TADC INSURANCE LAW UPDATE

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This newsletter is intended to summarize significant cases impacting the insurance practice since the Spring 2014 newsletter. It is not a comprehensive digest of every case involving insurance issues during this period or of every holding in the cases discussed. This newsletter was not compiled for the purpose of offering legal advice. Any opinions expressed herein are those of the authors and do not necessarily reflect the views of Beirne, Maynard & Parsons, L.L.P.

INDEPENDENT INJURY

***United National Ins. Co. v. AMJ Investments, Inc.*, No. 14-12-00941-CV, --S.W.3d--, 2014 WL 2895003 (Tex. App. – Houston [14th Dist.] June 26, 2014, no pet.).**

In the context of a first party property claim, the Court of Appeals held that the absence of an independent injury did not preclude the insurer's liability for violation of the Insurance Code.

The insured, AMJ, owned an office building that was damaged in Hurricane Ike. United paid approximately $2.4 million on AMJ's claim, the portion of the claim it contended was due. AMJ contended that a total of $3.4 million was due.

The jury found that United had breached the policy and that it owed an additional $300,000 under the policy. The jury also found that United violated the Texas Insurance Code in two respects: (1) by failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim when liability is reasonably clear; and (2) by attempting to enforce a full and final release of a claim from a policyholder when only a partial payment had been made. The jury awarded the same $300,000 of actual damages and assessed an additional $1 million based upon its finding that United had knowingly violated the Insurance Code.

The trial court rendered judgment awarding AMJ $300,000 in actual damages, a prompt payment penalty, $600,000 for United's knowing conduct, attorneys' fees, costs and interest.

On appeal, United asserted that AMJ was precluded from recovering under the Texas Insurance Code because it sustained no injury independent of its claim for policy proceeds. The Court of Appeals held that United's argument was contrary to the Texas Supreme Court's holdings in *Vail* and *Waite Hill Services.* The Court then distinguished *Castaneda* on the grounds that in that case, the insured did not allege or obtain findings that the insurer had breached the policy.

The Court of Appeals concluded that unlike the insured in *Castaneda,* AMJ had pleaded and proved that its claim was covered and that United breached the Policy.

CONTRACTUAL ONE-YEAR LIMITATIONS PERIOD APPLIED IN ARBITRATION

***Why Nada Cruz, L.L.C. v. Ace American Ins.*, 569 Fed.Appx. 339 (5th Cir. 2014).**

The Fifth Circuit affirms dismissal based on application of contractually shortened one-year statute of limitations in arbitration action.

On August 15, 2010, the vessel "Sweet Dreams" sank. Plaintiffs, Greg Anderson and Why Nada Cruz, L.L.C., sought recovery for the loss under a yachtsman policy of insurance issued by ACE. The policy included a mandatory arbitration provision requiring that a "request for arbitration must be filed within one (1) year of the date of loss or damage."

On August 11, 2011, instead of filing for arbitration, Plaintiffs sued ACE in Texas state court to recover under the Policy. ACE removed the case to federal court and filed an unopposed motion to compel arbitration, which the district court granted.

More than eight months later, Plaintiffs filed an arbitration demand with the American Arbitration Association ("AAA"). Once the parties selected an arbitrator, ACE sought dismissal of the arbitration on the ground that Plaintiffs failed to comply with the Policy's requirement that a request for arbitration be filed within one year of the loss. Of note, no party complained of the shortened contractual one-year limitations period.

The arbitrator ultimately entered an award dismissing the arbitration on the grounds that the arbitration was not filed in a timely manner and did not meet the specific requirements, as detailed within the Insurance Policy.

On ACE's motion, the district court entered an order confirming the arbitration award and dismissing the suit with prejudice. Plaintiffs filed a motion for new trial, which was denied. Plaintiffs appealed.

On appeal, Plaintiffs alleged the arbitrator exceeded his powers by: (1) dismissing the arbitration, (2) failing to reconsider Plaintiffs' waiver and estoppel arguments and new evidence to support same, and (3) impermissibly relying on events that occurred after the Policy's one-year deadline for requesting arbitration to determine the timeliness of the request for arbitration.

The Fifth Circuit affirmed dismissal of the arbitration. First, the Fifth Circuit held the arbitrator did not exceed his powers in rejecting Plaintiffs' argument that a letter to ACE sent within one year of the loss constituted a request for arbitration under the Policy.

Second, the Fifth Circuit held the arbitrator did not exceed his powers in considering Plaintiffs' actions after the one-year deadline for filing an arbitration request had run, as such evidence reasonably related to, and negated, Plaintiffs' equitable tolling of limitations argument, instead of Plaintiffs' failure to timely request arbitration under the Policy.

Finally, the Fifth Circuit held that the arbitrator did not exceed his authority by refusing to reconsider the new evidence of Plaintiffs, reasoning Plaintiffs had the opportunity to present all evidence and arguments in response to the original motion to dismiss, and failed to do so.

EXCESS INSURANCE: EXHAUSTION OF PRIMARY POLICY BY CLAIMS NOT COVERED BY EXCESS POLICY

***Indemnity Ins. Co. of North America v. W&T Offshore, Inc.*, 756 F.3d 347 (5th Cir. 2014).**

Insured submitted claims to primary carrier in excess of primary coverage limit. Excess carriers sought a declaratory judgment that the retained limit in the excess policies, which triggered coverage, had not been met because the underlying insurance had not been exhausted by claims that would have been covered by the excess policies. The district court granted judgment in favor of insurers, and insured appealed.

The Fifth Circuit reversed and rendered judgment in favor of insured. Focusing on the plain language of the policy, the court rejected the insurers' argument that the retained limit must be exhausted by claims covered by the excess policies. The court first noted the coverage provision required the excess carriers to pay "sums in excess of the Retained Limit," defined as the "total of the applicable limits of the underlying policies listed." The court further observed a "limits of insurance" provision required the excess carriers to (1) pay sums in excess of the reduced limit of the underlying policies if the underlying policies were reduced by claims covered by the excess policies, and (2) act as underlying insurers and defend against covered claims if the underlying policies were exhausted by claims covered by the excess policies.

Because nothing in the coverage provision or definition of retained limit specified how the limit of the underlying policies must be reached or that the retained limit referred exclusively to amounts covered by the excess policies, the court concluded the retained limit "must simply be met" to trigger the excess policies. It found this to be in stark contrast to other provisions requiring the excess carriers to pay claims only if they fell under the terms of the excess policies.

The court also reasoned the "limits of insurance" provision merely outlined what would happen *if* the underlying policies were reduced or exhausted by claims covered under the excess policies. It distinguished the provision from policies that explicitly provide what will happen if the underlying policy limits are exhausted by claims not covered by the excess policy. The court therefore concluded the excess policies were triggered by any damages in

excess of the "retained limit," regardless of whether the damages were covered by the excess policies.

CERTIFIED QUESTIONS: BUSINESS RISK EXCLUSIONS

***U.S. Metals, Inc. v. Liberty Mut. Group, Inc.*, No. 13-20433, --Fed. Appx.--, 2014 WL 4652892 (5th Cir. Sept. 19, 2014).**

The Fifth Circuit certified four questions to the Texas Supreme Court regarding the interpretation of the "your product" and "impaired property" exclusions. The questions include whether the terms "physical injury" and "replacement" are ambiguous, and if so, whether the insured's interpretation is reasonable, whether "physical injury" occurs to another party's product when it is irreversibly attached to the insured's product, and whether "replacement" includes removal or destruction of the third-party's product. The last three questions are conditioned on the answer to the first.

Exxon sued the insured, U.S. Metals alleging that flanges provided by U.S. Metals that were incorporated into Exxon's refineries did not meet ASTM standards. The flanges were irreversibly incorporated into Exxon's facilities by welding and bolting the flanges into unit pipes. Exxon contended that it had to replace all of the U.S. Metals flanges, requiring stripping of the temperature coating, removing and damaging the bolts and gaskets and grinding down the pipes. These repairs required the refineries to be shut down, resulting in loss of use.

U.S. Metals sought coverage under a CGL and an Umbrella policy issued by Liberty. Liberty denied coverage under the "your product" and "impaired property" exclusions. The district court granted summary judgment in favor of Liberty and U.S. Metals appealed.

The Fifth Circuit noted that there is no Texas Supreme Court case law interpreting the language of these two exclusions. It further found that no Texas court, or court of any other state or circuit, has determined whether the terms "physical injury" or "replacement" as used in these exclusions are ambiguous. Thus, the Fifth Circuit certified the following questions to the Texas Supreme Court:

1. In the "your product" and "impaired property" exclusions, are the terms "physical injury" and/or "replacement" ambiguous?

2. If yes as to either, are the aforementioned interpretations offered by the insured reasonable and thus, must be applied pursuant to Texas law?

3. If the above question 1 is answered in the negative as to "physical injury," does "physical injury" occur to the third party's product that is irreversibly attached to the insured's product at the moment of incorporation of the insured's defective product or does "physical injury" only occur to the third party's product when there is an alteration in the color, shape, or appearance of the third party's product due to the insured's defective product that is irreversibly attached?

4. If the above question 1 is answered in the negative as to "replacement," does "replacement" of the insured's defective product irreversibly attached to a third party's product include the removal or destruction of the third party's product?

CERTIFIED QUESTION: WHAT CONSTITUTES A "SUIT"

***McGinnes Indus. Maintenance Corp. v. Phoenix Ins. Co.*, 571 Fed.Appx. 329 (5th Cir. 2014).**

In this coverage dispute, the Fifth Circuit certified a question to the Texas Supreme Court asking whether the EPA's "potential responsible party" letters or unilateral administrative order, issued pursuant to the Comprehensive Environmental Response, Compensation and Liability Act, or both, constitute a "suit" within the meaning of commercial-general liability policies, triggering the duty to defend. The Texas Supreme Court accepted the certified question on June 23, 2014 and will consider the question over the coming term as Cause No. 14-0465.

CLAIMS-MADE POLICY: SUBMISSION OF CLAIM

***Netspend Corp. v. AXIS Ins. Co.*, No. A-13-CA-456-SS, 2014 WL 3568355 (W.D. Tex. July 18, 2014).**

AXIS issued two consecutive and identical claims-made-and-reported professional liability policies to Netspend. The policies provided coverage for claims made against Netspend based on Netspend's unintentional conduct. Such claims must have arisen

from a wrongful act or interrelated wrongful acts, which the policies defined as any "negligent act, error, or omission," or "unintentional breach of contract."

Netspend sought coverage for a lawsuit filed against it by its counterpart in a contract concerning banking services related to reloadable debit cards. The original petition was filed during the first policy period, but the claim was not reported to AXIS until after the first policy period ended. AXIS denied coverage and Netspend sued AXIS.

Addressing cross-motions for summary judgment on the issue of coverage, the focal point was whether the original petition constituted a claim arising out of (or for) a wrongful act (*i.e.*, from Netspends unintentional conduct). The original petition sought declaratory relief, an accounting, and injunctive relief, but no damages. As noted by the appellate court, if the original petition did constitute a claim, then the insured failed to timely report such claim, negated coverage. It was not disputed that the subsequent amendments to the petition included covered claims.

Noting it was compelled to construe the pleadings in favor of coverage, the court nevertheless concluded the original petition asserted claims for Netspend's unintentional conduct, reasoning that the only plausible inference was that Netspend was negligent or incompetent. Accordingly, the Court granted summary judgment in favor of AXIS because of Netspend's failure to timely report the claim.

CONTRACTUAL-LIABILIITY EXCLUSION

***Crownover v. Mid-Continent Cas. Co.*, 757 F.3d 200 (5th Cir. 2014).**

Sitting in diversity, the Fifth Circuit held that, under *Gilbert Texas Construction, L.P. v. Underwriters at Lloyd's London*, 327 S.W.3d 118 (Tex. 2010), there was no duty to indemnify based on the contractual-liability exclusion at issue.

After the plaintiff homeowners entered into a construction contract with the insured builder, they later discovered, among other things, cracks in the newly constructed home's foundation and walls. Because the contract contained a warranty-to-repair provision, the homeowners initiated arbitration against the builder when the builder failed to repair the problems or reimburse the homeowners for correcting them. At the arbitration proceeding, the arbitrator awarded the homeowners damages after finding that the builder breached the express warranty to repair contained in the contract. During the builder's subsequent bankruptcy proceeding, the bankruptcy court allowed the homeowners to seek recovery under the builder's insurance. Accordingly, the homeowners demanded that the builder's liability carrier pay for the damages awarded at the arbitration. The insurer denied, causing the homeowners to sue for breach of contract.

The lower court found that although the CGL at issue covered the builder while it constructed the home, the contractual-liability exclusion was triggered. Further, the court found, no exception to the exclusion applied.

The exclusion stated that "[t]his insurance does not apply to[] 'property damage' for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement." One of the exceptions to the exclusion provided that it would not apply to "liability . . . [t]hat the insured would have in the absence of the contract or agreement." The district court, however, found this exception inapplicable, as the arbitration award was based solely on the builder's breach of the express warranty, which showed that the builder had assumed liability through the contract that it otherwise would not have had but for that contract. Therefore, the lower court held that there was no coverage.

In affirming on appeal, the Fifth Circuit first discussed the homeowners' position that because there also existed under Texas law an "implied warranty of good workmanship," which the contract at issue did not disclaim, the exception should apply, as the builder would have that liability even in the absence of the contract. However, as the court noted, the arbitration award only found that the builder breached the express warranty and, under *Gilbert*, the court could not look beyond the award. Nevertheless, the court still addressed and summarily dismissed the homeowners' argument because it found that the express warranty – assumed by the insured builder through the contract – superseded the implied warranty of good workmanship. Therefore, the damages awarded against the insured builder were excluded from coverage and there was no duty to indemnify.

***Arch Ins. Co. v. USYSA, Inc.*, No. 05-12-00596, 2014 WL 2941372 (Tex. App.—Dallas May 12, 2014, no pet.).**

Exclusion for claims arising out of contractual obligations applied to negate coverage under claims-made policy despite collateral allegation of discrimination under Amateur Sports Act.

Appellate court reversed trial court's grant of summary judgment in favor of the insured, USYSA, on the issue of coverage. The appellate court agreed with insurer that policy exclusion for claims arising out of breach of contractual obligations applied to underlying plaintiff's allegation that USYSA had failed to abide by its internal bylaws and policies by discriminating against some of its constituencies, certain local and state youth soccer organizations.

The appellate court rejected USYSA's argument that the discrimination claim was the crux of the allegations in the underlying lawsuit, holding instead that although discrimination was alleged, the origin of the damages was breach of the internal bylaws and policies, which were contractual obligations it owed its constituent members.

LOSS-OF-USE DAMAGES

***American Alternative Ins. Corp. v. Davis*, No. 10-13-00275-CV, --S.W.3d--, 2014 WL 2917081 (Tex. App.—Fort Worth June 26, 2014, pet. filed).**

Chattel owner was not entitled to loss-of-use damages suffered when owner's chattel was totally destroyed.

AAIC appealed following a jury verdict finding the tow truck driver suffered $28,000 in loss-of-use damages as a result of a collision that rendered his tow truck a total loss and unusable. The tow truck driver received $25,000 from the other driver, but then sought loss-of-use damages under his underinsured-motorist policy with AAIC.

On appeal, the Tenth Court of Appeals recounted numerous Texas cases holding that a chattel owner is not entitled to replacement damages plus loss-of-use damages. The court ultimately reversed and rendered a take nothing judgment. In doing so, the court distinguished *Morrison v. Campbell*, No. 02-13-00174-CV, 2014 Tex. App. LEXIS 542, at *8 (Tex. App.—Fort Worth Jan. 18, 2014, no pet.). The court distinguished *Morrison* because it turned on a determination that the insurer caused loss-of-use damages by engaging in an unreasonable delay of payment. Since the jury in the present matter was not asked whether AAIC or the other driver's insurer unreasonably delayed payment, there was no fact finding to support application of the exception found in *Morrison*.

COVERED AND EXCLUDED PERILS AND PROMPT NOTICE OF CLAIM

***Hamilton Properties v. Am. Ins. Co.*, 3:12-CV-5046-B, 2014 WL 3055801 (N.D. Tex. July 7, 2014).**

Hamilton Properties, Hamilton 1011 LP, Hamilton Properties Corporation, Go–Kal LLC, and Ulysses LLLP (collectively "Hamilton") owned and operated hotel property in Dallas. The Property was originally covered under an umbrella insurance policy through Hamilton Properties' hospitality management company. However, the Property was later added to Hamilton Properties' insurance policy.

The Policy included a section entitled Covered Causes of Loss. That section indicated that the Policy insured "all risks of direct physical loss or damage, except as excluded or limited elsewhere" in the Coverage Section. Among the risks excluded from coverage were "[w]ear and tear, gradual deterioration, inherent vice, latent defect, depletion, erosion, corrosion, mold, wet or dry rot" and "[s]ettling, cracking, shrinkage, bulging, or expansion of pavements, foundations, walls, floors, roofs, or ceilings." Like many insurance policies, the Policy required that the insured give prompt notice of any covered loss or damage along with a description of how, when and where loss or damage occurred and take reasonable steps to protect the Covered Property from further damaged by a Covered Cause of Loss.

On July 8, 2009 there was a hailstorm (the "July Hailstorm") in Dallas, Texas, which rained ping-pong-sized hailstones down on the property. Within a month of the July Hailstorm, the property's manager noticed a pattern of falling ceiling tiles and water dripping on the 12th floor of the Property. The property manager did not notify Hamilton Properties of the problems he observed for several weeks thereafter.

The parties disagreed when Hamilton notified its insurer of the wind and hail damage from the July Hailstorm. Plaintiffs insisted they provided notice on February 14, 2011, while the insurer insists notice was deficient at that time because the agent was no longer Plaintiffs' broker of record and could not

accept or report the claim on their behalf. Thus, the insurer argued Hamilton did not give notice until their claim was filed in October 2011.

On February 16, 2012, the insurer, AIC, denied coverage. The Denial Letter stated that an engineer previously inspected the Property on July 27, 2009–nineteen days after the July Hailstorm-and noted no obvious hail or water damage at the time. In addition, AIC's roof consultant advised that the roof was about twelve to fifteen years old, that he saw no evidence of hail damage to its surface, and that the worst interior damage was over an area previously patched. The Denial Letter also noted that AIC reviewed historical weather data for the area and confirmed that inch-sized hail was reported on the date of the July Hailstorm. Further, there were three prior hail events between April 2007 and February 2008 that produced hail between 0.88 and 1.75 inches. There also was three hail events after the July Hailstorm during May 2011 that produced hail between 0.75 and 1.5 inches. Ultimately, because Plaintiffs did not notice the damage until 2011, AIC could not determine if the damage occurred during the coverage period, which ended on September 24, 2009. Consequently, AIC disclaimed the coverage and made no payment for the claim.

After AIC denied coverage, Hamilton sued for (1) breach of contract, (2) violations of the Texas DTPA, (3) violations of the Texas Insurance Code, (4) breach of the duty of good faith and fair dealing, (5) breach of fiduciary duty, (6) misrepresentation and (7) fraud. AIC moved for summary judgment on the Plaintiffs claims and the trial court granted the motion.

AIC's primary argument in its summary judgment motion was that Hamilton could not establish that the Property suffered a covered loss because it failed to allocate damages between the July Hailstorm and other excluded factors and Hamilton failed to provide prompt notice of the alleged damage, as was required under the Policy, and its delay in filing notice of the loss prejudiced AIC's ability to investigate the claim. The trial court agreed. It recited the well-known rule that an insured cannot recover under an insurance policy unless facts are pleaded and proved showing that damages are covered by his policy. Thus, when covered and excluded perils combine to cause an injury, the insured must present some evidence affording the jury a reasonable basis on which to allocate the damage. Failure to provide evidence upon which a jury or court can allocate damages between those that resulted from covered perils and those that did not is fatal to an insured party's claim.

Viewing the evidence in the light favorable to Hamilton, the court concluded Hamilton did not allocate its losses because, although affidavit evidence spoke to losses caused by the July Hailstorm, the affidavits were silent with respect to Hamilton's hotel either before or after the store. Nor did any testimony establish that the July Hailstorm was the sole cause of the loss. Meanwhile, AIC adduced evidence suggesting the loss could have been covered by non-covered perils like an earlier hailstorm or lack of maintenance on the property. For these reasons, the court concluded the Plaintiffs did not carry the burden of establishing evidence allowing a jury to allocate damages between covered and non-covered losses.

While the court's disposition regarding covered and non-covered losses disposed of Hamitlon's claims, it also addressed whether AIC received sufficient notice. The Court observed "Texas law requires a showing of prejudice in order to raise breach of a notice requirement as a defense against claims," and it examined whether Hamilton gave prompt notice and, if not, whether AIC was prejudiced as a result.

Relying on *OneBeacon Ins. Co. v. Don's Bldg. Supply, Inc.*, 496 F.3d 361, 365 (5th Cir. 2007), the court concluded the property damage occurred when actual physical damage to the property occurred. Thus, "[t]he date the physical damage is or could have been discovered is irrelevant under the policy." The Court concluded that the damage occurred on July 8, 2009–the date of the July Hailstorm. The Court further concluded that, because Hamilton waited anywhere from nineteen to twenty-seven months after the storm before contacting AIC about property damage, notice was not prompt as a matter of law.

Concerning prejudice, the Court concluded that AIC has demonstrated that it was prejudiced by Plaintiffs' untimely notice. Hamilton's property manager testified that the ceiling on the 12th floor deteriorated considerably in the weeks and months after the July Hailstorm. In addition, Hamilton's expert conceded that the July Hailstorm only initiated, rather than caused, the damage he observed in August 2013. He also stated the roof exhibited signs of damage from a variety of sources. All this indicates that the condition of the roof and 12th floor changed considerably over the nineteen to twenty-seven months before Hamilton gave notice. Further, no evidence indicated Hamilton attempted to mitigate the damage or document the changes in the interim.

In addressing Hamilton's non-contractual claims, the Court agreed with AIC that Hamilton did not suffer any injury independent of its policy claims and many other claims were properly disposed of as AIC did not breach the insuring agreement.

POLLUTION EXCLUSION

***Acadia Ins. Co. v. Jacob & Martin, Ltd.*, 4:13-CV-798-O, 2014 WL 2217399 (N.D. Tex. May 28, 2014).**

Acadia and Continental Insurance Company (collectively, "Acadia") sought a declaration as to their duties to defend and indemnify an underlying state court action. Focusing on the live-pleading in the case, the trial court adduced the following facts. Acadia issued general liability and umbrella policies to Jacob and Martin, Ltd. The policies covered the period from December 1, 2010, to December 1, 2011. In 2011, Jacob and Martin contracted with the city of Gordon, Texas, to design and install a new sewer system. Turner was the lead engineer on the project, and Lovelady was a project engineer. Martin is the general partner of Jacob and Martin.

The City of Gordon also contracted with Granbury Contracting & Utilities, Inc. to install sewer lines. While working on the project, Lovelady directed an employee of Granbury to open a manhole, climb inside it, and remove a plug from the sewer line. When the employee removed the plug, "toxic fumes were released and [the employee] died from asphyxia due to methane gas inhalation." The employees' survivors sued Jacob and Martin, Lovelady, Turner, and Martin under the Texas Wrongful Death and Survival statutes.

On summary judgment, the trial court examined the interrelated duties of an insurer to defend and indemnify its insured. It first addressed Acadia and Continental's claims they owed no duty to defend because the underlying suit fell within the policies' pollution exclusion. The general liability policy issued by Acadia excluded: "[b]odily injury" or "property damage" arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of "pollutants" ... [a]t or from any premises, site or location which is or was at any time used by or for any insured or others for the handling, storage, disposal, processing or treatment of waste ...." Similarly, the umbrella policy issued by Continental Western excluded: " '[b]odily injury' or 'property damage' which would not have occurred in whole or part but for the actual, alleged, or threatened discharge, dispersal, seepage, migration, release or escape of 'pollutants' at any time The Continental Western policy further recited the pollution exclusion does not apply if valid "underlying insurance" for the pollution liability risks described above exists or would have existed but for the exhaustion of underlying limits for "bodily injury" and "property damage." Coverage provided will follow the provisions, exclusion, and limitations of the "underlying insurance." Both policies defined "pollutants" as "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed." The plaintiffs in the underlying wrongful death litigation contended that Ramirez died from asphyxia due to methane gas inhalation. The insured did not dispute that methane is a pollutant or that the exclusions otherwise apply to the facts alleged in the underlying suit. Rather, the insured asked the trial court to consider extrinsic evidence that they contend demonstrates Ramirez may have died from a lack of oxygen. The trial court rejected this invitation, noting a long line of Texas case law holding that the duty to defend must be decided within the eight corners of the policy and underlying petition.

While the court concluded Acadia and Continental owed no duty to defend the insureds, the trial court denied Acadia and Continental summary judgment on the duty to indemnity. It concluded an autopsy report listing "asphyxia due to oxygen displacement in a confined space" as the cause of death raised a genuine issue of material fact as to whether Ramirez's death fell outside the pollution exclusions. In so doing, the Court rejected the insurers' attempts to show that if the oxygen was displaced it would have to have been displaced by methane or some other gaseous substance that was present in a concentration capable of causing injury or death. The court stated plaintiffs must show, by competent summary judgment evidence, that the substance which displaced the oxygen was a pollutant under the policies and that the means by which the oxygen was displaced falls within the exclusions.

***Liberty Mutual Ins. Co. v. Linn Energy, LLC*, 574 Fed.Appx. 425 (5th Cir. 2014).**

Commercial insurance policy had an endorsement affording coverage to "property damage," including underground resources. It also included a total pollution exclusion, excluding coverage for property damage that would not have occurred but for actual,

alleged or threatened pollution. The district court found insurer did not have a duty to defend and indemnify insured in underlying lawsuit, which alleged insured's pipeline leaked contaminants, polluting plaintiffs' property.

The Fifth Circuit affirmed, rejecting the insured's contention that the coverage-adding endorsement superseded the total pollution exclusion. The court reasoned the exclusion did not render the endorsement wholly meaningless; rather, the endorsement provided coverage for non-pollution damage. Because the exclusion and endorsement were not irreconcilable, the exclusion was enforceable under the policy's plain language.

NO CAUSE OF ACTION FOR NEGLIGENT CLAIMS HANDLING

***O'Quinn v. General Star Indemnity Co.*, No. 1:13–CV–471, 2014 WL 3974315 (E.D. Tex. Aug. 5, 2014).**

The Eastern District of Texas affirmed that there is no cause of action for negligent claims handling.

Plaintiff/insured purchased insurance from General Star for "Alibi's," a nightclub/restaurant in Jefferson County, Texas. Allegedly, fire to the property resulted in significant damage, but General Star refused to pay "certain depreciation losses, [and] omitted and underpaid some items." Plaintiff also alleged General Star had not attempted in good faith "to effect a prompt, fair, and equitable settlement of a claim submitted in which liability has become reasonably clear." Based on these allegations, plaintiff asserted causes of action for negligence, breach of contract, breach of implied covenant of good faith and fair dealing, and violations of the Texas Insurance Code.

General Star argued plaintiff's failure to complete a condition precedent prevented recovery of depreciation costs. Specifically, plaintiff did not repair or rebuild the property, as required by the policy. General Star also contended that plaintiff executed a policyholder release, which barred her from bringing certain claims arising from the fire.

The court upheld the release signed by plaintiff, releasing General Star from "any and all claims, demands, actions, liens or causes of action of any kind whatsoever, founded in tort, common law, statute, contract or otherwise, including common law and statutory bad faith claims and claims arising under the Texas Deceptive Trade Practices Act and Sections 541 and 542 of the Insurance Code." However, the defendant and plaintiff offered differing opinions on the interpretation of the policyholder release regarding the sentence "the Claimant reserves the right to pursue a supplemental claim for additional damages, if discovered." The plaintiff asserted that miscalculations constituted additional damages. The court disagreed, finding that miscalculations do not fall within the meaning of "additional damages." The court also held, notwithstanding the release, the replacement cost provision did require replacement of the building property in order for the plaintiff to be entitled to depreciation.

Even assuming that the plaintiff did not waive her rights to assert causes of action against the insurer in the release, the court found Texas law does not recognize a cause of action for negligent claims handling. If a defendant's conduct is actionable only because it breaches the parties' agreement, the claim is solely contractual in nature. In the absence of the duty to act in good faith and deal fairly, the only duty imposed on an insurance company, under Texas law, is the duty to exercise ordinary care and prudence in considering an offer of settlement within policy limits (per *Stowers*). In other words, Texas law does not recognize a cause of action for negligent claims handling. Finally, though there is a claim for bad faith claims handling, where an insured joins claims under the Texas Insurance Code and DTPA with a bad faith claim, all asserting a wrongful denial of policy benefits, if there is no merit to the bad faith claim, there can be no liability on either statutory claim. The suit was dismissed on the merits.

SETTLEMENT OF CLAIMS AND HOSPITAL LIENS

***Allstate Indemnity Co. v. Memorial Hermann Health Sys.*, 437 S.W.3d 570 (Tex. App—Houston [14th Dist.] 2014, no pet. h.).**

Insurer has standing to contest the charges for services reflected on a hospital lien under Chapter 55 of the Texas Property Code.

Allstate's insured was involved in a motor vehicle accident. The injured third party was treated at Memorial Hermann Hospital. The hospital filed and perfected a lien under Chapter 55 of the Texas Property Code (the "Hospital Lien Statute") for charges stemming from the injured person's diagnosis and treatment. After the hospital filed and perfected

its lien, Allstate settled the injured party's negligence claim against its insured without first satisfying the hospital's lien. The hospital sent a demand letter to Allstate seeking payment of the entire amount of the hospital's lien.

Allstate contested the reasonableness of the hospital's charges and filed a petition for declaratory judgment seeking a declaration that, under section 55.004 of the Hospital Lien Statute, Allstate has the right to challenge the reasonableness and necessity of the hospital's billed services. The hospital answered and asserted a counterclaim for payment of settlement proceeds in violation of the hospital's lien. The hospital also filed a plea to the jurisdiction challenging Allstate's standing to contest the amount of the lien because Allstate was a stranger to the transaction between the hospital and its patient. Concluding that the insurer did not have standing, the trial court granted the hospital's plea to the jurisdiction, dismissed Allstate's petition for declaratory relief, and granted summary judgment for the hospital on its counterclaim for damages and attorney's fees based on Allstate's payment of settlement funds to the patient in violation of the hospital lien. Allstate appealed.

The Fourteenth Court of Appeals concluded that Allstate alleged a distinct injury appropriate for declaratory relief. The Court of Appeals found Allstate was affected by the hospital's lien because Allstate paid settlement funds to the patient on behalf of its insured, the hospital's lien attached to the settlement proceeds, Allstate risked liability to the hospital for settling the claim against its insured in violation of the hospital lien statute, and the parties disagreed on whether Allstate was liable for the full amount of the charges or whether Allstate may challenge the reasonableness and necessity of the charges. Under these facts, the Court of Appeals held Allstate had not alleged a merely theoretical dispute and reversed the trial court's judgment.

MORTGAGEE CLAUSE AND VACANCY CLAUSE

***SWE Homes, LP, v. Wellington Ins. Co.*, 436 S.W.3d 86 (Tex. App—Houston [14th Dist.] 2014, no pet.).**

Operation of vacancy clause does not defeat mortgagee's right to bring a claim under a standard mortgage clause for property damage.

Wellington's insured purchased a residential property with a mortgage from SWE. Wellington's property policy named SWE as the mortgagee. The policy covered losses from various hazards including fire. The policy contained a mortgage clause, which read in pertinent part as follows:

> We will pay for any covered loss of or damage to buildings or structures to the mortgagee shown on the declarations page as interests appear...If we deny your claim because of your acts or because you have failed to comply with the terms of this policy, the mortgagee has the right to receive loss payment if the mortgagee..." The policy also included a vacancy clause that provided: "During the policy term, if an insured building is vacant for 60 consecutive days immediately before a loss, we will not be liable for a loss by the perils of fire and lightning or vandalism or malicious mischief...

The property was damaged by a fire apparently set by an unknown arsonist. Wellington's insured made a claim on the policy, but after the insured admitted the property had been left vacant for over a year prior to the fire, Wellington denied the claim under the policy's vacancy clause. SWE then filed a claim pursuant to the mortgage clause. Wellington did not respond to SWE's claim and SWE filed suit.

Wellington filed a motion for summary judgment in which Wellington argued that there was no covered loss—as required for a claim under the mortgage clause—because the property had been left vacant for over 60 consecutive days immediately before the loss occurred. In response, SWE argued that under the policy, coverage for the mortgagee could not be defeated by the mortgagor's actions triggering the vacancy clause when SWE had no knowledge of those actions. The trial court granted Wellington's summary judgment motion and SWE appealed.

By its sole issue on appeal, SWE contended that the trial court erred in granting summary judgment favoring Wellington because SWE's claim under the mortgage clause should not be defeated by operation of the policy's vacancy clause. The Fourteenth Court of Appeals began its analysis by noting there are two common types of mortgage clauses relevant to the case – the open clause type where the mortgagee stands in the shoes of the insured and the standard mortgage clause type giving the mortgagee rights to recover even when the insured does not. The Court of Appeals also noted the standard mortgage clause

creates a separate contract between the insurer and the mortgagee, in this case Wellington and SWE.

The Court of Appeals found the policy covers damage from fire, and it was Wellington's burden to prove an exclusion applicable to SWE. Construing the policy according to the general rules of contract interpretation, the Court of Appeals held that while there was no coverage for the insured under the vacancy clause because the property remained vacant for the specified period, the vacancy clause did not operate to defeat coverage for SWE as mortgagee, as long as SWE meets the required conditions, under the standard mortgage clause. The Court of Appeals determined that SWE, by the clear and unambiguous terms of the standard mortgage clause, could not be held responsible for acts of the mortgagor that defeated coverage. Finding that Wellington met all the required conditions under the standard mortgage clause, the Court of Appeals held SWE properly made a claim on the policy, reversed the summary judgment in favor of Wellington, and remanded the case to the trial court.

DIVERSITY JURISDICTION

***Bell v. State Farm Lloyds*, No. 3:13-cv-1165-M, 2014 WL 3058299 (N.D. Tex. Jul. 7, 2014) (slip op.).**

Lloyd's Plans in Texas have the citizenship of their members for diversity purposes and a Lloyd's Plan's attorney-in-fact or other representative is not considered a member for diversity purposes.

Plaintiffs sued State Farm Lloyds and certain adjusters in state court for alleged violations of the duty of good faith and fair dealing and various provisions of the Texas Insurance Code. State Farm Lloyds removed the case. The district court *sua sponte* questioned whether it had diversity jurisdiction. The court determined that Plaintiffs could not state claims against the adjusters and the adjusters were improperly joined, so the adjusters' citizenship(s) were irrelevant. The court also found the remaining parties to the case, Plaintiffs and State Farm Lloyds, to be diverse. After granting State Farm Lloyds's motion for judgment on the pleadings and/or for summary judgment, Plaintiffs moved to vacate and remand on the basis that the court lacked subject matter jurisdiction because the parties were not diverse. Plaintiffs argued that State Farm Lloyds, Inc., was formed as a Texas corporation and should be considered in determining the citizenship of State Farm Lloyds.

In considering Plaintiffs' motion, the Court determined that State Farm Lloyds was formed as a "Lloyd's plan" under Texas law, which allows a group of underwriters to form an association and sell insurance policies through an attorney-in-fact or other representative. Relying on Fifth Circuit precedent, the Court held that, for diversity purposes, unincorporated associations, such as State Farm Lloyd's, have the citizenship of their members and that the attorney-in-fact of a Lloyd's organization is not considered a member of the organization. The Court held, instead, that members of the organization, for diversity purposes, are the underwriters alone. The Court found that State Farm Lloyds, Inc., was the attorney-in-fact of State Farm Lloyds and held State Farm Lloyds, Inc.'s citizenship was irrelevant for determining the citizenship of State Farm Lloyds. Upon finding Plaintiffs were citizens of Texas and none of the State Farm Lloyds underwriters were citizens of Texas, the Court held State Farm Lloyds was not a citizen of Texas and diversity jurisdiction existed.