TADC INSURANCE LAW UPDATE

Fall 2015

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This newsletter is intended to summarize significant cases impacting the insurance practice since the Spring 2015 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 / PRIORITY OF COVERAGE

L-Con, Inc. v. CRC Ins. Svs. Inc., No. 4:13–CV–1526, 2015 WL 4724799 (S.D. Tex. August 24, 2015).

Court considered additional insured provisions in Master Services Agreement ("MSA") and other insurance clauses in primary and excess insurance policies to prioritize primary and excess policies of contractor and its customer.

L-Con entered into an MSA for terminal maintenance work for Oiltanking. One L-Con employee was killed and several were injured in an explosion at Oiltanking's tank facility at the Houston Ship Channel. As a result, a $21 million judgment was entered against Oiltanking in favor of the injured employees and their family members. The MSA required L-Con to carry at least $1 million of CGL insurance and $3 million of excess/umbrella coverage and to have Oiltanking named as an additional insured on such policies. The MSA also provided that the coverage provided to Oiltanking as an additional insured was primary to any other insurance available to the additional insured.

L-Con's primary policy with American Contractors Insurance Company Risk Retention Group ("ACIG") had limits of $2 million. The ACIG primary policy made Oiltanking an additional insured and provided that it was primary to any other insurance available to Oiltanking. L-Con also had an excess/umbrella policy issued by Interstate, which had stated limits of $15 million per occurrence. The Interstate policy was follow form, incorporating the terms of the underlying policy except where they conflicted with Interstate's policy terms.

The Interstate policy contained a provision that stated that the limits of insurance available to an additional insured were the lesser of the limits available under the Interstate policy or the amount of coverage L-Con had agreed to provide to the additional insured, in this case $3 million. Accordingly, the court held that Oiltanking was an additional insured under the Interstate policy, but the limits available to Oiltanking under the Interstate policy was $3 million, rather than the $15 million face amount of the policy.

The Interstate policy also contained another insurance clause that provided it was excess to all other available insurance. Accordingly, the court next addressed the priority of the Interstate policy and the primary and excess coverage procured by Oiltanking with London Underwriters. Oiltanking had a primary policy with limits of $5 million and an excess policy with limits of $46 million. Oiltanking's primary policy provided that where Oiltanking is named as an additional insured on the policies of others, the policy would only apply in excess of such policies.

The court rejected Interstate's argument that Oiltanking's $5 million primary policy had to exhaust before any coverage was available under the Interstate policy and then that Interstate should contribute on a pro rata basis with Oiltanking's $46 million excess policy (3/49). Rather, the court held that:

1) The Interstate policy was excess of the ACIG policy;

2) The limits of the Interstate policy were limited to the $3 million required by the MSA;

3) The other insurance clauses in the Interstate policy and Oiltanking's primary policy conflict;

4) Thus, the Interstate policy with limits of $3 million and Oiltanking's primary policy with limits of $5 million form the first layer of excess coverage over the ACIG policy and share on a pro rata basis; and

5) Upon exhaustion of Oiltanking's primary policy (and the Interstate policy), Oiltanking's $46 million excess policy form the final layer.

EXTENSION OF *DEEPWATER HORIZON*

Ironshore Specialty Ins. Co. v. Aspen Underwriting, Ltd., 788 F.3d 456 (5th Cir. 2015).

The court extended the landmark ruling of *In Re Deepwater Horizon*, --S.W.3d--, 2015 WL 674744 (Tex. Feb. 13, 2015) (addressed in the Spring 2015 newsletter). The court held an additional insured's coverage under a policy issued to an oil service company was subject to limits set forth in a separate Master Services Agreement (MSA). Whereas in *Deepwater*, a policy was held to incorporate an "above-water" limitation from an indemnity clause in a separate drilling contract; in *Ironshore*, the policy incorporated the agreed minimum amount of coverage set forth in a separate section of the MSA.

The case arose from a fire on an oil well owned by the additional insured, Endeavor Energy Resources, resulting in the death of two employees of the insured, Basic Energy Services. The MSA executed by the companies included knock-for-knock indemnity for "all claims, demands, and causes of action of every kind and character, without limit," brought by each party's respective employees. The MSA further stated:

> To support the indemnification provisions in this Contract but as a separate and independent obligation, each party shall ... maintain, with an insurance company or companies ...
> (b) Commercial (or Comprehensive) General Liability Insurance, including contractual obligations covered in this Contract and proper coverage for all other obligations assumed in this Contract., [sic] in the amount of $1,000,000 combined single limit per occurrence for Bodily Injury and Property Damage....
> (d) Excess Liability Insurance over that required in Paragraph ... (b) ... in the amount of $4,000,000, specifically including Contractual Liability.

Both parties obtained more insurance than required. Basic obtained a total of $51 million of coverage; Endeavor obtained $21 million. Endeavor's policies explicitly limited coverage to "the minimum Limits of Insurance [Endeavor] agreed to procure in [a] written Insured Contract." Basic's policy, however, did not expressly limit coverage to minimum agreed amounts.

The question before the court was whether Endeavor's additional-insured coverage extended to Basic's entire $51 million stack or was limited to the $5 million minimum required by the MSA. Applying the eight-corners rule, the Fifth Circuit concluded that the additional-insured clause in the policy "clearly manifested an intent" to incorporate the limitation. The clause stated:

The word "Insured", wherever used in this Policy, shall mean ...

> (c) any person or entity to whom [Basic] is obliged by a written "Insured Contract" entered into before any relevant "Occurrence" and/or "Claim" to provide insurance such as afforded by this Policy but only with respect to:
> i) liability arising out of operations conducted by [Basic] or on its behalf....

The policy defined "Insured Contract" as:

> any written contract or agreement entered into by [Basic] and pertaining to business under which [Basic] assumes the tort liability of another party to pay for "Bodily Injury", "Property Damage", "Personal Injury" or "Advertising Injury" to a "Third Party" or organization.

The court concluded Endeavor was an Insured, because it was an "entity to whom [Basic] [was] obliged" by an indemnity clause in the MSA, under

which Basic "assume[d] the tort liability of [Endeavor]." The court then held Endeavor was an Insured only to the extent of the minimum agreed coverage in the MSA. In other words, the minimum agreed coverage under the MSA was incorporated as the maximum allowed coverage under the policy.

In reaching this somewhat creative result, the court admitted that it had "initial doubts" but that its holding was dictated by *Deepwater*. The policy in that case included the same definition of "Insured," in addition to a provision not present in *Ironshore* stating that "where required by written contract, bid or work order, additional insureds are automatically included hereunder." The court in *Ironshore Erie*-guessed the second provision was an unnecessary alternative ground, so the sole fact that Endeavor was an additional insured to whom Basic was obliged to provide insurance would be enough for the Texas Supreme Court to conclude that Endeavor's coverage was limited to the minimum amount Basic was obliged to provide. *Ironshore* thus follows the underlying policy of *Deepwater* to read indemnity provisions narrowly and required coverage provisions broadly so as to effectuate the reciprocal coverage limits contemplated by parties to an indemnity agreement.

PROMPT PAYMENT: PENALTY TRIGGERED ON MISSED DEADLINE TO COMMENCE INVESTIGATION

Cox Operating, L.L.C. v. St. Paul Surplus Lines Ins. Co., 795 F.3d 496 (5th Cir. 2015).

Court affirmed an award of $13.5 million as an interest penalty under the Prompt Payment Act, Tex. Ins. Code § 542.060, on top of $9.5 million for breach of policy and $6.3 million for attorneys' fees, based on an insurer's failure to meet a deadline under § 542.055 to commence an investigation of an oil pollution claim after Hurricane Katrina.

The insured's CGL and umbrella policies covered pollution clean-up costs for "pollution work . . . reported to us within one year of the ending date of that pollution work." The insurer, St. Paul, made "preliminary contact" within ten days, but failed to commence an investigation or request documents to substantiate the claim. After eight months, it began paying invoices totaling $1.5 million over the course of a year. Meanwhile the insured received $5 million under a separate Removal of Wreckage and Debris (ROWD) policy. Then St. Paul sent a letter denying all unpaid claims, along with service of the complaint in the case, seeking declaratory judgment.

St. Paul sought to reduce the award on three grounds. First, $2 million of the clean-up costs were not covered, because they were reported within one year of the pollution work. The court held the deadline was waived by St. Paul's denial of the claims and filing of the lawsuit; "only at the edges of the imagination" could the court conclude the parties intended the insured to keep reporting costs after such events. The court described the deadline as a "cost-reporting requirement," rather than an incident-reporting requirement as provided in a "claims-made policy" and considered in *Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co.*, 174 F.3d 653 (5th Cir. 1999). *Matador* held an incident-reporting requirement ("covered pollution incident" includes incidents "reported to the company within 30 days") was a non-waivable part of the definition of covered risks, rather than a waivable condition precedent. The one-year requirement in *Cox* was similarly placed within a section defining covered risks "What this Agreement Covers" but was duplicated in a "conditional" section entitled "When this Agreement Covers." Such an ambiguity, the court concluded, must be resolved in favor of coverage.

Second, St. Paul argued $2 million of the clean-up costs had been previously paid by the ROWD insurer. The court reasoned that, even assuming St. Paul had shown invoices submitted to the two insurers directly overlapped, it had failed to evaluate more than $2 million of new invoices after determining the policy limit had been reached. The court was thus bound to accept the jury's determination after a five-week trial that all of the $9.5 million for breach of policy represented an amount "over and above" that which the insured had already recovered.

Third, St. Paul argued the 18% interest penalty under § 542.060 was improperly calculated from the deadline for commencing the investigation under § 542.055, rather than from the deadline for payment of claims under § 542.058(a) (60 days "after receiving all items, statements, and forms reasonably requested and required"). Only the latter section refers explicitly to § 542.060, which the court acknowledged was a "disturbing inconsistency." The "text of § 542.060 itself," however, "penalizes insurers 'not in compliance *with this subchapter*.'" Distinguishing *Lamar Homes, Inc. v. Mid–Continent Cas. Co.*, 242 S.W.3d 1 (Tex. 2007) (explaining that the deadline for acceptance or rejection of an insured's claim against a liability insurer for costs of defense is calculated from the date the insured

receives legal bills, rather than from the date of the underlying claim), *Cox* concludes that "a violation of any of the Act's deadlines . . . triggers the accrual of statutory interest under § 542.060." *Id.* at 508.

UNREASONABLE DELAY IN TENDERING DEFENSE IS A DENIAL

Yowell v. Seneca Specialty Ins. Co., No. 4:15-CV-80-LG-CMC, 2015 WL 4575450 (E.D. Tex. July 28, 2015).

The Eastern District of Texas held an unreasonably delayed defense is a denial of defense, resulting in an insurer's waiver of the right to control the defense.

Barry and Rebecca Schneider (the "Schneiders") sued David Yowell and David Yowell Construction, LLC (collectively, "Yowell") due to allegedly defective work Yowell had completed on the Schneiders' home. Yowell retained McCauley, Westberg, & Ramirez, PLLC ("MWR") to defend it in the Schneider suit. On September 12, 2014, MWR tendered Yowell's defense to Seneca Specialty Insurance Company ("Seneca"), which had issued a commercial general liability policy to Yowell. Seneca rejected the tender and denied coverage.

On November 13, 2014, the Schneiders amended their claims against Yowell. That same day, MWR forwarded the amended petition to Seneca and again tendered Yowell's defense. MWR subsequently contacted Seneca multiple times to obtain Seneca's involvement in the Schneiders' suit but did not receive a response.

On February 3, 2015, having yet to receive a response to its tender of defense, Yowell filed suit against Seneca. Yowell sought a declaratory judgment that Seneca had a duty to defend and indemnify in the Schneider suit and also asserted claims for breach of contract and violations of the Unfair Settlement Practices and Prompt Pay Acts.

On April 2, 2015, 140 days after MWR sent the amended claims to Seneca and 58 days after Yowell filed suit, Seneca agreed to defend Yowell in the Schneiders' suit under a reservation of rights. Yowell filed a motion for partial summary judgment against Seneca. In addressing that motion, the court analyzed whether: (1) Seneca breached its duty to defend Yowell; (2) Seneca waived its right to control Yowell's defense; (3) Seneca could contest the defense costs incurred in the Schneiders' suit; (4) Seneca violated the Prompt Pay Act; and (5) Seneca was liable to Yowell for the attorneys' fees incurred in Yowell's suit.

The court noted that no Texas opinion had addressed the issue of whether an insurer's delay in agreeing to provide a defense constituted a beach of the duty to defend. Here, after concluding Seneca had a duty to defend, the court rejected Seneca's arguments that its silence did not constitute a refusal of defense and held that the 140 day delay (a delay that Seneca did not even attempt to explain) was a denial of a defense. This breach by Seneca also constituted a waiver of the right to control the defense it was obligated to provide, freeing Yowell to use the attorney of its choosing in the Schneider suit. However, the court held that Seneca could still challenge the reasonableness of defense costs incurred by Yowell in defending the Schneiders' suit.

The court further held that Seneca's refusal to timely respond to Yowell's request for a defense constituted a violation of the Prompt Pay Act, and that Seneca was liable to Yowell for the attorneys' fees and expenses incurred in the lawsuit it initiated against Seneca. Seneca had submitted testimony challenging the reasonableness of the attorneys' fees incurred in both the Schneider lawsuit and the Yowell lawsuit, creating a fact questions on these fees. Thus, while Yowell was entitled to be compensated for these fees, summary judgment on the amounts to be awarded was not proper.

EQUITABLE LIEN DOCTRINE

Chartis Specialty Ins. Co. v. Tesoro Corp., -- F. Supp. 3d --. 2015 WL 4154136 (W.D. Tex. July 10, 2015).

Court rejects application of equitable lien doctrine when alleged promise by purported insured to obtain coverage was made to a different, albeit affiliated, entity – not the plaintiff.

At issue in this case was a Chartis policy insuring two properties, a refinery and a wharf, owned by Tesoro Refining. Tesoro Refining is a wholly owned subsidiary of Tesoro Corporation. Between 1989 and 1999, the EPA and the California Regional Water Quality Control Board for the San Francisco Bay Region (the "Water Board") issued a series of rendition orders pertaining to the refinery and the wharf. Tosco Corporation ("Tosco"), a previous owner of the refinery and the wharf, paid $16.3 million in remediation costs as a result of these orders. Tosco sold the refinery to Ultramar Diamond Shamrock Corporation ("Ultramar") in 2000.

Because the purchase agreement for this sale allocated all post-sale environmental liability to Ultramar, Ultramar secured a Specialty Pollution Legal Liability insurance policy from Chartis to cover certain environmental remediation costs (the "Policy"). The Policy had a $50 million SIR for pre-existing environmental conditions that provided Chartis would only pay clean-up costs for pre-existing environmental conditions in excess of $50 million.

Tesoro Refining purchased the refinery from Ultramar in 2002. Aware that the refinery had significant environmental liabilities attached to it, both Ultramar and Tesoro Refining understood the sale would include an assignment of the Policy. In the lawsuit, Chartis, Tesoro Refining and Tesoro Corporation did not agree on who was the intended assignee of the Policy. However, as part of the sale from Ultramar to Tesoro Refining, Chartis issued an endorsement to the Policy that named Tesoro Corporation – not Tesoro Refining – as an insured under the policy.

The following year, Tesoro Refining filed suit against Tosco alleging that Tosco had fraudulently concealed environmental conditions at the refinery. This suit eventually settled, with Tesoro Refining receiving $58.5 million in exchange for a release, and Tesoro Refining agreeing to assume liabilities at the refinery and the wharf moving forward.

The Water Board issued additional orders to Tesoro Refining regarding remediation at the wharf in 2004 and 2007. Tesoro Corporation requested coverage under the Policy, claiming it had incurred covered expenses of $70 million as of October 2010. The instant suit was initiated in November 2011.

The Tesoro entities and Chartis moved for summary judgment. Tesoro Refining and Tesoro Corporation argued that both the $58.5 million settlement and remediation costs dating back to 1993 satisfied the Policy's SIR. Chartis argued that any amounts paid by Tesoro Refining could not satisfy the SIR because Tesoro Refining was not a named insured.

Tesoro Refining conceded that it was not a named insured under the Policy, but argued that under the equitable lien doctrine, it was a third party beneficiary to the Policy because Ultramar was required to procure insurance for the benefit of Tesoro Refining and failed to do so.

The Western District reviewed Texas law pertaining to the equitable lien doctrine. The doctrine could apply wherever an insured has a duty to obtain insurance on behalf of a third party to protect that third party's interest in the subject property. When the insured fails to do so, the third party may obtain insurance proceeds that would otherwise only be payable to the named insured. However, this exception only applies when the insured has a pre-existing duty to obtain the insurance on behalf of the third party.

The doctrine was rejected here because the promise Tesoro Refining relied on was one made between Ultramar and Tesoro Corporation. Ultramar was no longer named on the policy, and in any event never made a promise to Tesoro Refining to procure insurance on that entity's behalf. The court held that the proper remedy here would be reformation of the Policy to name Tesoro Refining as the insured and not Tesoro Corporation. However, the limitations period in Texas for a reformation claim is four years. The court found that any claim for reformation was time barred because Tesoro Refining should have known of the need to reform the Policy by at least 2006, when it was involved in litigation with Tosco. This suit was initiated in 2011, beyond the limitations period. The court granted Chartis' motion for summary judgment

PROPERTY COVERAGE: FRAUD BY *INSURED* IN CLAIMS PROCESS

Fulgham v. Allied Prop. & Cas. Ins. Co., No. 05-14-00189-CV, 2015 WL 3413525 (Tex. App. – Dallas May 28, 2015, no pet. h.).

An insurer's investigation of a claim does not negate fraud claim against insurer when insurer's investigation relies on, and is thus hindered by, the insured's misrepresentations.

Fulgham obtained a property insurance policy from Allied. Beginning in 2009, Fulgham fabricated claims of property damage premised on false estimates and receipts for repairs never made, following hail-storm damage that was never actually sustained. Nevertheless, Allied paid Fulgham $899,160.

When Fulgham's later claim for additional damages was denied by Allied, Fulgham filed suit alleging breach of contract, statutory and common-law causes of action. Allied counterclaimed for fraud and unjust enrichment.

The jury awarded Allied damages of $899,160 (i.e., the total amount previously paid to Fulgham). On appeal, Fulgham argued, among other things, that Allied could not have justifiably relied upon his alleged misrepresentations as a matter of law, as Allied conducted its own independent investigation of the claims. In rejecting this argument, the court held Allied's investigation did not negate its fraud claim against Fulgham because Fulgham hindered the investigation through continuous misrepresentations that hindered the investigation.

EXCESS PROPERTY COVERAGE: AMBIGUITY CONSTRUED IN FAVOR OF COVERAGE

RSUI Indemnity Company v. The Lynd Company, -- S.W.3d--, No. 13-0080, 2015 WL 2194201 (Tex. May 8, 2015).

Excess policy's language could be reasonably construed to align with each parties' interpretation. Given this ambiguity, the Texas Supreme Court reaffirmed the rule that an ambiguous coverage limitation should be construed in favor of coverage.

The Lynd Company ("Lynd") purchased two layers of insurance covering over 100 commercial properties across 11 different states. The first layer, a primary policy issued by Westchester Fire Insurance Company provided coverage up to $20 million per occurrence. The second layer, an excess policy provided by RSUI Indemnity Company, covered losses in excess of the primary policy up to $480 million per occurrence. The excess policy required Lynd to provide quarterly value statements for each of the insured properties. RSUI would then use those reported values to update premiums every quarter using a $.025/$100 ratio.

Of all the properties insured, only one had a value statement in excess of $20 million. In other words, the primary policy was sufficient to cover all losses that a single occurrence could cause to any one property, meaning only an event catastrophic enough to cause damage to more than one insured property within the same occurrence was likely to trigger the excess policy.

In September 2005, Hurricane Rita damaged 15 insured properties to the tune of $24.5 million. Westchester paid $20 million under the primary policy, but RSUI refused to pay $4.5 million from the excess policy. In lieu of paying the $4.5 million excess, RSUI paid $750,000.

At issue in this case was a policy provision that provided coverage for the *least* of three alternative amounts: (a) the adjusted loss; (b) 115% of the value statement for the property; or (c) policy limits ($480 million). Option (c) was not at issue because the total loss was only $24.5 million. Lynd and RSUI disputed how the policy required choosing between the other two options ((a) and (b)) when multiple properties were damaged in the same occurrence. RSUI argued that this calculation should be done with each property at issue, with the excess policy providing coverage in the amount of the lowest value at each property. Lynd argued that the total sum of the valuations of all values (a) and (b) for all properties should be determined, and the excess policy provided coverage for the lesser of those two total sum values. To arrive at the $750,000 value paid, RSUI applied option (a) to 13 of the damaged properties and option (b) to the other two. The option (b) properties alone accounted for the difference in the parties' coverage positions.

The parties filed cross motions for summary judgment. The trial court accepted RSUI's construction of the policy and ordered Lynd take nothing. The court of appeals reversed and rendered judgment awarding Lynd the full amount of the disputed coverage plus statutory interest and penalties, attorneys' fees, and costs.

The Texas Supreme Court granted review and conducted a thorough analysis of Lynd's and RSUI's interpretation of the excess policy's terms. In the end, the court concluded that the excess policy's language could be reasonably construed to align with each party's interpretation. Given this ambiguity, the court reaffirmed the rule that an ambiguous coverage limitation should be construed in favor of coverage for the insured and affirmed the court of appeals' decision.

CHOICE OF LAW PROVISION AMBIGUOUS

In re ATP Oil & Gas Corp., 531 B.R. 694 (Bkrtcy. S.D. Tex. 2015).

Despite ATP's failure to provide timely notice of claim under its insurance policy, Water Quality Insurance Syndicate was required to reimburse ATP for its defense costs incurred in defending an underlying lawsuit.

The insurance policy issued by Water Quality to ATP insured against certain pollution-related losses. The policy required that ATP give immediate notice of any occurrence that could give rise to a claim under the policy. It was undisputed that ATP did not give timely notice. The policy contained a choice of law provision that provided that the interpretation of the policy would be governed by federal maritime law of the United States or, in the absence of federal maritime law, by the law of the State of New York. The outcome of the case ultimately turned on the bankruptcy court's decision to apply Texas law to the interpretation of the policy.

The court reasoned that although federal maritime law is the primary choice of law in the contract, there is no federally established rule concerning late notice. While the default choice of law in the insurance contract was New York law, the court held that "a policy of insurance, by necessity, incorporates applicable state law insurance requirements into the terms of the policy." Further, Texas may regulate insurance issued for the benefit of her citizens. When a Texas resident is an insured, § 21.42 of the Insurance Code dictates the application of Texas law. ATP was a Texas citizen.

Accordingly, given the conflict between the insurance contract and the Texas statute, the policy was ambiguous and had to be construed in favor of the insured. While New York law generally requires a showing of prejudice in order for an insurer to decline coverage based upon late notice, the New York statute contains an exception for maritime policies, which are enforced as written. However, Texas law requires a showing of prejudice in order for an insurer to deny coverage based upon late notice in the case of all but claims-made policies.

The court then weighed the Restatement factors and determined that they weighed heavily in favor of Texas law. Further, the court found that when a state has enacted a law to protect its citizens who were the intended beneficiaries of insurance policies, that law may be recognized as creating a compelling interest in favor of the state's regulatory insurance scheme.

Accordingly, "[w]hether determined under a plain reading of § 21.42 of the Texas Insurance Code, or under a more thorough analysis under federal maritime law applying the Restatement of Conflicts, Texas law applies to this dispute." Thus, in the absence of a showing of prejudice due to ATP's late notice, Water Quality had to pay ATP's expenses incurred to defend the underlying lawsuit.

STOWERS DOCTRINE

Am. Empire Surplus Lines Ins. Co. v. Occidental Fire & Casualty of N. Carolina, No. 2:14–CV–456, 2015 WL 4496699 (S.D. Tex. July 22, 2015).

An excess settlement can trigger *Stowers* liability.

American Empire contended that Occidental had a reasonable opportunity to settle an underlying case within policy limits, should have done so, but failed to do so. As a result, American Empire, as excess insurer, sought to recover the amount it paid to settle the matter over the amount of Occidental's tendered primary limits – an amount paid only because of Occidental's failure to settle. Occidental filed a Motion for Judgment on the Pleadings, asserting that American Empire had no valid cause of action because a *Stowers* claim requires that the plaintiff sue for the amount of an excess judgment rather than an excess settlement. The court disagreed, finding that only an obligation to pay a sum certain is required to ensure that the *Stowers* action is ripe for determination.

In so holding, the court found that *RLI Ins. Co. v. Philadelphia Indem. Ins. Co.*, 421 F. Supp. 2d 956, 968-69 & n. 10 (N.D. Tex. 2006) did not govern the matter because there, carriers jointly evaluated and settled the underlying claim against their common insured. And rather than presenting a *Stowers* tort-based scenario related to a carrier's failure to settle within its own policy limits when it had the opportunity to do so, the case was a contract based battle between all of the carriers as to how the policies were to be construed and liability divided. The court explained that *RLI* states that when the carriers evaluate and settle the case together, there is no predicate wrongful act of a primary carrier to trigger *Stowers* liability. The court found, however, that such a predicate wrongful act existed on the facts asserted.

EIGHT CORNERS RULE: ADVERTISING INJURY

Test Masters Educ. Services, Inc. v. State Farm Lloyds, 791 F.3d 561 (5th Cir. 2015).

Court held a claim that an insured's website was "confusingly similar" to the plaintiff's did not trigger coverage under an "advertising injury" provision that included trade dress infringement.

Applying the eight corners rule, the court found the advertising injury provision included infringement of trade dress in "notices" published on the internet but did not include trademark infringement. The court recognized a growing number of courts have confronted whether trade dress protection can extend to websites, so-called 'web dress' protection. The case before the court, however, did not present such an opportunity. The live pleading alleged the insured changed its website to "testmasters.com" so that it was confusingly similar to "testmasters.net", purporting to offer LSAT preparation courses in every state, although plaintiff had never before offered LSAT courses anywhere, and had never before offered any test preparation courses outside of the state of Texas. The court held these allegations only suggested trademark infringement and false advertising, rather than trade dress infringement.

To trigger coverage for a trade dress infringement claim involving a website, the claim must articulate "discrete elements" of the "look and feel" of the website that the defendant copied. Citing two prior Fifth Circuit decisions holding that product design and trademark infringement claims did not constitute trade dress claims, the court held the underlying complaint failed even to allege protectable trade dress.

BUSINESS RISK EXCLUSIONS

Lend Lease (US) Construction, Inc. v. Amerisure Mutual Ins. Co., Case 4:13-cv-03552 (S.D. Tex. June 16, 2015).

"Your Work" and "Your Product" exclusions operated to bar coverage for repair and replacement of defective flooring.

In this coverage dispute, Lend Lease, a contractor, sought indemnity coverage from its subcontractor's (Texan Floor) Amerisure CGL policy and Ohio Casualty excess policy with regard to a settlement of an underlying dispute regarding installation of improper flooring in a medical center. The parties agreed that relevant terminology was virtually identical between the Ohio Casualty and Amerisure policy. The parties further agreed that Lend Lease was an additional insured under the policies, and the policies state that an "Insured" is amended to include "Your Work" for the additional insured.

In pertinent part, Amerisure argued that there was no "property damage" because the flooring was defective upon installation. Amerisure also argued that even if there was "property damage," such claims were excluded by the "Your Work," "Your Product," and "Impaired Property" exclusions of the policy.

The policy defined "property damage" to include "physical injury to tangible property, including all resulting loss of use" as well as loss of use of "tangible property that is not physically injured." The court noted that Texas courts have addressed when replacement of an insured's faulty or defective construction is "property damage" (see *Lennar* and *Lamar Homes*). Here, Lend Lease did not allege that the flooring installation resulted in property damage to the existing medical center's structure, but rather, claimed that the damage due to the defectively installed flooring was to the flooring itself. Thus, the court held that there was no "property damage" under the Amerisure and/or Ohio Casualty policies. Further, because all damages at issue, including loss of use, were related to the repair and replacement of the defective flooring, the court held that the "Your Work" and "Your Product" exclusions operated to bar coverage for repair and replacement.

CLAIMS-MADE POLICIES: EXCESS COVERAGE AND NOTICE

Ill. Union Ins. Co. v. Sabre Holdings Corp., No. 02-14-00130-CV (Tex. App.—Fort Worth June 25, 2015).

Notice to excess carrier made outside of primary claims-made policy's coverage period was sufficient despite excess carrier's argument that excess policy was a "follow-form" policy.

Sabre obtained a primary insurance policy from American International Specialty Lines Insurance ("AISLIC") and an excess policy from Illinois Union. The policy period for both policies began March 15, 2004 and ended March 15, 2005. Beginning in December 2004, various government entities sued Sabre for allegedly failing to remit hotel taxes collected from consumers. Sabre's insurance broker notified AISLIC in writing of the first three suits on March 11, 2005. AISLIC acknowledged coverage for the three lawsuits and, over a period of time, paid policy limits for defense costs.

In December 2010, Sabre sent a letter to Illinois Union's policy representative, ACE USA, advising of the three lawsuits and requesting a coverage determination. Illinois Union denied coverage contending the excess policy was a "follow-form

policy" that required Sabre report the claim during the same policy period as the claim was reported to AISLIC. In September 2012, AISLIC notified Sabre that the limits of the primary policy had been fully exhausted. Sabre thereafter instituted a coverage action against Illinois Union.

The parties stipulated that Illinois Union's only defense to Sabre's duty to defend claim was Sabre's alleged failure to report the claim to Illinois Union during the same policy period as the claim was reported to AISLIC. Sabre and Illinois Union filed cross-motions for summary judgment. Illinois Union argued that the follow-form excess policy required Sabre to follow all the terms and conditions of the primary policy, and because the primary policy was a "claims made and reported policy", Sabre should have reported the claim to Illinois Union during the same policy period that it reported the claim to AISLIC. That is, Sabre was required to—but did not—notify *both* insurers of the claim within the end of the primary policy's period or extended reporting period in order to invoke coverage under the excess policy.

The trial court denied Illinois Union's summary judgment motion and granted partial summary judgment to Sabre ruling that Sabre gave proper notice under the excess policy to invoke coverage. The trial court eventually rendered a final judgment in Sabre's favor. Illinois Union appealed.

On appeal, Illinois Union challenged only the trial court's ruling on summary judgment. The Court of Appeals examined the excess policy and found that the section in the excess policy regarding primary policies contained conflicting provisions. One clause provided that the excess policy was subject to the same terms, definitions, conditions, exclusions and limitations contained in the primary policy, but another clause in the same section contained a non-follow form endorsement requiring Sabre to instead give Illinois Union written notice and the full particulars of … the exhaustion of the primary policy as soon as practicable. Thus, the court held it was not dispositive that the excess policy was a follow form policy.

Applying rules of construction to construe the policies and the non-follow form endorsement together, the appellate court reasoned that the insuring clause could be read to not incorporate the notice conditions of the primary policy because the reporting requirements in the primary policy are more properly characterized as conditions rather than definitions, exclusions, or limitations. The appellate court concluded that the insuring clause as amended by the endorsement could be reasonably interpreted to mean that the excess policy followed form to the definitions, exclusions, and limitations of the primary policy, but not the terms and conditions of the primary policy. Finding Sabre provided proper notice to invoke coverage under the excess policy, the court affirmed the trial court's judgment in favor of Sabre.

SOPHISTICATED-INSURED EXCEPTION

Certain Underwriters at Lloyds London v. Perraud, -- Fed. Appx.--, No. 14–10849, 2015 WL 4747318 (5th Cir. Aug. 12, 2015).

Fifth Circuit predicts the Texas Supreme Court would not adopt a broad sophisticated-insured exception, assuming, *arguendo*, that a sophisticated-insured exception is recognized in Texas.

Perraud and Raffanello were employees of the Stanford Financial Group which was covered under a D & O policy issued by Lloyds. After Perraud and Raffanello successfully defended federal criminal charges, Perraud and Raffanello sought reimbursement for attorneys' fees and costs under the D & O policy. Lloyds refused to pay the claim on the ground that the wrongful acts exclusion in the policy precluded coverage and sued for a declaratory judgment.

On cross-motions for summary judgment, the district court found that the exclusion was ambiguous and interpreted it in favor of coverage pursuant to Texas's doctrine of *contra proferentem*. Declining to apply the sophisticated-insured exception urged by Lloyd's, the district court concluded that even if Texas were to recognize the exception, Lloyds failed to present evidence indicating that Stanford negotiated or drafted the exclusion. Lloyd's appealed.

On appeal, Lloyd's challenged only the district court's ruling on the application of the sophisticated-insured exception but did not appeal the finding of ambiguity. The Fifth Circuit noted that Lloyd's appeal was premised on the assumption that the Texas Supreme Court would recognize the sophisticated-insured exception in response to a certified question in the *In re Deepwater Horizon* case before Lloyd's appeal was heard. The Texas Supreme Court, however, never reached the question regarding the sophisticated-insured exception in *In re Deepwater Horizon*. Despite expressly noting that no Texas court has ever recognized the exception, the

Fifth Circuit nevertheless addressed the scope of such exception, as if the exception existed, in Texas and the proof necessary to satisfy the exception in light of Texas's strong policy favoring coverage in instances where a policy is ambiguous.

The Fifth Circuit identified three different approaches taken by courts applying the exception: (1) the narrow approach applying only where the insured actually negotiated the particular provision at issue; (2) the broad approach applying the exception any time the insured is a sophisticated business entity; and (3) the middle ground approach applying the exception where the insured actually negotiates, drafts, or proposes portions of the policy. After laying out the three different approaches, the Fifth Circuit predicted that Texas would not adopt the broad approach to applying sophisticated-insured exception because of Texas's doctrine of *contra proferentem* and because there was otherwise no indication that Texas courts would recognize broad application of the sophisticated-insured exception.

Applying the narrow and middle ground approaches to the evidence submitted by Lloyd's, the Fifth Circuit determined that evidence that some negotiation occurred was insufficient to create a genuine dispute of material fact as to the exception's applicability under the narrow or middle-ground approaches "absent any information about the content of the negotiations, how the contracts were prepared, or other indicators of relative bargaining power..." The Fifth Circuit concluded the district court did not err by declining to apply the exception even if it were applicable in Texas, and affirmed summary judgment in favor of Perraud and Raffenello.

POLLUTION EXCLUSION

Evanston Ins. Co. v. Lapolla Indus, Inc., No. H-13-3157, 2015 WL 764409 (S.D. Tex. Feb. 23, 2015).

Total pollution exclusion applied to negate insurer's duty to defend the insured, a spray insulation manufacturer, in products liability suit where underlying complaint alleged bodily injury and property damage resulting from the release and migration of harmful vapors from the insured's product.

CGL POLICIES: EPA DEMAND LETTER TRIGGERS COVERAGE

McGinnes Indus. Main. Corp. v. Phoenix Ins. Co., --S.W.3d--, No. 14–0465, 2015 WL 4080146 (Tex. 2015).

A demand letter from the EPA to a potentially responsible party ("PRP") under CERCLA and administrative proceedings under CERCLA constituteS a "suit" that triggers an insurer's obligations under a CGL policy.

In the 1960s, McGinnes dumped pulp and paper mill waste sludge into disposal pits along the San Jacinto River near Houston, Texas. During the period that McGinnes dumped waste at the site, McGinnes held standard-form CGL policies issued by Phoenix and Travelers that did not contain, at that time, the "sudden and accidental" pollution exclusion, which the insurance industry incorporated into CGL policies after 1970.

The EPA began investigating the site in 2005, and in 2007, the EPA sent a section 104(e) letter demanding information from McGinnes concerning its activities at the San Jacinto River site. The EPA's letter threatened McGinnes with penalties of up to $32,500 per day if it did not comply. Two years later, the EPA demanded that McGinnes clean up the site and pay fines and penalties. The EPA also requested that McGinnes make a good faith offer to resolve its liability. McGinnes declined to do so and the EPA issued an administrative order directing McGinnes to conduct a remedial investigation and feasibility study at the site.

McGinnes tendered the dispute to its insurers for the period of time it conducted operations at the site, including Phoenix and Travelers. Although the policies did not define "suit," Phoenix and Travelers denied coverage, asserting that the EPA administrative proceedings did not constitute a "suit" that would trigger obligations under the policies.

A majority of the Texas Supreme Court held that without further definition, the word "suit" in these policies included the EPA proceedings for three reasons: (1) The process created by CERCLA, which did not exist when the policies were written, gave the EPA authority to conduct on its own what otherwise would have amounted to pretrial proceedings, but without having to initiate a court action until the end of the process, (2) the EPA proceeding sought covered "damages" under the policies and to interpret

the policies to cover damages incurred as a result of pollution cleanup proceedings without giving insurers the right and duty to defend those proceedings would lead to serious consequences, and (3) thirteen of the sixteen state supreme appellate courts considering the issue have found that the EPA proceedings were "suits."

APPORTIONMENT AND PROMPT PAYMENT

Interstate Fire & Cas. Co. v. Catholic Diocese of El Paso, No.14-51113, 2015 WL 4864909 (5th Cir. Aug. 14, 2015).

Insured's payment of settlement funds for global settlement and release of multiple defendants, including non-insureds, found to be properly apportioned fully to insured and thus covered.

The Catholic Diocese of El Paso was sued with two other defendants. While one of the other defendants had previously borne primary responsibility in other similar lawsuits, that defendant was essentially insolvent. Accordingly, the Plaintiffs dealt only with the Diocese in negotiating a settlement. Ultimately, the Diocese and Plaintiff agreed to settle the claims between them for $1.2 million. The parties then agreed that the settlement and corresponding releases would apply equally and extend to all defendants.

The Diocese paid the entire settlement amount of $1.2 million and submitted an indemnification claim under its insurance policy issued by Interstate.

After asking for and receiving more information, Interstate filed a declaratory judgment action seeking a determination of what portion of the $1.2 million was intended to cover the claims against the Dioceses. Interstate failed to notify the Diocese of is coverage decision prior to filing suit. The Diocese sought recovery of the entire $1.2 million and asserted what they would later deem as a Prompt Payment Act claim.

The trial court held the entire $1.2 million was intended to cover claims against the Diocese. The trial court denied, however, the Diocese Prompt Payment Act claim on the ground that no evidence of any particular violation had been presented.

Interstate appealed arguing 70% to 90% of the settlement covered the other defendants' claims. The appellate court rejected this argument, and in affirming the trial court's ruling on apportionment, stated: "[t]here is essentially no evidence supporting [Interstate's] wholly meritless argument."

With respect to the Diocese's purported Prompt Payment Act claim, the appellate court affirmed the trial court's ruling that it had been waived through the Diocese's failure to adequately present it to the trial court, stating:

> [T]he Diocese's failure to cite the relevant law, failure to identify the relevant facts, and failure to provide any analysis linking the law and the facts doomed its request for § 542.060 penalties and effected a waiver.

DECLARATORY JUDGMENT ACTIONS: FEDERAL COURT'S DISCRETION TO EXERCISE JURISDICTION

Ironshore Specialty Ins. Co. v. Tractor Supply Co., No. 14–51164, 2015 WL 5012122 (5th Cir. Aug. 25, 2015).

Trial court abused its discretion in dismissing declaratory judgment action based on *Trejo* factors.

McGowan sustained injuries while working at a distribution center owned by Tractor Supply Company ("TSC"). McGowan was placed in this job by a staffing company. TSC had elected not to subscribe to the Texas workers' compensation system and instead created an ERISA work-injury benefit plan, and obtained a Nonsubscriber Policy from Safety National.

McGowan sued TSC in state court. While McGowan's Texas state-court tort suit against TSC was pending, Ironshore, which provided an umbrella policy to TSC, commenced an action under the Declaratory Judgment Act (DJA) in federal district court against TSC and Safety National. Ironshore sought a declaration that Safety National's policy covered TSC's liability to McGowan, and that any indemnity owed by Ironshore was in excess of that coverage.

After the state court entered final judgment for McGowan, the federal district court, pursuant to its discretion under 28 U.S.C. § 2201(a), declined to exercise jurisdiction over the declaratory judgment action and dismissed Ironshore's claims against Safety National and TSC.

On appeal, the Fifth Circuit reiterated that, under *Orix Credit Alliance, Inc. v. Wolfe*, 212 F.3d 891, 895 (5th Cir. 2000), a district court considering a declaratory judgment action must engage in a three-step determination: (1) whether the declaratory judgment action is justiciable; (2) whether the court has the authority to grant the declaratory relief; and (3) whether to exercise its discretion to decide or dismiss the action.

After explaining only the first and third steps were at issue, the court turned to the justiciability prong. The court held that in light of established Texas precedent recognizing declaratory judgment actions were ripe while the underlying case was pending, coupled with the further fact that McGowan has already obtained a judgment in the Texas court, the case presented "a substantial controversy, between parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of a declaratory judgment," and was thus justiciable.

Turning to the third prong, the court recognized that the discretionary standard of *Brillhart v. Excess Insurance Co. of America*, 316 U.S. 491 (1942), rather than a more stringent test, governs a district court's decision to hear a declaratory judgment action. Under *Brillhart*, a district court should ascertain whether the questions in controversy between the parties to the federal suit can be better settled in the proceeding pending in state court. This involves consideration of the proper allocation of decision-making between state and federal courts, fairness, and efficiency. With this backdrop, the Fifth Circuit focused on seven nonexclusive *Trejo* factors to be considered by district courts, noting that failure to address and balance the factors relevant to the abstention doctrine on the record is an abuse of discretion.

Noting that district court listed all seven *Trejo* factors but specifically weighed only six of them, albeit tersely, the Fifth Circuit first dismissed Ironshore's claim that the district court abused its discretion by merely failing to address the seventh factor (i.e., whether the federal court is being called on to construe a state judicial decree involving the same parties and entered by the court before whom the parallel state suit between the same parties is pending). The court then looked to the district courts application of each of the other *Trejo* factors to determine whether the trial court abused its discretion.

Addressing each of the seven *Trejo* factors in turn, the Fifth Circuit held the district court's cursory analysis of the *Trejo* factors left much to be desired, and that all seven of the *Trejo* factors weigh against dismissal. Thus, the district court abused its discretion in applying the *Trejo* factors and dismissing the action.

FLOOD INSURANCE: FEDERAL PREEMPTION

Spong v. Fidelity Nat. Property and Cas. Ins. Co., 787 F.3d 296 (5th Cir. 2015)**.**

Federal flood insurance scheme does not preempt state tort claims pertaining to the marketing and selling of policies by the private flood insurance carriers. Further, under Texas state law, insureds could not reasonably rely on flood insurer's issuance of federal flood policy as a representation that their property was insurable.

Hurricane Ike swept away all improvements on the Spongs' property. The insurer, Fidelity National Property and Casualty Insurance Company, subsequently advised the Spongs that the policy was void from its inception because the property was ineligible for flood insurance under applicable federal laws and regulations. In particular, the Spongs' property was located within the John H. Chafee Coastal Barrier Resources System ("CBRS"), and the Coastal Barrier Resources Act provided that federal flood insurance could not be issued for property in the CBRS.

The confusion regarding the insurability of the Spongs' property stemmed from the fact that two federal agencies, FEMA and the Fish and Wildlife Service, had erroneously concluded the Spongs' property was not within the CBRS.

The Spongs sued Fidelity and its affiliate (collectively "Fidelity"), and the United States, asserting a number of federal and state-law claims. Fidelity sought summary judgment, asserting, among other grounds, that the Spongs' claims were preempted by federal law. The magistrate judge concluded that the Spongs' state-law insurance procurement claims were not preempted. However, the magistrate judge determined that an interlocutory appeal under 28 U.S.C. § 1292(b) was warranted.

On appeal, the Fifth Circuit also rejected Fidelity's preemption argument, reasoning that while FEMA extensively regulates administration of flood

insurance policies, it demonstrates no such interest in state tort claims pertaining to the marketing and selling of policies by the private carriers – otherwise known as "procurement" claims. Thus, procurement claims are not preempted.

In so holding, the court rejected Fidelity's argument that a FEMA bulletin was tantamount to a change in law. The court explained that the weight we accord the agency's explanation of state law's impact on the federal scheme depends on its thoroughness, consistency, and persuasiveness, of which the court indicated there was little in light of a prior ruling that the FEMA bulletin is not controlling. However, the court noted that all claims-handling actions are preempted.

Turning next to the procurement claims asserted by the Spongs, the court held that because the Spongs were seeking coverage that was to be provided from public funds, it was incumbent upon them to determine whether their property was eligible for such insurance. The Spongs could not reasonably rely on Fidelity to make that determination for them. Further, the court noted that at the time that the Spongs applied for a flood insurance policy and Fidelity issued the policy, the Spongs were in possession of essentially the same facts as Fidelity, including a copy of a 1998 elevation certificate stating the property was within the CBRS. Accordingly, the issuance of a policy by Fidelity was not a representation on which the Spongs could rely.