filed).
90. Trinity Universal Ins. Co. v. Cowan, 945 S.W.2d 819 (Tex. 1997).
91. Fielder Road Baptist Church v. Guideone Elite Ins. Co., 139 S.W.3d 384 (Tex. App.–Fort Worth, 2004, pet. filed).
92. Landmark Chevrolet Corp. v. Universal Underwriters Ins. Co., 121 S.W.3d 886 (Tex. App.–Houston [1st Dist.] 2003, pet. granted).
93. Hamm v. Allstate Ins. Co., 286 F. Supp.2d 790 (N.D. Tex. 2003).
94. Westchester Fire Ins. Co. v. Admiral Ins. Co., 152 S. W.3d 172 (Tex. App.–Fort Worth 2004, pet. filed)(en banc).
95. Royal Ins. Co. v. Hartford Underwriters Ins. Co., 391 F.3d 639 (5th Cir. 2004).
96. Roman Catholic Diocese v. Interstate Fire & Cas. Co., 133 S.W.3d 887 (Tex. App.–Dallas 2004, pet. denied).
97. PPG Indus., Inc. v. JMB/Houston Centers Partners Ltd., 146 S.W.3d 79 (Tex. 2004).
98. State Farm Fire & Cas. Co. v. Gandy, 925 S.W.2d 696 (Tex. 1996).
99. Stroop v. N. County Mut. Ins. Co., 133 S.W.3d 844 (Tex. App.–Dallas 2004, pet. denied).
100. Fortis Benefits Ins. Co. v. Guin, 2004 WL 1175487 (Tex. App–Amarillo 2004, no pet.).
101. Nationwide Mut. Ins. Co. v. Haffley, 78 Fed. Appx. 348 (5th Cir. 2003) (per curiam).
102. Rocor Int'l, Inc. v. Nation Union Fire Ins. Co., 77 S.W.3d 253 (Tex. 2002).
103. Travelers Indem. Co. v. Presbyterian Healthcare Res., 313 F. Supp.2d 648 (N.D. Tex. 2004).
104. Atlantic Lloyds Ins. Co. v. Butler, 137 S.W.3d 199 (Tex. App.–Houston [1st Dist.] 2004, pet. denied).
105. N. County Mut. Ins. Co. v. Davalos, 140 S.W.3d 685 (Tex. 2004).
106. See Ellen S. Pryor, *Mapping the Changing Boundaries of the Duty to Defend in Texas*, 31 TEX. TECH. L. REV. 869, 914 n. 317 (2000).
107. Travelers Indem. Co. v. Presbyterian Healthcare Res., 313 F. Supp.2d 648 (N.D. Tex. 2004); Housing Auth. of the City of Dallas v. Northland Ins. Co., 333 F. Supp.2d 595 (N.D. Tex. 2004).
108. TIG Ins. Co. v. Dallas Basketball, Ltd., 129 S.W.3d 232 (Tex. App.–Dallas 2004, pet. filed).
109. Atl. Lloyds Ins. Co. v. Butler, 137 S.W.3d 199 (Tex. App.–Houston [1st Dist.] 2004, pet. denied).
110. Med. Care America, Inc. v. Nat'l Union Fire Ins. Co., 341 F.3d 415 (5th Cir. 2003).
111. Med. Care America, Inc. v. Nat'l Union Fire Ins. Co., 341 F.3d 415 (5th Cir. 2003).
112. Maryland Ins. Co. v. Head Ind. Coatings & Servs., Inc., 930 S.W.2d 27 (Tex. 1996).
113. Travelers Indem. Co. v. Presbyterian Healthcare Res., 313 F. Supp.2d 648 (N.D. Tex. 2004).
114. Clements v. Minnesota Life Ins. Co., ___ S.W.3d ___, 2004 WL 1516450 (Tex. App.–Houston [1st Dist.] 2004, no pet.).
115. Mathis v. United Investors Life Ins. Co., 123 S.W.3d 654 (Tex. App.–Dallas 2003, pet. denied).
116. Nabors Corp. Servs., Inc. v. Northfield Ins. Co., 132 S.W.3d 90 (Tex. App.–Houston [14th Dist.] 2004, no pet.).
117. Vecellio Ins. Agency v. Vanguard Underwriters Ins. Co., 127 S.W.3d 134 (Tex. App.–Houston [1st Dist.] 2003, no pet.).
118. Tull v. Chubb Group of Ins. Cos., 146 S.W.3d 689 (Tex. App.–Amarillo 2004, no pet.).
119. Settlement Capital Corp. v. BHG Structured Settlements, Inc., 319 F. Supp.2d 729 (N.D. Tex. 2004).
120. Royal Maccabees Life Ins. Co. v. James, 146 S.W.3d 340 (Tex. App.–Dallas 2004, pet. filed).
121. Minnesota Life Ins. Co. v. Vasquez, 133 S.W.3d 320 (Tex. App.–Corpus Christi 2004, pet. filed).
122. Scottsdale Ins. Co. v. Nat'l Emergency Svcs., Inc., ___ S.W.3d ___, 2004 WL 1688540 (Tex. App.–Houston [1st Dist.] July 29, 2004, pet. denied).
123. Minnesota Life Ins. Co. v. Vasquez, 133 S.W.3d 320 (Tex. App.–Corpus Christi 2004, pet. filed).
124. Fairfield Ins. Co. v. Stephens Martin Paving, L.P., 381 F.3d 435 (5th Cir. 2004).
125. Primrose Oper. Co. v. Nat'l Am. Ins. Co., 382 F.3d 546 (5th Cir. 2004).
126. Trinity Universal Ins. Co. v. Brainard, 153 S.W.3d 508 (Tex. App.–Amarillo, 2004, pet. filed).
127. Norris v. State Farm Mut. Auto. Ins. Co., 2004 WL 811722 (Tex. App.–Waco 2004, pet. granted).
128. Am. Home Assurance. Co. v. United Space Alliance, Inc., 378 F.3d 482 (5th Cir. 2004).
129. Primrose Oper. Co. v. Nat'l Am. Ins. Co., 382 F.3d 546 (5th Cir. 2004).
130. U.S. Auto Ins. Servs. v. Les Marks Chevrolet, 2003 WL

22012670 (Tex. App.–Houston [14th Dist.] 2003, no pet.).
131. Trinity Universal Ins. Co. v. Brainard, 153 S.W.3d 508 (Tex. App.–Amarillo 2004, pet. granted).
132. State Farm Mut. Auto Ins. Co. v. Nickerson, 130 S.W.3d 487 (Tex. App.—Texarkana 2004, pet. granted).
133. Erivas v. State Farm Mut. Auto. Ins. Co., 141 S.W.3d 671 (Tex. App.–El Paso 2004, no pet.).
134. Franco v. Slavonic Mut. Fire Ins. Ass'n, 154 S.W.3d 777 (Tex. App.–Houston [14th Dist.] 2004, no pet. h.).
135. Ridglea Estate Condo. Ass'n v. Lexington Ins. Co., 309 F. Supp.2d 851 (N.D. Tex. 2004).
136. In re Nucentrix Broadband Networks, Inc., 309 B.R. 907 (N.D. Tex. 2004).
137. Singleentry.com, Inc. v. St. Paul & Marine Ins. Co., 117 Fed. Appx. 933, 2004 WL 2796534 (5th Cir. 2004). See also L'Atrium on the Creek I, L.P. v. Nat'l Union Fire Ins. Co., 326 F. Supp.2d 787 (N.D. Tex. 2004).
138. Comsys Info. Tech. Servs., v. Twin City Fire Ins. Co., 130 S.W.3d 181 (Tex. App.–Houston [14th Dist.] 2003, pet. granted).
139. Ridglea Estate Condo. Ass'n v. Lexington Ins. Co., 309 F. Supp.2d 851 (N.D. Tex. 2004).
140. Provident Life & Accident Ins. Co. v. Knott, 128 S.W.3d 211 (Tex. 2003).
141. Murray v. San Jacinto Agency, Inc., 800 S.W.2d 826 (Tex. 1990).
142. See Williams v. Khalaf, 802 S.W.2d 651 (Tex. 1990).
143. Franco v. Slavonic Mut. Fire Ins. Ass'n, 154 S.W.3d 777 (Tex. App.–Houston [14th Dist.] 2004, no pet. h.).
144. See, e.g., Murray v. San Jacinto Agency, Inc., 800 S.W.2d 826 (Tex. 1990) (claim for "bad faith" accrues when insurer denies claim); Abe's Colony Club, Inc. v. C & W Underwriters, Inc., 852 S.W.2d 86, 90-91 (Tex. App.–Fort Worth 1993, writ denied) (suit for misrepresentation accrued when insurer denied claim).
145. Med. Care Am., Inc. v. Nat'l Union Fire Ins. Co., 341 F.3d 415 (5th Cir. 2003).
146. Mayo v. Hartford Life Ins. Co., 354 F.3d 400 (5th Cir. 2004).
147. Ellis v. Liberty Life Assurance Co., 394 F.3d 262 (5th Cir. 2004).
148. Kentucky Ass'n of Health Claims, Inc. v. Miller, 538 U.S. 329 (2003).
149. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002). See also Burgos v. Group & Pension Admin., Inc., 286 F. Supp.2d 812 (S.D. Tex. 2003).
150. Owens v. Unum Life Ins. Co., 285 F. Supp.2d 778 (E.D. Tex. 2003).
151. Baylor Univ. Med. Ctr. v. Arkansas Blue Cross Blue Shield, 331 F. Supp.2d 502 (N.D. Tex. 2004).
152. Ins. Co. of Pennsylvania v. Ranger Ins. Co., 2004 WL 1089164 (Tex. App.–Dallas 2004, no pet.).
153. Bott v. J.F. Shea Co., 388 F. 3d 530 (5th Cir. 2004).
154. Esco Transp. Co. v. General Ins. Co., 75 Fed. Appx. 936 (5th Cir. 2003) (per curiam).
155. Tull v. Chubb Group of Ins. Cos., 146 S.W.3d 689 (Tex. App.–Amarillo 2004, no pet.).
156. DeLaurentis v. United Servs. Auto. Ass'n, ___ S.W.3d ___, 2004 WL 349922 (Tex. App.–Houston [14th Dist.] Feb. 26, 2004, no pet.) opinion withdrawn and supeseded on rehearing by 2004 WL 2186753 (Tex.App.—Houston [14th Dist.] 2004) opinion withdrawn and superseded on overruling of rehearing by 2005 WL 724893 (Tex. App.—Houston [14th Dist.] 2005).
157. Esco Transp. Co. v. Gen. Ins. Co., 75 Fed. Appx. 936 (5th Cir. 2003) (per curiam).
158. Scottsdale Ins. Co. v. Nation Emergency Servs., ___ S.W.3d ___, 2004 WL 1688540 (Tex. App.–Houston [1st Dist.] 2004, pet. denied).
159. Caplinger v. Allstate Ins. Co., 140 S.W.3d 927 (Tex. App.–Dallas 2004, pet. denied).
160. Mayo v. Hartford Life Ins. Co., 354 F.3d 400 (5th Cir. 2004).
161. Scottsdale Ins. Co, 2004 WL 1688540.
162. Reddy Ice, Corp. v. Travelers Lloyds Ins. Co., 145 S.W.3d 337 (Tex. App.–Houston [14th Dist.] 2004, pet. denied). See also Commercial Underwriters Ins. Co. v. Royal Surplus Lines Ins. Co., 345 F. Supp.2d 652 (S.D. Tex. 2004).
163. Hornbuckle v. State Farm Lloyds, 385 F. 3d 538 (5th Cir. 2004).
164. In re AIU Ins. Co., 148 S.W.3d 109 (Tex. 2004).
165. Commonwealth Gen. Corp. v. York, 141 S.W.3d 840 (Tex. App.–Corpus Christi 2004, pet. filed).
166. Bougie v. Tech. Risks, Inc., ___ S.W.3d ___, 2004 WL 2902508 (Tex. App.–Houston [14th Dist.] 2004, no pet. h.).
167. Corfield v. Dallas Glen Hills L.P., 355 F.3d 853 (5th Cir. 2003).
168. In re Texas Windstorm Ins. Ass'n, 121 S.W.3d 821 (Tex. App.–Beaumont 2003, no pet.).
169. Ellis v. Liberty Life Assurance. Co., 394 F.3d 262 (5th Cir. 2004).
170. North Carolina Mut. Ins. Co. v. Whitworth, 124 S.W.3d 714 (Tex. App.–Austin 2003, pet. denied).
171. In re Maher, 143 S.W.3d 907 (Tex. App.–Forth Worth 2004, orig. proc.).
172. Royal Maccabees Life Ins. Co. v. James, 146 S.W.3d 340 (Tex. App.–Dallas 2004, pet. filed).
173. Hamburger v. State Farm Mut. Auto. Ins. Co., 361 F.3d 875 (5th Cir. 2004).
174. *Id.*
175. Burford v. Great-West Life & Annuity Ins. Co., 95 Fed. Appx. 539 (5th Cir. 2004) (per curiam).
176. Allstate Texas Lloyds v. Mason, 123 S.W.3d 690 (Tex. App.–Fort Worth 2003, no pet.).
177. Taylor v. State Farm Lloyds, Inc., 124 S.W.3d 665 (Tex. App.–Austin 2003, pet. denied).
178. J.C. Penney Co. v. Pitts, 139 S.W.3d 455 (Tex. App.–Corpus Christi, 2004, no pet.).
179. Philadelphia Life Ins. Co. v. Turner, 131 S.W.3d 576 (Tex. App.–Fort Worth 2004, no pet.).
180. Republic Ins. Co. v. Paico Receivables, LLC, 383 F.3d 341 (5th Cir. 2004).
181. In re Caliber One Indem. Co., 153 S.W.3d 587 (Tex. App.–Amarillo 2004, orig. proc.).
182. Boyd v. Progressive County Mut. Ins. Co., 2003 WL 22681566 (Tex. App.–Houston [1st Dist.] 2003, pet. denied).
183. Utica Nat'l Ins. Co. v. Am. Indem. Co., 141 S.W.3d 198 (Tex. 2004).
184. Boyd, 2003 WL 22681566.
185. Hill v. State Farm Lloyds, 79 Fed. Appx. 644 (5th Cir. 2003) (per curiam).
186. U.S. Auto Ins. Servs. v. Les Marks Chevrolet, 2003 WL 22012670 (Tex. App.–Houston [14th Dist.] 2003, no pet.).
187. Erivas v. State Farm Mut. Auto. Ins. Co., 141 S.W.3d 671 (Tex. App.–El Paso 2004, no pet.).
188. City of Corpus Christi v. Gomez, 141 S.W.3d 767 (Tex. App.–Corpus Christi 2004, no pet.).
189. Am. Home Assurance. Co. v. Unauthorized Practice of Law Comm., 121 S.W.3d 831 (Tex. App.–Eastland 2003, pet. filed).