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This newsletter is intended to summarize significant cases impacting the insurance practice since the Spring 2016 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 Parsons McEntire McCleary & Clark, PLLC.

THE *STOWERS* DOCTRINE: COVERAGE FIRST, THEN DAMAGES

***Seger v. Yorkshire Ins. Co., Ltd.*, — S.W. 3d —, 2016 WL 3382223 (Tex. June 17, 2016).**

The Texas Supreme Court reaffirmed that the *Stowers* doctrine always requires that the plaintiff first prove the insured had underlying coverage: without coverage, there is no *Stowers* duty, negligence, or associated damages.

In 1992, Randy Seger ("Randy") died after the hydraulic-lift drilling rig he was working on collapsed. The rig was owned by Diatom Drilling Co. ("Diatom"). At the time of his death, Randy was not employed by Diatom but by an oilfield service company, Employer's Contractor Services, Inc. ("ECS").

After his death, Randy's parents, Roy Seger and Shirley Hoskin ("the Segers") sued Diatom for wrongful death; Diatom then demanded that its CGL insurers defend the litigation. The CGL insurers refused. The CGL insurers' position was that Randy's death was not a covered occurrence under the $500,000 policy.

Before trial, the Segers submitted multiple *Stowers* demands to the CGL insurers, but each one was rejected. Eventually, the Segers went to trial against Diatom. But by this time, Diatom was dissolved and Diatom's counsel had withdrawn from the case. Thus, at the bench trial, Diatom presented no opening or closing, presented no evidence and cross-examined no witnesses. At trial, the Segers obtained a $15 million judgment against Diatom. Diatom then assigned its rights against the CGL insurers to the Segers.

The Segers then filed a *Stowers* action against the CGL insurers for wrongful refusal to defend and negligent failure to settle within policy limits. After competing motions for summary judgment, the trial court granted the Segers' motion for partial summary judgment, finding coverage, a demand within limits, a fully adversarial relationship, and a trial.

The Segers then obtained favorable jury findings on the CGL insurers' negligence, causation, and damages. Because there was an underlying judgment, the trial court directed a verdict as to damages. Thus, in April of 2006, the Segers had a

$37,213,592.01 final judgment against the CGL insurers.

On appeal, the CGL insurers obtained a remand of the case back to the trial court. According to the court of appeals, the issue of coverage was a fact issue not appropriate for summary judgment. Additionally, the court remanded the case back to the trial court to determine whether a fully adversarial trial occurred in the earlier bench trial.

On remand, the trial court then re-tried the case and a second jury determined (1) that the CGL insurers were negligent in not settling the Segers' wrongful death claim and (2) that Randy was not an employee or leased-in worker under the policy. On these findings, the trial court entered a final judgment that the Segers' original wrongful death claim was covered under the Diatom CGL policy; and (2) that the original judgment set the amount of damages, now $71,696.547.

The CGL insurers appealed again. In this second appeal, the court of appeals reversed the trial court's judgment on damages. According to the court of appeals, the underlying judgment in the original bench trial was not the product of a fully adversarial trial. Thus, because the Segers relied solely on the underlying judgment to prove damages, there was no other evidence that Diatom was damaged by the CGL insurers. Because one element of the Segers' *Stowers* action was missing, the Segers' claim failed.

The Texas Supreme Court granted the Segers' petition for review, but limited its decision to one issue: coverage.

Under the policy, the CGL insurers were liable for bodily injuries to third parties, including independent contractors, but not to employees or leased-in workers of Diatom. The Segers argued, and the second jury agreed, that Randy was not an employee or a leased-in worker. Thus, the ultimate issue for the court was whether there was evidence that supported the jury's determination that Randy was not an employee or a leased-in worker.

To make this determination, the court first addressed the proper burden of proof: the Segers were required to prove initial coverage and the CGL insurers were required to prove an exclusion. There were two exclusions that could potentially apply: one for employees of Diatom and another for leased-in workers of Diatom.

The Segers met their initial burden to show coverage. Here, the policy language covered bodily injury to third parties. Since Randy was not an insured under the policy, only Diatom and ECS were insureds, the court concluded that Randy was necessarily a third party. Thus, the burden shifted to the CGL insurers to prove that one of the exclusions applied.

After determining that the CGL insurers could enforce the exclusions despite the insurers' failure to pay the Texas surplus lines premium tax, the court addressed whether Randy was an employee under the policy. Under the policy, an "employee" was a "person in the service of another with the understanding, express or implied, that such other person has the right to direct the details of the work and not merely the result to be accomplished." Here, there was evidence that supported the second jury's finding that Randy was an employee of ECS and not of Diatom. Thus, the jury finding was upheld, and the employee exclusion did not apply.

Next, the court addressed the leased-in worker exclusion. The court defined a "leased-in worker" as "a person that perform[s] work for the insured under an agreement with another allowing temporary use of the worker, even though the leased worker would not be an employee of [the] insured." The Segers argued that because Randy was an employee of ECS, which was an independent contractor of Diatom, Randy was also an independent contractor and not a "leased-in worker." To the court, however, Randy could be both under the definition above.

Under the evidence presented, Randy was "a person that performed work for the insured" because Randy was working at the Diatom drilling site when the accident occurred. Additionally, there was "an agreement with another allowing temporary use of the worker" because there was evidence that Diatom and ECS entered into a contract allowing for Diatom to use ECS employees when needed. Finally, the last clause, "even though the leased worker would not be an employee of insured," was met because it was undisputed that Randy was an employee of ECS.

To the court, the Segers failed to present any evidence that supported the second jury's finding that Randy was not a "leased-in worker." In fact, all the evidence presented proved the opposite. Thus, the court concluded that there was no coverage. Without coverage, the CGL insurers were not negligent for refusing to settle the Segers' original wrongful death action or for refusing to provide a defense to Diatom. Indeed, without coverage, Diatom suffered no damages. Importantly, the court reaffirmed the basic principle that there must be coverage to succeed in any *Stowers* action.

UNDER COMMERCIAL CRIME POLICY, FORGERY ALONE IS NOT "THEFT"

***Tesoro Ref. and Mktg. Co., L.L.C. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 833 F.3d 470 (5th Cir. 2016).**

This is an important case regarding the prerequisites for proving coverage under a standard commercial crime policy. The district court granted summary judgment in favor of National Union, holding there was no coverage for Tesoro's loss, and the Fifth Circuit affirmed.

In 2003, Tesoro began selling fuel on credit to Enmex Corporation. Tesoro set a $25 million credit limit for Enmex. Yet, by December 2007, Enmex's account balance had grown to $45 million. During year-end review, Tesoro's outside auditors questioned Calvin Leavell, Tesoro's credit manager, about the Enmex account. Leavell advised them that the account was secured by a $12 million letter of credit. Shortly thereafter, a document purporting to be a $12 million letter of credit was created, with Leavell's password, on Tesoro's computer system. In January 2008, a document purporting to be a $24 million letter of credit was similarly created using Leavell's password. A copy was forwarded to the outside auditors. By March 2008, the Enmex account balance reached $59 million and continued to grow. It reached $90 million in December 2008. Then, for the first time, Tesoro's risk management officer asked to see the letters of credit. When asked, Leavell denied creating the LCs; and, when requested, the bank advised Tesoro the LCs were not genuine. Thereafter, Tesoro ceased selling to Enmex and sued for breach of contract and fraud. After some litigation, Tesoro settled the Enmex lawsuit.

Tesoro then sought to recover its losses under National Union's commercial crime policy. After National Union denied coverage, Tesoro sued National Union. On cross motions for summary judgment, the district court granted judgment for National Union, concluding that to establish coverage under the National Union insurance policy (the "Policy"), Tesoro was required to prove an "unlawful taking" but its evidence failed that test.

The Fifth Circuit concluded that the National Union Policy is unambiguous and requires an insured to prove "theft" of its property—defined by the Policy as "the unlawful taking of property to the deprivation of the Insured." Tesoro argued that proof of "theft" was unnecessary because the Policy also provided: "[f]or the purposes of this Insuring Agreement, 'theft' shall also include forgery." Tesoro claimed that phrase expands coverage so that proof of forgery *alone* could trigger coverage, without proof of "theft". The Court disagreed, finding Tesoro's interpretation unreasonable, as it ignores the express definition and requirement of "theft" under the Policy.

The Court next considered whether there was sufficient evidence of an "unlawful taking" to raise a genuine issue of fact. The Policy did not define "unlawful taking". The district court gave it an ordinary meaning, while Tesoro argued it should mean any theft defined by Texas law. For purposes of argument, the Court analyzed the evidence based upon that definition. The Court observed that for theft by deception, Texas law requires that "the decision-maker must be aware of the false statement and induced by it." Moreover, the deception must be a "substantial or material factor" in the owner's decision.

The Court found that Tesoro's evidence did not satisfy even Tesoro's definition of "unlawful taking". To the contrary, the evidence created doubt that the forged documents mattered to Tesoro's decision making. Before the forged documents were created, Tesoro's officers had authorized sales to Enmex in excess of its credit limit. After the forged documents expired on their face, Tesoro continued to sell to Enmex on credit. And, although the letters of credit were available for any Tesoro officer to review, none had ever looked at them. Therefore, because Tesoro failed to show a genuine dispute of material fact as to whether theft by deception had occurred, the Fifth Circuit affirmed summary judgment for National Union.

HARMLESS ERROR: SUMMARY JUDGMENT DISMISSAL OF DUTY TO INDEMNIFY CLAIM SUA SPONTE

***Markel Am. Ins. Co. v. Verbeek*, No. 15-51099, 2016 WL 5400412 (5th Cir. Sep. 27, 2016) (per curiam).**

The Fifth Circuit affirmed a sua sponte summary judgment dismissal of a duty to indemnify claim when the pleadings in the underlying case negated both the duty to defend and the duty to indemnify.

In 2012, Color Star Growers of Colorado, Inc. ("Color Star") refinanced its debt by entering into a credit facility with several banks. Later, unable to meet its obligations, Color Star defaulted and entered into bankruptcy. Thereafter, the banks filed two lawsuits against the owners and officers of Color Star, Huibert Verbeek and Engelbrecht Verbeek ("the Verbeeks"), alleging that the Verbeeks misrepresented the true financial condition of Color Star.

The Verbeeks had previously obtained a D&O policy from Markel American Insurance Company ("Markel"). Thus, once the banks commenced the state court litigation, the Verbeeks requested that Markel provide them a defense. Markel, however, denied coverage based on the policy's "Bankruptcy and Creditors" exclusion, which according to Markel denied coverage for "lawsuits brought by any Color Star creditor so long as the credit transaction forms the basis of the claims brought, and damages sought."

On the same day that Markel denied coverage, it filed a declaratory judgment action in federal court seeking a declaration that it did not have a duty to defend or indemnify the Verbeeks. In due course, the parties filed cross motions for summary judgment on Markel's duty to defend. The district court granted summary judgment for Markel, agreeing that it had no duty to defend the Verbeeks, and then it entered a final judgment for Markel, which included a declaration that the "Bankruptcy and Creditors" exclusion also precluded Markel's duty to indemnify the Verbeeks for the state court actions.

The Verbeeks then moved to vacate the final judgment because (1) the parties' summary judgment motions only addressed the duty to defend and (2) the issue of indemnity was not ripe until the state court litigation was resolved. The district court denied the motion. On appeal, the Fifth Circuit addressed whether Markel had a duty to defend and whether the district court erred in granting summary judgment, sua sponte, on Markel's duty to indemnify.

After affirming the district court's holding that the "Bankruptcy and Creditors" exclusion precluded Markel's duty to defend, the Fifth Circuit addressed whether the district court erred in granting summary judgment on the Verbeek's duty to indemnify claim. The court pointed out that district courts have the power to enter summary judgments on their own motion if the losing party was on notice that it had to come forward with all of its evidence.

Reviewing for harmless error, the court held that any error by the district court was harmless. Generally, a duty to indemnify cannot be determined until there has been a judgment in the underlying suit. An exception exists, however, when the pleadings indicate that "the insurer has no duty to defend and the same reasons that negate the duty to defend likewise negate any possibility the insurer will ever have a duty to indemnify."

Here, the plain language of the "Bankruptcy and Creditors" exclusion "applie[d] to exclude coverage for both defense and indemnity." Thus, since all the damages in the underlying state court litigation allegedly stemmed from the banks' roles as defrauded creditors of Color Star, the court held that Markel had neither a duty to defend nor a duty to indemnify the Verbeeks.

PROFESSIONAL SERVICES EXCLUSION: NO DUTY TO DEFEND ENGINEERS WHO GAVE NEGLIGENT PROFESSIONAL ADVICE

***Hartford Cas. Ins. Co. v. DP Eng'g, L.L.C.*, 827 F.3d 423 (5th Cir. 2016).**

A professional services exclusion precludes an insurer's duty to defend a professional firm when the only allegations in an underlying lawsuit are that the firm was negligent in giving its professional judgment.

DP Engineering, L.L.C. ("DP") was hired by Entergy nuclear power plant to remove and refurbish a "stator," a 520-ton cylindrical component of an electricity-generation system. During this project, the stator was loaded onto a gantry crane. The gantry crane was intended to be used to move the stator outside the building. But during the lifting process, the gantry crane collapsed causing the stator to crash to the floor. From the collapse, several of the workers were hurt; one died.

Thereafter, Entergy filed suit against DP for breach of contract and negligence. The injured workers also filed suit against DP. Once these underlying lawsuits were filed, DP notified its primary and umbrella insurers of the lawsuits, but the insurers argued that the professional services exclusion found in the policies applied and precluded their duty to defend and indemnify DP for these lawsuits.

The insurers promptly filed a declaratory judgment action in federal court. DP responded by filing a counterclaim for breach of contract. Eventually, both parties moved for summary judgment, and the district court granted the insurers' motion. The district court held that there was no duty to defend or indemnify because the allegations in the lawsuits relating only to DP's professional engineering services, which were specifically excluded by the policies.

DP timely appealed and argued that the district court erred in holding that there was no duty to defend because some of the allegations in the lawsuits arose out of DP's rendition of non-professional services. The Fifth Circuit, applying the "Eight Corners Rule," disagreed. Looking only at the insurance policies and the pleadings in the underlying lawsuits, the court held that there was no duty to defend because of the professional services exclusion.

Initially, the court defined the scope of that exclusion. The court first looked at the relevant policy language. Substantively, all the policies contained the same professional services exclusion: the policies excluded coverage for bodily injury or property damage "arising out of" DP's "rendering of or failure to render any professional services."

The court also looked at the definition of "professional services," which was substantively the same for all three policies. Professional services included: "the preparing, approving, or failure to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders, designs or drawings and specifications; and . . . supervisory, inspection, architectural or engineering activities."

The court also contrasted professional services with administrative services, which were not excluded by the policies: "administrative services usually occur in the execution of a decision that was based on professional judgment." For example, "approval of a [] plan is a professional engineering service, but the execution of the plan . . . , does not clearly fall within the exclusion."

Lastly, the court examined the factual allegations in the underlying lawsuits. The court first examined the Entergy lawsuit. In that lawsuit, Entergy alleged that DP breached its contract and was negligent because it:

> (1) was involved in a decision not to perform a load test on the gantry to ensure it could lift the stator;

(2) knew or should have known of certain inaccurate and false statements by the gantry engineer . . . that it was not possible for the gantry to undergo a load test and such a test was unnecessary because the gantry had previously lifted heavier objects;
(3) had concerns about the failure to anchor the gantry to the building itself but did not act on those concerns;
(4) failed to provide qualified and competent personnel; and
(5) did not comply with applicable standards in Entergy's manual requiring a load test.

To the court, these allegations related to DP's professional judgment in designing, reviewing, and approving the plan to remove the stator and did not suggest that DP was negligent in executing the plan. Thus, the exclusion applied to this case.

Next, the court considered the personal injury lawsuits. In short, these allegations included DP's negligence in designing the plan and in hiring and training its staff. For the court, all these allegations centered on the fact that DP "improperly planned and designed the stator project." While DP argued that there were allegations that DP's employees aided in "non-engineering tasks," such as using the crane, the court rejected this reading of the complaints.

From the court's perspective, there were no factual allegations that any of DP's employees, specifically, used the crane, constructed the crane, or welded the crane. Thus, there were simply no factual allegations that DP employees were negligent in performing an administrative task.

Because all the allegations centered on DP's professional negligence, the court concluded that the underlying lawsuits arose out of DP's failure to "properly exercise its professional, engineering judgment on the stator project." Thus, these lawsuits were excluded by the policy.

NARCOTICS EXCLUSION APPLIED TO PRECLUDE COVERAGE UNDER HEALTH INSURANCE POLICY

***Crose v. Humana Ins. Co.*, 823 F.3d 344 (5th Cir. 2016).**

The Fifth Circuit affirmed trial court's summary judgment in favor of the insurer because a narcotic exclusion barred coverage under a health insurance policy.

The Fifth Circuit concluded that the definition of "narcotic" included ecstasy and that the insurer only had to show the insured's use of a "narcotic" was a significant or substantial cause of his injury, but not necessarily that it was the only cause.

After suffering a stroke, Ronald Crose submitted a claim for medical costs under his individual health insurance policy issued by Humana Insurance Company. Humana denied the claim based on the narcotic exclusion in the policy because Crose's medical records show he ingested ecstasy the night he suffered a stroke. Crose's wife filed a lawsuit against Humana alleging breach of contract and violations of the Texas Insurance Code.

The central dispute was over the application of the narcotic exclusion, which precluded coverage for "Loss due to being intoxicated or under the influence of any narcotic unless administered on the advice of a *health care*

practitioner." Using basic contract interpretation principles, the Fifth Circuit rejected Crose's technical definition that ecstasy is a hallucinogen, not a narcotic—a drug derived from a plant. Instead, the Fifth Circuit used an ordinary and generally-accepted meaning of narcotic: "a drug affecting mood or behavior which is sold for non-medical purposes, *esp.* one whose use is prohibited or under strict legal control but which tends nevertheless to be extensively used illegally."

Next, the Fifth Circuit considered whether Crose's stroke was "due to . . . being under the influence" of ecstasy. Relying upon relevant authority from the Texas Supreme Court in *Utica National Insurance Co. v. American Indemnity Co.*, the Fifth Circuit rephrased the consideration as whether the ingestion of ecstasy was a *significant or substantial cause* of Crose's stroke.

In *Likens v. Hartford Life & Accident Ins. Co.*, the Fifth Circuit previously interpreted an intoxication exclusion in an insurance policy that contained the phrase "as a result of" to require proof that intoxication was a proximate cause of the excluded loss. Thus, considering *Utica National* and *Likens*, the Fifth Circuit determined here that "due to" should be read as requiring a proximate cause analysis—that is, Humana had to show that Crose's use of narcotics was a "significant" or "substantial" cause of his stroke, but not that it was the only cause. The Fifth Circuit determined that there was ample summary judgment evidence that ecstasy contributed to the stroke suffered by Crose, an otherwise healthy man, with no medical or family history of strokes.

POLLUTION EXCLUSION DOES NOT AUTOMATICALLY BAR ALL VAGUE CLAIMS OF "ENVIRONMENTAL DAMAGE"

***Fed. Ins. Co. v. Northfield Ins. Co.*, — F.3d —, 2016 WL 4978361 (5th Cir. Sept. 16, 2016).**

In a duty to defend case, the Fifth Circuit reversed summary judgment in favor of CGL carrier based upon pollution exclusion endorsement, holding that vague allegations of "environmental damage" could allege damage that did not fall within the pollution exclusion.

Federal issued pollution liability insurance to Wagner from January 31, 2003 to January 31, 2010. Northfield issued Wagner a CGL policy and an umbrella policy effective from January 31, 1999 to January 31, 2000. Federal sought a declaration that Northfield owed a duty to defend Wagner in a Texas lawsuit brought against Wagner by ExxonMobil seeking indemnity and a defense from Wagner in three underlying Louisiana lawsuits pursuant to an Assignment, Bill of Sale and Quitclaim through which Wagner obtained oil and gas interests from ExxonMobil.

The district court granted Northfield's motion for summary judgment, holding that the Pollution Endorsement relieved Northfield of any duty to defend. The Pollution Endorsement in the Northfield policy contained a rather typical, broad pollution exclusion and definition of pollutants. The district court held that the language of the Pollution Endorsement was "broad and clearly excludes coverage for damages arising from the 'environmental damage' and 'restoration and remediation' alleged in ExxonMobil's Petition."

The Fifth Circuit disagreed, noting that while it is plausible that some of the environmental damage alleged by ExxonMobil may come within the scope of

the Pollution Endorsement, it was also possible that some environmental damage alleged in the underlying Louisiana lawsuits could fall outside of the pollution exclusion. For example, Federal suggested that negligent construction of facilities could have caused soil erosion, trucks and equipment could have damaged vegetation and wildlife habitats, and that these sorts of damage would fall within the general scope of "environmental damage." The Fifth Circuit pointed out that ExxonMobil did not attach copies of the Louisiana petitions to the Texas petition and, therefore, it had "no way of knowing at this juncture whether ExxonMobil is asserting claims such as the hypothetical ones described by Federal because we cannot look past the allegations in ExxonMobil's petition to ascertain whether all of the claims for which ExxonMobil seeks indemnity and defense costs are excluded under Northfield's policy." Accordingly, the Fifth Circuit held that Northfield had a duty to defend.

TEXAS DECLARATORY JUDGMENT ACT MAY BE USED TO RECOVER UNDERINSURED MOTORIST BENEFITS BUT NOT ATTORNEYS' FEES

***Allstate Ins. Co. v. Jordan*, No. 06-15-00042-CV (Tex. App.—Texarkana July 29, 2016, no pet.).**

An insured motorist may use the declaratory judgment act to recover underinsured motorist benefits from her carrier after settling with a negligent third party, but a court cannot grant attorney's fees.

On August 5, 2010, Margaret Jordan ("Jordan") was involved in an automobile accident with Nickel Ford ("Ford"). Alleging that she was injured because of the accident, Jordan sought to recover Ford's policy limits of $25,000.00, her personal injury protection ("PIP") benefits of $2,500.00, and her insurer's underinsured motorist ("UIM") benefits policy of $100,000.00.

Initially, Ford settled with Jordan for his policy limits, and her insurer Allstate Insurance Company ("Allstate") turned over the PIP benefits. Allstate, however, did not release the UIM benefits, even though Jordan filed a claim. Jordan then sued Allstate for breach of contract and sought a declaratory judgment under the Uniform Declaratory Judgment Act ("UDJA") that her compensable damages resulting from the accident were in excess of Ford's policy limits.

After a jury determined that Jordan had suffered $30,000.00 in damages, the trial court entered a judgment that declared that:

(1) Jordan's claim for underinsured motorist benefits was covered under the policy;
(2) Ford's negligence was the proximate cause of the motor vehicle accident;
(3) Jordan suffered compensable bodily injuries and damages as a result of the accident;
(4) Jordan's compensable damages were in excess of the policy limits of Ford's policy;
(5) Jordan was entitled to $30,000.00 for her personal injury damages, both in the past and in the future; and
(6) after allowable credits, Allstate owed Jordan $3,110.60, including prejudgment interest.

On appeal, Allstate argued that the trial court's declaratory judgment was improper for three reasons: (1) Jordan's claims did not implicate the UDJA; (2) the UDJA is not the proper vehicle for pursuing UIM benefits;

and (3) declaratory relief is inappropriate where the true cause of action lies in breach of contract.

The court rejected all three of Allstate's arguments.

First, the court rejected the argument "that the UDJA was not implicated because there was never a question about the construction or validity of the policy." To the court, this argument was incorrect because Allstate disputed whether Jordan's damages exceeded the amount of her settlement with Ford and thus whether Ford was an underinsured motorist under the policy. Because the policy provided UIM benefits and there was this dispute over Jordan's entitlement to those benefits, the UDJA was properly invoked.

Second, the court addressed Allstate's argument that the declaratory judgment act is not the proper vehicle for pursuing UIM benefits. In making this argument, Allstate relied upon the Texas Supreme Court's decision in *Brainard v. Trinity Universal Ins. Co.*, 216 S.W.3d 809 (Tex. 2006) ("*Brainard*"). According to the court, that case held that "a plaintiff seeking to obtain UIM benefits must demonstrate the existence of a duty or obligation that the opposing party has failed to meet." In the UIM context, "an insurer breaches the contract by withholding benefits after the insured has obtained a judgment establishing the liability and underinsured status of the other motorist."

Allstate interpreted *Brainard* as requiring an individual to bring a breach of contract action to recover UIM benefits; however, the court held that "*Brainard* does not clarify what causes of action may be brought in order to settle the liability and damages issues in the UIM litigation context." Thus, because there was nothing in *Brainard* precluding declaratory relief, the court rejected Allstate's argument.

Thirdly, the court addressed the fact that Jordan was also bringing a breach of contract claim. Allstate argued that, because she was seeking this relief, she could not obtain a declaratory judgment. According to the court, however, because of the unique procedure of a UIM case, "the duty of an insurance company to pay UIM benefits does not arise until liability is established." Thus, "[u]ntil that time, no remedy for breach of contract against the insurance company is actually enforceable." In short, Jordan had no breach of contract action against Allstate. Thus, the court concluded that Jordan could use the declaratory judgment method to recovery her UIM benefits.

Lastly, the court addressed whether the trial court erred in awarding Jordan attorney's fees under the declaratory judgment act. While a court may generally award attorney's fees under the declaratory judgment act, the court concluded that awarding them under these circumstances was not allowed. Generally, "the insurer has the right to make the plaintiff meet the liability and damages prerequisites to UIM recovery." Here, under these circumstances, if attorney's fees were allowed, a court would potentially be requiring an insurer to pay for exercising its right to make the plaintiff prove her entitlement to UIM benefits. According to the court, this result would be inequitable and unjust; thus, attorney's fees were precluded.

NO DIRECT ACTION FOR MED-PAY COVERAGE

***Auzenne v. Great Lakes Reinsurance, PLC*, — S.W.3d —, 2016 WL 2758615 (Tex. App.—Houston [14th Dist.] May 10, 2016, no pet.).**

The Court of Appeals affirmed the trial court's dismissal of the injured party's direct claim against the tortfeasor's insurer under Rule 91a of the Texas Rules of Civil Procedure, rejecting the argument that a no-fault medical payments coverage in a CGL policy is an exception to the no-direct-action rule when there has been no determination of an insured's liability.

Christopher Auzenne was injured in a slip-and-fall incident while at Snowflake Donuts. Auzenne made a claim under Snowflake's CGL policy with Great Lakes Reinsurance, PLC seeking recovery of his medical expenses under the "medical payments clause." When Great Lakes did not pay Auzenne sued Great Lakes for breach of contract and violations of the Texas Insurance Code. Snowflake was not a party to the lawsuit.

Great Lakes filed a Rule 91a motion to dismiss based upon Auzenne's lack of standing pursuant to the no-direct-action rule. Auzenne argued that the medical payments coverage clause negates the no-direct action rule and that he had standing as a third-party beneficiary under Snowflake's policy. The trial court granted Great Lakes' motion to dismiss.

The appellate court affirmed the trial court's dismissal of Auzenne's claims. At the outset, the appellate court explained that while the no-direct-action rule pertains to standing, the need for a determination of liability before bringing an action directly against the insurer is more appropriately characterized in terms of ripeness. An injured party does not have a ripe breach-of-contract claim against an insurer until a final determination of an insured's liability has been made. Thus, the appellate court concluded that Auzenne's claims were not ripe because Snowflake's obligation to pay damages to Auzenne had not been established by final judgment or agreement.

The appellate court also swiftly rejected Auzenne's argument that claims under a medical payments coverage clause are distinguishable from other no-direct-action cases because Texas courts have consistently refused to make any exceptions based on the types of claims brought or the status of the parties bringing them. The dissenting opinion sharply criticized this conclusion because, as a case of first impression, guidance from other jurisdictions would lead to a different result. Relying on a Seventh Circuit opinion, the dissent stated that an insurer's liability is not dependent on the liability of its insured under a medical payments provision. Regardless, the dissent stated that the pertinent issue (in this case, not appropriate for determination under a Rule 91a motion) is whether the claimant was a third-party beneficiary of the policy providing for medical payment benefits. In sum, the majority opinion held that Auzenne presented no evidence to overcome the strong presumption against conferring third-party beneficiary status to the policy and that medical payment coverage provisions have not been interpreted, under Texas law, to confer third-party beneficiary status or allow contractual strangers to enforce the policy through direct claims against the insurer.

RESCISSION REQUIRES TIMELY NOTICE

***Wallace v. AmTrust Ins. Co. of Kan., Inc.*, No. 10-14-00209-CV, 2016 WL 3136875 (Tex. App.—Waco June 2, 2016, no pet.).**

Section 705.005(b) of the Tex. Ins. Code authorizes an insurer to use a misrepresentation in an application for an insurance policy as a defense, but only if the defendant proves at trial that it gave notice of its refusal to be bound by the policy within 90 days after discovering the false representation. The Court of Appeals reversed trial court's summary judgment in favor of an insurer, determining, among other things, that there was a fact issue about whether the insurer complied with the notice provision of § 705.005(b) of the Ins. Code.

In 2009, following his father's death, Karl Wallace took possession of his father's property in Oakhurst, Texas. When Wallace took possession, the property and a mobile home on the property were vacant and deteriorating. Wallace decided to sell the property, and before doing so, he obtained property insurance through John Cole Insurance Agency, Inc. Cole submitted Wallace's application for insurance to AmTrust Insurance, despite the fact that AmTrust did not issue farm and ranch insurance policies on vacant or uninhabited property.

Wallace claimed that he disclosed to Cole that the property was vacant and unoccupied. However, the signed application submitted to AmTrust stated that the property was 100% occupied and that none of the dwellings on the property were vacant. Based on the application, AmTrust approved and issued a policy, and later renewed the policy without issue.

In 2011, a grass fire destroyed the mobile home on the property. Wallace submitted a claim the next day. Wallace testified that AmTrust was informed during its claim investigation that the mobile home was vacant, without utilities, and unoccupied at the time of the loss and had been in that condition since he took possession of it. Upon learning this information, AmTrust refused to pay Wallace any benefits under the policy because it would not have issued the policy had Wallace disclosed in the application that the property or mobile home was vacant. AmTrust offered to refund all premiums paid by Wallace in exchange for his dismissal of the lawsuit. Wallace rejected the settlement offer.

AmTrust filed dispositive motions asserting collateral estoppel and rescission arguments. The trial court granted summary judgment in favor of AmTrust and dismissed all of Wallace's claims against AmTrust, rescinded the insurance policies, and ordered AmTrust to refund the premiums to Wallace. Wallace appealed.

The appellate court determined that there was a fact issue concerning when AmTrust discovered the misrepresentation in Wallace's application. Wallace testified by affidavit, which was struck for other purposes, that he notified AmTrust that the mobile home was vacant and unoccupied at the time of the loss and had been so since he had taken possession of the property. This testimony conflicted with AmTrust's letter to Wallace, in which AmTrust claimed it did not discover the misrepresentations until six months after Wallace made the claim.

The appellate court held that the conflict between Wallace's testimony and AmTrust's letter raised a fact issue as to whether AmTrust complied with the notice

provision of § 705.005(b) before it denied coverage to Wallace. Thus, the appellate court reversed the summary judgment in favor of AmTrust.

RULE 167 SETTLEMENT OFFER: ATTORNEYS' FEES MUST BE CONSIDERED

***State Farm Lloyds v. Hanson*, — S.W.3d —, 2016 WL 3575069 (Tex. App.—Houston [14th Dist.] June 30, 2016, no pet. h.).**

State Farm Lloyds ("State Farm") appealed a jury verdict finding that State Farm breached its insurance policy to cover physical loss to Ginger Hanson's ("Hanson") roof. On appeal, State Farm raised two arguments of note: (1) whether Hanson proved that she satisfied the policy's condition precedent of "completing actual repair or replacement" and was entitled to payment of replacement costs; and (2) whether the rule 167 award of attorneys' fees was proper.

Hanson generally averred that "[a]ll conditions precedent to Plaintiff's right to recover have been fully performed, or have been waived by Defendants." State Farm alleged that (1) Hanson failed to prove the alleged loss was covered, and (2) Hanson did not provide timely or adequate notice of intent to sue. State Farm did not specifically deny that Hanson was not entitled to repair or replacement costs. Thus, the appellate court held that because State Farm did not specifically deny this condition precedent, Hanson was not required to prove at trial that she had completed any actual repair or replacement.

Next, the appellate court considered whether the rule 167 attorney fee award was proper. It was undisputed that State Farm made a rule 167 settlement offer of $30,000 which was effectively rejected by Hanson on December 5, 2013. The settlement offer covered all of Hanson's "claims for monetary damages, [her] attorneys' fees, exemplary damages, interest and costs." Under Rule 167.4(b), an offering defendant is entitled to an award of litigation costs following a rejected offer if the jury award on monetary claims is less than 80 percent of the offer. Accordingly, if the jury awarded less than $24,000 (80% of State Farm's offer), State Farm would be entitled to litigation costs it incurred after December 5, 2013.

The jury awarded Hanson $12,878 in replacement costs, which State Farm argued was less than the $24,000. "However, State Farm's position fail[ed] to account for the attorney's fee award." Noting that Texas courts have not determined if the calculation under rule 167.4 should include the total award of attorneys' fees or only those attorneys' fees as of the date of settlement rejection, the appellate court did not need to reach the question because "even using the lesser amount of only accrued fees, State Farm's argument fails." Specifically, the jury found that a reasonable fee for Hanson's attorneys for representation before the December 5, 2013 rejection of the settlement offer was $15,000. Because the award of $27,878 was greater than 80 percent of the $30,000 settlement offer, the appellate court determined State Farm was not entitled to litigation costs against Hanson under rule 167.

CONTROL OF WELL POLICY: COSTS INCURRED DUE TO EXISTING GEOLOGICAL CONDITIONS WERE NOT DUE TO BLOWOUT

***Gemini Ins. Co. v. Drilling Risk Mgmt., Inc.*, — S.W.3d —, 2016 WL 3625666 (Tex. App.—San Antonio July 6, 2016, no pet.).**

Control of Well Policy did not cover costs incurred as a result of change in drill plan due to natural conditions rather than by blowouts resulting from those conditions.

DRMI is a drilling contractor that was hired to drill a well to a total depth of 13,738 feet on a turnkey basis. DRMI was an additional insured on a Control of Well policy (the "COW Policy") purchased from Gemini. On two separate occasions during drilling, DRMI experienced a weak pressure zone followed by an unexpected high pressure zone. These geological and pressure conditions, present before the well was drilled, caused DRMI to alter its drilling plan. The conditions also resulted in two subsurface blowouts, which required DRMI to drill a total of three sidetrack wells. Ultimately, DRMI completed the third sidetrack well to total depth.

DRMI made a claim on the COW Policy after each of the blowouts, which occurred a month apart. Gemini reimbursed DRMI approximately $4.5 million in covered expenses to bring the well under control under Section IA of the COW Policy and approximately $3 million in covered re-drilling expenses under Section IB of the COW Policy. However, the insurer applied two $250,000 deductibles, having determined that the blowouts were two separate "occurrences," and denied an additional $1.45 million of the claim that was associated with changes in the drilling plan due to pre-existing hole conditions rather than damage to the well as a result of the blowouts. In particular, these denied costs included running 9 5/8 inch casing, the cost of a 7 inch liner, extra drilling time, and pro-rated logging.

The trial court granted partial summary judgment on all coverage issues in favor of DRMI and submitted DRMI's claims for lost profits and Insurance Code violations to a jury. The jury found in favor of DRMI and the trial court entered judgment for approximately $8 million.

Section IA of the COW Policy provided coverage for costs and expenses incurred in regaining control of a Well Insured. The coverage under Section IA was expressly limited to the costs and expenses incurred until the Well is brought under control, which as defined in the policy, included when the Well is returned to the same status that existed immediately prior to the Occurrence giving rise to a claim. The COW Policy further limited the insurer's liability by stating that its liability would cease when the Well was brought under control.

Section IB of the COW Policy provided coverage for the costs and expenses incurred to restore or re-drill a Well that was lost or damaged as a result of an Occurrence, subject to several conditions, including that the insurer would not be responsible for the costs of drilling beyond the depth reached when the Well became out of control, and the Well has been restored to a condition comparable to the condition existing prior to the Occurrence.

The COW Policy also provided that in the event the restoration or redrill Well becomes a Well Out of Control, it shall be a continuation of the original Occurrence.

Nevertheless, the Court of Appeals determined that the second blowout was a second Occurrence, implicating a second deductible. The court noted that the undisputed facts were that the two blowouts occurred at different depths and a month apart. Further, the restoration coverage for the first blowout under Section IB of the COW Policy had terminated before the second blowout occurred. Accordingly, reading all of the conditions of Section IB together, the two blowouts had to be regarded as separate events triggering two deductibles.

The expenses incurred with respect to the casing in the first sidetrack well and the cost of the liner used in the third sidetrack well were not covered because DRMI would have incurred those costs regardless of any blowout because of the pre-existing geologic zones. Thus, these expenses were not incurred "as a result of" an Occurrence. Rather, these expenses were incurred because of the necessary changes in DRMI's drilling plan dictated by the "natural geological and pressure conditions present before the well was drilled."

Accordingly, the Court of Appeals reversed the summary judgments in favor of the insured and rendered judgment in favor of Gemini on those issues. In light of the disposition of the coverage issues, the court did not address the jury's findings and rendered a take nothing judgment against DRMI.

INSURABILITY OF CPRC 82.002 OBLIGATIONS

***Mid-Continent Cas. Co. v. Petroleum Solutions, Inc.*, No. 4:09-0422, 2016 WL 5539895 (S.D. Tex. Sept. 29, 2016).**

Summary

In this case of first impression, Judge Nancy F. Atlas considered (in part) whether indemnity claims brought by an innocent seller against a product manufacturer under Texas Civil Practice and Remedies Code § 82.002 ("Section 82.002") were insurable "property damage" under a CGL policy. The court further considered whether an insured's refusal to accept a settlement offer violated the CGL policy's condition of cooperation, or alternatively, the policy's exclusion for intentional acts.

After a lengthy factual review and analysis, Judge Atlas held that the amounts incurred by the innocent seller in defending itself against a product liability suit (including attorney fees and costs) were reimbursable "property damage" under a CGL policy, but that the costs garnered in affirmatively prosecuting the indemnity claim against the product manufacturer were not "property damage" under a standard CGL policy.

With regard to the issue of cooperation, the Court held that the failure of the insured to settle claims against it by dismissing its own potential indemnity claim with prejudice was not a failure to cooperate as a matter of law. The court further held that reframing the failure to settle as "[l]oss caused intentionally by or at the direction of the insured" was merely reframing the same theory, and again denied summary judgment on that ground.

Factual Background and Procedural Posture

Mid-Continent filed this declaratory judgment action against Petroleum Solutions, Inc. ("PSI"), Bill Head ("Head"), and Titeflex Commercial Properties (Titeflex") to determine insurance coverage

issues arising out of an underlying product liability claim.

In 1997, Head contracted with PSI to construct and install an underground fuel storage system at his Silver Spur Truck Stop in Pharr, Texas. PSI purchased a component part for the fuel tank from Titeflex. In October 2001, Head discovered that 20,000 gallons of fuel had seeped into the soil under the truck stop. Head attributed the damage to a leak in the fuel storage system and contacted PSI. PSI notified Mid-Continent of the fuel spill because PSI believed any resulting liability would be covered by its Mid-Continent CGL Policy. PSI and Mid-Continent theorized that a flex connector manufactured by Titeflex in the fuel tank was faulty.

Eventually in 2006, Head sued PSI, and PSI filed a third-party action against Titeflex, which alleged that Titeflex was responsible for the failure of the fuel storage system and therefore that PSI was entitled to contribution and/or indemnity from Titeflex under Section 82.002. In January of 2007, Head then filed a strict products liability claim against Titeflex, but then non-suited his claim in March of 2008.

On May 19, 2008, Titeflex filed a counterclaim against PSI requesting indemnification of costs of court, reasonable expenses, and attorney's fees. PSI's attorney Victor Vicinaiz ("Vicinaiz") relayed to Mid-Continent and PSI that Titeflex offered to dismiss its counterclaim if PSI dismissed its third-party claim against Titeflex. As a result, on August 12, 2008, PSI dismissed its claim without prejudice. On August 13, 2008, Titeflex explained that it would only dismiss its counterclaim if PSI would agree to a mutual dismissal of their claims with prejudice (the "Settlement Offer"). Titeflex gave PSI two days to decide.

Vicinaiz and Mid-Continent urged PSI to accept the Settlement Offer. PSI decided, however, to reject it because PSI wanted to retain the option to pursue an indemnity action against Titeflex, if necessary, in light of Mid-Continent's prior reservation of rights regarding the defense of PSI against Head's claims. After trial, a jury awarded Head over a million dollars in damages and Titeflex $382,334.00 in attorneys' fees, $68,519.12 in expenses, $12,393.35 in costs, and post judgment interest (the "Titeflex Judgment") on its Section 82.002 counterclaim against PSI.

The case made its way to the Texas Supreme Court who affirmed the Titeflex Judgment but remanded Head's claims to the trial court for retrial. After the Texas Supreme Court issued its July 11, 2014 opinion, Mid-Continent denied coverage to PSI for the Titeflex counterclaim and resulting judgment on July 30, 2014. In the denial letter, Mid-Continent took the position that PSI's rejection of the Settlement Offer constituted a failure of cooperation that permitted Mid-Continent to deny coverage. Mid-Continent further cited "Exclusion q" of the policy, which excluded losses "caused intentionally by or at the direction of the insured."

While the original state court action was pending, Mid-Continent filed a declaratory judgment action in 2009 in the Southern District of Texas. The action, however, was stayed until the Texas Supreme Court issued its 2014 opinion. Once reopened, Mid-Continent sought a declaration that the Titeflex Judgment was not covered by the Policy because (1) the language of the Policy does not support a finding of coverage, (2) "Exclusion q" applies to the

Titeflex Judgment, and (3) PSI breached a duty to cooperate with Mid-Continent when PSI rejected the Settlement Offer. PSI counterclaimed on the grounds that Mid-Continent's denial of coverage constituted (1) a breach of contract and (2) a breach of Chapter 541 of the Texas Insurance Code. The parties therefore moved for summary judgment on all issues.

The district court found that the case presented a question of first impression: "[d]oes a CGL policy provide coverage for a judgment against a manufacturer for loss incurred in meeting its statutory obligation under Section 82.002 of the Texas Civil Practice and Remedies Code, which requires manufacturers to indemnify an innocent seller for losses incurred by the seller in a products liability action."

Coverage Analysis

1. **Did PSI's failure to dismiss its claim against Titeflex amount to a failure to cooperate under the CGL policy's cooperation clause?**

According to the court, the duty to cooperate, as set forth in the CGL policy, was a standard provision intended to guarantee the insurer the right to adequately prepare the insured's defense on questions of substantive liability. Only a violation of the cooperation clause that prejudices the insurer will preclude coverage, however.

PSI bore the burden of establishing that it performed under the CGL policy, including the cooperation clause. Mid-Continent, however, bore the burden of showing that it was prejudiced by any failure to cooperate.

On these facts, the court held that the duty to cooperate could encompass PSI's failure to settle with Titeflex if PSI's decision was "[un]reasonable and [un]justified under the circumstances;" but, the court held that there was a fact issue. Here, the evidence was conflicting because there was competing evidence in the record that showed that PSI was and was not negligent in rejecting the settlement.

2. **Does Section 82.002 "innocent seller" indemnity fall within the definition of "damage" under a CGL policy?**

Under the CGL policy, Mid-Continent agreed to pay those sums that the insured became legally obligated to pay as damages because of property damage.

Section I(A)(1)(b) of the Insuring agreement defines the scope of the phrase "'property damage' . . . to which [the Policy] applies."

Section I(A)(1)(b) provides:

> The insurance applies to . . . "property damage" only if:
>
> (1) The . . . "property damage" is caused by an "occurrence" that takes place in the "coverage territory"; and
>
> (2) The . . . "property damage" occurs during the policy period; and
>
> (3) Prior to the policy period, no insured . . . knew that the . . . "property damage" had occurred, in whole or in part . . . .

Summarily, the court first held that the fuel seepage damages on Head's property met all three requirements above and that PSI did not know about the damage.

The court then addressed the real issue: whether Mid-Continent's agreement to pay "those sums that the insured becomes legally obligated to pay *as damages* because of 'property damage' to which the insurance applies" obligated Mid-Continent to pay for the Titeflex Judgement when that judgment consisted (1) of attorney's fees incurred in defending Head's products liability claim and (2) of damages for Titeflex's successful prosecution of its indemnity claim against PSI.

To the court, the Titeflex Judgment consisted of two authorized Section 82.002 parts: Section 82.002(a) damages and Section 82.002(g) ancillary damages. But only one of those was insured under this CGL policy.

The court first held that Section 82.002(a) damages were "damages" because, looking not at the policy, but at Texas law, the court concluded that "Section 82.002(a) creates an independent cause of action that, as the Titeflex Judgment exemplifies, may comprise solely [of] attorney's fees, expenses, and court costs incurred in defense of claims by a third party in an underlying products liability action." Thus, these compensatory damages were considered damages under Texas law and the policy.

Next, the court addressed Section 82.002(g). For that section however, the court held that Section 82.002(g) damages were not "damages" under the policy. Looking at Texas law again, the court held that those damages were "ancillary to recovery on the substantive cause of action created by Section 82.002(a)." Thus, the court held that the portion of the Titeflex Judgment that comprised of Section 82.002(g) damages was not covered under the policy.

While Section 82.002(g) indemnity damages did not fall within "property damage," the court concluded that those damages did fall within the definition of "Money Damages" under the policy's Professional Liability Endorsement. In the policy, "Money Damages" was defined as "a monetary judgment, award, or settlement." Thus, Section 82.002(g) indemnity damages were included there. The court, however, concluded that because those damages did not occur until 2008 (the date of the Titeflex Judgment) the damages were outside of the 2001-2002 Policy Period.

3. Does PSI's refusal to settle constitute "Loss" "caused intentionally by or at the direction of the insured?"

Mid-Continent's final argument alleged that even if the Titeflex Judgment was covered, the Titeflex Judgment was excluded from coverage by "Exclusion q" which precluded coverage for any:

> Loss caused intentionally by or at the direction of the insured; or any dishonest, fraudulent, criminal, malicious and knowingly wrongful acts.

Mid-Continent contended that PSI's rejection of the Settlement Offer was an intentional act that caused the loss. Judge Atlas held, however, that Mid-Continent's argument regarding "exclusion q" was a repackaging of its duty to cooperate argument and was contrary to the Policy language. Thus, Mid-Continent failed to carry its burden of showing that "Exclusion q" applied.

Conclusion

District Judge Atlas has now notified Texas insurers that their CGL policies may, provide coverage for indemnity awards against an insured under Section 82.002(a)—defensive indemnity awards incurred by an "innocent seller" who seeks indemnity from the insured for an occurrence during the policy period. Section 82.002(g) damages, those incurred by the innocent seller to prosecute its Section 82.002(a) claim, however, are excluded.

IMPROPER JOINDER OF ADJUSTER: PARTICULARITY REQUIRED FOR ALLEGATIONS OF DTPA VIOLATIONS

***Lopez v. United Prop. & Cas. Ins. Co.*, — F. Supp. 3d —, 2016 WL 3671115 (S.D. Tex. July 11, 2016).**

A Texas Deceptive Trade Practices Act violation must be pleaded with particularity for purposes of a fraudulent joinder analysis.

After the home of Fidel Lopez ("Lopez") was damaged by flooding, he filed a first party claim with his insurer, United Property & Casualty Insurance Company ("UPC"). When UPC failed to fully cover the damage, Lopez filed suit in state court against UPC for fraud, breach of contract, Texas Insurance Code violations, and Texas Deceptive Trade Act ("DTPA") violations and against the adjuster assigned to his case, Bibiana Aguilar ("Aguilar") for violations of the Texas Insurance Code and the DTPA. In his complaint, Lopez alleged that UPC and Aguilar "failed to assess the claim thoroughly" and acted unreasonably, recklessly, and intentionally in failing to investigate and adjust the claim properly.

UPC then removed the suit to federal court based on diversity jurisdiction; it argued that complete diversity existed because Aguilar, a Texas citizen, was improperly joined. UPC argued that improper joinder existed because Lopez failed to plead a cause of action against Aguilar. Thus, the issue for the court was whether "Aguilar ha[d] been improperly joined."

Using the standard under Rule 12(b)(6), the district court first dismissed the plaintiff's Texas Insurance Code claims against Aguilar, as a matter of law, because an adjuster cannot be liable for violations of the Texas Insurance Code.

Then, the court addressed the DTPA violations. Initially, the court pointed out that DTPA violations are subject to the particularity requirement of Rule 9(b): "[a]t a minimum, Rule 9(b) requires allegations of the particulars of time, place, and contents of the false representations, as well as the identity of the person making the representation and what he obtained thereby."

Finding that the plaintiff did "not point to any specific statements [by Aguilar] that would satisfy Rule 9(b)'s requirements," but only alleged that "Aguilar's evaluation of the damage to his home was grossly unreasonable and inadequate," the court held that the plaintiff failed to plead a cause of action against Aguilar. Thus, there was complete diversity between Lopez and UPC, and the plaintiff's motion to remand was denied.

PROPER JOINDER: ADJUSTER MAY BE LIABLE FOR TEXAS INSURANCE CODE VIOLATIONS AFTER SUBSTANDARD INVESTIGATION

***Robinson v. Allstate Tex. Lloyds*, No. H-16-1569, 2016 WL 3745962 (S.D. Tex. July 13, 2016).**

A plaintiff may allege a cause of action under the Texas Insurance Code against an individual adjuster by alleging that the adjuster conducted a substandard investigation of the plaintiff's damages resulting in a lower damage estimate.

After a storm damaged her home, Avalon Robinson ("Robinson") filed a claim under her Allstate Texas Lloyds ("Allstate") insurance policy. Allstate selected individual adjuster Timothy Wesneski ("Wesneski"), a Texas citizen, to investigate the damage caused by the storm; he produced a final damage estimate of $484.93.

Thereafter, Robinson hired a private adjuster to estimate the damage. The private adjuster concluded that the damage was $25,818.77. Robinson then filed suit in state court against Allstate and Wesneski, asserting violations of the Texas Insurance Code and the Texas Deceptive Trade Practices Act. The core of Robinson's allegations against Wesneski were that "Wesneski failed to conduct a reasonable and adequate investigation, which caused Allstate to undervalue Plaintiff's insurance claim."

Allstate then filed a Notice of Removal based on the improper joinder of the individual adjuster, and Robinson filed a Motion to Remand. Allstate did not "dispute that it may be possible to maintain a cause of action under chapter 541 of the Texas Insurance Code against an individual adjuster." Thus, the court simply addressed whether the factual allegations against Wesneski satisfied Rule 12(b)(6).

According to the court, the Robinson's detailed factual allegations were sufficient because she had alleged "specific conduct" by Wesneski, separate from Allstate, that included (1) Wesneski's failure to discover significant interior damage to plaintiff's garage, kitchen, and family room and (2) Wesneski's failure to conduct a proper inspection of the roof's damage. For the roof, Wesneski had found only $484.93 in damage; in contrast, Robinson's adjuster had found $7,868.50 in damage. The court then concluded that Wesneski was properly joined, precluding the court's diversity jurisdiction and requiring a remand.

EXTRINSIC EVIDENCE CAN BE CONSIDERED ON ISSUE OF WHO IS AN INSURED

***State Farm Fire & Cas. Co. v. Neuman*, — F. Supp. 3d —, 2016 WL 2858956 (W.D. Tex. May 13, 2016).**

Adult child, was not a covered insured under his parent's umbrella policy because his "primary residence" at the time of the accident was not his parent's home.

Clayton Neuman was involved in an automobile accident that killed one of his passengers, Ellis McClane. McClane's parents brought suit against Neuman, among others, for the wrongful death of her son. Neuman sought coverage under an automobile policy and umbrella policy issued by State Farm to his parents. State Farm provided Neuman with a defense under the automobile policy. However, State Farm filed a declaratory judgment action seeking a declaration that there was no

coverage for Neuman under his parents' umbrella policy

The umbrella policy provided that State Farm would pay damages on behalf of and defend any "insured" against claims for which the insured is liable and to which the policy applies. The umbrella policy defined "insured" as "*you* and *your relatives* whose primary residence is your household." The parties did not dispute that "*you*" and "*your*" referred to Neuman's parents, the named insureds under the umbrella policy, and that their household was located on Lynncrest Cove in Austin. At the time of the accident, Neuman was living in an apartment on West Parmer Lane in Austin, Texas not with his parents at the Lynncrest address. After the accident, Neuman moved back to the house on Lynncrest due to his severe injuries.

On cross-motions for summary judgment. The court held that State Farm did not have a duty to defend or indemnify Neuman under the umbrella policy because he did not qualify as an "insured" under the policy based on his primary residence. Employing the eight-corners doctrine and extrinsic evidence under a narrow exception to the doctrine, the court determined that Neuman's primary residence was the Parmer apartment. The court primarily relied upon the following facts, among others: (1) Neuman spent the majority of his time at the apartment (and not his parents' house on Lynncrest), (2) his (and his infant daughter's) essential belongings and items for daily living were at the apartment, and (3) he planned to stay at the apartment for another nine months had the accident not occurred.

The court also rejected Neuman's alternative argument that the Umbrella Policy was intended to be connected with the automobile policy, and there should be coverage under the umbrella policy because State Farm provided coverage under the corresponding automobile policy. The court held that this argument was fatally flawed because it would require the parties' to ignore defined terms controlling interpretation of the umbrella policy when such terms were unambiguous.

INDEMNITY OBLIGATIONS UNDER A CONTRACT (WHETHER INSURING OR OTHER) ONLY TRIGGERED BY ACTUAL FACTS

***Lexington Ins. Co. v. ACE Am. Ins. Co.*, — F. Supp. 3d —, 2016 WL 3251748 (S.D. Tex. June 14, 2016).**

This case involved the interplay between the indemnity and insurance obligations set forth in an ACE American Insurance Company policy on one hand, and in a Professional Sales Agreement ("PSA") between Midcontinent Express Pipeline, LLP and its alleged affiliations (collectively "MEP") and Mustang Engineering L.P. ("Mustang") on the other. Lexington Insurance Company sought declaratory judgment that ACE was liable to Lexington for costs and expenses incurred in the defense of MEP in eight underlying lawsuits arising out of a natural gas explosion.

In 2014, Lexington and ACE filed cross-motions for summary judgment concerning ACE's liability for some or all of defense costs for MEP. Lexington argued that MEP were additional insureds under the ACE Policy because the PSA required Mustang's insurance policies to name MEP as additional insureds.

ACE argued that under the PSA, Mustang and MEP only agreed to indemnify one another for the proportional share of any settlement or judgment that corresponds to

Mustang's percentage of negligence or fault that contributed to the loss at issue. ACE also argued that policy language in the CGL section of the PSA requiring that "[s]olely to the extent of Consultant's indemnity obligation . . . all insurance policies carried by [Mustang] hereunder shall name [MEP] . . . as additional insureds . . ." supported its argument because "[s]olely to the extent of Consultant's indemnity obligation" should be read as language limiting indemnity only to liability, and not defense costs.

ACE contended that it had no duty to defend or share defense costs because indemnity only exists for contribution of the loss at issue under the PSA, no determination had been made that any negligence or fault of Mustang contributed to any loss or damages claimed by the third parties, and there was no language in the third-party section of the General Indemnity provision that MEP and Mustang agreed to defend and hold each other harmless for and against costs of defense. In sum, ACE posited that (1) the PSA only required Mustang to cover MEP as additional insureds solely to the extent of Mustang's indemnity obligation to MEP in accordance with the PSA, and (2) no indemnity obligation had been triggered because it did not include the defense of MEP. Put differently, MEP was not an additional insured unless and until Mustang was actually required to indemnify MEP under the PSA.

In July 2014, the Texas federal court entered an interlocutory order granting Lexington's dispositive motion because, in part, the phrase "[s]olely to the extent of Mustang's indemnity obligation" in the PSA did not limit coverage under the policy and should be construed "in accordance with Texas law to mean that [MEP] are additional insureds and that ACE has a duty to defend them when the allegations contained in the pleadings in the underlying lawsuits potentially trigger Mustang's indemnity obligation. . ." The court explained that ACE's argument would ignore the provisions of the Policy altogether, and run contrary to Texas law that "[t]he indemnity interpretation is made after the facts in the underlying lawsuits have been developed through litigation, while, in contrast, the duty to defend under Texas law arises when allegations in the pleadings *potentially* trigger coverage." (*emphasis* in original).

ACE then brought a motion for reconsideration of the court's summary judgment on these issues, arguing that the Texas Supreme Court's opinion in *In re Deepwater Horizon*, 470 S.W.3d 452 (Tex. 2015), affected the relationship between the additional insured provision in the ACE Policy and the applicable provisions of the PSA. ACE argued *Deepwater Horizon*'s holding that "an insurance policy may incorporate an external limit on additional-insured coverage" is inconsistent with the court's interlocutory order that the scope of the indemnity obligation set forth in the PSA does not operate to limit the additional insured coverage owed to MEP under the Policy.

The court again disagreed with ACE, and held that "*Deepwater Horizon* does not present an intervening change in the controlling law; it does not expressly overrule any previous case law." The court noted that for this reason alone the motion for reconsideration should have been denied as the remedy of appeal is sufficient given no definitive change to the law, but continued to reinforce that the court's original interpretation was correct: the silence of the PSA regarding the duty to defend does not show an intent that the duty to defend be covered by either party, so the terms of the insurance policy itself must determine the duty to defend.

ACCEPTANCE OF APPRAISAL VALUE BARS SUBSEQUENT BREACH OF CONTRACT CLAIM

***Powell v. State Farm Lloyds*, No. 7:14-CV-580, 2016 WL 3654762 (S.D. Tex. July 7, 2016).**

In March 2012, the Powells sustained hail damage to their property in Hidalgo County. They promptly filed an insurance claim with their insurer, State Farm Lloyds ("State Farm"). In April 2012, State Farm inspected the property, estimated the loss at $17,446.71, and paid $9,996.41 to the Powells after applying depreciation and the deductible. That same month, State Farm issued a second payment of $2,985.60 to the Powells for the replacement cost benefits associated with roof repairs.

In April 2014, the Powells filed suit against State Farm alleging various insurance related causes of action arising from their hail damage claim. On February 6, 2015, for the first time, the Powells invoked the appraisal provision of the insurance policy, which allows either party to demand that the amount of a disputed loss be set by appraisal by competent, disinterested appraisers. In May 2016, upon receipt of the appraisal, State Farm paid the appraisal award to the Powells and extended their deadline to complete the repairs in order to receive replacement cost benefits until May 2018.

Thereafter, State Farm filed a motion for summary judgment contending the Powells are estopped from maintaining their breach of contract claim because State Farm timely paid the appraisal award. On the other hand, the Powells argued they could maintain the claim because State Farm only paid the actual cash value portion of the appraisal award, and that the Powells still had not received the replacement cost benefits they contracted for under the policy. In Texas, the effect of an appraisal provision is to estop one party from contesting the issue of damages in a suit on the insurance contract, leaving only the question of liability for the court. Under the circumstances, the Texas federal court stated that the Powells are effectively foreclosed from bringing a breach of contract claim due to State Farm's payment of the appraisal award, unless the Powells raise an issue concerning the validity of the appraisal award or one some distinct contractual provision.

Under the insurance policy, State Farm was required to pay "only the actual cash value at the time of the loss" and, upon completion of the repairs, the covered additional amount actually and necessarily spent to repair or replace the damaged property. But, as the court held, State Farm was not in breach of the policy by simply extending the two-year time period by which the Powells must complete the repairs to receive the replacement cost benefits, noting that the extension solely benefited the Powells. Thus, the court granted State Farm's motion for summary judgment because the acceptance of the binding and enforceable appraisal award estopped the Powells from asserting their breach of contract claim.

NO INSURABLE LOSS WHEN INSURED IS INDEMNIFIED IN A RELATED TRANSACTION

***Southwest Risk, L.P. v. Ironshore Specialty Ins. Co.*, No. H-14-1745, — F. Supp. 3d —, 2016 WL 2898040 (S.D. Tex. May 18, 2016).**

Claim against insurance broker was deemed first made prior to policy period as a result of related wrongful acts alleged in a prior lawsuit. Further, coverage was precluded because insured was fully indemnified in a related transaction and thus suffered no pecuniary loss.

Southwest Risk was an insurance broker that formed the American Real Estate Advisory Counsel ("AMREAC") to provide commercial property insurance to owners of apartment complexes in the Houston area. Southwest represented to insureds under the AMREAC program that Southwest would place property coverage with limits of $100 million. Thirty-four different owners insured their properties with AMREAC for a total insured value of $1.1 billion.

Southwest timely placed the first two layers of coverage for the AMREAC program, having limits of $35 million. Before Southwest could place the remaining $65 million of limits it had promised to the AMREAC insureds, Hurricane Ike was moving towards Houston and insurers were unwilling to issue property policies covering Hurricane losses in Houston. Southwest was unable to place any additional coverage that would cover damage from Hurricane Ike. A number of insureds under the AMREAC program sustained property damage as a result of Hurricane Ike and their claims exhausted the limits of the two layers of insurance placed by Southwest.

After the available limits of the AMREAC program were exhausted, on September 10, 2010, Adams LaSalle Realty sent Southwest a demand letter and filed suit against Southwest in Harris County district court. The demand letter demanded payment of $1.2 million in damages. The original petition alleged that Southwest "misrepresent[ed] one or more material facts and/or policy provisions relating to coverage." Southwest answered the Adams LaSalle lawsuit on October 8, 2010.

On October 6, 2010, the Adams LaSalle plaintiffs filed a more specific amended petition that alleged that Southwest had delivered "a product that now appears to be inadequate and wholly different from what ... was promised" and that plaintiffs had "only recently discovered that some or all of the excess carriers may not provide coverage for the Hurricane Ike damages or associated losses." While plaintiffs never formally served the amended petition on Southwest, Southwest's attorneys learned of the amended petition and emailed a copy to Southwest executives on June 15, 2011.

On December 27, 2010, Southwest's owner, Houston International, sold Southwest to ClearView. The contract for sale provided that Houston International would indemnify ClearView against any claims "arising out of or relating to ... any inaccuracy of any representation or warranty of the Seller."

Southwest and ClearView purchased a professional liability insurance policy from Ironshore with effective dates of December 27, 2010 to February 15, 2012. Southwest and ClearView renewed the policy on February 15, 2012. The policy covered claims first made against the insured during the policy period. The policy also provided that all claims arising from the same wrongful act or a related wrongful act would be deemed to have been made on the earlier of the date the first such claim was made against the insured or the date the insurer first receives written notice of the wrongful act.

On May 4, 2012, Centaurus sued Southwest alleging that it was never informed of any coverage issues regarding gaps in coverage under the AMREAC program. Centaurus alleged that Southwest was negligent in failing to inform it of the gap in coverage. ClearView sought indemnification from Houston International. Southwest settled with Centaurus for $6.9 million and Houston International funded the entire settlement.

Southwest and ClearView brought suit against Ironshore seeking to recover the $6.9 million paid in settlement of the Centaurus claims and in excess of $20 million in alleged damages under the Texas Insurance Code.

The district court decided the case on cross-motions for summary judgment. The court noted that when dealing with multiple claims involving "related wrongful acts," the policy provided that the claims are deemed to have been made on the date the first such claim was made. The policy defined "related wrongful acts" as acts that "arise from a common nucleus of facts" even if the claims involve different claimants or legal causes of action.

The policy period of Ironshore's claims made policy was February 2012 through February 2013. Centaurus filed suit in May of 2012 during the policy period. However, the court held that the September 10, 2010 demand letter and lawsuit from Adams LaSalle constituted a claim and that the *Adams LaSalle* lawsuit and the *Centaurus* lawsuit arose from a common nucleus of facts – Southwest's misrepresentation of the AMREAC program's coverage. Accordingly, the court found that the Centaurus claim was deemed first made prior to the Ironshore policy period. Even if the September 10, 2010 demand letter and original petition were not claims, the amended petition clearly alleged "related wrongful acts" and it was emailed to Southwest's executives by Southwest's attorney on June 15, 2011. Therefore, the claim would not be covered by the Ironshore policy, which did not incept until eight months later.

The court granted Ironshore's motion for summary judgment on an alternative ground as well, holding that because Houston International fully indemnified Southwest and ClearView for the Centaurus claim, they did not suffer a loss recoverable under the Ironshore policy. The court relied upon *Paramount Fire Insurance Co. v. Aetna Casualty & Surety Co.*, 353 S.W.2d 841 (Tex. 1962), for the proposition that an insured sustains no pecuniary loss when the loss is paid by another pursuant to a related transaction. The court noted that Houston International sold Southwest to Clearview and that same day they purchased a professional liability policy from Ironshore. Both Houston International's indemnity agreement and the insurance policy protected Southwest and ClearView from liability arising out of the AMREAC program. The court found that Houston International fully indemnified Southwest and ClearView, that it was not a stranger to the transactions and that it did not do so out of charity. Therefore, looking at the transaction as a whole and the need to prevent a double recovery, the court held that Southwest and ClearView did not suffer a pecuniary loss because the full loss was compensated by Houston International in a related transaction.