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This newsletter is intended to summarize significant cases impacting the insurance practice since the Fall 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.

ADDITIONAL INSURED COVERAGE LIMITED – DEEPWATER HORIZON

In re Deepwater Horizon, No. 13-0670, 2015 WL 674744 (Tex. Feb. 13, 2015).

In a long-awaited decision, the Texas Supreme Court recently recognized that the extent to which an additional insured is entitled to insurance coverage can require reference to the "insured contract" requiring that the party be named as an additional insured. Specifically, the Texas Supreme Court held that:

(1) the Transocean insurance policies include language that necessitates consulting the drilling contract to determine BP's status as an "additional insured";

(2) under the terms of the drilling contract, BP's status as an additional insured is inextricably intertwined with limitations on the extent of coverage to be afforded under the policies;

(3) the only reasonable construction of the drilling contract's additional insured provision is that BP's status as an additional insured is limited to the liabilities assumed by Transocean; and

(4) BP is not entitled to coverage under the Transocean policies for damages arising from subsurface pollution because BP, not Transocean, assumed such liability.

While this case is of significance not only in the oil and gas industry, it should be recognized that the court's holding is dependent upon the specific language of the insurance policies at issue. It should also be noted that BP has filed a motion for rehearing.

Transocean owned and operated the *Deepwater Horizon*, a mobile drilling unit, pursuant to a drilling contract with BP. The drilling contract contained standard "knock for knock" indemnity provisions requiring Transocean to indemnify BP for any pollution originating on or above the surface of the water or land, while BP was required to indemnify Transocean for all pollution risk not assumed by Transocean. The drilling contract also required Transocean to carry various types of insurance, including liability insurance with limits of at least $10 million, and to name BP and its affiliates as additional insureds "for liabilities assumed by [Transocean] under the terms of [the drilling] contract."

In April 2010, there was an explosion aboard the *Deepwater Horizon* resulting in the deaths of eleven crewmembers, numerous personal injuries, loss of the rig, and the discharge of millions of gallons of oil into the Gulf of Mexico. Both Transocean and BP sought coverage under Transocean's primary and excess liability policies for the myriad of claims arising from the explosion. Transocean's insurers sought a declaration that BP was not entitled to additional insured coverage for subsurface pollution claims because the drilling contract limited Transocean's obligation to have BP named as an additional insured to "liabilities assumed by [Transocean] under the terms of [the drilling] contract." Faced with erosion of its $750 million of liability coverage by BP's claims for coverage, Transocean intervened in the declaratory judgment action aligning itself with the insurers.

The district court held that BP was not an insured for subsurface pollution claims. On appeal, the Fifth Circuit reversed, holding that under *Evanston*

Insurance Co. v. ATOFINA Petrochemicals, Inc., 256 S.W.3d 660 (Tex. 2008), the coverage dispute must be resolved solely from the four corners of the insurance policies. The Fifth Circuit initially concluded that the Transocean policies "imposed no relevant limitations upon the extent to which BP is covered." On rehearing, the Fifth Circuit withdrew its prior opinion and certified questions to the Texas Supreme Court, including:

> Whether *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008), compels a finding that BP is covered for the damages at issue, because the language of the umbrella policies alone determines the extent of BP's coverage as an additional insured if, and so long as, the additional insured and indemnity provisions of the Drilling Contract are "separate and independent"?

There was no dispute that BP was an additional insured on Transocean's insurance policies and that the drilling contract was an insured contract. The dispute involved whether the extent to which BP was entitled to coverage as an additional insured was limited by the provisions of the drilling contract. To answer this question, the Texas Supreme Court stated that its analysis must begin with the language in the insurance policy, but that it has long recognized that insurance policies can "incorporate limitations on coverage encompassed in extrinsic documents by reference to those documents." The court held that the scope of coverage is determined based upon the language of the insurance policy and that it would not consider limitations on coverage in "underlying transactional documents" unless obligated to do so by the terms of the policy.

In this case, however, the Transocean policies required reference to the drilling contract to determine BP's status as an additional insured. Importantly, it is the language of the insurance policy that determines the extent to which an analysis of the language of an underlying service contract is necessary to determine the existence and scope of additional insured coverage. Here, the Transocean policies granted additional insured status to any "person or entity to whom the Insured is obliged by … Insured Contract … to provide insurance such as afforded by [the] Policy" and that "where required by written contract, … additional insureds are automatically included hereunder …" (emphasis added). The emphasized language in the quoted language above was of particular importance to the court, which stated that "[c]ontrary to any suggestion otherwise, the foregoing authority [*Evanston* and other cases relied upon by BP] cannot be interpreted as excluding from consideration restrictions on the scope of additional-insured coverage contained in a contract that has been incorporated into the terms of an insurance policy." "Rather, this authority affirms the principle that we must consider the terms of an underlying contract to the extent the policy language directs us to do so."

Because the policies only provide additional insured coverage "where required by written contract" and where the Insured "is obliged" to provide such coverage, the court held that it was required to consult the drilling contract and after doing so, it was apparent that the parties did not intend for BP to be an additional insured for liability arising out of subsurface pollution.

Because the court concluded that the drilling contract, read in conjunction with the insurance policies, was not ambiguous, it did not answer the Fifth Circuit's second certified question regarding the doctrine of *contra proferentem.*

As stated above, BP has filed a motion for rehearing.

MURDER FALLS WITHIN ASSAULT AND BATTERY EXCLUSION

Dewey Bellows Operating Co., Ltd. v. Admiral Ins. Co., No. CV-14-042 (S.D. Tex. Nov. 14, 2014).

Assault and battery exclusion precluded coverage for plaintiffs' claim that employer was negligent in hiring and retaining co-worker who shot and killed underlying plaintiffs' decedent.

Dewey Bellows brought this declaratory judgment action seeking a determination that Admiral was obligated to defend it in a wrongful death lawsuit pursuant to a CGL policy. The policy contained an exclusion for bodily injury "arising out of assault and battery."

In the wrongful death lawsuit, the plaintiffs alleged that Dyron Green, an employee of Dewey Bellows, was shot and killed by a co-worker, Milton Mitchell. The plaintiffs alleged that Dewey Bellows was negligent in hiring and retaining Mitchell and in

failing to prevent him from bringing a loaded weapon to the workplace.

Dewey Bellows first argued that the claim in the wrongful death lawsuit did not arise out of an assault and battery, but rather arose out of a murder. The court disagreed, focusing on the specific factual allegations stating that Mitchell shot Green, who died from his injuries. Thus, the court had little difficulty concluding that Green's death arose out of assault and battery.

Dewey Bellows also contended that the assault and battery exclusion did not apply because the claim against Dewey Bellows in the wrongful death lawsuit was for negligence. The court found this argument to be contrary to clearly-established legal authority holding that an assault and battery exclusion precludes coverage for injuries caused by an assault or battery regardless of the cause of action stated.

SHOOTING WOULD-BE BURGLAR FALLS WITHIN INTENTIONAL ACT EXCLUSION

Texas Farm Bureau Underwriters v. Graham, 450 S.W.3d 919 (Tex. App. – Texarkana, pet. filed).

The Texarkana Court of Appeals holds insurer owed no duty to defend wrongful death lawsuit against insured who shot and killed a suspected burglar at the insured's ranch house.

The insured, Graham, shot and killed would-be burglar, Chambers, at Graham's ranch house in Smith County, Texas. Graham then successfully defended the resulting wrongful death lawsuit prosecuted by Chambers' family members at a cost of $130,841.43. Graham sought to recover such defense costs, plus additional damages, from Texas Farm Bureau Underwriters ("Underwriters"). Underwriters denied Graham's claim on the grounds that the shooting was an excluded intentional act and, after applying the eight-corners rule, did not constitute an occurrence under the policy. A coverage lawsuit was filed and the parties submitted competing motions for summary judgment. The trial court entered judgment in favor of Graham, holding Underwriters liable for the defense costs and other damages.

On appeal, the appellate court reversed applying the eight-corners rule. First, in looking at the four corners of the policy, the appellate court noted that there was no coverage for "bodily injury or property damage which is caused intentionally by or at the direction of an insured." Then, turning to the four corners of the live petition, the appellate court noted that the allegations omitted the fact that Chambers was committing burglary of a habitation when he was shot, but instead only alleged that Graham committed "a violent assault and battery" on Chambers and, in the alternative, that Graham was "negligent and grossly negligent" in causing Chambers' death. In particular, the live petition alleged Graham first instructed another person, Osborn, to shoot Chambers, and when Osborn refused, Graham took a 410 gauge shotgun out of Osborn's hands and shot Chambers.

Refusing the recognize and apply an exception to the eight-corners rule, the court noted that the pleaded facts could not be classified as negligent actions or an accident, but instead were intentional acts excluded from coverage.

BONA FIDE COVERAGE DISPUTE PRECLUDES EXTRA-CONTRACTUAL CLAIMS

First Community Bancshares v. St. Paul Mercury Ins. Co., No. 13-50657 (5th Cir. Nov. 14, 2014).

The Fifth Circuit declined to reach the issue of whether a common law duty of good faith and fair dealing exists in the duty to defend context, but affirmed summary judgment in favor of the insurer on this issue, finding that the summary judgment evidence presented only a bona fide coverage dispute.

First Community brought a declaratory judgment action against St. Paul seeking a determination that St. Paul owed a duty to defend two class action lawsuits under a liability policy. The policy provided coverage for professional services, but also contained an exclusion for claims "based upon, arising out of or attributable to any dispute involving fees or charges for an Insured's services." Although the introductory paragraph of each petition characterized the lawsuits as "arising from [First Community's] unfair and unconscionable assessment and collection of excessive overdraft fees," both the trial court and the Fifth Circuit focused on the specific factual allegations and noted that in addition to the return of fees, the lawsuits sought other actual damages and injunctive relief. Thus, because at least some of the factual allegations arguably fell outside the scope of the exclusion, the court found a duty to defend. The

Fifth Circuit did not discuss the breadth of the phrase "arising out of" as used in the exclusion.

The district court granted St. Paul's summary judgment on First Community's bad faith claim, holding that there is no common law duty of good faith and fair dealing arising out of a contractual duty to defend and even assuming the existence of such a duty, the evidence established that this was merely a bona fide coverage dispute. The Fifth Circuit declined to address the issue of whether a common law duty of good faith and fair dealing can exist in the context of a third-party claim, but affirmed the district court's summary judgment in favor of St. Paul.

Even assuming the existence of such a duty, the Fifth Circuit concluded that the "[coverage] question was a close one such that the duty to defend under the St. Paul policy never became reasonably clear." Thus, the case involved a bona fide coverage dispute and could not support extra-contractual claims.

SEVERANCE AND ABATEMENT OF EXTRA-CONTRACTUAL CLAIMS

In re Allstate County Mut. Ins. Co., No. 01-14-00068-CV (Tex. App.—Houston [1st Dist.] Oct. 16, 2014, no pet.).

In this mandamus proceeding, the court reaffirmed that severance of bad faith claims relating to an insurer's settlement efforts and claim handling is mandatory because an insured first has to establish liability under the policy before such claims could even accrue. According to the court, requiring the insurer to litigate the bad faith settlement claims before coverage under the contract was established would not do justice, avoid prejudice, or further convenience.

FORUM SELECTION CLAUSE ENFORCEABLE

Chandler Mgmt. Corp. v. First Specialty Ins. Corp., 452 S.W.3d 887 (Tex. App. – Dallas 2014, no pet. h.).

Insured appealed trial court's order dismissing its lawsuit against its insurer and the adjusters hired to handle its property claim, asserting various reasons the forum selection clause in the policy should be unenforceable. The Dallas Court of Appeals affirmed the dismissal.

Chandler managed various apartment complexes in Texas and Virginia. It purchased property insurance on the complexes from First Specialty, an eligible surplus lines insurer, through Westrope, a licensed surplus lines agent. The policy provided that it would be governed by New York law and that exclusive jurisdiction would be in the courts of the State of New York.

After Chandler made a claim for wind and hail damage to its Dallas apartments, First Specialty hired Vericlaim and Keen to adjust the claim. Ultimately, First Specialty determined that the damage was below the deductible and denied the claim.

Chandler filed suit in Dallas alleging that its damages exceeded $1.5 million. Chandler sued First Specialty for breach of contract and breach of the duty of good faith and fair dealing. Chandler sued First Specialty, Vericlaim and Keen for alleged violations of the Texas Insurance Code and the DTPA.

With the consent of Vericlaim and Keen, First Specialty filed a motion to dismiss the Dallas suit without prejudice based upon the forum selection clause in the policy. The trial court granted the motion to dismiss.

On appeal, Chandler asserted that the forum selection clause was unenforceable for a number of reasons. The Dallas Court of Appeals rejected Chandler's contention that the trial court's order was excessive in scope in that it dismissed Chandler's claims against Vericlaim and Keen. The court found that by agreeing to First Specialty's motion, Vericlaim and Keen had effectively joined in the motion. The court further held that even as non-signatories to the insurance contract, Vericlaim and Keen could compel compliance with the forum selection clause because Chandler relied on the terms of the insurance policy in asserting its claims against Vericlaim and Keen and its claims against Vericlaim and Keen alleged "substantially interdependent and concerted misconduct" by the parties.

Chandler also contended that First Specialty was a surplus lines insurer and, therefore, under Tex. Ins. Code § 981.002 was not authorized to issue policies in Texas and that ordinarily, an unauthorized insurer cannot enforce the terms of an insurance contract. In rejecting this argument, the appellate court noted that this restriction does not apply to insurance procured by a licensed surplus lines agent from an eligible surplus lines insurer. While the burden of proof is on

the insurer to establish this exception, the court found that First Specialty met that burden.

Chandler also contended that the forum selection clause was unenforceable because First Specialty had violated various provisions in Chapter 981 of the Insurance Code by not identifying the insurance agent who obtained the surplus lines coverage, by not including the admonition in § 981.101(b) regarding surplus lines insurance, and by not establishing that the full amount of coverage could not be procured from an admitted carrier. The court of Appeals rejected these arguments as well, noting that § 981.005 provides that violations of chapter 981 do not affect the enforceability of insurance policies unless the violations are "material and intentional" and that Chandler had not offered evidence on that issue. The court also stated that while violations of chapter 981 might subject First Specialty to various administrative penalties, they did not prohibit First Specialty from enforcing the forum selection clause.

"CONCURRENT CAUSATION" PROVISIONS

JAW The Point, LLC v. Lexington Ins. Co., No. 13-0711, --S.W.3d-- (Tex., Jan. 13, 2015).

As a matter of first impression, the Texas Supreme Court holds that losses incurred as a result of both covered wind damage and excluded flood damage are excluded under policy's anti-concurrent-causation clause.

In 2007, JAW The Pointe, LLC ("The Pointe") purchased an apartment complex adjacent to the Galveston seawall for $5.7 million. The Pointe procured insurance from Lexington and other insurance companies under a group program to insure the complex.

On September 13, 2008, Hurricane Ike hit Galveston and caused substantial damaged to the complex. City officials subsequently announced that apartment owners would be required to demolish and rebuild apartment complexes whose damages exceeded half their market value, and that those rebuilt complexes would have to meet current building codes.

On November 12, 2008, The Pointe submitted a building permit application to the City with estimated repair costs in excess of $6 million. On December 19, 2008, the City informed The Pointe via letter that the damage to the complex exceeded the 50% market value threshold and that compliance with the current flood code was required. The Point concluded the complex had to be demolished and rebuilt because elevating the existing structure to 11 feet as required by the flood code was not possible. The Pointe incurred $600,000 in demolition expenses and made a formal claim under the policy relying on two endorsements – Ordinance or Law Coverage ("Ordinance") and Demolition and Increased Cost of Construction ("DICC").

Lexington's building consultant provided a $4.8 million damage estimate - $1.3 million from wind, $3.5 million from flood. Lexington paid the $1.3 million for wind damage minus the deductible. The Pointe claimed it did not receive a formal letter denying the remaining portion of its claim for flood damage.

The Pointe filed suit against Lexington alleging breach of contract, violations of the Texas Insurance Code, violations of the DTPA, and bad faith. The jury found Lexington had engaged in unfair insurance practices and awarded $1.2 million in damages to The Point for repair or replacement to the complex under the Ordinance and DICC endorsements. The jury further found knowing conduct and awarded an additional $2.5 million plus attorneys' fees.

Lexington appealed, and the Houston Fourteenth Court of Appeals reversed and rendered a take-nothing judgment against JAW, concluding that the policy excluded coverage for JAW's code-compliance losses and therefore Lexington could not be liable for Insurance Code and DTPA violations. Relying on the policy's anti-concurrent-causation clause, the court of appeals held that the policy excluded coverage of JAW's costs to comply with the city's ordinances because the necessity of compliance resulted at least in part from flooding, coverage for which the policy expressly excluded.

On appeal to the Texas Supreme Court, the judgment of the Houston Fourteenth Court of Appeals was affirmed. The Texas Supreme Court reasoned that the ordinance endorsement provided coverage as a result of the enforcement of an ordinance or law only if a "Covered Cause of Loss" occurred. Turning to the concurrent causation clause, the court recognized no coverage existed for "loss or damage caused directly or indirectly" by flood, "regardless of any other cause or event that contributes concurrently or in any sequence to the loss." The net result of these provisions was that demolition and increased rebuilding costs caused by the enforcement of an ordinance resulting from an unsegregated

combination of wind and flood damage were not covered.

The same analysis applied to the DICC endorsement. That endorsement provided coverage for costs incurred in rebuilding and additional loss sustained in demolishing as a result of enforcement of a law or ordinance as a direct result of any physical loss or damage "insured against by this policy." The "Covered Causes of Loss" section determined the scope of physical loss or damage "insured against by this policy." Again, under the concurrent causation provision of the "Covered Causes of Loss," the policy did not insure against any physical loss or damage caused directly or indirectly by flood.

Finding covered wind losses and excluded flood losses combined to cause the enforcement of the ordinances concurrently or in a sequence, the supreme court affirmed the Houston appellate court's holding that the policy's anti-concurrent-causation clause excluded coverage for JAW's losses, and therefore affirmed judgment in favor of Lexington.

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EVIDENCE RELATED TO OTHER INSURANCE CLAIMS NOT DISCOVERABLE

In re Nat'l Lloyds Ins. Co., No. 13-0761 (Tex. 2014).

In this mandamus proceeding, the Texas Supreme Court ruled that evidence relating to insurance claims other than those at issue were not discoverable and directed the trial court to vacate an order compelling the insurer to produce irrelevant claim files from other property claims.

THE DIRECT ACTION RULE

In re Essex Ins. Co., 450 S.W.3d 524 (Tex. 2014).

A plaintiff may not directly sue a defendant's liability insurer to recover benefits under an insurance policy until the defendant's liability to the plaintiff has been established.

Essex Insurance Company ("Essex") issued a general commercial liability policy to Sand Diego Tortilla ("SDT"). Rafael Zuniga ("Zuniga") sued SDT after he lost his hand while operating a tortilla machine at SDT's facility, and SDT filed a claim with Essex. Essex concluded Zuniga's injuries were not covered because Zuniga was an employee of SDT. Both Zuniga and SDT claimed Zuniga was an independent contractor at the time of the accident. Essex nevertheless agreed to defend SDT under a reservation of its rights to refuse to indemnify SDT against any judgment.

After Essex rejected Zuniga's offer to settle his claims against SDT for policy limits, Zuniga added Essex as a defendant, seeking a declaration that the policy required Essex to indemnify SDT for its liability to Zuniga. Essex filed a motion to dismiss Zuniga's claims under Rule 91a of the Texas Rule of Civil Procedure. The trial court denied Essex's motion and the court of appeals denied mandamus.

The Texas Supreme Court conditionally granted the writ after determining that (1) the trial court abused its discretion in denying Essex's Rule 91a motion to dismissal, and (2) Essex had no adequate remedy by appeal.

Essex relied on the direct action rule to show abuse of discretion. The rule prohibits a plaintiff from suing a defendant's liability insurance carrier to recover benefits under an insurance policy until the defendant's liability to the plaintiff has been established. Zuniga argued his claims against Essex did not violate the direct action rule because he was merely seeking a declaration, as opposed to a monetary judgment. Zuniga also argued that the Texas Declaratory Judgment Act permitted him to seek this relief. The Texas Supreme Court rejected Zuniga's arguments, finding that permitting Zuniga to simultaneously pursue claims against both Essex and SDT would: (1) create a conflict of interest for Essex; and (2) require the admission of evidence of liability insurance in violation of Texas Rule of Evidence 411. There was no authority to support Zuniga's argument that a plaintiff who is not a party to an insurance policy may seek a declaratory judgment regarding an insurer's duty to indemnify an insured defendant against liability to the plaintiff before that liability has been determined.

APPRAISAL BARRED EXTRA-CONTRACTUAL CLAIMS

United Neurology, P.A. v. Hartford Lloyd's Ins. Co., 2015 WL 1470296 (S.D. Tex. March 31, 2015).

Insurer's timely tender of payment of appraisal award barred insured's extra-contractual claims for common law bad faith, as well as for alleged violations of Chapters 541 and 542 of the Texas Insurance Code and the DTPA despite the insured's refusal to accept the insurer's payment.

United Neurology was the insured on a commercial property policy issued by Hartford. United Neurology made a claim for property damage due to Hurricane Ike. United Neurology did not initially make a business income claim, but purported to add such a claim with the service of an expert report two years and eight months after the hurricane. The court granted Hartford's motion for summary judgment on the insured's business income claim finding that vague, general references in United Neurology's pleadings seeking recovery of all amounts due under the policy were not sufficient to give Hartford notice of its business income claim, that a delay of over two years failed to satisfy the prompt notice provision of the policy, and that Hartford was prejudiced as a matter of law because it was deprived of its right to investigate the claimed loss in the manner it would have liked.

The court further held that both the insured and Hartford were in substantial compliance with the appraisal award provisions of the policy. Accordingly, the award was binding and precluded United Neurology's contract claim, as well as all of its extra-contractual claims. Notwithstanding the fact that United Neurology refused to accept Hartford's payment of the appraisal award, it was unable to recover because it could not show that Hartford failed to comply with the contract.

TIMELINESS OF PROOF OF LOSS

Fennelly v. Texas Farmers Ins. Co., 2015 WL 106061 (S.D. Tex. Jan. 7, 2015).

Farmers insurance filed a motion for summary judgment against individual Fennelly, who had not timely filed his proof of loss for property damage (caused by a hurricane) within the time period authorized by FEMA. Fennelly did not dispute his untimeliness, but rather argued that FEMA had waived the deadline to file his proof of loss, with no limitations on the subject matter or amount of the claim. The court found that though FEMA could have been clearer in its correspondence to Fennelly, which did extend the period of time to file Fennelly's proof of loss, FEMA had the right to, and did, waive the deadline only as to a limited portion of a claim. Thus, Fennelly's proof of loss was untimely as to part, though not all, of all matters claimed therein. Of further note, the court stated that if an insurer continues to evaluate an otherwise untimely claim, that will not alone constitute a waiver of a "timeliness" defect.

CERTIFICATE OF MERIT REQUIRED IN CASE AGAINST ADJUSTER

Craig Penfold Properties, Inc. v. The Travelers Cas. Ins. Co., 2015 WL 356885 (N.D. Tex. Jan. 28, 2015).

Plaintiff was required to file a certificate of merit with respect to its claims against an engineering firm that allegedly acted as a *de facto* adjuster by inspecting property and recommending appropriate repairs to plaintiff's insurance carrier. Its failure to file the certificate of merit resulted in dismissal of its claim against the engineering firm, without prejudice.

Penfold brought suit against its insurer, Travelers, and Unified Building Sciences & Engineering, Inc. ("UBSE") in connection with a dispute over a property damage claim. Penfold alleged that UBSE was negligent in connection with its inspection of alleged hail damage to the roof of Penfold's building and its alleged failure to recommend appropriate repairs. Penfold alleged that UBSE knew that Travelers would rely on its report to adjust the claim and that USBE breached its duty to Penfold by failing to properly investigate and adjust the claim.

Tex. Civ. Prac. & Rem. Code § 150.002 requires a plaintiff to file a certificate of merit in any action for "damages arising out of the provision of professional services." The certificate of merit must include an affidavit of a third-party licensed professional and must set forth which damages are sought, the negligence, act, error or omission of the licensed or registered professional in providing the professional service. Failure to file the affidavit "shall result in dismissal of the complaint against the defendant" and the dismissal "may be with prejudice."

Penfold did not file a certificate of merit with respect to UBSE's alleged negligence, contending that it was not required to do so because its allegations against UBSE did not relate to professional negligence, but rather arose out of UBSE's role as "a *de facto* adjuster."

Although the district court acknowledged that there is debate as to the application of § 150.002 in federal court, it ruled that Penfold must comply with the statute if it was applicable. The court then found that the statute applied because Penfold's negligent claim against UBSE arose out of the provision of professional engineering services. Thus, Penfold was required to file a certificate of merit and its failure to

do so mandated dismissal of Penfold's case against UBSE.

Noting that Texas courts disagree regarding the extent of the trial court's discretion to dismiss without prejudice for failure to comply with the statute, it ultimately held that the statute provides courts with the discretion to dismiss without prejudice. Accordingly, the district court dismissed Penfold's negligence claim against UBSE without prejudice.

OWN, RENT OR OCCUPY EXCLUSION: DEFINITION OF "OCCUPY"

Liberty Mut. Fire Ins. Co. v. Lexington Ins. Co., 446 S.W.3d 835 (Tex. App.—San Antonio 2014, no pet.).

"Own, rent, or occupy" exclusion in CGL policy barred coverage for property damage claim when insured damaged building while in the course of conducting business operations for building lessee.

Liberty Mutual's insured, Total Warehousing, Inc., leased a warehouse owned by DCT. DCT insured the warehouse through Lexington. In 2006, CHEP USA assumed Total's lease of the DCT warehouse, but retained Total to operate its business in the DCT warehouse. In August 2008, a Total employee struck a structural support column with a forklift causing a large portion of the warehouse roof to collapse. DCT suffered approximately $2.9 million in property damage. Lexington reimbursed DCT for its losses.

Lexington, as DCT's subrogee, then sued Liberty Mutual – Total's carrier, alleging Liberty Mutual's policy provided coverage for the accident. Liberty mutual argued its policy's "own, rent or occupy" exclusion precluded coverage. In response, Lexington argued that the exclusion was inapplicable, as CHEP, not Total, leased the warehouse. Liberty Mutual and Lexington filed competing motions for summary judgment. The trial court held the exclusion was inapplicable and entered judgment from Lexington. Liberty Mutual appealed.

In reversing the trial court's judgment and rendering judgment in favor of Liberty Mutual, the court of appeals held that while Total did not own or rent the premises, Total was nevertheless authorized to be on the premises and was conducting operations on the premises under its agreement with CHEP within the scope of the lease's permitted uses of the premises, and thus Total "occupied" the premises.

Noting the word "occupy" was not defined by the Liberty Mutual policy, the appellate court held the unambiguous term meant: (1) a continued physical presence on the premises, and (2) control of the premises for the insured's own benefit.

DUTY TO DEFEND: PROFESSIONAL SERVICES EXCLUSION

Nicklos Drilling Co. v. Ace American Ins. Co., No. V-14-021, 2014 WL 6606575 (S.D. Tex., Nov. 5, 2014).

Professional Services Exclusion barred coverage when allegations in underlying action involved only alleged failures by insured to exercise its specialized knowledge particular to the insured's specialized vocation.

Ace issued a CGL policy to Miramar Petroleum, Inc., under which Nicklos was an additional insured. Nicklos, an oil and gas drilling company, was hired by Miramar to drill a well known as the "Sartwelle # 1." After the well blew out, Miramar sued Nicklos and others in the 267th Judicial District Court for Jackson County, Texas. Miramar continuously maintained that Nicklos, as an experienced operator, should have recognized the well was on the verge of blowing out and that the mud weight was insufficient, and that the well could not be closed quickly.

Nicklos sought a defense and indemnity from Ace. Ace denied coverage based on the Professional Services Exclusion in the policy and Nicklos then brought suit. The parties filed competing motions for summary judgment.

In granting summary judgment in favor or Ace, the trial court turned to the Professional Services Exclusion, which excluded coverage for "preparing, approving, or failure to prepare or approve maps, shop drawings, opinion, reports, surveys, field orders, change orders, or drawing and specifications and supervisory, inspection, architectural or engineering activities" and "[a]ny other professional services provided by the insured."

Noting the policy's failure to define "professional services," the court relied on Texas case law defining "professional services" as a task "aris[ing] out of acts particular to the individual's specialized vocation" and that requires "the professional to use his specialized knowledge or training."

The court then turned to Miramar's allegations, which stated that Nicklos breached its contract

because it failed to exercise its specialized knowledge regarding the pressure and mud weight required to prevent a blowout of the well. Noting Miramar did not sue Nicklos based on any conduct other than Nicklos' failure to utilize its allegedly specialized knowledge to prevent a well blowout, the court held Miramar's allegations fell within the Professional Services Exclusion in the policy.

DUTY TO DEFEND: PERSONAL AND ADVERTISING INJURY

Uretek (USA), Inc. v. Continental Cas. Co., No. 4:13-CV-03746, 2015 WL 667880 (S.D. Tex. Feb. 17, 2015).

No coverage existed under personal and advertising injury clause when underlying lawsuit against insured was premised on false and misleading statements about insured's own services and patent, as opposed to false and misleading statements about the goods or services of the claimant in underlying lawsuit.

Uretek was in the business of performing roadway repair and maintenance for various state and municipal agencies. In 2011, Uretek sued a competitor—Applied Polymerics, Inc. ("Applied") — in the Eastern District of Virginia for infringement of a patent on which Uretek held an exclusive license. Applied filed counterclaims based on its allegation that Uretek had knowingly misrepresented to competitors and customers that certain road repair and maintenance contracts were covered by a particular patent, and that these misrepresentations were intended to and did have an anti-competitive effect.

Uretek sought coverage from Continental under the Personal and Advertising Injury Coverage clause of its policy with Continental. Continental denied coverage. Uretek brought action seeking declaratory judgment that Continental had duty under general liability policy to defend it against Applied's counterclaims. The parties filed cross-motions for summary judgment.

The trial court held that Applied's allegations did not fall within scope of policy's coverage for advertising injury. The court reasoned that the allegations did not concern publication of material that "disparages a person's or organization's goods, products or services," as required by the policy. Instead, Applied alleged Uretek attempted to mislead competitors and contracting bodies as to scope of Uretek's own patent so as to coerce potential customers that Uretek was the only contractor that could perform the work. The court further rejected Uretek's argument that coverage necessarily existed because Applied sued under the Lanham Act, holding that the facts pleaded under Applied's Lanham Act claim did not fall under the "personal and advertising injury" coverage clause. Accordingly, judgment was entered for Continental.

DUTY TO INDEMNIFY: CONTRACTUAL LIABILITY EXCLUSION

Crownover v. Mid-Continent Casualty Co., 772 F.3d 197 (5th Cir. Oct. 29, 2014) (*Crownover II*).

Contractual liability exclusion did not bar insurer's duty to indemnify its insured where there was no proof that insured's contractual "assumption of liability" exceeded insured's liability under Texas law.

Doug and Karen Crownover contracted with Arrow Development ("Arrow") to construct a home. The contract contained a warrant-to-repair clause that provided that Arrow would "promptly correct work . . . failing to conform to the requirements of the Construction Documents" ("paragraph 23.1"). Arrow performed defective work, and then failed to promptly correct it. The Crownovers initiated an arbitration proceeding against Arrow. The arbitrator awarded damages to the Crownovers for Arrow's breach of paragraph 23.1.

Arrow eventually filed for bankruptcy. The bankruptcy court limited the Crownovers' damages to the amount that could be recovered from any applicable insurance. The Crownovers demanded that Mid-Continent pay the arbitration award. Mid-Continent denied the Crownovers' demand, citing numerous exclusions including a contractual liability exclusion that provided: "[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." The exclusion also contained an exception for "liability…[t]hat the insured would have in the absence of the contract or agreement." The Crownovers sued Mid-Continent for breach of contract.

Both sides moved for summary judgment. Mid-Continent argued the contractual liability exclusion applied because the arbitrator's award to the Crownovers was based only on Arrow's breach of

paragraph 23.1. The Crownovers argued that the exception to the exclusion applied because Arrow would have been liable in the absence of the express warranty to repair. The district court determined that the contractual-liability exclusion applied and granted summary judgment in Mid-Continent's favor. The district court held that the contractual liability exclusion applied with no applicable exception because the arbitrator's award to the Crownovers was based solely on Arrow's breach of the express warranty to repair nonconforming work. The Crownovers appealed.

In *Crownover v. Mid-Continent Casualty Co.*, 757 F.3d 200 (5th Cir. June 27, 2014) (*Crownover I)*, the Fifth Circuit affirmed the summary judgment in favor of Mid-Continent holding that the Crownovers were unable to recover damages from Mid-Continent because paragraph 23.1 reached beyond Arrow's liability under common law and was liability Arrow took on exclusively through its contract with the Crownovers. The Crownovers petitioned for rehearing.

A unanimous three-judge panel granted Crownovers' petition for hearing. In *Crownover II*, the Fifth Circuit, relying on the Texas Supreme Court's opinions in *Gilbert* and *Ewing*, determined that an insurer must prove that a contractually assumed duty expanded liability beyond that supplied by common law. "The key question, therefore, becomes whether the source of adjudicated liability—[paragraph 23.1]—expanded Arrow's obligations." The Fifth Circuit found that "Mid-Continent failed to proffer evidence creating a fact dispute concerning whether the arbitrator's award was based on liability greater than that dictated by general law." The Fifth Circuit in *Crownover II* held that paragraph 23.1 did not expand Arrow's liability beyond that supplied by common law, and therefore, the contractual-liability exclusion did not apply. The Fifth Circuit withdrew its opinion in *Crownover I*, reversed summary judgment for Mid-Continent, rendered summary judgment for the Crownovers, and remanded for calculation of the Crownovers' legal fees.

DUTY TO INDEMNIFY: SEGREGATION OF DAMAGES

Dallas Nat'l Ins. Co. v. Calitex Corp., 2015 WL 968308 (Tex. App.—Dallas, March 3, 2015).

In this declaratory judgment action, Calitex sought a declaration that Dallas National Insurance Company ("DNIC") owed a duty to indemnify Calitex regarding a judgment Calitex obtained in a separate underlying lawsuit against a third party insured by DNIC. The Dallas Court of Appeals affirmed that the insured has a duty to segregate covered versus uncovered damages. DNIC argued that because the insured had the burden to segregate damages for any covered claims from non-covered claims, but did not do so, that DNIC was entitled to summary judgment against the declaratory judgment sought by Calitex if the court found any of the damages awarded against a third party in an underlying lawsuit were excluded by any policy exclusion. The Dallas court agreed.

PROMPT PAYMENT ACT NOT PREEMPTED BY ERISA

Aetna Life Ins. Co. v. Methodist Hosps. of Dallas, No. 3:14-cv-347-M, 2015 WL 918586 (N.D. Tex. March 4, 2015).

ERISA does not preempt or prohibit application of the Texas Prompt Pay Act ("TPPA") to Third Party Administrators of self-funded benefit plans.

Aetna contracted with Methodist Hospitals and Texas Health Resources (the "Providers") to act as Providers' Third Party Administrator for Providers' self-funded employee benefit plans. The contract between Aetna and Providers required Aetna to pay Providers on a timely basis consistent with the TPPA. Aetna allegedly incurred millions of dollars in billed charges penalties from paying claims late. Providers demanded Aetna pay the late-payment penalties.

In response to Providers' demand, Aetna filed a declaratory judgment action in federal court asking the court to declare that (1) the TPPA does not apply to self-funded plans or (2) the TPPA is preempted by ERISA. Around the same time Aetna sued Providers, Providers filed lawsuits in state court seeking recovery of the TPPA penalties. The district court abstained from ruling on the first request for declaratory relief until one of the state courts presiding over the related proceedings ruled on that issue. The state court subsequently found the TPPA applies to claims administered by third party administrators ("TPAs") for self-funded plans.

Deferring to the state court's findings on Aetna's first request for declaratory relief, the district court turned its attention to whether the TPPA is preempted by ERISA. The parties filed cross-motions for summary judgment on the issue. Aetna argued that ERISA preempts the TPPA because the TPPA's payment deadlines imposed on TPAs will subject TPAs to

different regulations in different states thereby undermining ERISA's primary goal of uniformly regulating plan administration. Providers countered by arguing that regulating the timing of payment of uncontested claims between two entities on the fringe of an ERISA plan (*i.e.*, a TPA and a provider), does not affect the relationship between the plan and the beneficiary—the traditional ERISA entities—and therefore is not preempted. In the Fifth Circuit, ERISA preemption analysis turns, in part, on whether the state statute *directly affects* the relationship between the traditional ERISA entities. Strictly applying that part of the test, the district court granted Providers' motion for summary judgment, finding the contract between Providers and Aetna was not directly connected with the ERISA plans under which the patients were enrolled, and, therefore, there was no ERISA preemption. Aetna has appealed the district court's ruling to the Fifth Circuit.

EXCESS COVERAGE: EXHAUSTION OF UNDERLYING INSURANCE

Plantation Pipe Line Co. v. Highlands Ins. Co., 444 S.W.3d 307 (Tex. App.—Eastland, pet. filed).

Insured's out-of-pocket payments applied towards exhaustion of underlying policy limits, despite fact that settlement payments by underlying carriers were for less than their respective policy limits.

On March 19, 1975, Plantation discovered a leak in one of its pipelines located in North Carolina. Plantation repaired the leak immediately, and collected 2,000 barrels of oil in remediation and recovery operations over a period of nine years. Plantation incurred approximately $18,663 in recovery costs.

In 1990, the State of North Carolina directed Plantation to further remediate the leak site. Plantation subsequently recovered over 200,000 additional gallons of leaked petroleum materials at a cost of nearly $12 million.

Before the leak was discovered, Plantation procured the following multiple layers of liability insurance:

1. $0-$900,000 – Self Insured
2. $100,000 to $1MM – American
3. $1MM to $3MM – Cal Union
4. $3MM to $8MM – Lumbermens
5. $8MM to $18MM - Highlands

Plantation notified its insurance carriers that it was required to perform further remedial action under North Carolina pollution control laws and that it faced potential liability to third parties. Plantation requested that the insurers defend and indemnify it. American, Cal Union, and Lumbermens all disputed coverage. A coverage action was subsequently brought, which resulted in a settlement under which American agreed to pay Plantation $750,000; Cal Union agreed to pay $1 million; and Lumbermens agreed to pay Plantation $2.8 million.

Plantation then notified Highlands that Plantation had incurred losses in connection with the leak that exceeded $8 million, and demanded indemnity and reimbursement from Highlands. Highlands ultimately denied coverage, and Plantation brought suit for breach of contract. Highlands moved for summary judgment, arguing it did not owe Plantation anything under its policy because the policy limits of the other insurance policies had not been fully exhausted as was required under the Highlands policy. The trial court granted Highlands' motion and rendered judgment against Plantation.

On appeal, Plantation presented one issue: whether the trial court erred in ruling that Plantation forfeited all of its coverage under the excess policy it purchased from Highlands by settling its coverage claims against its lower-level insurers for less than the full limits of those policies, even though Plantation agreed to pay the difference between the underlying settlement amounts and the underlying policy limits.

Turning to the language of the Highlands policy, the appellate court recognized that, contrary to Highlands' argument, the Highlands policy did not require exhaustion of the "full policy limits" of the underlying policies. Instead, the Highlands policy was triggered when the underlying insurers paid or were held liable to pay their respective "ultimate net loss liability" – a term that was not defined by the Highlands policy. The Highlands policy stated, however, it was subject to the defined terms contained within the underlying policies – and the Lumbermen policy defined "ultimate net loss liability" as including: "all sums which the insured *or* any organization as his insurer, *or both*, become legally obligated to pay as damages, whether by reason of adjudication *or settlement* …." (emphasis added). With this backdrop, the appellate court held that payment by the underlying insurers, coupled with the payments by the insured, which totaled $8 million, triggered the Highlands policy.

Accordingly, the appellate court distinguished cases interpreting policies that required exhaustion of the underlying limits, holding that the Highlands policy was unambiguous and did not require such exhaustion. For further support, the appellate court looked also to the Highlands policy's "Maintenance Clause," which recognized that even if the underlying policies had expired prior to the loss and resulting claim, the Highlands policy would have nevertheless been triggered at the $8MM level. The appellate court then held that even if there were an ambiguity, such ambiguity would be resolved in favor of coverage.

FIDELITY COVERAGE

Tesoro Refining & Marketing Co., LLC v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., No. SA:13-CV-931-DAE, 2015 WL 1529247 (W.D. Tex. April 7, 2015).

The court found that the definition of "theft" was unambiguous and that the policy covered losses resulting from an *unlawful taking* by an employee by means of a forgery, but not *any loss* resulting from an employee's forgery. Proof of an unlawful taking was still required.

Tesoro was the insured on an insurance policy issued by National Union that provided coverage for losses "resulting directly from 'theft' committed by an 'employee', whether identified or not, acting alone or in collusion with other persons."

The policy defined "theft" as "the unlawful taking of property to the deprivation of the insured." The policy also contained the statement that "'theft' shall also include forgery."

Tesoro began selling fuel to Enmex, a petroleum distributor, on credit. By 2007, Enmex's credit balance was approximately $45 million. Tesoro's auditor contacted Tesoro's credit manager concerning Enmex's outstanding balance. Tesoro's credit manager provided the auditor with a document purporting to be a $12 million letter of credit from a bank. Accordingly, the auditor noted that the account was secured by a letter of credit. Subsequently, a Tesoro consultant contacted the credit manager about Enmex's past due balances. The credit manager provided the consultant and Tesoro's auditor with a document purporting to increase the letter of credit to $24 million. Drafts of these purported letters of credit were created and stored in the part of Tesoro's server that stored the credit manager's documents.

Enmex's outstanding balance continued to increase and by September of 2008 was over $88 million. Shortly thereafter, a document purporting to be a new $24 million letter of credit with Bank of America, which was later determined to have been created and stored in the portion of Tesoro's server that stored the Tesoro credit manager's documents, was presented by the Tesoro credit manager to Tesoro's CFO.

In December 2008, Tesoro presented the $24 million letter of credit to Bank of America and was informed that it was not valid. Tesoro stopped shipping fuel to Enmex and sued Enmex for breach of contract. While the forensic evidence showing the creation of the letters of credit suggested that Tesoro's credit manager created the documents and forged the signatures on the documents, he denied either creating the documents or forging the signatures.

Tesoro submitted an insurance claim to National Union contending that its losses associated with the Enmex account were due to employee theft. National Union denied the claim and this lawsuit ensued.

In granting National Union's motion for summary judgment and denying Tesoro's competing motion, the court held that there was no evidence of an "unlawful taking" by Tesoro's employee. Interpreting the evidence in the light most favorable to Tesoro, the most that could be concluded was that Tesoro's credit manager forged letters of credit that misrepresented the amount of collateral held by Tesoro, causing Tesoro to continue selling fuel to Enmex. Even assuming these allegations to be true, there was no evidence that the Tesoro credit manager ever exercised control over or possessed the fuel.

Therefore, the court concluded that Tesoro's interpretation of the contract to mean that "a forgery always constitutes a theft" and "creates a basis for coverage separate and independent from an unlawful taking" was unreasonable.

INSURED VS. INSURED EXCLUSION

Primo v. Great Am. Ins. Co., 455 S.W.3d 714 (Tex. App.—Houston [14th Dist.] 2014, pet. filed).

Insured vs. Insured exclusion, which applied to successors of any insured, did not apply to exclude coverage in an underlying suit between an insured and the assignee of another insured.

Primo was serving as a director and the Treasurer of Briar Green Condominium Association when disputes arose regarding checks that Primo wrote to himself from Briar Green's account. Briar Green's board of directors filed a claim on a fidelity bond issued by Travelers Casualty and Surety. Travelers paid Briar Green's claim in exchange for Briar Green's assignment of all Briar Green's claims and rights against Primo.

Travelers filed suit against Primo. Among the various causes of action plead by Travelers, Travelers included an indemnity claim for payment on the bond. Travelers alleged Briar Green "assigned all rights to this matter, including recovery rights of the amount paid on the [b]ond," and it stood in Briar Green's shoes.

While the Travelers suit was pending, Primo filed a claim with Great American under an E & O policy Great American issued to Briar Green, requesting reimbursement for expenses he paid defending the Travelers lawsuit. Primo contended he was covered under the policy as a former director and officer. Great American offered to reimburse a portion of Primo's costs of defense under a reservation of rights. Primo rejected Great American's offer and filed suit.

Relying on the eight corners rule, Great American moved for summary judgment contending, in part, that the policy's "Insured v. Insured" exclusion applied to negate coverage. The language of that exclusion excepted from coverage claims for suits "made against any Insured . . . by, or for the benefit of, or at the behest of . . . any person or entity which succeed[ed] to the interest of [Briar Green]." Both Primo and Briar Green undisputedly met the definition of an "Insured" under the policy. Because Travelers alleged in its petition that Briar Green assigned all its rights to Travelers and that Travelers stepped into Brian Green's shoes, Great American contended Travelers was an entity that had unambiguously "succeed[ed] to the interest of [Briar Green]." The trial court granted Great American's motion for summary judgment and signed a take-nothing judgment on Primo's claims.

On appeal, Primo argued that Great American failed to prove as a matter of law that the policy unambiguously excluded coverage for the claim brought by Briar Green's assignee, Travelers. Because the parties did not dispute that Travelers brought suit against Primo as Briar Green's assignee, Great American countered that Travelers' claims against Primo were brought as Briar Green's successor.

The Fourteenth Court of Appeals disagreed with Great American. The Court of Appeals found the following: (1) an "assignee" is not necessarily a "successor" under Texas law; (2) Great American failed to show as a matter of law that the assignment created a successor to Briar Green's interest; and (3) neither the exclusion nor the policy's definitions unambiguously included or designated assignees as persons or entities that "succeed to the interest of [Briar Green]." The appellate court held that evidence of Briar Green's assignment of its claim against Primo to Travelers was insufficient to prove as a matter of law that Travelers was a successor to the interest of Briar Green. In reaching its holding, the appellate court noted that Great American failed to assert in its motion for summary judgment that Travelers's claims were "by, or for the benefit of, or at the behest of [Briar Green]" or that Travelers was a subrogee.