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

WHEN PROOF OF INDEPENDENT DAMAGES IS REQUIRED CLARIFIED BY TEXAS SUPREME COURT

There has been considerable debate for some time whether an insured is required to establish damages independent of the policy benefits sought in order to recover under Chapter 541 of the Texas Insurance Code. On April 7, 2017 the Supreme Court addressed the issue in *USAA v. Menchaca*, providing the possibility for Chapter 541 damages despite lack of independent injury. The lower court trend leading to *Menchaca*, however, as evidenced by the most recent December 2, 2016 *Emerald Management* decision out of the Northern District and the March 9, 2017 *Webb* decision by the Beaumont Court of Appeals, appeared to require proof of independent injury. For ease of reference, summaries of both *Emerald Management* and *Webb* appear immediately after the summary of the Texas Supreme Court's opinion in *USAA v. Menchaca* below.

Independent Damages Not Always Required to Recover Under Chapter 541

USAA Texas Lloyds Company v. Menchaca, ___S.W.3d ___, 2017 WL 1311752 (Tex. April 7, 2017).

The Texas Supreme Court recently issued an opinion in *USAA Texas Lloyds Company v. Menchaca,* seeking to clarify conflicting case law concerning whether an insured may recover policy benefits for violations of the Texas Insurance Code when a jury determined that the insurer did not breach the policy. Acknowledging that the Court's prior decisions in this area have led to a significant amount of confusion among courts, the Texas Supreme Court announced "five rules to address the relationship between contract claims under an insurance policy and tort claims under the Insurance Code."

The Texas Supreme Court defined the following "five distinct but interrelated rules" governing the relationship between contractual and extra-contractual claims:

1. An insured cannot recover policy benefits as damages for an insurer's statutory violation of the Insurance Code if the policy does not provide the insured with a right to receive those benefits.

2. An insured who establishes a right to receive benefits under an insurance policy can recover those benefits under

the Texas Insurance Code if the insurer's violation of the Insurance Code caused the loss of benefits.

3. The insured can recover policy benefits under the Insurance Code if the insured proves that the insurer's statutory violation caused the insured to lose a contractual right to policy benefits.

4. An insured may recover for an injury independent of the loss of policy benefits caused by a statutory violation even if the policy does not provide the insured with a right to benefits.

5. As a corollary of the first four rules, an insured may not recover any damages based upon a statutory violation if the insured has no rights to benefits under the policy and did not sustain any injury independent of a right to receive policy benefits.

Menchaca arose out of a Hurricane Ike claim under a homeowner's policy. USAA investigated the claim and determined that, while the policy covered some of the damage, the estimated repair costs were within the deductible. Menchaca sued USAA for breach of contract and for unfair settlement practices under the Texas Insurance Code. Menchaca sought only benefits under the insurance policy, court costs and attorneys' fees. The jury found that USAA did not fail to comply with the terms of the insurance policy, but found that USAA refused to pay a claim without conducting a reasonable investigation. In a single damage question, the jury was asked what sum would compensate Menchaca for her damages resulting from either USAA's failure to comply with the contract or its statutory violations. The jury was instructed that damages were to be calculated as "the difference, if any, between the amount USAA should have paid Gail Menchaca for her Hurricane Ike damages and the amount that was actually paid." The jury awarded $11,350.

In *Provident American Insurance Company v. Castaneda,* 988 S.W.2d 189, 198 (Tex. 1998), the Texas Supreme Court held that "failure to properly investigate a claim is not a basis for obtaining policy benefits." USAA relied on *Castaneda* for the proposition that Menchaca could not recover under the Insurance Code because she did not plead or prove any damages "independent" from her claim for benefits under the policy. Menchaca, on the other hand, relied principally on *Vail v. Texas Farm Bureau Mutual Insurance Co.,* 754 S.W.2d 129, 136 (Tex. 1988), in which the Texas Supreme Court stated that an insurer's "unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld."

The Court reconciled *Castaneda* and *Vail* by noting that an insured can only recover under the Insurance Code for damages *caused* by a statutory violation. Thus, if the insurer's violation of the Insurance Code caused the insured to lose her rights to policy benefits, then the policy benefits could be recovered as actual damages under the Insurance Code (Rules 2 and 3). Further, if the insured sustained damages "independent" of her claim for policy benefits as a result of a statutory violation, she could recover those damages under the Insurance Code regardless of whether the insurer breached its insurance policy. Thus, if an insurer's wrongful denial

of a valid claim for benefits under the policy either "results from or constitutes" a statutory violation, the recoverable damages will include at least the policy benefits. However, the general rule that an insured cannot recover policy benefits for a statutory violation if the claim is in fact not covered has not changed. And, under those circumstances, an independent injury is still required to recover under the Insurance Code.

Menchaca is being heralded by policyholders' lawyers as a sea change in Texas jurisprudence. Whether that is in fact the case remains to be seen, but this opinion is likely to steer policyholders toward claiming that a statutory violation deprived them of policy benefits, increasing the difficulty in obtaining summary judgment as to extra-contractual claims and, presumably, allowing a jury to award additional damages based upon policy benefits if a knowing statutory violation is found.

Independent Damages Required for Extra- Contractual Claims

Seneca Ins. Co. v. Emerald Mgmt., LLC, No. 4:16-CV-294-A, 2016 WL 870583 (N.D. Tex. Dec. 2, 2016).

An insured's counterclaims for alleged unfair settlement practices and violations of the Prompt Payment Act were subject to dismissal because the insured did not allege an independent injury and because the extra-contractual claims did not meet the heightened pleading standards of Rule 9 of the Federal Rules of Civil Procedure.

This coverage suit arose out of a hail/windstorm property claim. After the insured made the claim, the insurer investigated the claim, issued a reservation of rights letter, and requested that the insured be examined under oath. The insured did not respond to the insurer's request. The insurer then filed a declaratory judgment action seeking declarations that there was no coverage under the policy and that the insured failed to comply with the policy's conditions precedent. The insured answered and counterclaimed for breach of contract, violations of Chapters 541 and 542 of the Insurance Code, and violations of the DTPA.

The court reaffirmed the principal that there can be no recovery from extra-contractual damages for mishandling claims unless the complained of acts or omissions caused injuries independent from those that would have resulted from a wrongful denial of policy benefits. Because the insured did not allege a separate injury caused by the manner in which the claim was investigated, the court granted the insurer's motion to dismiss as to all extra-contractual claims.

First Party Property Claim Must Have Evidence of Independent Injury to Support Extracontractual Award.

State Farm Lloyds v. Webb, 2017 WL 927848, at *1 (Tex. App.—Beaumont Mar. 9, 2017, no. pet. h.)

In May 2012, Dennis Webb discovered a water leak at his home originating from a cold water line running beneath his garage. Webb contacted State Farm Lloyds, which sent an adjuster to inspect the damage. Webb told the adjuster he had hired a plumbing company to repair the leak, which it did. At the time of this inspection, Webb did not report any damage to any flooring tiles. State Farm denied Webb's claim for reimbursement for the plumbing repairs as it determined there was no water damage to Webb's property.

Webb sued State Farm and four of its adjusters for breach of contract and extra-

contractual claims arising from State Farm's denial of Webb's claim. Webb asserted claims for fraud, conspiracy to commit fraud, breach of contract, unfair settlement practice, failure to promptly pay as required by the Texas Insurance Code, and breach of common law duty of good faith and fair dealing.

The jury awarded Webb $15,000 for breach of the insurance policy, $20,000 for unfair settlement practices, and $60,000 in additional damages because the unfair or deceptive practice was committed knowingly. In addition, the jury awarded Webb attorney's fees of $80,000 for representation in the trial court, $50,000 for representation in the Court of Appeals, and an aggregate of $35,000 for various stages of representation before the Supreme Court.

State Farm appealed on multiple grounds, including that the evidence was legally and factually insufficient to support the jury's award of extra-contractual damages. The Beaumont Court of Appeals noted that "[a]n insured is not entitled to recover extra-contractual damages unless the complained-of actions or omissions cause injury independent of the injury resulting from the wrongful denial of policy benefits." After a thorough accounting of the pertinent evidence introduced at trial, the appellate court determined that the record "shows that Webb did not prove damages unrelated to and independent of the wrongful denial of his policy claim. . . . Webb only sought to obtain the benefits of the policy he had with State Farm." Since "[a]n extra-contractual claim cannot stand when the plaintiff fails to allege and prove damages unrelated to and independent of the policy claim," Webb's failure to prove unrelated damages led the court to reverse the jury's award of $20,000 for unfair settlement practices and $60,000 for knowingly engaging in unfair settlement practices. The appellate court upheld the $15,000 award for breach of contract, and remanded the award of attorney's fees to the trial court due to lack of segregation of the fees recoverable on Webb's breach of contract claim.

Fencing May be Covered Under Texas Homeowners Policy.

Nassar v. Liberty Mut. Fire Ins. Co., 508 S.W.3d 254 (Tex. 2017).

Under a Texas Standard Homeowners Policy, fencing may be covered under the plain language of both the policy's "dwelling" provision and the "other structures" provision.

On September 13, 2008, Hurricane Ike caused significant damage to structures built on six acres of land owned by Elie and Rhonda Nassar in Richmond, Texas. The Nassars filed a claim with Liberty Mutual under their Texas Standard Homeowners' Policy—Form A. A dispute arose between the Nassars and Liberty Mutual regarding which part of the policy—the "dwelling provision" or the "other structures" provision—covered extensive damage to fencing on the property. The policy provided $247,200 in coverage under the "dwelling" provision and only $24,720 under the "other structures" provision. After conducting an investigation, Liberty Mutual valued the damage to the dwelling at $20,090.61 and the damage to other structures at $70,449.02. The undisputed value of damage to fencing on the property totaled $58,665. Liberty Mutual paid the Nassars $20,090.61 for damage to the dwelling and an amount equal to the policy limits ($24,720) for damage to the other structures.

The relevant policy provisions under "Coverage A (Dwelling)" provide as follows:

We cover:

1. the dwelling on the **residence premises** shown on the declarations page including structures attached to the dwelling.
2. other structures on the **residence premises** set apart from the dwelling by clear space. This includes structures connected to the dwelling by only a fence, utility line or similar connection. The total limit of liability for other structures is the limit of liability shown on the declaration page or 10% of Coverage A (Dwelling) limit of liability, whichever is greater. This is additional insurance and does not reduce the Coverage A (Dwelling) limit of liability.

The definition section provides:

"**Residence premises**" means the **residence premises** shown on the declarations page. This includes the one or two family dwelling, including other structures, and grounds where an **insured** resides or intends to reside within 60 days after the effective date of this policy.

Importantly, the policy did not define "structure." Both parties filed summary judgment motions. The Nassars argued their fencing, which was attached to their house at four separate points, was a "structure attached to the dwelling." By contrast, Liberty Mutual contended that, under the only logical reading of the policy, a fence could not operate to connect the dwelling to other structures, and therefore, the fencing must be an "other structure." The trial court granted Liberty Mutual's motion for summary judgment, and a divided court of appeals affirmed.

Relying on *Black's Law Dictionary* definitions of "structure" and "attach," the Texas Supreme Court reversed and remanded, holding the Nassars' policy interpretation was reasonable and the policy language was unambiguous. The court reasoned that "Subsection (1) is straightforward: the policy requires that 'structures attached to the dwelling' be afforded coverage," and it was undisputed that the Nassars' fencing was "fastened to the dwelling[.]" Under the plain meaning of the policy language, "courts may have to treat fencing as both part of the 'dwelling' and 'other structures' depending on the circumstances."

An Assignment of Claim Does Not Negate an Insured v. Insured Exclusion as "Successor" Should be Defined Broadly.

Great Am. Ins. Co. v. Primo, 2017 WL 749870, at *1 (Tex. Feb. 24, 2017).

Robert Primo served as a director and treasurer of Briar Green, a nonprofit condominium association. Shortly before he resigned his position, he wrote himself two checks totaling just over $100,000 from Briar Green's account. Briar Green made a claim with its fidelity insurer, Travelers Casualty & Surety Company ("Travelers"). Travelers paid the claim in exchange for a written assignment of all of Briar Green's rights and claims against Primo for the loss. Travelers, standing in the shoes of Briar Green, then sued Primo to recover the funds. Primo, in turn, asserted a third-party claim against Briar Green and demanded that Great American Insurance Company defend him in the Travelers suit under its D&O Policy. While Travelers ultimately non-suited its claims against Primo, Primo brought this action against Great American seeking

reimbursement for the defense costs and attorney's fees he incurred defending the suit.

The D&O Policy contained the following insured v. insured exclusion:

> This Policy does not apply to any Claim made against any Insured by, or for the benefit of, or at the behest of [Briar Green] or … any person or entity which succeeds to the interest of [Briar Green].

It was undisputed that as a former director of Briar Green, Primo was an insured under the D&O Policy. The court explained "the exclusion means that no coverage exists for any claim made against Primo by 'any person or entity which succeeds to the interest of' Briar Green." The court considered "whether Briar Green's assignment to Travelers of its claims against Primo means that Travelers 'succeed[ed] to the interest of' Briar Green." If so, the exclusion applies and there would be no coverage under the Policy.

The majority opinion from the court of appeals relied upon a previous interpretation of "successor" which required that Great American show that Travelers assumed Briar Green's obligations as well as its rights and claims. The Texas Supreme Court disagreed with the majority, and adopted the dissent's view that for the purposes of the Policy such a strict interpretation of "successor" was not warranted. The Supreme Court concluded that the appellate court ignored the context surrounding the D&O policy's 'insured v. insured' exclusion, which is intended to "prevent both collusive suits between business organizations and their directors and officers as well as actions arising out of the 'bitter disputes that erupt when members of a corporate … family have a falling out.'"

Noting that to hold otherwise would allow a mere assignment of a claim to circumvent an 'insured v. insured' provision, the Supreme Court decided to interpret successor broadly and give effect to the clause. The Supreme Court reversed the appellate court's reversal of the trial court's summary judgment because "Great American has shown as a matter of law that the insured-v.-insured exclusion in the D&O policy applies in this instance, [and] the policy provides no coverage for the claims Primo asserts."

Insurer's Arbitrary Deductions of Attorneys' Fees May Be Breach of Contract.

Aldous v. Darwin Nat'l Assur. Co., 2017 WL 1032616 (5th Cir. March 16, 2017).

The Fifth Circuit found that each write-off of an insured's defense costs must be supported by a claim adjuster's reasonable analysis in order for those costs to *not* be due and owing under a policy's duty to defend. Moreover, billing guidelines provided to the insured with the reservation of rights letter were a unilateral extra-contractual agreement that could not modify the policy's terms and the insurer's obligations under its duty to defend.

Attorney Charla Aldous sued her former client Albert Hill, III for failure to pay costs associated with Hill's representation. Hill filed counter-claims to Aldous' action, which triggered Darwin National Assurance, Co.'s duty to defend Aldous under the insurance policy Darwin issued to her. In the instant matter, Aldous claims Darwin did not pay enough to fully cover the costs of her defense. Darwin asserted it paid too much. Aldous alleged breach of contract, breach of the duty of good faith and fair dealing, violations of the Texas Insurance Code, and violations of the Texas Deceptive Trade Practices Act.

In short, the Fifth Circuit concluded that Darwin could not reasonably write-off all costs associated with both prosecution and defense of the underlying suit. Thus, Darwin did not appear to overpay. Turning to whether the district court's grant of summary judgment to Darwin in the breach of contract issue was proper, the Fifth Circuit reviewed the district court's interpretation that Darwin "did not breach the contract as a matter of law because the terms of the Policy provide Defendant with discretion to determine reasonable claim expenses." The Fifth Circuit did not agree. The Policy contained a promise that Darwin will pay "all" covered "Claim Expenses." Only "reasonable" expenses qualify, however, and "[t]he determination by the insurer as to the reasonableness of Claim Expenses shall be conclusive on all Insureds." The district court interpreted these provisions to provide Darwin with a right to decide how much it wants to pay. And there was no breach, according to the district court, because Darwin merely exercised that right and did not do so arbitrarily:

> Darwin's stated reasons for making the deductions demonstrate that it did not arbitrarily make these deductions but rather made a determination as to the reasonableness of the Claim Expenses, as permitted by the Policy, according to reasonable considerations, such as its Billing Guidelines and the fact that it did not have a duty to pay for attorney's fees associated with [the] affirmative claims.

Darwin asserted that its reliance on billing guidelines to categorically exclude certain expenses represents a reasonableness determination and explains that "Darwin was clear from the beginning that its consent to [counsel] was conditioned upon 'adherence to Darwin's Billing and Reporting Guidelines.'" But the Fifth Circuit stated that the "Billing Guidelines are not part of the Policy, and Darwin informed Aldous of its intent to utilize them only in a reservation-of-rights letter. However, a unilateral reservation-of-rights letter cannot create rights not contained in an insurance policy." "The same is true of the Billing Guidelines themselves. As a matter of basic contract law, an extra-contractual document – a document to which Aldous never agreed – cannot limit or define her rights under the Policy." Thus, the district court's grant of summary judgment to Darwin on Aldous' breach of contract claim was in error, and agreement with the district court would otherwise render the Policy's duty to defend illusory.

With regard to Aldous' claims that the failure to properly pay defense costs under the policy was a breach of Darwin's duty of good faith and fair dealing, the Fifth Circuit recognized that such a duty only arose in the context of first party claims where the alleged loss is originally suffered by the insured. Here, where the alleged loss was originally suffered by Hill, resulting in his claims against Aldous and that triggering the duty to defend, the attorney's fees were associated with a third party claim. As such, Aldous could not recover against Darwin for breach of a duty that did not exist, so summary judgment had been properly entered against her claims for common law bad faith, breach of the bad faith provisions of the Texas Insurance Code, and under the DTPA.

To conclude, while this case should modify the insurance industry's bare application of billing guidelines to support write-offs, this case does not present, in total, bad news for insurance companies as it shows that treble damages for such actions are likely not

recoverable under the common claims of bad faith.

Notice of Settlement

Gonzalez v. Philadelphia Indem. Ins. Co., 663 Fed. Appx. 302 (5th Cir. 2016) (per curiam).

Insured's failure to give proper notice of settlement deprived his insurer of valuable rights and prejudiced it as a matter of law.

On August 16, 2010, Gaspar Gonzalez was involved in an automobile accident with another motorist. When the other motorist collided with Gonzalez, she was driving a car owned by her mother and insured under an Allstate Indemnity Company policy owned by the motorist's father. The Allstate Policy provided a $25,000 limit.

Gonzalez's employer's insurance policy with Philadelphia Indemnity Insurance Company also covered the collision because Gonzalez was acting within the course and scope of his employment at the time of the accident. The Philadelphia policy contained an endorsement, which provided that damages resulting from accidents with underinsured vehicles were covered under the policy "only if" Philadelphia was "given prompt written notice of [any] tentative settlement" with the underinsured motorist and Philadelphia "[a]dvance[d] payment to the 'insured' in an amount equal to the tentative settlement within 30 days after receipt of notification." The endorsement expressly excluded "any claim settled without [Philadelphia's] consent," unless the "insured" gave Philadelphia "prompt written notice" of any "tentative settlement" and Philadelphia "[a]dvance[d] payment to the 'insured' in an amount equal to the tentative settlement within 30 days after receipt of notification."

Gonzalez incurred at least $26,000 in medical bills as a result of the August 2010 accident, about which he notified Philadelphia in September 2012. In November of that year, Gonzalez settled with the other motorist, her parents, and Allstate for $25,000—the limit of the Allstate policy. The settlement released all the parties thereto from all liability arising from the accident. Gonzalez did not notify Philadelphia about the settlement until March 2014, over 16 months later, when Gonzalez made an Underinsured Claim against the Philadelphia policy. Philadelphia refused to pay his claim, and Gonzalez sued for breach of contract. Philadelphia moved for summary judgment, and the district court granted its motion, concluding that Gonzalez's failure to timely notify Philadelphia of the settlement prejudiced Philadelphia as a matter of law, and this prejudice entitled Philadelphia to summary judgment.

Relying on *Berkley I* and *Berkley II*,[1] The Fifth Circuit affirmed, explaining that notice provisions like the one included in the Philadelphia policy "afford the insurer valuable rights, such as the rights to join in the investigation, to settle a case or claim, and to interpose and control the defense." Failure to provide proper notice under the policy prejudiced Philadelphia by depriving it the ability to investigate the facts or parties involved in the settlement, participate in settlement negotiations, or pursue subrogation.

The Fifth Circuit distinguished its holding from *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691 (Tex. 1994) on the grounds that, in that case, "the insurer stipulated that (1) it had never before refused to settle a claim for

[1] The court noted that, although the *Berkely* case involved post-verdict notice, an insurer loses the same valuable rights when it receives post-settlement notice. *Berkley Reg'l Ins. Co. v. Phila. Indem. Ins. Co.* (*Berkley II*), 600 Fed. Appx. 230, 236–37 (5th Cir. 2015) (per curiam) (unpublished).

the full limit of the uninsured/underinsured motorist policy, (2) the tortfeasor had no assets other than the policy and this was not likely to change in the foreseeable future, and (3) the insurer did not incur any financial loss as a result of the lack of notification." Philadelphia, by contrast, made no such stipulations, and instead argued that Gonzalez's failure to notify deprived the insurer of valuable rights, including the opportunity to investigate whether the other motorist's parents could have paid more than the $25,000 settlement before releasing them from liability. Unlike the insurer in *Hernandez*, Gonzalez's failure to give Philadelphia notice as required by the policy prejudiced it as a matter of law.

Broad Scope of the Duty to Defend

Colony Nat'l Ins. Co. v. United Fire & Cas. Co., --- Fed. Appx. ----, 2017 WL 436042 (5th Cir. Jan. 31, 2017).

If the petition alleges facts that are even potentially within the coverage of the policy, the insurer is obligated to defend.

Carothers Construction, Inc., the general contractor on a Red River Army Depot project, contracted with two subcontractors to complete work involving tilt wall concrete panels. Carothers hired Self-Concrete, Inc. to form and pour tilt wall panels and Premier Constructors, Inc. to erect tilt wall panels. Premier then hired Joyce Steel Erection to hoist and lift the tilt wall panels into position. While being hoisted into place by Joyce, one of Self-Concrete's tilt wall panels swung out in an uncontrolled manner and seriously injured Gordon Bonner, a Premier employee.

Bonner filed a lawsuit against Carothers, Self-Concrete, and Joyce (the "Bonner lawsuit"), alleging that, through its actions and supervision on the jobsite, Carothers undertook "to perform services they knew or should have known were necessary for ... BONNER'S protection." Bonner also alleged that Carothers was under an obligation to ensure that work on the jobsite was implemented, complied with, and enforced, in accordance with its contracts and with applicable regulations, as well as ensuring subcontractor implementation, compliance, and enforcement under the same. Bonner claimed that Carothers breached its duty to Bonner with respect to ensuring that (1) he had a safe place to work, (2) unsafe conditions were corrected, including bringing such unsafe conditions to the attention of subcontractors, and (3) subcontractors complied with applicable safety plans and regulations. Bonner alternatively pled that Carothers had general supervisory authority and control over the jobsite, including the power to detect, correct, require others to correct, and prevent unsafe conditions and safety hazards on the site. Bonner further alleged that Carothers failed to implement an effective system for promptly correcting discovered hazards and failed to ensure subcontractor compliance with safety requirements.

Bonner claimed that Self-Concrete had a duty to follow the plans furnished by Carothers when forming, pouring, and preparing the panels, and that it had breached such duty. Bonner also alleged that the subcontract required Self-Concrete to clean the jobsite at the end of each day, which it failed to do at the worksite in question, resulting in a dangerous jobsite condition that was a direct and proximate cause of Bonner's injuries. Bonner additionally alleged gross negligence in Self-Concrete's failure to clean the worksite so that workers coming in to assist in the erection of the tilt wall would have a clear area in which to do their work, amounting to an extreme degree of risk to Bonner.

Claiming additional insured status, Carothers tendered the defense of the Bonner lawsuit to Self-Concrete's insurer, United Fire & Casualty Company, and Premier's insurer, Colony National Insurance Company. Colony accepted the tender and defended Carothers, ultimately settling the suit, but United declined to defend. As a result, Colony filed this action against United to collect half of the defense costs incurred. United argued that Bonner did not allege any facts or claims that imputed liability of Self-Concrete to Carothers.

United reasoned that, because the accident was caused by an out of control tilt wall panel, and the contract between Self-Concrete and Carothers specifically excluded lifting tilt wall panels from the scope of Self-Concrete's work, United was not under a duty to defend Carothers. Affirming summary judgment in favor of Colony, however, the Fifth Circuit noted that Bonner expressly alleged Carothers retained authority over the jobsite and plans for the tilt wall panels and further failed to ensure that its subcontractors abided by the requirements and standards contained in the subcontracts. The court concluded that this allegation was sufficient to find liability on the part of Self-Concrete, which could be imputed to Carothers, giving rise to a duty to defend. "This is especially true under Texas's broad scope of the duty to defend which extends even '[w]here the [petition] does not state facts sufficiently to clearly bring the case within ... coverage' because 'the general rule is that the insurer is obligated to defend if there is, potentially, a case under the [petition] within the coverage of the policy.'"

<u>*Stowers* Demand</u>

OneBeacon Ins. Co. v. T. Wade Welch & Assocs., 841 F.3d 669 (5th Cir. 2016).

Professional liability insurer's erroneous reliance on an overbroad prior-knowledge exclusion to deny coverage and refuse a settlement offer within policy limits resulted in a $28 million judgment against the insurer for violating its *Stowers* duties.

In 2003, DISH Network Corporation hired its "go-to litigation counsel," T. Wade Welch & Associates (the "Welch Firm") to defend it against a suit brought in federal court in Connecticut by Russian Media Group ("RMG") (the "RMG Litigation"). Ross Wooten served as the first chair attorney from the Welch Firm on the case. When Wooten failed to timely respond to discovery requests, RMG's counsel moved to compel a response. Wooten did not respond to the motion, and the court ordered DISH to respond to all of RMG's requests by March 16, 2006. Wooten partially complied with the order by producing documents and serving written discovery responses. Wooten believed he had satisfied his discovery obligations, but deficiencies remained.

RMG moved for sanctions against DISH for its failure to comply with the court's discovery order. Thereafter, despite Wooten's efforts to comply with the order and resolve the discovery dispute, the magistrate judge entered death penalty sanctions against DISH on July 12, 2007 (the "Sanctions Order"). Without telling DISH or the Welch Firm about the Sanctions Order, Wooten filed objections to it, but the district Court affirmed the order in February 2008. Welch first learned of the Sanctions Order from another associate and notified DISH. DISH hired another firm to replace the Welch Firm, but the Sanctions Order was not overturned.

In April 2008, the Welch Firm notified its insurer, OneBeacon Insurance Company

("OneBeacon") of a potential malpractice claim relating to the RMG Litigation. In June 2008, the Welch Firm advised the insurer that RMG was demanding over $105 million. On June 14, 2011, DISH offered to settle and release the Welch Firm in exchange for OneBeacon's policy limits, but it did not offer to release Wooten.

Relying on the prior-knowledge exclusion, OneBeacon denied the claim,[2] rescinded the policy, and filed a declaratory judgment action against the Welch Firm on August 22, 2011 (the "Coverage Litigation"). The Welch Firm counterclaimed, asserting violations of the common law *Stowers* doctrine and the Texas Insurance Code. OneBeacon and the Welch Firm filed cross motions for summary judgment on the prior knowledge exclusion. As evidence of prior knowledge, OneBeacon pointed to the Welch Firm's failure to disclose Wooten's conduct that would eventually give rise to the sanctions against DISH when the Firm signed the application for renewal insurance on December 20, 2006.

The trial court granted the Welch Firm's motion for summary judgment, which the Fifth Circuit later affirmed, concluding that the extreme overbreadth of the policy's definition of "wrongful act" rendered coverage illusory under the OneBeacon policy, as written, because it encompassed everything an attorney does, wrongful or not. The district court adopted the Welch Firm's construction of the prior-knowledge exclusion: "whether a reasonable attorney with Wooten's subjective knowledge on December 20, 2006, could have reasonably expected his or her acts, errors and omissions to lead to a malpractice claim by DISH." On December 20, 2006, Wooten was merely under an order to provide discovery—the motion for sanctions was not even filed until February 2007. Wooten's "wrongful acts" at the time of the renewal application could have been rectified, and no sanctions would have been entered. Thus, OneBeacon could not establish as a matter of law that the exclusion barred coverage.

When the Coverage Litigation proceeded to trial, the jury returned a verdict in favor of the Welch Firm equal to the amount of the malpractice judgment obtained by DISH against the Welch Firm ($12.5 million) plus $8 million in lost profits, $5 million in exemplary damages, and $7.5 million for knowing violation of Chapter 541 of The Texas Insurance Code. The trial court required the Welch Firm to elect between the exemplary damages and those recovered for the knowing violation.

On appeal, the Welch Firm claimed the election of damages mandated by the trial court was improper, but the Fifth Circuit affirmed under the one satisfaction rule. The court explained that the two causes of action are "almost identical," and "a party bringing a claim under Chapter 541 premised on the failure to settle must meet the requirements of a *Stowers* claim."

OneBeacon argued that DISH's settlement demand was not a proper *Stowers* demand because it only offered to release the Welch Firm and not Wooten, who was also an insured under the policy. Distinguishing the Texas court of appeals case cited by the insurer to support this argument,[3] the Fifth Circuit relied on its own precedent to hold

[2] In March 2013, well after OneBeacon denied the Welch Firm's claim and refused the settlement offer, DISH pursued its malpractice claim in arbitration against the Welch Firm. The arbitrator awarded DISH $12.5 million in damages as a result of the alleged malpractice. In June 2013, a Texas state court confirmed the arbitration award.

[3] *Patterson v. Home State County Mut. Ins. Co.*, 01-12-00365-CV, 2014 WL 1676931, at *10 (Tex. App.—Houston [1st Dist.] Apr. 24, 2014, pet. denied)

that the trial court did not err in determining the Welch Firm made a valid *Stowers* demand.

Finally, OneBeacon challenged the lost profits awarded by the jury, but failed to properly preserve the issue for review on the merits. The court did, however, indicate in an advisory footnote that lost profits would be available under Chapter 541 if an insured offers proper evidence to prove its damages.

Computer Fraud

Apache Corp. v. Great Am. Ins. Co., 662 F. Appx. 252 (5th Cir. 2016).

The receipt of a fraudulent email is not enough to establish a loss under a standard computer fraud provision.

In March of 2013, an employee of Apache Corporation received a telephone call from Emily Hebditch, an employee of Petrofac, one of Apache's vendors.

Ms. Hebditch instructed Apache to change the bank-account information for Petrofac's invoices. In response, the Apache employee told Ms. Hebditch that Apache could not change Petrofac's bank-account information without a formal request on Petrofac letterhead.

Within a week, the Apache accounts-payable department received an email from "petrofacltd.com," which stated that Petrofac's bank-account information needed to be changed. Attached to the email was a letter on Petrofac Letterhead with instructions to change the bank-account information for Petrofac's invoices immediately.

An employee of Apache then called Petrofac, using the number on the Petrofac Letterhead to confirm the request. An individual at Petrofac confirmed that the request was valid, and Apache approved the change and changed the bank-account number. Sometime later, Apache paid approximately $7 million into Petrofac's new bank account.

Regrettably, all of the above communications that Apache thought were with Petrofac were actually with Latvian criminals, impersonators, and imposters. The real Petrofac did not request a bank-account change. After an investigation of these criminals and a recoupment of some of the money, Apache submitted a claim to its insurer, Great American Insurance Company ("GAIC"), under its crime-protection insurance policy and specifically under its computer fraud provision. That provision stated that GAIC: will pay for loss of money "resulting *directly* from the use of any computer to fraudulently cause a transfer" of that money from inside the premises to a person or place outside those premises.

GAIC denied the claim. In its denial letter, GAIC took the position that the "loss did not result directly from the use of a computer nor did the use of a computer cause the transfer of funds."

Thereafter, Apache sued GAIC in Texas state court, and GAIC removed the action to the Southern District of Texas. After competing motions for summary judgment were filed, the district court granted Apache's motion holding that the email was a substantial factor in bringing about the loss. Specifically, the district court rejected GAIC's proposition that the intervening steps of the confirmation

(holding no valid *Stowers* demand where only the insured employer and not the employee (an additional insured) would have been released).

phone call and the supervisory approval by Apache negated causation.

Applying Texas law, making an *Erie*-guess, and relying solely on non-Texas authority, the Fifth Circuit reversed the district court and rendered a judgment for GAIC. The court held that the loss was not covered because the loss did not result directly from the use of a computer, but from Apache's own actions.

Crucially, the computer use (the email) was "merely incidental to the occurrence of the authorized transfer of money." The Court found that Apache had multiple chances to prevent the transfer from occurring, but its process failed at each step. Thus, the loss did not result directly from the email, but from Apache's failure to accurately investigate the new, but fraudulent, information provided to it by the imposters.

With the ever-present use of computer-facilitated communication, the court stated that it could not interpret "resulting directly from" in a manner that would reach any fraudulent scheme in which an email was part of the process because that would change the computer fraud provision into a general fraud provision.

Denial of Unrelated Claims Not Discoverable

In re Hallmark County Mutual Ins. Co., 504 S.W.3d 916 (Tex. App.—El Paso 2016, orig. proceeding).

The El Paso Court of Appeals conditionally granted a writ of mandamus, holding that trial court abused its discretion in granting a motion to compel production of all petitions and complaints regarding a denial of coverage or denial of a defense filed against the insurer in the past ten years.

After an explosion that caused property damage to the insured and the death of one of the insured's employees, Hallmark paid the property damage claim, but denied the insured's tender of the defense of the wrongful death lawsuit. After a significant judgment was entered against the insured, the underlying plaintiffs obtained an assignment and turnover order to pursue the insured's causes of action against Hallmark.

In this litigation, the plaintiffs sought production of all other lawsuits in the past ten years involving a denial of coverage or of a defense. The court noted that the determination of the duty to defend is a question of law that depended upon the allegations in the pleading and the language of each individual policy. Accordingly, the insurer's "denial of a defense with respect to unrelated third parties is not probative of the denial of a defense claim in this case." Therefore, the Court of Appeals concluded that the request for such information was an "impermissible fishing expedition" and that the trial court abused its discretion in granting the motion to compel.

Abatement

In re Allstate County Mutual Ins. Co., No. 14-16-00963-CV, 2017 WL 536629 (Tex. App.—Houston [14th Dist.] Feb. 9, 2017, orig. proceeding).

When the insured simultaneously pursues contractual and extra-contractual claims against her insurer, the extra-contractual claims must be severed and abated when the insurer has made a settlement offer.

Alexa St. Julian made an underinsured motorist claim against Allstate, her insurer. Allstate offered $12,000 in settlement, but St. Julian rejected the offer. St. Julian sued Allstate seeking recovery of underinsured

motorist benefits and alleging bad faith and statutory violations related to Allstate's offer. Allstate filed a motion to sever and abate the extra-contractual claims. The trial court granted the motion for severance but refused to abate discovery related to the extra-contractual claims. Allstate sought mandamus relief.

The Fourteenth Court of Appeals conditionally granted the writ of mandamus. The court noted that it has consistently held that extra-contractual claims must be severed and abated when the insurer has made a settlement offer. The court noted that abatement is necessary because the scope of permissible discovery differs between the two types of claims and without abatement, the parties will be put to the expense of conducting discovery on claims that may be disposed of in the first trial.

Mandamus Available For Trial Court's Refusal To Compel Appraisal

In re State Farm Lloyds, No. 14-16-00696-CV, 2017 WL 123275 (Tex. App.—Houston [14th Dist.] Jan. 10, 2017, orig. proceeding).

A trial court abuses it discretion if it fails to compel an insured to participate in an appraisal process.

Hai and Kieu Nga Tran (the "Trans") reported storm damage under their homeowner's policy. State Farm's adjuster prepared an estimate of repair costs that was less than the deductible. Thus, the Tran's filed suit. State Farm answered, requested a jury trial, and then invoked the policy's appraisal provision by letter.

The Trans refused to participate in the appraisal process. State Farm filed a motion to compel appraisal and abate the lawsuit. In response, the Trans contended that State Farm had waived appraisal by denying their claim and by demanding a jury trial. The trial court ruled in favor of the Trans and denied State Farm's motion. State Farm thus filed a petition for writ of mandamus.

The Court of Appeals conditionally granted the writ, holding that trial courts have no discretion to ignore a valid appraisal clause and this error cannot be remedied by appeal.

The court first examined whether State Farm had waived the appraisal provision. The Trans argued that State Farm's outright denial of the claim caused State Farm to waive the appraisal provision. The Court of Appeals concluded, that State Farm's denial of the claim did not constitute an "intentional relinquishment" of the insurer's right to invoke the appraisal provision because State Farm acknowledged that there was covered damage, but determined that it was less than the deductible.

State Farm did not waive the appraisal provision by requesting a jury trial. While State Farm requested a jury trial in its answer, the court concluded that State Farm had not requested a specific jury determination on damage issues. Thus, State Farm's jury demand also did not amount to a waiver.

The Court of Appeals further determined that the appraisal provision was not illusory and was not lacking in mutuality of obligation. The policy gave both parties the right to demand appraisal and did not give State Farm the right to modify the appraisal provision on its own. Further, State Farm's letter invoking appraisal did not and could not change the terms of the policy.

Since the insureds did not raise a fact issue concerning whether State Farm waived appraisal, the court held that the trial court

abused its discretion in failing to compel the appraisal.

Duty to Cooperate Applies to Insured's Affirmative Claim

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

An insured did not breach the duty to cooperate as a matter of law by refusing to agree to a settlement requiring mutual dismissal with prejudice of the Insured's third-party claim and a third-party counterclaim if the insured's conduct was reasonable and justified under the circumstances.

Bill Head filed suit in Hidalgo County against PSI, Mid-Continent's insured, alleging that his property was damaged by a fuel leak from a fuel storage system installed by PSI. PSI asserted a third-party claim against Titeflex, a component part manufacturer. PSI sought indemnity and it asserted an affirmative claim for damages caused by Titeflex's negligence. Titeflex filed a counterclaim against PSI seeking indemnification for fees and for damages.

During settlement discussions, PSI nonsuited its affirmative claims against Titeflex without prejudice. Titeflex made it clear that a settlement with PSI required mutual dismissals with prejudice. Mid-Continent and PSI's defense counsel urged PSI to accept the settlement, but PSI refused. After the settlement offer expired, Titeflex expanded its counterclaims against PSI. The jury awarded Titeflex $463,000 on its counterclaim against PSI.

After refusing to indemnify PSI, Mid-Continent filed suit and contended that PSI's failure to agree to a settlement with Titeflex based upon a mutual dismissal with prejudice was a breach of PSI's duty to cooperate and thus voided coverage. PSI argued that Mid-Continent waived its right to rely on the duty to cooperate condition because its reservation of rights letters failed to apprise it that Mid-Continent might take this position. The court disagreed and noted that the reservation of rights letters did mention the duty to cooperate.

Next, the court addressed PSI's argument that the duty to cooperate did not apply to PSI's affirmative claims, but only against the claims that were asserted against it by Mr. Head. Reading the text of the clause, the court concluded that PSI had agreed to cooperate with Mid-Continent for the "suit." And because "suit" was defined to include the entire civil proceeding, PSI's third-party claim and Titeflex's counterclaim were included.

Mid-Continent also argued that PSI should not be allowed to present evidence or argue that its refusal to agree to a mutual dismissal with prejudice was reasonable and that the jury should receive no instruction on reasonableness. The court disagreed. The court concluded that the standard for whether an insured breached the duty to cooperate is whether the insured's conduct was "reasonable and justified under the circumstances" and the entire chronology leading up to the settlement proposal was admissible into evidence, including the negotiations with Titeflex regarding the third-party claim and third-party counterclaim. The court pointed out that whether or not there has been a breach of the duty to cooperate is generally a question of fact for which the jury was best suited to determine.

TEXAS DISTRICT COURTS UNCLEAR REGARDING AGENT LIABILITY UNDER SECTION 541 FOR FAILURE TO EFFECTUATE A FAIR SETTLEMENT

Texas law remains unsettled as to whether an adjuster, or even an attorney, may be held liable under Section 541 of the Texas Insurance Code for unfair claims settlement practices. Two opinions, two days apart, issued from the same jurisdiction reached conflicting results. On October 12, 2016, the Western District of Texas held that an attorney acting on behalf of an insurer could not be held liable under Section 541 because he did not have the ultimate authority to settle a claim. On October 14, 2016, the Western District of Texas held that 541's language regarding an agent's authority to "effectuate" a settlement did not require the adjuster to have ultimate authority to settle the claim, but rather only authority to assist in bringing about settlement of the claim. The two opinions are summarized below.

Montoya v. State Farm Mut. Auto. Ins. Co., No. 16-00005, 2016 WL 5942327 (W. D. Tex. Oct. 12, 2016).

Amanda and Deandra Montoya (the "Montoyas") were injured in a car accident caused by Andrew Acosta ("Acosta"). In addition to the Montoyas' injuries, Acosta and one of Acosta's passengers were killed and two of Acosta's other passengers were injured. Acosta's insurer, State Farm, retained defendant Jeff B. Frey ("Frey"), an attorney, to represent the Acosta estate in connection with claims arising out of the accident. According to the Montoyas, Frey – representing the Acosta estate – told the Montoyas that an *attorneys ad litem* would be appointed to victim-minors, including Deandra Montoya. Frey also allegedly told the Montoyas that there would be a hearing "to discuss and arrive at, with the assistance and direction of the Court, an equitable apportionment of the insurance proceeds." Things did not progress in that fashion however, and Frey settled with the injured passengers without the knowledge of the Montoyas. The Montoyas sued Acosta estate in Bexar County, Texas and obtained a judgment for $542,933.67. The Montoyas entered into a Covenant not to Execute and Assignment of Interest with Araceli Acosta, individually and as the representative of the estate of Andrew Acosta.

The Montoyas, standing in the shoes of the Acosta estate by assignment, sued State Farm and Frey, asserting multiple common law and statutory causes of action. Against Frey specifically, the Montoyas claimed that he violated Section 541 of the Insurance Code and the DTPA because Mr. Frey failed to fairly and reasonably evaluate, negotiate, and/or finalize the multiple settlements arising out of the collision exposing Acosta to an excess judgment.

State Farm removed the case to federal court arguing that Frey (who, like the Montoyas was a Texas citizen) had been improperly joined. The Montoyas argued otherwise, pointing to an unreported case –*Linron Props., Ltd v. Wausau Underwriters Inc. Co.* – for the proposition that an adjuster may be liable because he plays a role in effectuating or bringing about a settlement. *See Linron*, 2015 WL 3755071 at *3 (finding plausible claims against an adjuster by construing §571.060(a)(2)'s use of the word "effectuate" rather than a word that conveys finality, to include anyone who plays a role in bringing about a settlement). The Montoyas argued that because Frey had authority to investigate the claims at issue, he played a role in effectuating the settlement and should be liable as if he was an independent adjuster. But the court decided to go with another line

of case law that had dismissed claims against adjusters when there was no allegation that the adjuster had the authority to settle. Without holding that Section 541 could not apply to an attorney representing an insurer, the court held that Mr. Frey himself had no authority to finalize a settlement, and therefore could not be held liable for failing to fairly effectuate a settlement under Section 541. Moreover, the court held that like DTPA claims, claims under the Insurance Code are similarly "personal and punitive" and therefore cannot be assigned. As such, the Montoyas did not have standing to bring the claims against Frey. Thus, the court concluded that the Montoyas had no reasonable basis of recovery against Frey, and therefore Frey was improperly joined to the suit.

Mehar Holdings, LLC v. Evanston Ins. Co., No. 5:16-CV-491-DAE, 2016 WL 5957681 (W.D. Tex. Oct. 14, 2016).

The court reviewed and granted a motion for reconsideration filed by Mehar Holdings, LLC ("Mehar") finding that the defendant adjuster may have independent liability for effectuating a settlement.

In this first-party insurance case, Mehar owned a Fiesta Inn and Suites Hotel located in San Antonio, Texas. The property was damaged by fire and covered by an insurance policy issued by Evanston Insurance Company ("Evanston"). Mehar filed a claim with Evanston, who in turn assigned it to Brush Country Claims, Ltd ("Brush"). Brush assigned Robert Soefji ("Soefji") as the adjuster for the claim responsible for investigating and reporting the loss. In its state court lawsuit, Mehar contended that Defendants failed to comply with the Texas Insurance Code and had not adequately paid Plaintiff in accordance with the Policy. Plaintiff sought a declaratory judgment against Evanston that the Policy provided coverage for the cost to repair the Property, and it also asserted causes of action against Evanston for (1) breach of contract; (2) violations of the Texas Insurance Code Sections 541 and 542; (3) violations of the DTPA; and (4) common law bad faith. Plaintiff asserted a single cause of action against Brush and Soefje for violations of Section 541.060. Evanston removed the case to federal court arguing that Brush and Soefje were improperly joined. Initially, the court found that Mehar failed to plead any facts to state a claim under Section 541.060 (a)(1) of the Texas Insurance Code. Additionally, the court held that an insurance adjuster could not be liable under Sections 541.060(a)(2)-(4) and (7).

In considering Mehar's motion for reconsideration, the court began by stating that for an adjuster to be held individually liable, they had to have committed some act that is prohibited by Section 541, not just be connected to an insurance company's denial of coverage. "A plaintiff can't just allege a violation of the general insurance code and hope for the best." Thus, in evaluating whether a plaintiff has stated a claim against an adjuster, the Court must determine whether (1) an adjuster can be liable under the specific section of the Insurance Code as a matter of law, and (2) if so, whether plaintiff has pled sufficient factual content to create a reasonable basis of recovery under state law.

The court recognized that federal district courts are split as to whether an adjuster may be held liable under Section 541.060(a)(2)(A). This section states that "it is an unfair method of competition or an unfair or deceptive act or practice [by] failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a

claim with respect to which the insurer's liability has become reasonably clear."

Those federal district courts holding that the section does not apply to adjusters, reason that an adjuster cannot be held liable because they lack settlement authority, and thus cannot effectuate a prompt, fair and equitable settlement. On the other hand, those district courts that find an adjuster may be liable under Section 541.060(a)(2)(A) reason that an adjuster has the ability to "effectuate a prompt, fair, and equitable settlement" because the adjuster is the one who investigates and evaluates insurance claims. Unlike the Western District's opinion just two days prior in *Montoya*, the court here relied on *Linron Prop., Ltd. v. Wausau Underwriters Ins. Co.*, rationale, which drew on the definition of "effectuate" to explain that "[t]he fact that the statute uses the word 'effectuate' rather than a word that conveys finality (e.g., finalize), suggests that its prohibition extends to all persons who play a role in bringing about a prompt, fair, and equitable settlement of a claim, including adjusters."

Finding that all ambiguities are construed against removal and in favor of remand to state court, and that Plaintiff had alleged that the adjuster failed inspect the property and the claimed damages, failed to request information, failed to fully investigate the claim, failed to respond to requests for information from plaintiff, failed to timely evaluate the claim, failed to timely estimate the claim, and to timely and properly reports and recommendations to Evanston; the court held that sufficient allegations had been alleged by Plaintiff to prove a reasonable chance of recovery against Brush and Soefje. Remand was granted, and the claim of improper joinder denied.

Assault and Battery Exclusion Bars Duty to Defend And Duty To Indemnify

Atain Specialty Ins. Co. v. Sai Darshan Corp., No. H-16-1446, 2016 WL 7494890 (S.D. Tex. December 29, 2016).

Tommy Thurman was assaulted and shot dead outside of an America's Best Value Inn. The owners of the inn were then sued for negligence in failing to protect Thurman. The inn's insurer, Atain Specialty, subsequently sought a declaratory judgment that it had no duty to defend or indemnify the Inn under its CGL policy due to the policy's Assault and Battery Exclusion, which read as follows:

> This insurance does not apply to 'bodily injury' or 'property damage,' in whole or in part, either directly or indirectly, or in any way arising out of any of the following:
>
> 1. Assault and Battery committed **by any Insured, any employee of any Insured or any other person**;
> 2. The failure to suppress or prevent Assault and Battery by **any person** in 1 [,] above;
> 3. Resulting from or allegedly related to the negligent hiring, supervision or training of any employee of the Insured; or
> 4. Assault or Battery, whether or not caused by or arising out of negligent, reckless or wanton conduct of the Insured, the Insured's employees, patrons of **other persons lawfully or otherwise on, at or near the premises owned or occupied by the insured, or by any other person**.

> For the purpose of this exclusion, Assault and Battery includes, but is not limited to, the use of reasonable force or self-defense by any party, person, insured or employee of any insured.
>
> Furthermore for this Exclusion, SECTION I – COVERAGES COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY, Section 2. Exclusions, Paragraph a. Expected or Intended Injury is replaced by the following:
>
> Expected Or Intended Injury "Bodily Injury" or "property damage" **expected or intended from the standpoint of the insured**.

America's Best's main argument was that coverage existed because the exclusion was ambiguous. "The exclusion appears in almost all respects to be aimed at excluding damages arising out of the conduct of the insured or someone within the insured's control." According to America's Best, because it had no control over the individuals who committed the assault, coverage should be available in the underlying lawsuit. Indeed, America's Best noted that its interpretation was consistent with the expected or intended injury exclusion, which required that the injury be expected or intended from the standpoint of the insured.

The court held that the construction of the Assault and Battery Exclusion urged by America's Best "[wa]s unreasonable because it effectively works an Amelia Earhart disappearing act on the offending phrase[s]." The court stated that it was not a reasonable interpretation of the exclusion because it fails to give any effect at all to the phrases "any other person" found in § 1, "any person" found in § 2, and "other persons" found in § 4. Noting that a reasonable construction is one that attempts to give meaning to the policy language as a whole and noting that a number of courts have held similar Assault and Battery exclusions to be unambiguous, the court concluded that the Assault and Battery Exclusion applied to bar coverage under the policy. Importantly, "none of the claims in the lawsuit underlying this action would have been brought absent Thurman's shooting." Thus, Atain Specialty had no duty to defend America's Best.

Atain Specialty further argued that it had no duty to indemnify America's Best or any other defendant named in the underlying lawsuit because the Assault and Battery Exclusion, which negated the duty to defend, also negated any possibility that Atain Specialty will have a duty to indemnify, relying on *Griffin* and its progeny.

There were simply no reasonably foreseeable facts that could be pled in connection with this matter that would otherwise remove the case from the Assault and Battery Exclusion. The court thus entered summary judgment for Atain Specialty on both the duty to defend and duty to indemnify.

Narrow Exception May Swallow Eight-Corners Rule

Sentry Select Ins. Co. v. Drought Transportation, LLC, No. 15-cv-890, 2016 WL 6236375 (W.D. Tex. Oct. 24, 2016).

Sentry Select sought a declaration that it had no duty to defend or indemnify Craig Goeckeritz, Drought Transportation, and Circle Bar ("Defendants") in an underlying lawsuit filed by Adrian Martinez. In the underlying suit, Martinez claimed that he was involved in an auto accident with Goeckeritz who was driving a 2004 Freightliner tractor trailer. Martinez sought recovery against

Goeckeritz for negligence in causing the accident and against both Drought Transportation and Circle Bar under a theory of respondeat superior. Martinez alleged that Goeckeritz was the agent of either or both Circle Bar or Drought Transportation.

With regard to who is an insured under the policy, the policy states that Drought Transportation is insured for any "covered auto," as well as "anyone else while using with [Drought's] permission a covered 'auto' [Drought] own[s], hire[s] or borrow[s]." The policy listed the covered auto in a "Schedule of Vehicles" that included the 2004 Freightliner. However, the policy included a business-use exclusion:

> Liability Coverage, Uninsured Motorist Coverage, Underinsured Motorist Coverage, Personal Injury Protection Coverage, Property Protection Insurance Coverage or any other Liability Coverage provided by this policy, for a covered "auto" described in this policy, is changed as follows:
>
> 1. The following exclusions are added:
>
>   This insurance does not apply to:
>   a. A covered "auto" while used to carry property in any business.
>   b. A covered "auto" while used in the business of anyone to whom the "auto" is rented, leased or loaned.
>
> 2. Who Is An Insured does not include anyone engaged in the business of transporting property by "auto" for hire who is liable for your conduct.

Sentry sought a declaratory judgment that it had no duty to defend or indemnify the Defendants because the accident occurred while Goeckeritz was conducting business for Circle Bar. Defendants argued that the facts raised in the pleadings triggered the duty to defend, and that extrinsic evidence – such as the testimony from Goeckeritz or Drought's Fleet Manager that the 2004 Freightliner was being leased by Circle Bar—should not be considered.

The court first recognized that under Texas law, questions of the duty to defend and the duty to indemnify are justiciable when 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. Thus, the court held that here, if the facts triggered the business-use exclusion, there was no duty to defend under the policy, and the business-use exclusion would also negate any duty to indemnify. Thus, the court held the duty to indemnify issue was ripe.

The court next considered whether it may look to extrinsic evidence in determining whether the 2004 Freightliner was being used for a business purpose. Relying on *GuideOne's* limited exception to the eight-corners rule - whether (1) it is initially impossible to discern whether coverage is potentially implicated by Martinez's complaint, and (2) Sentry's evidence goes solely to a fundamental issue of coverage which does not overlap with the merits of or engage the truth or falsity of any facts alleged by Martinez - the court held that it could consider extrinsic evidence.

The court first found that it was impossible to discern whether coverage is potentially implicated because the underlying petition included no allegations concerning whether the 2004 Freightliner was used to further the

commercial interests of Drought Transportation or Circle Bar. The court rejected that argument that the underlying petition alleged that Goeckeritz was working for Drought Transportation and thus the 2004 Freightliner was not being used in the business of Circle Bar. According to the court, it is customary for trucking companies to allow other another company to use its trucks and this counts as a business use. "Thus, whether Goeckeritz was acting within the scope of his employment for Circle Bar, Drought Transportation, or both, it is impossible to discern the fundamental fact concerning coverage: whether the [2004] Freightliner had been leased, and whether it was being used to further the interests of a lessee." Thus, the first prong of the *GuideOne* exception was satisfied.

Second, the court held that the evidence showing that the 2004 Freightliner was leased to Circle Bar and was being used in furtherance of Circle Bar's business interests at the time of the accident. Over the objection of the Insureds, the court held that this evidence did not overlap with the pleadings alleging that Goeckeritz was an agent of Drought Transportation and Circle Bar at the time of the accident. A key legal question in the underlying lawsuit to establish vicarious liability. For the court, the agency of Goeckeritz was irrelevant to coverage because the proper focus was on whether or not the auto was leased to Circle Bar. If it was leased, then the business-use exclusion applied, and whether or not it was leased did not affect the underlying case. Thus, the court concluded that the lease to Circle Bar went to a fundamental issue of coverage and did not engage the truth or falsity of the underlying petition. Thus, the court found itself free to consider the extrinsic evidence, and, under the business-use exclusion, it held that coverage was precluded under the policy.

Sentry has filed an appeal of the district court's decision to the Fifth Circuit.

An Amended Pleading with Additional Claims Arising Out of Same Facts is Not Considered a New Claim for a Claims Made Policy.

Wesco Ins. Co. v. Ledford E. White, Et Al, 4:14-CV-572-Y (N.D. Tex. Mar. 10, 2017).

This case involved a coverage dispute over a lawsuit filed by Gwendolyn and Troylynn Layton (collectively "Laytons") against their former attorney and friend, Ledford E. White. On February 19, 2015, a jury found White and his law firm liable for fraud, breach of fiduciary duty, theft, civil conspiracy, and negligence. The jury awarded the Laytons $680,000 in actual damages, $100,000 in exemplary damages, $100,000 in attorney's fees, and $12,008 in expert witness fees and costs. Wesco brought this declaratory judgment action seeking a ruling it had no duty to defend or indemnify White or his firm for the *Layton* case. Westco moved for summary judgment that there was no coverage under the Policy for the *Layton* case, and the Laytons moved for partial summary judgment that coverage was not precluded under the Policy.

The Policy at issue in the underlying case was a claims-made-and-reported professional liability policy. Under the Policy, "claim" meant a written or verbal demand received by the insured for money or services arising out of an act or omission in rendering or failing to render legal services. It was undisputed that the policy period was March 14, 2014, to March 14, 2015.

The Laytons filed their original state-court petition on August 16, 2013, approximately seven months before the policy period began. The Laytons argued that amending their

petition on May 30, 2014 to include a negligence claim and adding White's law firm as a party brought their claims into the policy period. The court reviewed the original and amended petitions and, citing *Nat'l Union Fire Ins. Co. of Pittsburgh v. Willis*, 296 F.3d 336, 339 (5th Cir. 2002), concluded "that the claims asserted by the Laytons in their amended petition allege, arise out of, are based upon, or derive from the same or essentially the same facts as alleged in their original petition and were therefore not first made during the policy period."

The court continued that even if the Laytons' claim had fallen in the policy period, any available coverage would otherwise be precluded by the fortuity doctrine since the Laytons alleged that White engaged in fraudulent and otherwise wrongful conduct from April 1997 to January 2013 and had "actual awareness" that his representations were false at the time he made them. Accordingly, the court concluded that "the acts allegedly committed by White constitute a 'loss in progress,' which precludes Wesco's duty to defend White [or his firm] for the Laytons' claims.

The court granted Wesco's summary judgment, and denied the Laytons'.

Insured Bears the Burden to Submit Extrinsic Evidence if it Asserts an Exception to the Eight Corners Rule.

Atl. Cas. Ins. Co. v. PrimeLending, 2017 WL 951878, at *1 (N.D. Tex. Mar. 10, 2017)

This case involved a declaratory judgment brought by Atlantic Casualty Insurance Company which sought a determination that it had no duty to defend or indemnify First Choice Construction, LLC in an underlying state court lawsuit. Atlantic moved for summary judgment on its declaratory judgment action and on First Choice's counterclaims. Atlantic also moved to dismiss First Choice's third amended counterclaims under Fed. R. Civ. P. 12(b)(6) and 9(b). First Choice in turn moved for partial summary judgment on its counterclaims against Atlantic. Finally, third-party defendant Connect Insurance Agency, Inc. moved to dismiss First Choice's third-party action under Tex. R. Civ. P. 12(b)(6) and 9(b).

In 2012, First Choice purchased a CGL policy issued by Atlantic. In November 2013, PrimeLending sued First Choice in Texas state court for claims based on allegedly shoddy remodeling work performed on Deborah White's residence. This district court suit was brought as a declaratory judgment action by Atlantic seeking a determination that it did not have a duty to defend or indemnify First Choice based on the underlying state court lawsuit. First Choice counterclaimed against Atlantic and brought claims against third-party Connect alleging violations of the DTPA, Tex. Bus. & Com. Code § 17.41 *et seq*, and the Texas Insurance Code.

Atlantic contended that PrimeLending's petition did not allege any claims in the underlying lawsuit based on allegations of property damage caused by an occurrence. PrimeLending's petition asserts claims against First Choice for breach of contract, negligence, negligent misrepresentation, fraud/fraudulent misrepresentation, and that First Choice had fraudulently requested payments from PrimeLending based on substandard work or work that was never done at all. The petition did not specify what construction work was "poor". First Choice maintained that it was reasonable to infer from the allegations that the allegedly substandard work caused physical injury to

White's property, and that, even if the face of the third amended petition does not contain enough facts to determine whether the duty to defend is triggered, the court can look to extrinsic evidence to determine whether property damage occurred.

The court acknowledged it was theoretically conceivable to infer from the petition at issue that First Choice's allegedly substandard work caused physical injury to White's residence, but noted that there was a stronger reasonable inference that could be drawn that PrimeLending was not seeking damages for physical injury to tangible property. "In fact, it is difficult to draw the reasonable inference that PrimeLending was alleging that First Choice damaged White's property through poor and untimely construction work caused by an 'accident.'

The district court admitted that if one were to assume that both parties' interpretations were reasonable the court may look to extrinsic evidence to determine whether PrimeLending was seeking property damage caused by an occurrence. But, the court made it clear that "the insured bears the burden of establishing that the insurance policy covers the claim. Thus, at the summary judgment stage First Choice had a burden to produce evidence that would enable a reasonable trier of fact to find that PrimeLending sued for property damage caused by an occurrence. Although First Choice maintained that the court should look to extrinsic evidence, it submitted no evidence for the court's consideration. Because First Choice failed to meet its burden, the court granted Atlantic's motion for summary judgment on its declaratory judgment claim and held that Atlantic had neither a duty to defend nor indemnify First Choice in the underlying lawsuit.

No Prejudice Required for the TWIA to Deny Coverage for Untimely Claims.

Housing & Community Services, Inc. and HCS 401, LLC d/b/a Lantana Square Apartments v. Texas Windstorm Insurance Association, 2017 WL 1228901, at *1 (Tex. App.—Corpus Christi Mar. 2, 2017, no. pet. h.)

This case involved a lawsuit by HCS against TWIA. The parties stipulated that: (1) on May 15, 2012, a storm occurred in Corpus Christi that caused the alleged damages to the property at issue; (2) HCS filed claims for such damage one year and thirteen days after the storm; (3) TWIA denied the claims as untimely because they were filed in excess of one year form the date of loss; and (4) TWIA was not prejudiced by HCS's untimely filed claims.

The policy at issue required an insured to file a claim under an association policy within a year from the date the damage to the property occurs. The period was subject to a provision which allows a claimant to seek a discretionary 180-day extension for the claim deadline upon a claimant's showing of good cause.

TWIA argued that the policy provisions were mandatory and barred coverage for any claim which was not within a year and for which a good faith extension had not been granted. HCS countered that, pursuant to *PAJ v. Hanover Insurance Company*, 243 S.W.3d 639 (Tex. 2008), HCS's thirteen-day lapse should not bar coverage if TWIA was not prejudiced. TWIA acknowledged *PAJ* and the related cases, but argued that the cases were inapplicable and distinguishable because of the "special statutory nature of windstorm coverage and its departure from the common law."

The court explained that the purpose of TWIA is to serve as a residual insurer of last resort for wind and hail insurance in the seacoast territory. Noting that when a legislature creates a statutory cause of action and a remedy for its enforcement dealing with an administrative agency the statutory provisions are mandatory and exclusive, the court pointed to the clear statutory mandate in Tex. Ins. Code §2210.573(a) which "sets forth a clear and unambiguous one-year limitations period for when a claimant may file a claim with TWIA, subject to a 180-day discretionary extension form the commissioner of insurance."

In light of the TWIA Act limitations provision, the court held that "TWIA may deny untimely-filed claims, regardless of whether TWIA was prejudiced by the untimely filed claim." The court affirmed the trial court's grant of summary judgment in favor of TWIA, but noted that the holding imposes "'draconian consequences' for *de minimis* deviations by TWIA policyholders."

Extra-Contractual Claims Relating to Claims Handling of NFIP Policies Preempted by Federal Law.

Jianhua Ling v. Farmers Ins. Group, 2017 WL 451222, at *1 (S.D. Tex. Feb. 2, 2017)

In this case the Plaintiff brought claims alleging breach of a flood insurance contract and extra-contractual state law claims for violations of the Texas Insurance Code, the common law duty of good faith and fair dealing, fraudulent misrepresentations, common law fraud seeking treble damages under the Texas Insurance code, exemplary damages, attorney's fees, and pre and post-judgment interest. The Defendant filed a 12(b)(6) motion to dismiss with prejudice all of Plaintiff's extra-contractual claims on the basis that the extra-contractual state-law claims involving the United States Government's National Flood Insurance Program ("NFIP") were preempted by federal law. Plaintiff, although represented by counsel, did not file a response to the motion to dismiss.

Importantly, as the district court noted, the NFIP draws funds from the federal treasury to cover approved claims because it is operated by FEMA, an agency of the Department of Homeland Security. The NFIP's regulations, therefore, implicate sovereign immunity. Additionally, the provisions of an insurance policy issued under a federal program are strictly construed and enforced. Homeowners have the option of purchasing policies either directly from FEMA or from private insurers, which function as Write Your Own ("WYO") providers and fiscal agents of the United States.

The court examined a line of cases, including *Wright v. Allstate Ins. Co.*, which the Fifth Circuit decided in 2005. 415 F.3d 384 (5th Cir. 2005). The court observed that prior to *Wright*, "courts interpreted the Circuit's case law as ruling that state law claims are not preempted by the NFIP." But in *Wright*, the Fifth Circuit ruled that "state law tort claims arising from claims handling by a WYO are preempted under federal law." Since *Wright*, "[t]he Fifth Circuit has continued to distinguish between" claims for policy handling and claims for policy procurement. Claims for policy handling have traditionally been considered subject to federal jurisdiction and which the Treasury reimburses. Claims for policy procurement have traditionally not been subject to federal jurisdiction and WYO's must generally defend such claims on their own. The court went on to quote extensively from *Wright*, noting, among other things, that "[i]n 2000, FEMA amended the language of SFIP

policies to state: 'This policy and all disputes arising from the handling of any claim under the policy are governed exclusively by the flood insurance regulations issued by FEMA, the National Flood Insurance Act of 1968 . . . and Federal common law.'"

Next, the court considered *Wright v. Allstate Ins. Co. (Wright II)*, in which the Fifth Circuit examined in detail the issue of extra-contractual claims in the context of the NFIP, specifically "federal common law" claims. In analyzing whether there was an implied right to bring extra-contractual federal common law claims against the WYO Program carrier, the Fifth Circuit applied the four-prong test of *Cort v. Ash*, 422 U.S. 66 (1975). Among other things, the *Wright II* court found that the last two prongs of the *Cort* test are relevant only if the answers to the first two prongs indicate congressional intent to create a private remedy – which under its findings, clearly do not.

Ultimately, after analyzing *Wright* and *Wright II*, the district court agreed that there are no express or implied extra-contractual claims authorized by the National Flood Insurance Act of 1968 or the Standard Flood Insurance Policy. The court further explained "it is black letter law that claimants cannot recover attorney's fees in an NFIP claims handling dispute."

The Court granted the motion to dismiss with prejudice the extra-contractual claims alleged by Plaintiff, and allowed the sole breach of insurance contract claim to proceed.

Mental Anguish is Not Bodily Injury Under Commercial General Liability Policy.

McClain v. State Farm Fire & Cas. Co., 2017 WL 817152, at *1 (Tex. App.—Fort Worth Mar. 2, 2017, no. pet. h.)

In this case, the Fort Worth Court of Appeals held that a CGL policy did not cover claims for pure mental anguish or other mental injury.

The Ramirezes purchased a home from the McClains. In connection with the purchase, the Ramirezes paid some cash to the McClains, and signed a promissory note calling for monthly installments over eighteen years. After eight years, the McClains foreclosed on the property, and repurchased the property at a foreclosure sale. The Ramirezes sued the McClains for wrongful foreclosure and breach of contract.

The McClains requested that State Farm defend them in the Rameriz lawsuit. State Farm denied coverage.

State Farm denied that it had a duty to defend because the Ramirezes did not allege a type of harm covered by the policy. Although the McClains were eventually granted judgment as a matter of law on the Ramirezes' claims, they incurred significant defense costs. The McClains filed suit against State Farm on February 18, 2016, arguing that State Farm had a duty to defend and was now liable for the incurred attorney's fees.

The Ramirezes' petition alleged that the McClains' actions caused the Ramirezes and their grandchildren "extreme emotional distress." The McClains asserted that the allegations of emotion distress were sufficient to constitute bodily injury because the phrase "caused by the 'bodily injury'" modifies only mental injury, not mental anguish. State farm contended that neither mental injury nor mental anguish were covered under the policy without accompanying physical injury. The court denied the McClains attempt to invoke "the rule of the last antecedent" as "tortured"

because it "relies too heavily on the absence of a comma between 'injury' and 'caused.'"

In conclusion, the court held that the "clearly written provision means exactly what it says: Stand-alone claims for the recovery of damages for mental anguish or other mental injury are not covered by the policy."

"Other" Insurance Clauses Only Knocked Out When in Direct Conflict.

Scottsdale Ins. Co. v. Steadfast Ins. Co., 2017 WL 661520, at *1 (S.D. Tex. Feb. 17, 2017)

This case involved a dispute between two insurers over which policy covers what part of an apartment manager's liability for negligence. Scottsdale had defended and settled a lawsuit against its insured, Kaplan Management Company, Inc. Scottsdale then sued Steadfast Company, alleging that Steadfast had issued a policy providing primary insurance coverage for the claim against Kaplan Management, obligating Steadfast to defend the underlying litigation and to contribute pro rata to the settlement. Scottsdale further alleged that Steadfast's insurance coverage is primary to Scottsdale's excess insurance policy, and that Steadfast's coverage should have been exhausted before Scottsdale was required to contribute under its excess policy. Both insurers moved for summary judgment: Scottsdale arguing for contribution, and Steadfast arguing that it only issued Kaplan Management an excess insurance policy and that Scottsdale did not make a *prima facie* showing of Kaplan Management's liability for the settlement amount.

Scottsdale issued a primary policy and an excess policy that contained a standard excess clause. As the court summarized: "Scottsdale's primary policy had a pro rata 'other insurance' clause, while Scottsdale's excess policy had an excess 'other insurance' clause.

Steadfast issued a $1,000,000 policy stating: "[t]his insurance is primary except when there is other insurance applying on a primary basis." If other insurance did apply on a primary basis, Steadfast's insurance was treated as excess instead as Steadfast's policy had an excess "other insurance" clause.

The court noted that conflicts involving "other insurance" clauses arise when more than one policy covers the same insured and each policy contains an "other insurance" clause that restricts its liability based upon the existence of other coverage. Under *Hardware Dealers Mut. Fire Ins. Co. v. Farmers Ins. Exch.*, 444 S.W.2d 583, 586 (Tex. 1969), when an insured would receive coverage from either one of two policies but for the other, and each contains a provision that it conflicts with a provision in the other concurrent insurance, the conflict is solved by ignoring the two offending provisions. To determine whether the contractual provisions conflicted, the court used a "but for" analysis for each policy: "If the insured would have a primary policy but for the presence of the other insurance, both insurers are primary and must contribute pro rata despite the terms of their 'other insurance' clauses."

The court determined that but for Steadfast's policy, the insured would have had a primary policy from Scottsdale requiring Scottsdale to defend the insured in the underlying suit. However, under the terms of the Steadfast policy, the insured has primary coverage regardless of the presence of other insurance. The court noted also that the absence of the Scottsdale policy would not convert the Steadfast excess policy to a primary policy.

In conclusion, the court ruled that the insured had primary coverage from Scottsdale and

excess coverage from Steadfast. "Between the two insurers, Scottsdale, and only Scottsdale had the right and duty to defend Kaplan Management in the [underlying] suit, and Scottsdale is solely responsible to pay the costs of defending the underlying suit." Further, the court noted that Scottsdale's primary coverage must be exhausted before Steadfast was required to contribute to the insured's portion of liability under Steadfast's excess policy.

General Scaling Provision

Houston Casualty Company v. Anadarko Petroleum Corporation, No. 09-14-00459-CV, 2016 WL 6809215 (Tex. App.—Beaumont Nov. 17, 2016, pet. filed).

The Beaumont court of appeals held that a general scaling provision applied to limit the amount an insurer was obligated to pay.

Following the explosion of the Deepwater Horizon, the oil spill that followed and the litigation that followed, Anadarko submitted a claim on its Energy Package Policy with Houston Casualty Company and various other underwriters ("the Underwriters"). The Underwriters agreed that they were liable on the claim, but only for twenty-five percent of the policy limit of $150 million. The Underwriters took this position based on a general scaling provision (a clause that proportionally reduces the liability of the insurer in accordance with the ownership interest of the insured) in the policy and Anadarko's twenty-five percent interest in the underlying lease for the Macondo Well.

Anadarko disagreed that the provision applied because it had been found liable in an underlying MDL case related to the Deepwater Horizon. In the underlying MDL case brought by the United States, a federal district judge entered a declaratory judgment against Anadarko and BP holding that each were jointly and severally liable for violating the Clean Water Act. The MDL case was later settled by Anadarko's co-lessee, BP.

Anadarko eventually filed suit seeking coverage for the rest of the policy limit. After competing motions for summary judgment were filed, the trial court granted Anadarko's motion. It found that the general scaling provision applied; however, it ruled that because there was an underlying declaratory judgment in the MDL case that found that Anadarko was jointly and severally liable, the scaling provision's exception also applied.

On appeal, the Beaumont court of appeals first considered the text of the policy. By the terms of the policy, Section III provided excess liability insurance coverage of $150 million per Occurrence for the Assured's Ultimate Net Loss.

The policy also contained a "Joint Venture Provision" endorsement, which provided that "the liability of Underwriters under this Section III shall be limited to the product of (a) the percentage interest of the Assured in said Joint Venture and (b) the total limit afforded the Assured under this Section III."

This general scaling provision, however, was not effective: (1) "when as a result of the circumstances of the Occurrence, the terms of the Joint Venture *agreement place the whole of the liability of the Joint Venture on the Assured*" and (2) "[when] the Assured becomes legally liable in a court of competent jurisdiction *for an amount greater than their proportionate ownership interest*."

Anadarko contended that the general scaling provision did not apply because of these two exceptions. The Underwriters argued that neither exception applied based on the terms of the policy.

The court of appeals first addressed whether the scaling provision applied at all. After considering the policy, the court held that the general scaling provision applied because the provision provided that "any liability" of the Assured shall be limited.

Next, the court addressed the first exception. While the trial court made no ruling regarding this clause, the court of appeals held that it was not applicable because the Joint Venture Agreement between Anadarko and BP did not place the "whole of the liability for the Joint Venture on" Anadarko. Indeed, even though Anadarko was jointly and severally liable in the underlying MDL case, the court of appeals held that this type of liability was not the only potential source of liability for the Deepwater Horizon incident. Anadarko had shared much of that responsibility with BP. Thus, the court held that the first exception did not apply.

Next, the court addressed the second exception. That provision provided that "[w]hen the Assured becomes legally liable in a court of competent jurisdiction for *an amount* greater than their proportionate ownership interest" the general scaling provision does not apply. Anadarko had argued that since the MDL court found that it was jointly and severally liable, that is, 100% at fault, that this clause applied. The Underwriters, on the other hand, disagreed because the MDL court had not found that Anadarko was liable for an "amount."

The court of appeals held that the Underwriters were correct. Looking at the MDL court's order, the court concluded that the MDL court's order was a declaratory judgment, which was not the same as a judgment for recovery of a particular amount. Thus, the court concluded that since "[a]n action to declare rights is not an action for money damages" there was no "amount" for which Anadarko was liable that was greater than its working interest in the lease.

Additionally, the court supported its conclusion with the definition in the policy of "Ultimate Net Loss." That term was defined as "the amount [Anadarko] is obligated to pay, by judgment or settlement, as damages." Here, according to the court, all Anadarko had was a declaratory judgment stating that it was liable. Anadarko never became obligated to pay by judgment or settlement an amount that was more than its proportionate interest in the lease. Thus, the court held that the scaling provision applied and rendered judgment for the Underwriters.

Estoppel and the Extended Reporting Period

Campmed Casualty & Indemnity Company, Inc. v. Specialists on Call, Inc., No. 4:16-CV-00452 (E.D. Tex. Jan. 26, 2017).

If an insured fails to purchase an extended reporting period for a claims-made policy, can the insurer waive or become estopped from relying on the lack of payment if the insured makes a claim within the extended reporting period and the insurer unconditionally defends the insured?

Specialist on Call, Inc. and Dr. Leonard DaSilva (together DaSilva") purchased a claims-made policy from Campmed Casualty & Indemnity Company, Inc. for the policy period of November 16, 2012 to November 15, 2013.

The policy provided that DaSilva could purchase an extended 30-day reporting period if DaSilva notified Campmed of her intent to purchase the period within 30 days after coverage expired.

On November 15, 2013, DaSilva received a demand letter from a patient claiming that she had been misdiagnosed. Thereafter, on December 2, 2013, DaSilva forwarded the demand letter to Campmed, which was within the extended reporting period.

DaSilva, however, never provided her intent to purchase the extended reporting period to Campmed.

On December 5, 2013, Campmed, advised DaSilva that Campmed would cover the case and had retained counsel to represent DaSilva. On January 7, 2014, Campmed confirmed coverage again for DaSilva.

Almost two years later, in October of 2015, the patient filed suit against DaSilva, and DaSilva alerted Campmed. Then, on October 26, 2015, Campmed issued a letter to Dr. DaSilva acknowledging its retention of counsel for her and representing that there was $1 million dollars of coverage.

Finally, on June 21, 2016, Campmed sent a denial letter to DaSilva stating that there was no coverage for the patient's lawsuit because DaSilva failed to purchase the extended reporting period.

Eight days later, Campmed filed a declaratory judgment suit in federal court against DaSilva seeking a declaration that the policy did not provide coverage. DaSilva answered the complaint and asserted the affirmative defenses of waiver and estoppel.

The district court struck DaSilva's defense of waiver but would not strike her defense of estoppel.

Here, the actions of Campmed did not amount to a waiver. There were no facts alleged that plausibly suggested that Campmed voluntarily and intentionally "abandoned its right to receive notice of a claim within the policy period."

Next, the court addressed estoppel. Relying on Virginia case law, the court stated that an insurer can waive or become estopped from denying coverage if the insurer unconditionally defends its insured. Here, Campmed had done just that with the October 26, 2015 letter where it indicated that defense counsel was retained and there was $1 million in coverage. Because there were no conditions in the letter, the court concluded that DaSilva had plausibly pled enough facts to allege estoppel.

Thus, the Court made clear that if the insured detrimentally relies upon the insurer's actions in unconditionally defending the suit, the Insurer may not later claim that the Insured failed to pay for the extended reporting period.

Overpayment On Actual Cash Value Basis Precludes Chapter 541 Claim

Triyar Companies, LLC v. Fireman's Fund Insurance Company, No. 14-14-00160-CV, (Tex. App.—Houston [14th Dist.] Feb. 9, 2017, no pet.).

The Houston Court of Appeals held that an insurer's overpayment of a claim on cash value basis defeated the insured's Chapter 541 violation if there is no other legally sufficient evidence of actual damages.

After Hurricane Ike swept through Houston in 2008, the owners of Greenspoint Mall and San Jacinto Mall, Triyar Companies, LLC ("Triyar" or "Insured") filed a claim on their commercial insurance policy with Fireman's Fund Insurance Company ("Fireman's Fund").

Under the Policy, Fireman's Fund agreed to pay "Actual Cash Value" or "Replacement Cost." But if a claim was made for "Replacement Cost," the Insured had to actually repair or replace the property as soon as reasonably practicable.

After investigating the claim, Fireman's Fund determined that "Replacement Cost" was not appropriate because the Insured failed to make the necessary repairs to the properties. Thus, Fireman's Fund paid the claims on an Actual Cash Value basis. Fireman's Fund paid $262,483 for the damage to the Greenspoint Mall and paid $3,814,273 for the damage to the San Jacinto Mall.

Triyar felt that the claims were underpaid and filed suit, alleging breach of contract, breach of an insurer's common law duty of good faith and fair dealing, and violations of Chapters 541 and 542 of the Texas Insurance Code.

After a jury trial, which lasted a month, the jury, among other things: (1) found that Fireman's Fund complied with the policy; and (2) failed to find that Fireman's Fund had violated various provisions of the Texas Insurance Code, but found that Fireman's Fund knowingly failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim when Fireman Fund's liability had become reasonably clear. Additionally, the jury found that Triyar was excused from complying with its obligation to actually repair the property because Fireman's Fund made compliance impossible.

Triyar moved the trial court to disregard the jury's answer that Fireman's Fund complied with the policy as immaterial and render judgment for Triyar based on the jury's finding that Fireman's Fund failed to effectuate a prompt settlement.

In contrast, Fireman's Fund moved the trial court to disregard the jury's findings in favor of Triyar and render judgment that Triyar take nothing because of the jury's finding that Fireman's Fund complied with the policy. The trial court granted Fireman Fund's motion, and both parties appealed.

In a strange procedural twist, the court of appeals presumed that the trial court erred in rendering a take nothing judgement for Fireman's Fund and instead addressed Fireman's Fund cross-points, which included Fireman Fund's arguments that there was no evidence to support the finding of impossibility and that Fireman's Fund was not liable to Triyar on the chapter 541 violation because Fireman's Fund had overpaid on the only legally recognizable damages.

The court first noted that Fireman's Fund had overpaid the Insured on an Actual Cash Value basis for both properties. The jury had found that the actual cash value of the San Jacinto Mall was $4,400,000. Fireman's Fund paid $3,814,273 and the applicable deductible was $2,062,147. Thus, Fireman's Fund had overpaid by $1,476,420.

The jury had also found the Actual Cash Value of the Greenspoint Mall was $2,200,000. Fireman's Fund paid $262,483 and the applicable deductible was $1,964,673. Thus, Fireman's Fund overpaid on the Greenspoint Mall by $27,156.

After concluding that Fireman's Fund had overpaid for both properties, the court then addressed whether there was legally sufficient evidence to support the jury's finding that Triyar was excused from the requirement that it repair the property

because Fireman's Fund made compliance impossible. After considering the record, the court concluded that there was simply no evidence presented by Triyar that showed that Triyar was prevented from repairing the property by Fireman's Fund's actions. To the contrary, while Triyar testified that it lacked the wherewithal to repair the property, Triyar failed to present any evidence that repairs were made impossible. For example, the court pointed out that Triyar failed to present any evidence that it had applied for and was refused financing for a loan to repair the property. Thus, the court concluded that Triyar's failure to repair the property precluded Triyar from recovering Replacement Cost and, therefore, under the policy Triyar was only entitled to recover Actual Cash Value.

The court also addressed the jury's findings that Fireman's Fund knowingly committed the conduct amounting to bad faith. The issue was whether Triyar had presented any evidence of actual damages to support such findings. Since Fireman's Fund paid more than the amounts found by the jury for the Actual Cash Value of the property damage, which were the only legally viable damage findings the jury made, there was no basis for awarding Triyar any actual damages based on any of the bad-faith claims.

Additionally, Triyar also could not recover for "temporary repairs." This was true even though Fireman's Fund's own adjuster stated that he believed that temporary repairs were provided under the policy. The court pointed out that an adjuster's subjective belief about the policy does not change the unambiguous policy language. Ultimately, the court affirmed the trial court's judgment.

Appraisal Award – Clerical Error of Failure to Include Check Did Not Matter

McEntyre v. State Farm Lloyds, Inc., No 4:15-CV-00213, 2016 WL 6071598 (E.D. Tex. Oct. 17, 2016).

A clerical error does not negate an insurers tender of a check in response to an appraisal award.

After a wind and hail storm damaged their home, Travis and Carolyn filed a claim under an insurance policy issued by State Farm Lloyds, Inc.
In March of 2013, State Farm sent an adjuster to the property to do an inspection. Finding no damage, State Farm sent a letter to the McEntyres stating that State Farm would not issue payment for their claim.

On October 24, 2013, the McEntyres sent a letter of representation to State Farm and requested information regarding the original 2013 inspection. State Farm responded by asking to re-inspect the property. The McEntyres obliged, and State Farm conducted a second inspection. After the inspection, State Farm sent the McEntyres a payment of $5,065.80 on March 21, 2014.

Not happy with this amount, the McEntyres sent a letter to State Farm on January 26, 2015, in which they invoked the Appraisal provision of their policy. State Farm accepted the McEntyres' appraisal offer, and the McEntyres and State Farm chose independent appraisers.

While awaiting a decision from the appraisers, the McEntyres filed suit in Texas state court on February 24, 2015, and State Farm promptly removed the action. The McEntyres alleged breach of contract and extra-contractual claims.

Eventually on October 7, 2015, the appraisers reached a decision for the McEntyres - $10,730.06 in damages at an actual cash value basis. State Farm learned of the award that same day. Eight days later, on October 15, 2015, State Farm sent the McEntyres a letter, which stated that a check was enclosed with the letter for $4,326.26, the amount owed from the appraisal.

Inadvertently, State Farm failed to include the check with the letter; however, the McEntyres received the check via overnight mail on October 29, 2015.

After the appraisal was completed, State Farm moved for summary judgment in the district court arguing that State Farm's payment of the appraisal award barred the McEntyres's breach of contract and extra-contractual claims. The McEntyres opposed the entry of summary judgment by arguing that (1) State Farm's payment was not timely because there was no check enclosed in the letter and (2) State Farm's initial denial of the claim was not covered by the appraisal process.

Applying Texas law, the District Court held that the policy's appraisal clause – and State Farm's payment of the appraisal award – precluded all of the McEntyres' claims. As the court explained, "[t]he 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." "To estop a breach of insurance claim a defendant must show (1) the existence and enforceability of an appraisal award; (2) the timely payment of the award by the insurer; and (3) the acceptance of the appraisal award."

Here, based on the evidence, the Court concluded that State Farm timely paid the appraisal award because it had sent the October 15, 2015 letter. This was true even though State Farm "inadvertently did not include the payment in the October 15, 2015 letter." The court stated that "[t]his clerical error does not create a fact issue as to whether State Farm timely tendered the appraisal award." State Farm's attempted tender of payment on the same day as it sent its notice of payment was enough to show a timely payment of the award.

Next the court addressed State Farm's initial denial of the claim. The McEntyres argued that State Farm's initial denial of the claim in full was evidence that the initial inspection was improper and therefore State Farm breached the contract. To the court, however, this evidence was immaterial in face of the appraisal award. "Here, Plaintiffs' entire claim was disputed and subject to appraisal." Thus, "Plaintiffs may not argue that State Farm's initial failure to pay damages equates to a breach of contract."

The court then summarily dealt with the extra-contractual claims – holding that the claims, like the breach of contract claim, were barred by the appraisal defense. Since State Farm paid timely and in full, there could be no penalty for late payment.

McEntyre illustrates the potential benefit an insurer reaps if it properly utilizes a policy's appraisal provision. Once the appraisal procedure is invoked, timely payment of the appraisal award causes the plaintiff's breach of contract and extra-contractual claims to evaporate.

What We've Got Here is a Failure to Cooperate

Metro Hospitality Partners, Ltd v. Lexington Insurance Co., No. H-15-1307, 2017 WL 1106271 (S.D. Tex. Mar. 24, 2017).

After a hailstorm ravaged the Crowne Plaza Hotel in Houston, Texas, the owner of the hotel, Metro Hospitality Partners, Ltd., filed a claim on its property insurance policy with Lexington. Lexington immediately began adjusting the claim and paid for the undisputed portion of the loss.

Thereafter, a dispute arose between the parties over the roof damage. Metro asserted that the entire roof needed to be replaced; Lexington, however, believed that the damage to the roof was not due to the hail damage but to age and poor maintenance. To resolve the dispute, Lexington asked for information from Metro to substantiate the need for a new roof and to support Metro's estimates that it would need about $3 million to fix the roof. Metro continually failed to respond and, instead of providing the documentation, filed suit against Lexington for bad faith and breach of contract.

After discovery, Lexington moved for summary judgment on both claims. The Court summarily dismissed Metro's claim for bad faith because Metro failed to present evidence of an independent injury. Then, the Court addressed Metro's breach of contract claim.

Metro had alleged that Lexington breached the contract by failing to pay adequate compensation for its claim. Lexington's main counterargument was that Metro's failure to cooperate, by failing to provide the necessary documentation to support its demand, violated the policy's "suits against us" clause. That clause provided that Metro could not sue Lexington unless all of the policy requirements had been met. One such requirement was that Metro had to cooperate with Lexington in adjusting the claim. According to Lexington, because Metro failed to cooperate with Lexington in settling the claim, Metro could not sue Lexington and the claim should be dismissed.

The court accepted Lexington's argument. Based on the evidence presented, Metro had failed to comply with its obligation to cooperate. In fact, this was undisputed by Metro who admitted that it had still not provided the documents requested by Lexington to substantiate the condition of the roof. Thus, the court concluded that Metro could not bring suit against Lexington under the no action clause.

Finding a violation of the policy, the Court then addressed the remedy. Lexington argued that the case should be dismissed; however, the Court ruled that the no action clause was a condition precedent and that a violation of this type of condition only leads to an abatement of the case. Thus, the Court gave Metro an ultimatum – provide the documents or your case will be dismissed.

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