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This newsletter is intended to summarize significant cases impacting the insurance practice since the Fall 2017 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.

Recovery of Actual Damages under Texas Insurance Code

USAA Texas Lloyds Co. v. Menchaca, 2018 WL 1866041, —S.W.3d — (Tex. Apr. 13 2018).

The Texas Supreme Court withdrew its April 7, 2017 opinion, but unanimously reaffirmed the legal principles and rules set forth in that opinion. The Court defined the primary issue as whether an insured can recover policy benefits based upon an insurer's violation of the Texas Insurance Code in the absence of a finding that the insurer breached the insurance policy. The Court went on to elaborate on the five rules announced in the original *Menchaca* opinion:

1) The general rule is that an insured cannot recover policy benefits as damages for a statutory violation if the policy does not give the insured the right to receive those benefits.

2) If the insured establishes an entitlement to receive benefits under the policy, the insured can recover those benefits as actual damages under the Texas Insurance Code if the insurer's statutory violation causes the loss of benefits.

3) However, even if the insured cannot establish a contractual right to policy benefits, the insured can recover policy benefits as actual damages under the Texas Insurance Code if the insurer's statutory violation caused the insured to lose the right to benefits.

4) If an insurer's statutory violation causes independent injury (other than a loss of benefits) the insured can recover for that independent injury even if the policy does not cover the insured's loss.

5) However, an insured cannot recover any damages based upon an insurer's statutory violation if the insured is not entitled to recover benefits under the policy and sustained no independent injury.

The general rule that an insured cannot recover policy benefits as actual damages under the Texas Insurance Code, if the policy does not provide coverage, is based upon the fundamental principle that an insured can only recover damages caused by the statutory violations. So, if the insured is not entitled to any benefits under the policy, a violation of

the Insurance Code could not cause the loss of those benefits.

USAA contended that the jury's negative answer to the question asking if USAA failed to comply with the policy precluded Menchaca from recovering policy benefits as actual damages under the Texas Insurance Code. The Court disagreed, finding that the issue is whether the insured was entitled to benefits under the policy.

In other words, if the insured was entitled to benefits under the policy and the insurer's statutory violation caused the insured to lose those benefits, the benefits are recoverable under the Texas Insurance Code even in the absence of an independent injury or a finding of breach of contract. The Court reconciled *Vail, Stoker* and *Castaneda*, noting that *Stoker* and *Castaneda* both stand for the general proposition that an insured cannot recover policy benefits as damages for an extra-contractual violation if the policy does not give the insured a right to those benefits. *Vail*, on the other hand, stands for the proposition that if the insured is entitled to benefits under the policy, the insured can recover those benefits as actual damages resulting from a statutory violation.

Even if the policy does not give the insured a right to benefits, however, if the insurer misrepresents the policy's coverage in violation of the Insurance Code, the insured can recover actual damages in the amount the insured reasonably believed she was entitled to receive. In addition, if the insurer's statutory violation prejudices the insured, the insurer can be estopped from denying benefits "that would be payable under its policy as if the risk had been covered." And, an insurer can be liable for policy benefits under the Texas Insurance Code if the insurer's statutory violations actually causes the policy not to cover the loss. For example, where a policy's limits were exhausted by the payment of claims of others during the insurer's delays in adjusting the claim, the policy benefits that would have been payable had the claim been adjusted in a timely fashion were recoverable as actual damages.

There are two aspects to the independent injury rule. First, if an insurer's statutory violation causes an independent injury, the insured can recover for that injury despite the fact that the policy does not entitle the insured to any policy benefits. Second, an insured may not recover any damages beyond policy benefits unless the violation causes an independent injury.

Finally, an insured cannot recover any damages based upon a violation of the Texas Insurance Code unless the insured establishes either that the insured is entitled to policy benefits, or an independent injury.

The Court went on to offer suggestions regarding submitting breach of contract and statutory violation claims to the jury in order to avoid conflicting findings.

Ancillary Complications Stemming from an Accidental Bodily Injury may not Serve as Concurrent Proximate Causes of an Accidental Death

Wells v. Minnesota Life Insurance Company, 885 F.3d 885 (5th Cir. 2018).

The Fifth Circuit recently addressed whether an insured's death after being bitten by a mosquito carrying the West Nile Virus was covered under an accidental-death policy. In reversing the District Court's summary judgment in favor of the insurer on the breach of contract issue, the Fifth Circuit found that fact issues existed as to whether a mosquito bite was an accidental bodily injury, whether West Nile Encephalitis was the sole

proximate cause of the insured's death, and whether an exclusion for conditions existing when an accident happened precluded coverage. The Fifth Circuit affirmed the trial court's summary judgment as to the extra-contractual claims.

Melton Dean Wells, age 68, went to the hospital on August 21, 2013 for a fever, headache, and altered mental status. At the hospital, Melton was diagnosed with West Nile Encephalitis, which is caused by West Nile Virus. West Nile Virus is carried and transmitted to humans by the Culex mosquito. Over the next three weeks, Melton's condition deteriorated as he developed respiratory failure, multi-system organ failure, and septic shock. Melton died on September 17, 2013. On his death certificate, the certifying physician marked Melton's death as "natural," rather than as an "accident."

Melton was insured under a Decreasing Term Accidental Death Insurance Policy issued by Minnesota Life Insurance Company. This policy provided coverage:

> only when your death results, directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected and unforeseen. The bodily injury must be evidenced by a visible contusion or wound... The bodily injury must be the sole cause of your death... Your death must occur within 90 days after the date of the accidental injury.

However, the policy also contained the following exclusion:

> In no event will we pay the accidental death benefit where your death is caused directly or indirectly by, results from, or there is contribution from... bodily or mental infirmity, illness or disease...

Following Melton's death, his widow, Gloria Wells, submitted a claim under the policy for accidental-death benefits. She told Minnesota Life that a mosquito caused Melton's death. Minnesota Life denied her claim on the grounds that Melton's death was not the direct and independent result from an accidental bodily injury. Rather, Minnesota Life took the position that Melton's West Nile Encephalitis was exacerbated by his diabetes, obesity, and age. Furthermore, Minnesota Life asserted that exclusion number four precluded coverage because an accidental bodily injury did not cause Melton's death directly and independently from all other causes. Instead, his death was contributed to by bodily or mental infirmity, illness, or disease—namely, his respiratory failure, multi-system organ failure, and septic shock.

Gloria subsequently filed suit against Minnesota Life alleging breach of contract, breach of the duty of good faith and fair dealing, violation of the Texas Insurance Code, and violation of the Texas Deceptive Trade Practices Act. Gloria argued that her claim fell within the policy's insuring agreement because Melton's mosquito bite, a visible wound/contusion, was an unintended, unexpected, and unforeseen accidental bodily injury that resulted in West Nile Encephalitis that was a substantial factor in bringing about Melton's death. Minnesota Life moved for summary judgment on all of Gloria's claims and the district court granted the motion in its entirety. The district court held that Gloria's insurance claim did not fall under the insuring clause because she did not satisfy the "sole cause" requirement due to septic shock, respiratory failure, and multi-system failure all contributing to Melton's death.

On appeal, the Fifth Circuit noted that under Texas law, to recover benefits under an accidental death policy that limits coverage to death from an accidental injury "independently of other causes," the accident must be the "sole proximate cause" of death. Applying this concept to Melton's death, the Fifth Circuit stated that Gloria could recover benefits if the mosquito bite was the sole proximate cause of his death with no concurrent proximate causes acting alongside it. Agreeing with Gloria's argument, the Court concluded that complications arising from, solely because of, and dependent upon the accidental injury (i.e., Melton's respiratory failure, multi-system failure, and septic shock brought on by West Nile Encephalitis) may not be concurrent proximate causes of an accidental death sufficient to strip the accident of its "sole proximate cause" status. As a result, the district court's grant of summary judgment to Minnesota Life was reversed, and the case remanded.

However, the Fifth Circuit found that whether the policy covered Melton's death was a close call. There was evidence supporting both sides of the argument. Therefore, the court held that Minnesota Life had a reasonable basis for denying Gloria's claim, so the court affirmed the district court's summary judgment as to Gloria's extra-contractual claims.

Fortuity Doctrine Precludes Duty to Defend and Indemnify

Wesco Ins. Co. v. Layton, No. 17-10362, 2018 WL 1472937 (5th Cir. Mar. 26, 2018).

The Fifth Circuit held that the fortuity doctrine precluded an insurer's duty to defend and indemnify the insured for allegations of a breach of fiduciary duty by an attorney when the insured/attorney had notice of the allegations in the original petition before inception and his knowledge of the acts underlying those claims meant that the insured knew the loss was ongoing when he obtained the policy.

Plaintiffs, Gwendolyn Gene and Troylynn Ann Layton, sued their long time attorney and friend, Ledford White, for fraud and breach of fiduciary duty on August 16, 2013. They claimed that they had twice loaned White or his colleagues $400,000.00, only to have White lie about his ability to repay them and enrich himself off of the loan proceeds. In March of 2014, White purchased a claims-made-and-reported Lawyers Professional Liability Policy from Wesco Insurance Co. for himself and his firm, White, P.C. He notified Wesco of the lawsuit in May of 2014. Later that month, the plaintiffs filed an amended petition, alleging the same facts and fraud claims, but adding White, P.C. as a defendant and adding allegations of legal malpractice.

After a jury returned a verdict against White and White, P.C, Wesco filed a declaratory action in federal district court, seeking a judgment of no coverage. Wesco moved for summary judgment, arguing that the fortuity doctrine precluded coverage because White knew of the original petition prior to obtaining the policy. The district court granted the motion, and the Fifth Circuit affirmed. The Court observed that the original petition alleged breach of fiduciary duty, which fell squarely within the Policy's definition of legal services. To the Court, even though White claimed that he did not know the original petition alleged a covered claim, this knowledge was immaterial.

As the Court put it, the key question under the fortuity doctrine is whether the wrongdoing was alleged to have occurred before the purchase of the insurance sufficient to put

White on notice of an ongoing, potential loss. Here, according to the Court, even if White did not know the petition alleged a covered claim, he should have known that an ongoing loss existed when he purchased the policy, since he knew about the underlying acts. This knowledge was also imputed to his firm, White, P.C. Although the firm was not named as a defendant until the first amended petition (filed within the policy period), the imputed knowledge still invoked the fortuity doctrine and barred coverage.

Discovery Seeking Evidence of Insurance Claims by Other Insureds are Overbroad

In re Allstate Ins. Co., 04-18-00060-CV, 2018 WL 1610927 (Tex. App.—San Antonio Apr. 4, 2018, no pet.).

Discovery requests served on an insurer seeking information related to claims by other insureds, even when limited in scope by date and location, is an impermissible fishing expedition.

Allstate Insurance Company ("Allstate") issued an insurance policy on Plaintiff Brian Jones' property in San Antonio. After an April 2016 hailstorm, Jones filed a claim with Allstate, which it denied in part. Jones filed suit and served Allstate with discovery, including two requests seeking information about other claims filed by Allstate's other insureds arising out of the same hailstorm. Allstate objected to producing that information, and Jones moved to compel. The disputed discovery requests and the trial court's ruling on each are as follows:

> **Request for Production 1:** Produce any and all documents, relating to or arising out of any and all claims filed by your insured(s) and/or paid by you arising out of the hail storm(s) on or about April 2016, within a 5 mile radius of 103 Tabard Dr., San Antonio, Texas 78213.
>
> **Trial court ruling:** Overrules Defendant's objection(s) to Plaintiff's First Request for Production, production number 1, and compels Defendant to fully respond within 14 days. Limited to Zip Codes 78213, 78201 and 78230 only to investigation and photos and photos produced in native format.
>
> **Interrogatory 17:** Please state the address, name, and telephone number of every insured of you [sic] within a 5 mile radius of 103 Tabard Dr., San Antonio, Texas 78213 in which you paid for any damage relating to the event, resulting out of a litigation, mediation, claim, or otherwise.
>
> **Trial court ruling:** Overrules Defendant's objection(s) to Plaintiff's First Set of Interrogatories, interrogatory number 17, and compels Defendant to fully respond within 14 days. Limited to Zip Code 78213 and produce for in camera review.

Allstate filed a petition for writ of mandamus complaining about only those two rulings. Jones defended his requests, arguing they were limited in scope to only claims arising out of the same hailstorm near Jones' home.

The court of appeals conditionally granted Allstate's petition, relying primarily on the Texas Supreme Court's decision in *In re National Lloyds Ins. Co.*, 449 S.W.3d 486 (Tex. 2014). The court of appeals noted that, whether a request for discovery is overbroad is distinct from whether it is burdensome or harassing. Overbroad requests for irrelevant information are improper whether they are burdensome or not, and how an insurer may

have handled the claims of unrelated third parties is not probative of its conduct with respect to Jones' claims. Scouring claim files in hopes of finding similarly situated claimants whose claims were evaluated differently in order to prove that the insurer breached the contract is, at best, an impermissible fishing expedition. As a result, the trial court's order compelling discovery of such information was necessarily overbroad.

Misrepresentation Exclusion Explained

Columbia Lloyds Ins. Co. v. Liberty Ins. Underwriters, Inc., No. 3:17-CV-005, 2018 WL 1569718 (S.D. Tex. March 14, 2018) *adopted by* 2018 WL 1561816 (S.D. Tex. March 30, 2018).

Common law "misrepresentation defense" and 90-day statutory notice requirement do not apply to a policy exclusion which excludes claims arising from a misrepresentation in the application. However, damages must bear more than an "incidental relationship" to the misrepresentation for the exclusion to apply

Columbia Lloyds Insurance Company ("Columbia"), its subsidiary, MDOW Insurance Company ("MDOW"), and Columbia's shareholders, John Dunn and Milby Dunn, II (the "Dunns"), (collectively the "Insureds"), brought suit against Liberty Insurance Underwriters, Inc. ("Liberty") seeking a declaration that Liberty was obligated to defend them in an underlying state court action (the "State Court Lawsuit") and an arbitration proceeding (the "Arbitration Proceeding").

Prior to the two underlying proceedings, MDOW had retained FarmAssure, LLC ("FarmAssure") as the exclusive managing general agent to sell farm insurance in Oklahoma. Jeffrey Mann was the President and Chief Executive Officer of FarmAssure. Under an arrangement, Mann also was hired to act as Columbia's President and Chief Executive Officer. Columbia later terminated Mann and shortly thereafter hired Sam Bana, a former FarmAssure executive, as its Chief Operating Officer.

Two months after Mann was terminated and a month after Bana was hired, Columbia completed an application to renew Columbia's and MDOW's Directors and Officers liability policy with Liberty. In the application, Columbia was asked "Has the Applicant experienced changes to its Board of Directors or to its Key Executives over the past 12 months?" To this question, Columbia answered "No." Liberty thereafter issued the Directors and Officers liability policy to Columbia (the "Policy"), which contained an exclusion providing that "in the event there is any misstatement or untruth in the answers to the questions contained herein [including the application], Insurer have [sic] the right to exclude from coverage any claim based upon, arising out of, or in connection with such misstatement or truth" ("Application Exclusion").

Thereafter, the Dunns sued FarmAssure in their capacity as FarmAssure's minority shareholders, seeking an inspection of FarmAssure's corporate books and records, as well as an accounting. FarmAssure counterclaimed against the Dunns, alleging the Dunns, in their capacity as officers and directors of Columbia, "perpetrate[d] a campaign of disparagement, fraud and other tortious conduct aimed at destroying FarmAssure's reputation in the insurance industry," and asserting causes of action alleging: (1) business disparagement; (2) defamation; (3) usurpation of corporate opportunities and breach of the duties of loyalty, good faith, and fair dealing; (4)

conspiracy to tortiously interfere with FarmAssure's customer contacts; (5) conspiracy to tortiously interfere with a contract; (6) conspiracy to tortiously interfere with prospective business relations; (7) conspiracy to defraud FarmAssure; and (8) unjust enrichment.

In addition to the counterclaims in the State Court Action, FarmAssure initiated the Arbitration Proceeding against Columbia and MDOW, complaining that Columbia and MDOW engaged in an "active effort to disparage FarmAssure among its customers, agents and reinsurance partners" and "misappropriated[ed] FarmAssure's methods, ideas, and process for their own gain," while asserting causes of action for: (1) tortious interference with FarmAssure's customer and agent contracts; (2) tortious interference with a contract; (3) tortious interference with prospective business relations; (4) business disparagement; (5) breach of the Restated Managing General Agency Agreement between Columbia, MDOW, and FarmAssure; (6) breach of the Cooperation Agreement between Columbia, MDOW, and FarmAssure; (7) tortious interference by Columbia with the Restated Managing General Agency Agreement; (8) fraud; (9) theft of trade secrets; and (10) unjust enrichment.

The Insureds tendered the defense and indemnity of the State Court Lawsuit and the Arbitration Proceeding to Liberty. Liberty declined coverage, claiming the misrepresentation in the application triggered the Application Exclusion. The Insureds then initiated the coverage lawsuit against Liberty seeking declaratory relief and alleging breach of contract and violation of Section 542.060 of the Texas Insurance Code. The Insureds moved for partial summary judgment, seeking a declaration that Liberty had a duty to defend the Insureds in the State Court Lawsuit and the Arbitration Proceeding and that Liberty's prior denial breached the Policy, while Liberty simultaneously moved for summary judgment, seeking a declaration that it did not owe a duty to defend or indemnify the Insureds due to the Application Exclusion, as well as seeking dismissal of the Insureds' Texas Insurance Code claim.

In the initial issue, the magistrate judge considered whether the "misrepresentation defense" under Texas common law, which allows an insurer to void or rescind a policy based on the insured's misrepresentation, applied to the Application Exclusion and whether Liberty had failed to plead and prove the elements necessary to rely on the Application Exclusion. Liberty argued that the "misrepresentation defense" did not apply because it was seeking to be bound by and to enforce the express terms of the Policy, not to void or rescind the Policy. Finding the cases relied upon by the Insureds as readily distinguishable, the Court agreed with Liberty and held that the "misrepresentation defense" did not apply.

Next, the Court considered whether Liberty was required to comply with the 90-day notice requirement under Section 705.005(b) of the Texas Insurance Code which provides that "[a] defendant may use as a defense a misrepresentation made in the application for or in obtaining an insurance policy only if the defendant shows at trial that before the 91st day after the date defendant discovered the falsity of the representation, the defendant gave notice that the defendant *refused to be bound by the policy* (emphasis added). Relying on the canon of statutory construction that, absent an absurd result, a court must enforce the plain language of a statute, the Court held the statutory language was clear and unambiguous and did not apply to Liberty's defense because Liberty, again,

was not refusing to be bound by the Policy, but rather was seeking to enforce the specific terms of a policy exclusion.

After finding that the claims in the State Court Lawsuit and the Arbitration Proceeding potentially fell within the Policy's insuring agreement, the Court then turned to whether the Application Exclusion precluded a duty to defend in both underlying proceedings. Looking to the language of the Application Exclusion and recognizing the burden on the insurer to show an exclusion applies to all claims alleged against an insured to avoid a duty to defend, the Court stated it was its duty to determine if "all of FarmAssure's alleged damages, as supported by its factual allegations, are 'based upon, arising out of or in connection with [the] misstatement or untruth' in the Application *e.g*. that there were no changes to Columbia Lloyds' Board of Directors or Key Executives during the preceding 12 months."

Reviewing the counterclaims in the State Court Lawsuit, the Court noted that none of the allegations in the pleadings – namely, that the Dunns' conspired to "perpetrate a campaign of disparagement, fraud and other tortious conduct aimed at destroying FarmAssure's reputation in the insurance industry, eliminating FarmAssure as a potential competitor, cutting FarmAssure out of its own programs and stamping out FarmAssure's ability to service its customers, agency relationships, and other partnerships" – appeared to have any relation to the change in Columbia's executive leadership. While the termination of Mann and the hiring of a new Chief Operating Officer was indeed mentioned in the pleadings, the change in leadership was presented as nothing more than a background fact.

Nevertheless, Liberty took the position that in order to establish a sufficient causal connection between the misrepresentation and the harm, it needed only to demonstrate an "incidental relationship" between the change in leadership and FarmAssure's alleged damages, which it argued in fact existed because Mann's termination began the course of conduct allegedly designed to steal business from FarmAssure. In response, the Court identified the "arise out of" language in the Application Exclusion which has been interpreted as creating a "but for" causation standard, as well as the principle that an insurer must provide coverage when a covered event and excluded event each independently cause a plaintiff's injury. Based on these guidelines, the Court found that the change in leadership was, at most, a separate and independent cause of many of FarmAssure's damages because the damages could have occurred without the change in leadership, while other damages appeared to have no relationship to the change in leadership, such as the Insureds' alleged disparaging and fraudulent statements about FarmAssure. Accordingly, the Application Exclusion did not negate Liberty's obligation to defend the Insureds in the State Court Lawsuit. Further, finding that the damages and alleged factual allegations presented in the Arbitration Proceeding were substantially similar to those the State Court Lawsuit, the Court held Liberty must also defend the Insureds in the Arbitration Proceeding.

The magistrate judge therefore recommended that the Insured's Partial Motion for Summary Judgment be granted and that Liberty's Motion for Summary Judgment be denied. On March 30, 2018, the district court accepted and adopted the magistrate's recommendations.

Drunk Driving Wreck is not an "Accident" or "Occurrence"

Frederking v. Cincinnati Ins. Co., No. SA-17-CV-651-XR, 2018 WL 1514095 (W.D. Tex. Mar. 27, 2018).

Judge Xavier Rodriguez held that a drunk driving collision was not an accident because the collision was the natural and expected result of the insured's intentional act of driving while intoxicated.

Sanchez was involved in an automobile collision while operating a vehicle owned by his employer, Advantage Plumbing Services ("Advantage"). The jury found that Sanchez was negligent and that Advantage negligently entrusted its vehicle to Sanchez. The jury further found that Sanchez was grossly negligent. The jury awarded actual damages against Sanchez and Advantage and exemplary damages against Sanchez.

Advantage was covered by a Commercial Auto Policy that covered bodily injury caused by an "accident" and a Commercial Umbrella Policy that covered bodily injury caused by an "occurrence." The insurer paid the actual damage award in full, but refused to pay the exemplary damage award. Frederking, the plaintiff in the underlying lawsuit, brought suit against the insurer seeking to recover the exemplary damage award.

The insurer moved for summary judgment on three grounds: (1) Sanchez's gross negligence was not an "accident" or an "occurrence;" (2) exemplary damages are not insurable as a matter of Texas public policy; and (3) Sanchez was not an insured because he did not have Advantage's permission to operate the vehicle.

The court granted the insurer's motion for summary judgment on the first ground, holding that Sanchez intentionally became intoxicated and operated a vehicle, that the collision was the natural and expected result, and that Frederking's injuries were highly probable. Thus, the court concluded that the collision was neither an "accident" under the Commercial Auto Policy, nor an "occurrence" under the Umbrella Policy.

The court relied heavily on *Trinity Universal Insurance Co. v. Cowan*, 945 S.W.2d 819 (Tex. 1997) and *Wessinger v. Fire Insurance Exchange*, 949 S.W.2d 834, 841 (Tex. App. – Dallas 1997, no writ), although the facts of those cases were quite different. *Cowan* involved a clerk at a photo lab who intentionally copied revealing photographs of the plaintiff and showed them to his friends. The Texas Supreme Court held that what the clerk did was not an accident because he did exactly what he intended to do. In *Wessinger*, the plaintiff became intoxicated and repeatedly hit someone in the head, causing severe injuries.

The court did not address the *Cowan* court's rejection of Trinity's contention that there can be no accident if an actor intended to engage in the conduct that gave rise to the injury. In rejecting Trinity's argument to that effect, the Texas Supreme Court stated that "adopting Trinity's approach would render insurance coverage illusory for many of the things for which insureds commonly purchase insurance."

Unfortunately, the court did not reach the other grounds in the insurer's motion, including whether it was against Texas public policy to insure against exemplary damages.

Letter Requesting Proof of Loss Coupled with Denial of Uncovered Damage was Sufficient to Trigger Accrual of Flood Insurance Claim

Ekhlassi v. National Lloyds Ins. Co. and Auto Club Indemnity Co., No. H-17-1257, 2018 WL 341887 (S.D. Tex. Jan. 9, 2018).

Judge Rosenthal held that a letter sent by an insurer that stated that payment could not be mailed until the insurer received a signed proof of loss triggered the one-year limitations period for flood claims when the letter also informed the insured that the insurer was denying payment for anything not subject to direct physical loss from the flood.

Ali Ekhlassi obtained flood insurance for his Houston home from National Lloyds for 2015. After a storm damaged Ekhlassi's home in May of 2015, he filed a claim, asserting nearly $275,000.00 in flood damage. After inspecting the property, National Lloyds' inspector recommended paying only $3,700.00. Then, on its own initiative, National Lloyds notified Ekhlassi via letter in October of 2015 that it could not process Ekhlassi's claim until he filed a sworn proof of loss. The letter also notified Ekhlassi preemptively that National Lloyds was denying payment for "any building and contents items not subject to direct physical loss by or from flood" and "all non-covered items located below the lowest elevated floor of your post-FIRM elevated building."

After receiving the October letter, Ekhlassi sent in the sworn proof of loss in December of 2015, claiming approximately $275,000.00 in flood damage. In January of 2016, National Lloyds notified Ekhlassi via letter that it was rejecting his proof of loss and stated that it would only pay the $3,700.00. The letter referred Ekhlassi to the prior October letter for the reasons.

Ekhlassi then filed suit exactly one year from the January letter alleging breach of contract. National Lloyds moved for summary judgment, claiming that the one-year limitations period was triggered by its October 2015 letter, not the January 2016 letter. Judge Rosenthal agreed. Despite the fact that the October letter was sent to the insured before a signed proof of loss was filed, the court concluded that the October letter began the limitations period because the October 2015 letter stated that "we are denying payment for all non-covered items." The court held that this letter makes clear that National Lloyds was denying the majority of Ekhlassi's claim at that time, thereby triggering limitations and making Ekhlassi's suit untimely.

Primary May Exhaust Limits by Exchanging Limits for a Covenant Not to Execute

Aggreko, LLC v. Chartis Specialty Ins. Co., No. 1:16-CV-00297-MAC (E.D. Tex. Mar. 12, 2018).

Judge Crone held that a primary insurer may exhaust its policy limits by exchanging them for a Covenant Not to Execute in favor of its insured.

This case arises out of the death of James Andrew Brenek, II. In 2014, James was fatally electrocuted at a well site in Texas after touching an electronically-energized generator during his employment with Guichard Operating Company, LLC. The generator was provided by Aggreko. The rig site was owned by Rutherford Oil Company.

At the time of the accident, Guichard held a primary policy with Gray Insurance

Company with $1 million in limits subject to a $50,000.00 self-insured retention. The Gray policy listed Aggreko as an additional insured. The Gray policy also provided that Gray's "right and duty to defend ends when [it has] used up the applicable limit of insurance in the payment of judgments or settlements." Guichard also had an excess policy with Chartis Specialty Insurance Company with $5 million in limits subject to a $1 million retained limit.

The parents of James (hereafter Plaintiffs) filed suit against Aggreko in January of 2015. Aggreko then tendered its defense to Gray. Gray accepted the defense of Aggreko in the underlying suit. At a later date, Chartis, notified Aggreko that Aggreko was not entitled to coverage as an additional insured under the Chartis policy.

Aggreko then filed suit in federal court seeking a declaration, among other things, that Aggreko was entitled to coverage under the Chartis policy. In the interim, as Gray was defending Aggreko in the underlying suit, Gray reached two agreements with the Plaintiffs. The first agreement was a "Covenant Not To Execute Agreement" where Gray agreed to pay the Plaintiffs $950,000.00 in exchange for providing Aggreko with a covenant not to execute that limited Plaintiffs' execution on any judgment to any insurance company policy and forbidding Plaintiffs from executing against the assets of Aggreko. The second agreement was entitled a "Release and Settlement Agreement" where Gray provided $50,000.00 to the Plaintiffs for a release of Rutherford.

Gray then issued both checks to Plaintiffs and asserted that it had exhausted its policy limits under the Gray policy. Gray then withdrew its defense of Aggreko. Aggreko's own primary insurer, Indian Harbor, picked up the defense of Aggreko and then filed suit against Gray seeking a declaration that Gray was required to defend Aggreko and pay Indian Harbor for its defense costs, among other things. Aggreko's suit and Indian Harbor's suit were then consolidated.

Gray then filed a motion for summary judgment arguing that it had exhausted its policy limits and seeking a declaration that it had no duty to defend or indemnify Aggreko. Chartis, Indian Harbor, and Aggreko opposed the motion, and Indian Harbor filed a cross-motion requesting that the Court hold that the Covenant Not To Execute was not a final settlement and that Gray had an ongoing duty to defend and had an obligation to reimburse Indian Harbor for picking up the defense of Aggreko.

After holding that Texas law applied to the dispute, the court examined the nature of the Covenant Not To Execute. Initially, the Court noted that Gray's obligations to Aggreko ceased when Gray had "used up the applicable limit of insurance in the payment of judgments or settlements." To the court, the issue was whether the Covenant Not To Execute could be considered a "settlement."

Indian Harbor argued that the Covenant Not To Execute should not be considered a settlement because it did not terminate any of the claims asserted by Plaintiffs against Aggreko. While on one hand recognizing that Texas law defined a settlement to mean "the conclusion of a disputed or unliquidated claim, and attendant differences between the parties, through a contract in which they agree to mutual concessions in order to avoid resolving their controversy through a course of litigation," the Court still sided with Gray. Although recognizing that a Covenant Not To Execute was a contract rather than a release, the Court held that the Plaintiffs' claims "against Aggreko's assets have been

fully resolved." This was enough for the Court, in accordance with both relevant Fifth Circuit and Texas case law in support, to hold that the Covenant Not To Execute was a settlement and that Gray's duty to defend and indemnify had terminated.

"Expected and Intended" Consequences Narrowly Interpreted in Construction Context.

Greystone Multi-Family Builders, Inc., v. Gemini Ins. Co., H-17-921, 2018 WL 1579477 (S.D. Tex. April 2, 2018).

Judge Miller ruled that a number of failures at a construction site by subcontractors were not the "expected or intended" consequences of mis-management by contractor, and that an insurer had a duty to defend based on allegations arising from the mis-management.

This is a duty to defend lawsuit arising out of the alleged breach of a construction contract. Greystone Multi-Family Builders, Inc. ("Greystone") had entered into a contract with TPG (Post Oak) Acquisition, LLC ("TPG") to perform services as a general contractor on a construction project. Greystone did not complete its obligations under the contract and asserted the failure was based in part on TPG's failure to make timely payments. TPG eventually terminated the construction contract and hired Allied Realty Advisors ("Allied") to complete the construction. Greystone sued TPG and Allied in state court.

TPG filed a counterclaim against Greystone alleging Greystone breached the construction contract. When requested, Gemini denied coverage for Greystone, asserting that it was not obligated to indemnify or defend Greystone for property damage that occurred while Greystone was performing (ongoing) operations nor property damage caused by mold. In response to Greystone's second request, Gemini stated it had no duty to defend or indemnify Greystone because Greystone never completed its work and the property damage alleged therefore occurred during Greystone's operations. Greystone filed suit against Gemini, the magistrate recommended (in part) that the duty to defend existed, and Judge Miller upheld the ruling.

The main issues Gemini highlighted in the counterclaim to support its contention that the events outlined in the counterclaim did not qualify as an "occurrence" were the allegations that Greystone hid costs so that it could continue to collect its contractor's fees, paid subcontractors up front so that it could collect higher contractor's fees resulting in lower incentive for them to complete their work, and withheld information from TPG, all of which Gemini contends resulted in predictably poor workmanship.

The Gemini policy issued to Greystone defined an "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." Both parties relied on *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, 242 S.W.3d 1 (Tex. 2007) to support their arguments that the counterclaim did or did not allege an "occurrence."

In *Lamar Homes*, the Texas Supreme Court held that "a claim does not involve an accident or occurrence when either direct allegations purport that the insured intended the injury…or circumstances confirm that the resulting damage was the natural and expected result of the insured's actions, that is, it was highly probably whether the insured was negligent or not." The court noted that the "determination of whether an insured's faulty workmanship was intended or accidental is dependent on the facts and

circumstances of a particular case." In this case, Greystone contended that there were not any allegations in the counterclaim that Greystone intended the defective work or resulting damage and that, while the counterclaim asserted that Greystone intended the deficiencies, this does not mean it intended for any damage to occur. Gemini argued that the counterclaim indicated that the injury was the "predictable result" of Greystone's actions.

Ultimately, the court concluded that, while the inflammatory language highlighted by Gemini provides the temptation to conclude that the alleged damages were the "natural and expected result" of Greystone's actions, there were a number of factual allegations, upon careful review, which the court found did not necessarily relate to the "expected" result of Greystone paying its subs up front and mis-managing the site – including "the framing subcontractor allegedly failed to construct frames with the required amount of studs, often using only one when the plans called for two or three; Greystone installed power conduit's under the building's garage and these were later lost or destroyed when concrete was poured over them; the masonry subcontractor installed the trash-chute walls without leaving access to install the trash chutes, which required retrofitting of the doors; Greystone builders 'forgot to install' pipe; and the emergency exit door was literally installed backwards."

Additionally, with regard to the arguments that the "your work" exclusion would apply, the court refused to consider extrinsic evidence in that regard as it would overlap the merits of the case.

In short, the value of the opinion appears to lie in the continuously broad interpretation of the duty to defend, even in light of *Lamar Homes*' language regarding foreseeable consequences perhaps giving rise to expected or intended injuries.

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