RIGHT OFF THE PRESS (PARTS I AND II): UPDATE ON RECENT INSURANCE DECISIONS IN THE SUPREME COURT OF TEXAS AND BEYOND

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I. *Christus Health Gulf Coast v. Aetna, Inc.*, 397 S.W.3d 651 (Tex. 2013)

On April 19, 2013, the Supreme Court of Texas, in a question of pure statutory interpretation, held that the Texas Prompt Pay Statute, which entitles physicians and providers to swift payment of undisputed healthcare claims, requires contractual privity between providers and health maintenance organizations ("HMOs") in order to be enforced. *See Christus Health Gulf Coast v. Aetna, Inc.*, 397 S.W.3d 651 (Tex. 2013).

A. Background Facts

Christus Health Gulf Coast, Christus Health Southeast Texas, Gulf Coast Division, Inc., Memorial Hermann Hospital System, and Baptist Hospitals of Southeast Texas (the "Hospitals") sued Aetna, Inc. and Aetna Health, Inc ("Aetna") for allegedly violating the Texas Prompt Pay Statute. *See* TEX. INS. CODE ANN. § 843.336–.344. Aetna and its predecessor provided a Medicare plan through an HMO called NYLCare. It delegated the administration of its NYLCare plan, including claims processing, to North American Medical Management of Texas ("NAMM"), which is a third-party administrator. IPA Management Services ("IPA"), a physician owned affiliate of NAMM, was formed to provide the actual primary care and specialist medical services to NYLCare enrollees. IPA separately entered into contracts with the Hospitals to secure hospital services for the NYLCare enrollees. Aetna was not a party to these contracts and did not take part in their drafting. Aetna paid IPA a capitated fee, or fee per enrollee, for medical care provided to enrollees. NAMM and IPA began facing financial difficulties and notified Aetna of their resultant insolvency. Aetna then de-delegated NAMM and immediately assumed responsibility for claims processing and payment, but instructed the Hospitals to continue submitting their bills to NAMM. Aetna then refused to pay more than $13 million that the Hospitals had billed to NAMM for services rendered to NYLCare enrollees before Aetna de-delegated NAMM as its claims processor. *Id.* at 652–53.

In a prior holding in the case, the Supreme Court of Texas held that determining Aetna's responsibility for unpaid bills was within the trial court's jurisdiction. *See Christus Health Gulf Coast v. Aetna, Inc.*, 237 S.W.3d 338 (Tex. 2007). Accordingly, the Hospitals then claimed that Aetna was liable under the Prompt Pay Statute for NAMM's failure to timely pay claims. At trial, the Hospitals moved for summary judgment on Aetna's alleged violation. Aetna filed a cross-motion for summary judgment, arguing that it was not responsible for the $13 million in outstanding bills because of prepaid capitated fees. The trial court granted Aetna's motion for summary judgment and denied the Hospitals' motion. The court of appeals affirmed, concluding "that the plain language of the Prompt Pay Statute requires contractual privity between the HMO and the provider." *Christus Health*, 397 S.W.3d at 653 (quoting the court of appeals decision). Simply put, the court of appeals found that, because the Hospitals entered into contracts with IPA and not Aetna directly, the Hospitals have no viable prompt payment claim.

B. Analysis by the Supreme Court of Texas

The Court began its analysis by noting that this is a pure statutory-construction case and as such, the analysis began with the Legislature's chosen language. Specifically, the statute provides, in pertinent part, as follows:

> (c) Not later than the 45th day after the date that the health maintenance organization receives a clean claim from a physician or provider, the health maintenance organization shall:
>
> (1) pay the total amount of the claim in accordance with the contract between the physician or provider and the health maintenance organization;
>
> (2) pay the portion of the claim that is not in dispute and notify the physician or provider in writing why the remaining portion of the claim will not be paid; or
>
> (3) notify the physician or provider in writing why the claim will not be paid.

Id. at 654. Thus, the Court held, an HMO is only required to pay within the 45-day deadline "the total amount of the claim *in accordance with the contract between the physician or provider and the health maintenance organization*." *Id.* (emphasis in original). The Court then noted that the penalty likewise shows there must be a direct HMO-provider contract. If an HMO fails to pay within the statutory time limit, it is penalized with the "contracted penalty rate." *Id*. The key inquiry, the Court held, is "[w]hat duties did Aetna have under the Insurance Code?" *Id.* at 655. This inquiry overcame the Hospitals' argument that the unambiguous statutory language requiring contractual privity is trumped by the overall structure of the statute. Specifically, the Hospitals pointed the Court to a section of the Insurance Code that required the delegation agreement between Aetna and IPA to include "a provision that the delegation agreement may not be construed to limit in any way the health maintenance organization's authority or responsibility, including financial responsibility, to comply with all statutory and regulatory requirements." *Id.* (internal citations omitted). The Court held that an agreement between Aetna and IPA that requires Aetna to abide by "all statutory and regulatory requirements" cannot enlarge Aetna's duties under the statute. The Court found all other arguments made by the Hospitals unpersuasive and held that the lack of privity between the Hospitals and Aetna precluded the Hospitals' suit under the prompt payment statute. *Id.* at 655–56.

II. *Yorkshire Insurance Co., Ltd. v. Seger*, 407 S.W.3d 435 (Tex. App.—Amarillo 2013, pet. denied)

On July 19, 2013, the Amarillo Court of Appeals issued an important ruling touching on two long-standing principles of Texas insurance law: the *Stowers* doctrine and the application of *Gandy*. *See Yorkshire Ins. Co., Ltd. v. Seger*, 407 S.W.3d 435 (Tex. App.—Amarillo July 19, 2013, pet. denied).

A. Background Facts

The facts surrounding the underlying lawsuit that led to *Seger* are extensive. The lawsuit arises out of the death of a man in 1992 while working on an oil rig owned by Diatom Drilling Co., L.P. The man, Randall Jay Seger, did drilling work for both Diatom and Employer's Contractor Services, Inc. ("ECS") and, on the day in question, he was employed by ECS and providing services to Diatom. Diatom was insured by a Lloyd's of London-type commercial general liability insurance policy at the time of the accident, and the subscribing insurers were notified of the accident. Then, after Seger's parents filed suit against Diatom, its partners, and

ECS, the Insurers were notified, but they ultimately refused to provide a defense, "contending that Randall's death was not a covered occurrence and that Diatom failed to provide timely notice of suit." *Id.* at 436.

Seger's parents made two policy-limits settlement demands and then a $250,000 settlement demand, but all them were refused by the Insurers. The underlying lawsuit proceeded to trial after the plaintiffs non-suited all the defendants except for Diatom. At the trial, Diatom's principal, Cynthia Gilliam, was subpoenaed to attend and did attend as a witness, but she did not appear in a representative capacity on behalf of Diatom. According to the court of appeals, her participation was consistent with that of a witness and not a party. Diatom was not represented by counsel in any way. After the trial, the court entered judgment in favor of each parent to the tune of $7.5 million plus interest.

Thereafter, Gilliam contacted Diatom's Insurers about satisfying the judgment, but she did not receive a response. Accordingly, Diatom assigned its rights against the Insurers to the Segers (save and except for the right to recover Diatom's attorneys' fees incurred in defending the underlying suit). The Segers then filed a *Stowers* action against the Insurers for their wrongful failure to settle the underlying case within policy limits.

The Segers ultimately settled with all the Insurers except Yorkshire and Ocean Marine. By way of pretrial summary judgment, the trial court found that the parties in the underlying suit were in a "fully adversarial relationship" and that the proceeding was a "trial." Thus, all that remained to be determined in the *Stowers* case was the Insurers' negligence, causation and damages. The court ordered a directed verdict on damages based on the underlying judgment and submitted the other issues to the jury, which returned a verdict in favor of the Segers. *Id.* at 437. In the court of appeals' first bite at the case, the court agreed that the underlying plaintiffs had made a sufficient demand within policy limits. However, the court reversed the judgment in all other respects and remanded the case for a new trial. *Id.*

On retrial, the case was submitted to a jury. "Based on the jury's findings, the trial court entered a judgment that recites that the Segers' claims were covered by the CGL insurance policy, and that the underlying judgment was the result of a fully adversarial trial and, therefore, establishes the Segers' damages as a matter of law." *Id.* at 438. Each parent was awarded more than $35 million, which was the current amount of the previously issued underlying judgment. *Id.* The Insurers then appealed again, raising seven issues. The court of appeals addressed only the first issue, which it found to be dispositive, and that issue was that the evidence was legally and factually insufficient to establish that Diatom was damaged by the insurers. *Id.*

B. A "Fully Adversarial Trial"

According to the Insurers, the Segers' only evidence of their damages was the underlying judgment that had been issued. However, because that judgment was not obtained through a fully adversarial trial, the Insurers argued that was insufficient evidence of the damages. *Id.* (citing *State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696, 714 (Tex. 1996)). In response, the *Segers* contended that, under *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660, 671–72, 674 (Tex. 2008), the *Gandy* requirement of a fully adversarial trial is

inapplicable where an insurer wrongfully fails to provide a defense to its insured or wrongfully denies coverage.

Addressing the *ATOFINA* decision, the Amarillo Court of Appeals noted that the Supreme Court in *ATOFINA* discussed the effect of *Gandy* on another of its decisions, *Employers Casualty Co. v. Block*, 744 S.W.2d 940, 943 (Tex. 1988), where the Court held that an insurer cannot challenge the reasonableness of a settlement amount as part of an agreed judgment if the insurer wrongfully denied coverage. The Court ultimately held that *Gandy* did not apply to the settlement agreement in *ATOFINA* because of two key distinctions: (1) there was no assignment; and (2) there were no *Gandy* concerns. More specifically, ATOFINA had not assigned its claim against Evanston to anyone and sued Evanston directly. As to the concerns raised in *Gandy*, the Court found that preventing insurers from litigating the reasonableness of a settlement shortens a dispute rather than extending it, and no risk of distorting litigation or settlement motives existed because, at the time of the settlement, ATOFINA did not know whether coverage ultimately would exist or not. Thus, *Block* was applied to bar Evanston from challenging ATOFINA's settlement agreement and found *Gandy* wholly inapplicable.

Relying on that holding, the Segers argued that the Insurers could not challenge the underlying judgment because they failed to defend Diatom and denied coverage. The Amarillo Court of Appeals disagreed, however, concluding "that the arrangement between Diatom and the Segers does not meet *ATOFINA's* exception to *Gandy*." *Seger*, 407 S.W.3d at 440. First, Diatom had assigned its rights against its Insurers to the Segers so, unlike in *ATOFINA*, that key factual predicate of *Gandy* existed. *Id.* Second, the concerns of *Gandy* also were present because the assignment by Diatom specifically was made to prolong the litigation and allow the Segers to pursue the Insurers, as Diatom was judgment-proof and each of its principals had been non-suited. *Id.* at 440-41. Moreover, the assignment also distorted the litigation. "Because neither Diatom nor its principals had any financial exposure in the underlying trial, unlike ATOFINA, Diatom had no incentive to contest its liability or to attempt to limit the assessment of damages after it was found liable." *Id.* at 441 (citations omitted). Moreover, as assignee of the *Stowers* claim, the Segers had to argue that they would not have recovered more than policy limits against Diatom if Diatom had been provided a defense. But the reality was that they recovered $15 million. "In fact, the Segers argued to the trial court in their *Stowers* action that admission of the amount of damages recovered by them in the underlying proceeding would be 'completely prejudicial.'" *Id.*

In light of the foregoing, the court of appeals was left to assess whether Diatom's assignment was valid and whether, under *Gandy*, the underlying judgment was the result of a fully adversarial trial. *Id.* According to the court, the assignment was obtained after the underlying proceeding took place, the Insurers refused to tender a defense to Diatom, and the Insurers neither accepted coverage nor made a good faith effort to adjudicate coverage prior to the adjudication of the Segers' claims. As such, under *Gandy*, the assignment was valid. *Id.*

Turning to the "fully adversarial trial" requirement, the court quoted its prior decision in the case in which it discussed that requirement:

> When the judgment is an agreed judgment, default judgment, or when the underlying defendant's participation is so minimal as to evidence that the hearing

was not adversarial, the judgment resulting from that hearing may not be admitted as evidence of damages in the Stowers action.

Id. at 442 (quoting *Yorkshire Ins. Co., Ltd. v. Seger*, 279 S.W.3d 755, 772 n.25 (Tex. App.—Amarillo 2007, pet. denied)). Looking at the evidence before it, the court found that "Diatom's participation was so minimal that we cannot conclude that the underlying judgment was the result of a fully adversarial trial." *Id.* Moreover, with respect to the evidence presented for the Segers' damages, no evidence was submitted to support the $7.5 million awards issued to each parent. Accordingly, it was clear to the court that the Segers' claims against Diatom were not "fairly determined" by that proceeding. *Id.* Thus, the court ruled "that the underlying judgment was not only not conclusive as to the damages suffered by Diatom, but is inadmissible as evidence of damages in the present action." *Id.* at 443. And, because that was the only evidence of damages that was presented, the Segers' claims failed and the court of appeals ordered the trial court to render judgment that the Segers take nothing. *Id.*

Commentary:

While the decision in *Seger* certainly touches on the *Stowers* doctrine, it is clear that the central holding is that *Gandy's* requirement for a fully adversarial trial still exists. More importantly, although *ATOFINA* seemed to suggest that the wrongful denial of coverage would enable an insured to settle its case as it deemed fit, the reality is that specific requirements of *Gandy* must still be attained if the underlying claimant wants to bind the insurer to an underlying judgment that it obtains. To do so, a claimant must obtain a valid assignment of the claim and participate in a fully adversarial trial against the insured. Without one or both requirements satisfied, an underlying judgment may not hold up against an insurer.

III. *Mid-Continent Casualty Co. v. Krolczyk*, 408 S.W.3d 896 (Tex. App.—Houston [1st Dist.] 2013, pet. denied)

In mid-August 2013 and on rehearing, the First Court of Appeals in Houston issued a decision on an agreed interlocutory appeal involving an insurer's duty to defend its insured in connection with an underlying lawsuit wherein the insured was sued for its work on a road construction project. *See Mid-Continent Cas. Co. v. Krolczyk*, 408 S.W.3d 896 (Tex. App.—Houston [1st Dist.] 2013, pet. denied). In a somewhat confusing opinion, the court ultimately ruled that the duty to defend existed and rendered judgment for the insured.

A. Background Facts

Robert Krolczyk owned land in Waller County that he subdivided and sold as home sites. As part of the project, he built a road through the middle of the subdivision, the base of which he completed in 2000 and the paving and sealing of which was completed in 2003. *Id.* at 899. In 2006, Krolczyk sued the neighborhood's maintenance association for damaging the road, alleging that they moved dumptruck-loads of earth over the road despite his objection. He sought declaratory relief regarding the parties' rights and responsibilities for the repairs and the homeowner's association intervened and counterclaimed against Krolczyk for building a "totally inadequate" road that resulted from faulty construction. *Id.*

Krolczyk tendered the lawsuit to his insurer, Mid-Continent, for a defense and indemnity, and Mid-Continent agreed to defend him subject to a reservation of rights. Ultimately, though, Mid-Continent contended that coverage did not exist, so Krolczyk filed the instant declaratory judgment action against the company. In response, Mid-Continent argued that exclusion j.(6)[1] and an "earth movement" exclusion applied to negate coverage. After the trial court denied the parties' cross-motions for summary judgment, the parties filed an agreed interlocutory appeal. *Id.* at 901.

B. Analysis by the Court of Appeals

With respect to exclusion j.(6), the court noted that liability coverage does not apply when two conditions are met: (1) the property damage is to "[t]hat particular part" that must be restored, repaired, or replaced (2) because the insured incorrectly performed work on it. *Id.* at 902 (citing *Mid-Continent Cas. Co. v. JHP Dev., Inc.*, 557 F.3d 207, 215 (5th Cir. 2009)). Further, the court emphasized that an exclusion that purports to unambiguously preclude coverage for *all* property damage caused by the insured's defective work should omit limiting language that references "that particular part" of property. *See id.* (citing *Gore Design Completions, Ltd. v. Hartford Fire Ins. Co.*, 538 F.3d 365, 371–72 (5th Cir. 2008) (construing the "that particular part" language not to exclude coverage for the insured's nondefective work damaged by defective work performed elsewhere in the same project)). Thus, "[t]he exclusion only precludes coverage for repairing or replacing the insured's defective work; 'it does not exclude coverage for damage to other property resulting from the defective work.'" *Id.* (citing *Wilshire Ins. Co. v. RJT Constr., L.L.C.*, 581 F.3d 222, 226 (5th Cir. 2009) (citing *Travelers Ins. Co. v. Volentine*, 578 S.W.2d 501, 503 (Tex. Civ. App.—Texarkana 1979, no writ)); *see also Mid–Continent Cas. Co. v. Bay Rock Operating Co.*, 614 F.3d 105, 115–16 (5th Cir. 2010) (holding that the j.(6) term restricts the exclusion to property damage to that particular part of the project that was subject to the insured's defective work); *Gore Design*, 538 F.3d at 371–72 (same)).

Looking to the allegations of the underlying lawsuit, the court noted that Krolczyk built the road in three phases: (1) the drainage ditches and road base of the whole road were constructed and he laid asphalt on the first third of the road; (2) eighteen months later, he laid asphalt on the second third of the road; and (3) finally, he laid the remainder of the asphalt on the road. *Id.* at 902–03. In phases 2 and 3, Krolczyk did not "rework" the road base, which—along with the allegedly inadequate drainage—formed the basis of the HOA's claims with respect to the resulting damage to the road surface that cracked and exhibited potholes after less than one year of use. *Id.* at 203.

Turning back to *JHP*, Mid-Continent claimed that, unlike in that case, all the work performed by Krolczyk was alleged to have been defective as opposed to just a portion of it. The court, however, said that the allegations were not that clear. Rather, the HOA had alleged that the asphalt laid on the surface of the road cracked, but no allegations existed that the surfacing work was defective. *Id.* at 903–04. Instead, the surface was alleged to have cracked because of the

[1] The court routinely refers to this exclusion as the "your work" exclusion throughout the opinion. However, because exclusion *l.* is the "your work" exclusion, and to prevent any confusion, it is referred to as exclusion j.(6) herein.

insured's failures with respect to the road base. *Id.* at 904. Accordingly, applying Texas law, only the defectively performed work would be excluded, such as the work on the road base, while the non-defectively performed work would be covered, such as his paving and repaving work. *Id.* Importantly, the court rejected Mid-Continent's argument that the road should be considered a unitary whole so as to minimize the limitation of "that particular part." *Id.* at 904–05 (noting that the allegations clearly separated the work into three phases and recognizing that such a large project lends itself to the use of various construction techniques, equipment and materials, which makes it comparable to projects like that at issue in *JHP*). Thus, the court found the exclusion did not negate coverage.

The court also found that the "earth movement" exclusion did not apply. In doing so, the court noted that, other than allegations concerning the road base, no allegations existed that the road damage was related to the movement of land, earth or mud. *Id.* at 905. The ordinary meanings of those words would not include concrete or other man-made materials, so Krolczyk's interpretation of the exclusion that limits its application was adopted by the court. *Id.* Because the pleadings did not specify whether the "part of the [road] base" that was "exposed to the elements" and washed out was built of land, earth or mud, the exclusion did not negate the duty to defend. Simply put, because the road base could have been built of materials *other* than earth, land or mud, and the allegations did not mention any other earth movement, the duty to defend still existed. *Id.* at 906.

Commentary:

The *Krolczyk* decision further delineates the narrow application of exclusion j.(6)—and exclusion j.(5), although it was not mentioned in the decision—because of the limiting language found therein that only precludes coverage for "that particular part" of an insured's work that is defective. The case further illustrates the critical importance of an underlying plaintiff's pleadings. Had the plaintiff not alleged that the road was constructed in three phases and emphasized the separation of those phases, the same result may not have existed. Although not monumental by any means, the court's ruling with respect to the "earth movement" exclusion also illustrates that same point. Had it been alleged that the earth or land *under* the road base had been washed out, causing the surface to crack, the court may have reached an altogether different conclusion. After obtaining an extension, Mid-Continent ultimately filed a petition for review with the Supreme Court of Texas, but the petition was denied by the Court on January 17, 2014.

IV. *Mid-Continent Casualty Co. v. Castagna*, 410 S.W.3d 445 (Tex. App.—Dallas 2013, pet. denied)

Just a few days after *Krolczyk* was issued, the Dallas Court of Appeals opined on two key duty to defend issues—namely, when "property damage" occurred so as to determine which policy (or policies) were triggered and whether the "contractual liability" exclusion operated to negate coverage. *See Mid-Continent Casualty Co. v. Castagna*, 410 S.W.3d 445 (Tex. App.—Dallas 2013, pet. filed). While the trial court ruled in the insured's favor, on appeal, the court affirmed in part and reversed in part.

A. Background Facts

The Castagnas contracted with McClure Brothers Custom Homes, LP to build a residence in Frisco, which was completed in late 1999. In 2008, Mrs. Castagna filed suit against McClure Brothers in connection with problems with the foundation of the home. Mid-Continent defended the builder in that lawsuit, which was subject to arbitration, and in which Castagna obtained an arbitration award that ultimately was confirmed. Castagna then sued McClure Brothers' insurers (although she ultimately non-suited Great American) for indemnity for the final judgment confirming the arbitration award. Her motion for summary judgment was granted and this appeal followed. *Id.* at 447–48.

B. When Did Covered "Property Damage" First Occur?

Mid-Continent contended that the arbitration award did not trigger policies covering the 2001 to 2002 and 2002 to 2003 time periods, but *only* triggered the 2006-2007 policy. The court noted that the relevant policy provisions were standard CGL provisions like those at issue in *Don's Building Supply, Inc. v. OneBeacon Insurance Co.*, 267 S.W.3d 20 (Tex. 2008), where the Supreme Court of Texas held that property damage "occurred when the home in question suffered wood rot or some other form of physical damage." *Castagna*, 410 S.W.3d at 450–51. (quoting *Don's Bldg.*, 267 S.W.3d at 30). Moreover, the court found that Mid-Continent was bound by the findings of the arbitration. *Id.* at 452 (citation omitted).

In that regard, the arbitrator's findings were that cracks commenced in 2001 and progressed through late 2006 or early 2007. *Id.* at 453. "Further, the arbitrator found the foundation failure and resulting damage were the unintended result of McClure Brothers Custom Homes, LP's and its subcontractors' failure to design and construct a foundation that was capable of withstanding the movement of the soil which resulted in a structural failure of the foundation of part of the residence." *Id.* Thus, the court found Mid-Continent's claim that such cracks were not "property damage" caused by an "occurrence," but rather the result of normal shrinkage or settling, was unpersuasive. *Id.* at 454. As such, the court held that property damage occurred during the three policy periods at issue and, therefore, each of them was triggered. *Id.*

Undeterred Mid-Continent also argued that the arbitrator's failure to apportion damage in each of the policies and Castagna's failure to present any independent evidence of such an apportionment meant that Castagna could not prevail as a matter of law. The court, however, disagreed, noting that Mid-Continent relied on case law discussing the doctrine of concurrent causes and the requirement that an insured apportion or distinguish covered losses from non-covered losses. *Id.* "Mid-Continent has provided no authority to support an argument that Castagna had the burden to prove an allocation of covered property damage to particular policy periods." *Id.* at 454–55 (citing *Keene Corp. v. Ins. Co. of N. Amer.*, 667 F.2d 1034, 1047–49 (D.C. Cir. 1981) (finding that it is the insured's right to select which of the triggered policies provides indemnification; each insurer is fully liable for indemnification); *see also Amer. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 855 (Tex. 1994) (finding that if a single occurrence triggers more than one policy covering different policy periods, the insured may select from multiple consecutive insurance policies the one under which it is to be indemnified; "insured's indemnity limit should be whatever limit applied at the single point in time during the

coverage periods of the triggered policies when the insured's limit was highest")). Thus, on that ground, the court affirmed the lower court's decision.

C. Application of Exclusions to Coverage

After ultimately determining that no coverage existed under the 2006-2007 policy because the judgment was against a different entity than the named insured on that policy, the court turned back to the two earlier policies and addressed whether any exclusions negated coverage. In particular, the court focused on the "your work" exclusion and the "contractual liability" exclusion.

With respect to the "your work" exclusion, the court clarified that the subcontractor exception to that exclusion remained intact on the policies at issue from 2001 to 2003. However, that exception was removed by endorsement on the 2006-2007 policy. Nevertheless, because the court already determined that coverage did not exist under the later policy, the removal of the exception was irrelevant. And, further, because no dispute existed that subcontractors performed the work in question and because the 2001-2003 policies were triggered, the exception would apply in those policies to reinstate coverage that otherwise would have been excluded for damage to the insured's own work. *Id.* at 457–58.

Finally, the court addressed the applicability of the "contractual liability" exclusion in each of the policies. Mid-Continent argued that no evidence existed of a non-contractual basis under which McClure Brothers' liability was established. Rather, the only liability was based on the breach of the implied warranty of good workmanship that was created by contract. *Id.* at 460. Because the arbitrator awarded attorneys' fees under Section 38.001 of the Texas Civil Practice and Remedies Code, Mid-Continent argued that the breach of implied warranty claims sounded in contract and, therefore, fell within the exclusion under the reasoning of *Gilbert Texas Constr., L.P. v. Underwriters at Lloyd's London*, 327 S.W.3d 118 (Tex. 2010). In response, Castagna contended that the implied warranty of good workmanship arises under the common law and, therefore, was not a liability that the insured "assumed" for purposes of the contractual liability exclusion, but was liability imposed for breach of the common law implied warranty. *Castagna*, 410 S.W.3d at 461.

After reviewing the decision in *Gilbert*—in which the same exclusion negated coverage for damage to a third-party property that Gilbert had agreed by contract to protect and repair—the court found it was unpersuaded by Mid-Continent's expansive interpretation of the holding in *Gilbert*. *Id.* at 463. Rather, the court agreed that the implied warranty was not an "assumed" liability because it would have existed in the absence of the contract. In other words, the insured, unlike in *Gilbert*, "did not assume any contractual obligation in addition to, or that extended beyond, the 'general law' of implied warranty of good workmanship." *Id.* (citing *Gilbert*, 327 S.W.3d at 127; *see also Sipes v. Longford*, 911 S.W.2d 455, 457 (Tex. App.—Texarkana 1995, writ denied) ("Implicit in every contract is a common-law duty to perform the terms of the contract with care, skill and reasonable experience.")). "The construction contract does not include any provision enlarging the contractor's obligations beyond performance of its construction work in a good and workmanlike manner, and accordingly there is not an assumption of liability for damages sufficient to trigger the contractual liability exclusion." *Id.* (citing *Gilbert*, 327 S.W.3d at 134 (quoting *Cagle v. Commercial Standard Ins. Co.*, 427 S.W.2d

939, 943–44 (Tex. Civ. App.—Austin 1968, no writ))). At bottom, because the terms of the contract "actually add nothing to the scope of the insured's liability for the foundation problems," the contractual liability exclusion did not apply. *Id.*

Commentary:

This Dallas Court of Appeals decision provides a good analysis of the burden an insured (or judgment creditor) faces in establishing that "property damage" occurred during an insured's policy period. At the end of the day, that burden may not be as steep as once suspected. Beyond that, the court's decision to not apply the "contractual liability" exclusion under this set of facts is certainly a pro-insured decision, as the court recognized that the implied warranty at issue in *Castagna* is set forth in the common law and therefore not an "assumed liability" for purposes of the exclusion. What remains to be seen is whether the Supreme Court will deny the petition for review in light of its decision in *Ewing Construction Co., Inc. v. Amerisure Insurance Co.*, 2014 WL 185035 (Tex. Jan. 17, 2014) (discussed below), where the Court found that the "contractual liability" exclusion did not apply to negate coverage for a general contractor in connection with a lawsuit brought by a school district.

In the meantime, however, the court's analysis of the apportionment of damages issue proved ultimately to be right, as made clear by the Supreme Court of Texas's decision in *Lennar Corp. v. Markel American Insurance Co.* In that decision, discussed immediately below, the Court reached a similar conclusion.

V. *Lennar Corp. v. Markel American Insurance Co.*, 413 S.W.3d 750 (Tex. 2013)

An important decision from the Supreme Court of Texas was issued on August 23, 2013 when the opinion in *Lennar Corp. v. Markel American Insurance Co.*, 413 WL 750 (Tex. 2013), was released. That decision touched on several major insurance coverage issues: (1) whether an insurer must be prejudiced by an insured's settlement without the insurer's consent in connection with coverage under a CGL policy; (2) whether such settlements constitute the insured's legal obligation to pay damages; and (3) whether Texas truly is the "all sums" state that insureds have contended it is for years. The Court's decision resoundingly answered "yes" to each of those questions, finding that coverage existed under Markel's CGL policy that it issued to Lennar for settlements entered into by Lennar with homeowners whose homes were damaged as a result of the installation of defective EIFS.

A. Prejudice

At the outset, the Court addressed the prejudice issue and, consistent with its prior holding in *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691, 692–64 (Tex. 1994), held that, even when a settlement-without-consent provision is incorporated into an insuring agreement (as opposed to just being a condition), the insurer still must establish that it was prejudiced by the insured's failure to adhere to that requirement before the insurer can successfully avoid coverage. *See* Lennar, 413 S.W.3d at 754–56. Like the Court did in *Hernandez*, it grounded its holding in *Lennar* in general contract principles. That is, because Lennar's failure to adhere to the settlement-without-consent provision was not a material breach, Markel was not excused from adhering to the terms of the parties' contract unless it could show that it had been prejudiced—

something Markel did not accomplish. On that point, Justice Boyd, who issued an opinion concurring in the judgment, argued that the Court should have abandoned its "contract principles" claim and grounded the decision in public policy. Notably, Justice Boyd actually would have found that no prejudice requirement existed in the first place, but he agreed that the Court's precedent, as set out in *Hernandez* and its progeny, could not be avoided. *Id.* at 759 *et seq.*

B. Legal Obligation to Pay Damages

Moreover, the Court found that the non-prejudicial settlements could be used by Lennar to establish the amount of its loss under the Markel policy. The Court said that a finding otherwise would enable Markel to "subvert the requirement that Markel show that Lennar's non-compliance was material." And, with respect to Markel's legal obligation to pay, the Court noted that the jury's finding of no prejudice could mean only one thing: "that Lennar's loss as shown by the settlement is the amount Markel is obligated to pay under the policy." *Id.* at 756. This is a significant holding in that insurers oftentimes argue that an insured cannot be legally liable unless there has been an adjudication in litigation/arbitration or a compromise settlement to which the insurer consents. Here, there was no lawsuit or arbitration and the insurer did not consent to Lennar's remediation efforts.

C. Insurance Coverage for Lennar's Damages – An "All Sums" State

Turning to coverage for the damages incurred by Lennar, the Court emphasized that Markel agreed to pay "the total amount" of its insured's loss "because of" property damage that "occurred during the policy period." *Id.* at 757. Markel argued that Lennar could not recover anything because it failed to segregate its damages between the costs of repair of damage to the homes and the cost of locating that damage. The Supreme Court, however, disagreed, noting that the phrase "because of"—even without a broad reading of the phrase—could not be reasonably construed to preclude coverage for the cost of finding the damage so that it could be repaired. Markel conceded that each home was actually damaged, and the only way to find all the damage was to remove all the EIFS. Thus, the jury's verdict was supported by the evidence. Accordingly, in addition to the "property damage" itself, the Court held that the investigation and access costs were covered as well. *Id.*

Further, the Court noted that the damage at issue all began before or during Markel's policy period and continued thereafter. Markel, however, only wanted to pay for damage that existed during the policy period. The Court, emphasizing Markel's agreement to pay for the "total amount" of loss, noted again that all the homes at issue suffered at least some damage during the policy period and, therefore, "the policy covered Lennar's total remediation costs." *Id.* at 758. Additionally, the Court reasoned that its holding was confirmed by its prior decision in *American Physicians Insurance Exchange v. Garcia*, 876 S.W.2d 842 (Tex. 1994), where the Court found that an insured could select the policy or policies that would maximize coverage and the insurer selected could then allocate funding of indemnity among themselves pursuant to their rights of subrogation. Thus, despite Markel urging the Court to adopt a "pro rata" approach, as some courts in other jurisdictions have done recently, the Court refused to abandon its holding in *Garcia*. Likewise, the Court refused to find—as many insurers have argued—that its prior

language in *Garcia* was merely dicta. As such, the Court concluded "that Markel's policy covered Lennar's entire remediation costs for damaged homes." *Lennar*, 413 S.W.3d at 758–59.

Commentary:

In sum, the Court held that: (i) Markel is responsible for the costs incurred by Lennar's voluntary remediation program even though Markel had not consented because Markel could not demonstrate that it had been prejudiced; (ii) Markel is responsible for the costs incurred to determine "property damage" as well as to repair it; and (iii) Markel is responsible for the entirety of Lennar's damages even though only a portion of the damage occurred during its policy period.[2]

The *Lennar* opinion is a terrific victory for policyholders. For a time, though, and after all of the Court's hard work in resolving many thorny issues, the ultimate holding in *Lennar* quoted above—much like the holding in *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, 242 S.W.3d 1 (Tex. 2007)—could have been rendered meaningless if the Court had decided that the "contractual liability" exclusion applies in the manner urged by Amerisure in *Ewing Construction Co., Inc. v. Amerisure Insurance Co.*, 2014 WL 185035 (Tex. Jan. 17, 2014). In *Lennar*, the damages at issue were to the subject matter of the construction contract (i.e., the homes Lennar contracted to build). Under the interpretation advanced by Amerisure in *Ewing*, both a duty to defend and a duty to indemnify would be barred in their entirety by the "contractual liability" exclusion because those damages could be recovered only through causes of action sounding in contract and/or warranty. Under Ewing's interpretation, on the other hand, coverage is preserved because Lennar's liability was not in any way increased or enlarged by the terms of its contracts with the homeowners. *Lennar* is typical of most construction defect cases in this regard and helps demonstrate that applying the "contractual liability" exclusion as urged by Amerisure would eliminate insurance for otherwise covered "property damage." Thankfully, as discussed below, the Supreme Court of Texas agreed with Ewing, finding the "contractual liability" exclusion did not apply.

VI. *In re Deepwater Horizon*, 728 F.3d 491 (5th Cir. 2013)

In the ongoing dispute concerning the explosion and sinking of the Deepwater Horizon offshore drilling platform, and the resultant oil spill in the Gulf of Mexico, the U.S. Fifth Circuit Court of Appeals has certified two questions to the Supreme Court of Texas. The court, upon request for rehearing, withdrew its previous opinion, *In re Deepwater Horizon*, 710 F.3d 338 (5th Cir. 2013), and certified the following questions:

> (1) Whether *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008), compels a finding that BP is covered for the damages at issue, because the language of the umbrella policies alone determines the extent of BP's

[2] Approximately a month after issuing *Lennar Corp.*, the Court denied the petition for review that was filed in *Vines-Herrin Custom Homes, LLC v. Great American Insurance Co.*, 357 S.W.3d 166 (Tex. App.—Dallas 2011, pet. denied), in which the court of appeals found that an insured need not present expert testimony on the precise date of injury in order to trigger the duty to indemnify where the insurer at issue provided coverage for the insured throughout the period in which damage possibly could have occurred.

coverage as an additional insured if, and so long as, the additional insured and indemnity provisions of the Drilling Contract are "separate and independent"?

(2) Whether the doctrine of *contra proferentem* applies to the interpretation of the insurance coverage provision of the Drilling Contract under the *ATOFINA* case, 256 S.W.3d at 668, given the facts of this case?

A. Background Facts

Transocean Holdings, Inc. ("Transocean") owned the *Deepwater Horizon*, a semi-submersible offshore oil drilling platform. In April 2010, the *Deepwater Horizon* sank into the Gulf of Mexico after burning for two days following an explosion (the "Incident"). At the time of the Incident, the Deepwater Horizon was engaged in offshore exploratory drilling under a Drilling Contract between BP American Production Company's predecessor (collectively with its affiliates, "BP") and Transocean's predecessor. The Drilling Contract required certain minimum coverage amounts for BP's benefit. The amount of coverage relating to BP's pollution-related liability is the subject of this appeal and certification. *In re Deepwater Horizon*, 728 F.3d at 494.

1. The Insurance Contracts

Transocean held insurance policies with a primary liability carrier, Ranger Insurance Ltd. ("Ranger"), as well as several excess carriers led by London market syndicates (the "Excess Insurers") (collectively with Ranger, the "Insurers"). The Ranger policy provided at least $50 million of general liability coverage, and the Excess Insurers' policies provided four layers of excess coverage on top of the Ranger policy, providing at least an additional $700 million of general liability coverage. The Ranger and excess policies contain near identical provisions, allowing the court to treat the policies as one for purposes of this litigation.

According to the court, the definitions of "Insured" and "Insured Contract" were most important to the court's analysis. *See In re Deepwater Horizon*, 728 F.3d at 495. The policies defined "Insured" as including the Named Insured, other parties, and:

> (c) any person or entity to whom the "insured" is obliged by any oral or written "Insured Contract" (including contracts which are in agreement but have not been formally concluded in writing) entered into before any relevant "Occurrence," to provide insurance such as is afforded by this Policy . . . .

Id. The policies defined "Insured Contract" as follows:

> The words "Insured Contract," whenever used in this Policy, shall mean any written or oral contract or agreement entered into by the "Insured" (including contracts which are in agreement but have not been formally concluded in writing) and pertaining to business under which the "Insured" assumes the tort liability of another party to pay for "Bodily Injury," "Property Damage," "Personal Injury" or "Advertising Injury" to a "Third Party" or organization. Tort

> liability means a liability that would be imposed by law in the absence of any contract or agreement.

Id. The policies also included an endorsement that automatically included other parties as additional insureds where required by written contract. *Id.* at 495 n.3.

2. The Drilling Contract

The Drilling Contract defines the rights and obligations BP and Transocean have as to one another. Article 20 of the Drilling Contract imposes insurance obligations upon Transocean:

> 20.1 *INSURANCE*
>
> Without limiting the indemnity obligations or liabilities of CONTRACTOR [Transocean] or its insurer, at all times during the term of this CONTRACT, CONTRACTOR **shall maintain insurance covering the operations to be performed under this CONTRACT as set forth in Exhibit C.**

Id. at 495 (emphasis in original).

Exhibit C of the Drilling Contract set for the insurance requirements to be fulfilled by Transocean, including the requirement that BP be named as an additional insured under Transocean's policies. Specifically, the provision provided:

> [BP], its subsidiaries and affiliated companies, co-owners, and joint ventures, if any, and their employees, officers and agents **shall be named as additional insureds in each of [Transocean's] policies, except Workers' Compensation for liabilities assumed by [Transocean] under the terms of this contract.**

Id. (emphasis in original).

3. Procedural History

Following the Incident, BP notified the Insurers of its losses related to the *Deepwater Horizon*. Ranger and the Excess Insurers each filed substantively identical declaratory judgment actions against BP requesting that the court find "no additional insured obligations to BP with respect to pollution claims against BP for oil emanating from BP's well" as a result of the Incident. *Id.* at 496. Although the parties conceded that the Drilling Contract was an "Insured Contract" and that the policies provided some additional insured coverage to BP, the scope of the additional insured coverage owed to BP remained in dispute.

In July 2011, BP moved for judgment on the pleadings against the insurers relying on Texas and Fifth Circuit precedent found in *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008) ,and *Aubris Resources LP v. St. Paul Fire & Marine Insurance Co.*, 566 F.3d 483 (5th Cir. 2009). Specifically, BP argued it was an additional insured under the policies and that the policies alone, not the Drilling Contract, govern the scope of BP's additional insured coverage. In November 2011, the trial court found that *ATOFINA* and *Aubris* were distinguishable from the case at bar and denied BP's motion for judgment on the pleadings.

Specifically, the trial court found Transocean's insurance obligation in Exhibit C of the Drilling Contract required that BP was to be named as an "additional insured in each of [Transocean's] policies. . . for liabilities assumed by [Transocean] under the terms of the contract." *Id.* Put simply, the trial court found BP's argument unreasonable, and instead the court read the clause as if there was a comma following the phrase "except Workers' Compensation." Such a reading of the polices rendered that phrase a separate and distinct carve out from liability. Additionally, the trial court reasoned that its interpretation required that it look to the Drilling Contract, specifically Article 24, and concluded that BP was not an additional insured under Transocean's polices for the pollution-related liabilities, as the oil spill originated below the surface of the Gulf of Mexico. Article 24 provided that Transocean assume full responsibility for and protect, release, defend, indemnify, and hold harmless BP for any loss or liability for pollution or contamination from spills originating on or above the surface of the land or water. The Article also provided that BP shall assume full responsibility for and shall protect, release, defend, indemnify, and hold harmless Transocean for losses arising from or connected with operations pursuant to the Drilling Contract and not assumed by Transocean in Article 24. Following further submissions by the parties, the trial court entered a partial final judgment on the Insurers' complaints. The court held "by its terms, the Court's Order and Reasons [on BP's motion for judgment on the pleadings] not only denied BP's motion but also granted judgment on the pleadings against [BP] and in favor of the Plaintiff Insurers' complaints." *Id.* at 497. On appeal, a unanimous Fifth Circuit panel reversed the district court's judgment in the court's initial opinion. *See In re Deepwater Horizon*, 710 F.3d 338 (5th Cir. 2013). The Insurers and Transocean petitioned for rehearing and the court withdrew its ruling to certify questions to the Supreme Court of Texas.

B. Legal Issues

The first issue before the court was the scope of BP's additional insured coverage and whether the policy itself determines the extent of coverage, or whether the indemnity clauses in the Drilling Contract effectively limit BP's coverage. *In re Deepwater*, 728 F.3d at 497. The court considered the *ATOFINA* opinion from the Supreme Court of Texas, which addressed "whether a commercial umbrella insurance policy that was purchased to secure the insured's indemnity obligation in a service contract with a third party also provides direct liability coverage for the third party." *Id.* (quoting *ATOFINA*, 256 S.W.3d at 662).

In *ATOFINA*, ATOFINA owned an oil refinery which it hired Triple S to maintain. Both entities entered into a service contract that stipulated ATOFINA was to be named an additional insured in each of Triple S's policies. That contract provision read as follows:

> [ATOFINA], its parents, subsidiaries and affiliated companies, and their respective employees, officers and agents shall be named as additional insureds in each of [Triple S's] policies, except Workers' Compensation; however, such extension of coverage shall not apply with respect to any obligations for which [ATOFINA] has specifically agreed to indemnify [Triple S].

Id. (citation omitted).

A Triple S employee drowned while servicing the ATOFINA refinery. His estate then sued ATOFINA and Triple S for wrongful death. Triple S's insurer and ATOFINA disagreed as to who was required to pay for the resultant litigation. ATOFINA sought additional insured status under its contract with Triple S, while the insurer argued that ATOFINA's agreement to indemnify Triple S for ATOFINA's sole negligence precluded coverage. The Supreme Court of Texas began by noting that ATOFINA sought coverage from the insurer as an additional insured, and had not sought indemnity directly from Triple S. The Court then looked to the policy, which defined who is an insured as:

> A person or organization for whom you have agreed to provide insurance as is afforded by this policy; but that person or organization is an insured only with respect to operations performed by you or on your behalf, or facilities owned or used by you.

Id. at 498 (internal citation omitted).

The foregoing section, by its own terms, was held to cover ATOFINA "with respect to operations performed by" Triple S, even for its sole negligence. The court reached its conclusion, in part, because it found "it . . . unmistakable that the agreement in this case to extend *direct* insured status to ATOFINA as an additional insured is separate and independent from ATOFINA's agreement to forego *contractual* indemnity for its own negligence." *Id.* (emphasis in original) (citation omitted).

In the *Deepwater Horizon* appeal, BP focused upon the *ATOFINA* court's statement that "[i]nstead of looking, as the court of appeals did, to the indemnity agreement in the service contract to determine the scope of coverage, we base our decision on the terms of the umbrella insurance policy itself." *Id.* (quoting *ATOFINA*, 256 S.W.3d at 664). BP further argued that, as in ATOFINA, it seeks insurance coverage, not indemnification, and the policy itself does not limit additional insured coverage. In other words, because the additional insured provision in the policies and the indemnity provisions in the Drilling Contract are separate and distinct, and because the policies provide additional insured coverage "such as is afforded by this Policy," and because Transocean would be covered for the loss resulting from the Incident, BP contends that it, too, is entitled to coverage.

The Insurers and Transocean highlighted the differences in the policies at issue and the policy under review in *ATOFINA*. The contractual clause in *ATOFINA*, they argued, imposed a broad requirement to list ATOFINA as an additional insured, as opposed to a narrower requirement in the Drilling Contract, which only required Transocean to name BP as an additional insured for liabilities Transocean specifically assumed in the contract. According to the parties, that language rendered the additional insured provision and indemnity provision inextricable from each other. Further, they argued that the policies required that an "Insured Contract" exist between the named insured and any potential additional insured, but in *ATOFINA* no such requirement existed. Noting the "potentially important distinctions between the facts of the instant case and *ATOFINA*, the outcome is not entirely clear." *Id.* at 499.

Assuming the two were inextricable, the court also faced an issue as to how to interpret BP's status as an additional insured. More specifically, determining which party may prevail

could depend on whether the doctrine of *contra proferentem* applies. The court noted that well-established Texas law holds "if an insurance coverage provision is susceptible to more than one reasonable interpretation, the court must interpret that provision in favor of the insured, so long as that interpretation is reasonable." *Id.* (citation omitted). The court continued, "[t]his rule favoring the insured derives, in part, from the 'special relationship between insurers and insureds arising from the parties' unequal bargaining power.'" *Id.* (citation omitted). This Texas law stems from the *contra proferentem* doctrine, which construes any ambiguities in a contract against the drafter, and the "sophisticated insured" exception, which may apply when a contract is not a contract of adhesion and "the insured is as capable as the insurer of interpreting the contract."

The Fifth Circuit noted that the Supreme Court of Texas has never recognized this exception, but opined that *if* the Court were to recognize it, this could be the case in which to do so, as all the parties involved are "highly capable contractors." *Id.* The court concluded its opinion by noting that "[o]n the one hand, the facts indicate Insurers were not involved in drafting the Drilling Contract, and thus construing ambiguities in that contract against them might not be appropriate. But on the other, the insurers were involved in drafting the umbrella policy language at issue, and the failure of that policy language to limit coverage in underlying 'Insured Contracts' to the liabilities assumed by the named insured in those contracts is part of what ails the Insurers now." *Id.* at 500.

Commentary:

Whether the Supreme Court of Texas's answers to the certified questions will have a sweeping effect on Texas insurance law remains to be seen. For one, the parties' contracts were, as noted by the Fifth Circuit, fairly sophisticated and, therefore, likely unique. However, the case provides the Supreme Court an avenue for further clarifying its analysis in *ATOFINA* as to how indemnity and additional insured provisions should be analyzed—whether inextricable or not. In any event, the parties in the case and the insurance law community in Texas will eagerly await the Supreme Court's decision in *In re Deepwater Horizon*. On that note, as of publication of this article, briefing in the Supreme Court of Texas remains ongoing.

VII. *Liberty Mutual Insurance Co. v. Adcock*, 412 S.W.3d 492 (Tex. 2013)

In an important victory for individuals receiving Lifetime Income Benefits ("LIBs") under the Texas Workers' Compensation Act (the "Act"), the Supreme Court of Texas refused to grant the Texas Department of Insurance, Division of Workers' Compensation (the "Division") deference in its request to judicially engraft into the Act a statutory procedure to re-open determinations of eligibility for permanent lifetime income benefits—a procedure specifically removed from the Act by the Legislature in 1989. The Court, in light of the Act's comprehensive statutory scheme, declined to grant the Division, and a Workers' Compensation insurance carrier, their request to reopen LIB determinations. *See Liberty Mut. Ins Co. v. Adcock*, 412 S.W.3d 492 (Tex. 2013).

A. Background Facts

In 1991, Ricky Adcock suffered a compensable workplace injury to his right ankle. After the injury, Mr. Adcock underwent reconstructive surgery that was not successful, resulting in the loss of use of his right foot. Six years later, he was awarded LIBs because "the great weight and preponderance of the evidence is that the claimant has the total and permanent loss of use of his right hand *at* his wrist." *Id.* at 493 (emphasis in original). Liberty Mutual Insurance Co. ("Liberty Mutual"), the workers' compensation insurance carrier for Mr. Adcock's employer, did not dispute the award and began issuing payments pursuant to the award. Over ten years later, Liberty Mutual sought a new hearing, contending that it had received video evidence of Mr. Adcock walking and handling objects—an indication that his condition had improved since the award and that he was no longer entitled to LIBs. The hearing officer determined that Liberty Mutual could re-open the previous LIB award but ultimately concluded that Mr. Adcock still was entitled to the previously awarded LIBs by virtue of loss of use of his right hand and both feet. The hearing results were appealed, with the Division's appeals panel affirming the decision.

Both parties sought judicial review of the appeals panel's decision. Mr. Adcock moved for summary judgment, arguing that the hearing officer lacked jurisdiction to re-open the previous LIB determination. The Division subsequently intervened, asserting that it had jurisdiction to re-open LIB determinations. The trial court granted Mr. Adcock's motion for summary judgment. The court of appeals affirmed, noting that the Legislature specifically removed the procedure to re-open LIB determinations in 1989 and the current Act only provides for ongoing review of temporary benefits.

B. Analysis by the Supreme Court of Texas

At the outset, the Court addressed its role in statutory interpretation and, consistent with its prior holding in *Entergy Gulf States, Inc. v. Summers*, 282 S.W.3d 433, 443 (Tex. 2009), reiterated that "[e]nforcing the law as written is a court's safest refuge in matters of statutory construction, and we should always refrain from rewriting the text that lawmakers choose." *See Adcock*, 412 S.W.3d at 494. Regarding the statute before it, Liberty and the Division argued that, if an employee improves medically and no longer meets the requirements for LIBs, then the Division has "necessarily implicit" authority to re-open the determination. Adcock, on the other hand, argued that the plain language of the statute indicates that such determinations are permanent and does not provide a procedure for reopening it.

Turning to the plain language of the Act, the Court quoted the statute in question, which states that, in situations such as Adcock's, "[l]ifetime income benefits are paid until the death of the employee." TEX LAB. CODE § 408.161(a)(4). The Court found the use of the phrase "are paid until the death of the employee" illustrative of the Legislature's intent to make LIB determinations permanent. The Court further noted that, importantly, the current Act does not provide any procedure to re-open such a determination. The Court found unpersuasive Liberty Mutual's argument that the term "lifetime" in the statute pertains to the duration of benefit eligibility and does not determine entitlement. The Court noted that the statute does not say that LIBs "may be paid" until the death of the employee; rather, it mandates that LIBs "are paid" until the death of the employee. *Adcock*, 412 S.W.3d at 495.

The Court then turned to the comprehensive nature of the Act, which requires it to respect the Legislature's intent to not include any procedures to re-open a LIB determination. The Court acknowledged and held consistently with its prior holding in *Texas Mutual Ins. Co. v. Ruttiger*, 381 S.W.3d 430 (Tex. 2012), that "[t]he Act effectively eliminates the need for a judicially imposed cause of action outside the administrative process and other remedies in the Act." *See Adcock*, 412 S.W.3d at 495. Simply put, the legislature devised a comprehensive system to address worker's compensation claims, with specific benefits and procedures based on Texas's public policy, and the Court reaffirmed that it should not alter that scheme.

The revised Act, the Court noted, removed the procedure previously available for the Division to re-open *any* award of benefits under the Act and established a dichotomy containing two distinct classes of income benefits: temporary benefits and permanent benefits. Temporary benefits are available only if certain conditions continue to exist, whereas permanent benefits continue until the statute dictates—i.e., the death of the employee. Thus, temporary benefits are subject to a review process, but permanent benefits are just that—permanent. "When the Legislature expresses its intent regarding a subject in one setting, but, as here, remains silent on that subject in another, we generally abide by the rule that such silence is intentional." *Id.* at 497. Therefore, the Court refused to "judicially engraft a procedure inconsistent with the dichotomy the Legislature constructed." *Id.* Moreover, the Court rejected Liberty Mutual's claim that an employee cannot obtain LIBs where his claim initially is denied, but his health deteriorates. To the contrary, the statute requires that benefits be paid when eligibility is established and there is no limitation on *when* that eligibility may be established. *Id.* at 498.

The Court concluded its analysis by rebuffing the arguments of the dissent, which were as follows: (1) despite the statute's failure to include a procedure to re-open the LIB determination, the Act's general definition of "impairment" implies such a procedure; (2) the Act also necessarily implies the authority of the Division to re-open the LIB determination; (3) the Court's prior remand in *American Zurich Insurance Co. v. Samudio*, 370 S.W.3d 363 (Tex. 2012), required the Court now to allow the Division to re-open LIB determinations; and (4) the Legislature's framework credits the Division as "being able to predict the future and knowing absolutely which claimants will always be entitled to" LIBs. The majority opinion dismissed the dissent's support of its first argument as unpersuasive. Specifically, the dissent claimed that the Act's general definition of "impairment" as "reasonably presumed to be permanent" merely established a prediction by the Division. The majority countered this assertion by stating that the "generic definition of impairment does not re-inject into the Act an entire procedure for re-opening LIB determinations that the Legislature previously removed." *See Adcock*, 412 S.W.3d at 498. Next, the majority rejected any implied authority for the Division to re-open LIB determinations based on principals of agency. Such a determination would conflict with the well-established principle that an administrative agency may only exercise the powers conferred upon it by the Legislature. The majority also found the dissent's reliance on *Samudio* misplaced. Specifically, the *Samudio* court was focused on impairment income benefits, and the Act specifies that the Division assign an impairment rating to an individual based upon certain criteria. The parties to that case disagreed upon what impairment rating the employee had suffered. The Division had not assigned a valid impairment rating; therefore, the Court remanded the case and ordered the Division to abide by the statute's mandate. In *Adcock*, on the other hand, re-opening the determination would not enforce the statute's mandate, but violate it because the Act clearly mandates the carrier to make payments until the employee's death. Finally, the Court

rejected the argument that the majority's construction of the Act's comprehensive scheme requires the Division to predict which claimants will be entitled to LIBs—a requirement that would be unworkable because the future is unknown. The majority responded by stating that "the question is not whether future damages are absolutely knowable but whether the plaintiff proved such damages within a reasonable degree of certainty." *Id* at 499 (citation omitted). According to the Court, simply because a plaintiff incurred fewer medical expenses than a judgment awarded was not grounds to re-open a Division determination. *Id.* At bottom, "the question is whether the Division could determine that an employee lost the use of two limbs," and that decision had been made over a decade earlier and with little difficulty based on the record. *Id.*

In light of the foregoing, the Court concluded that Adcock's right to LIBs could not be revisited under the Act. The Legislature specifically removed such a procedure in 1989 and, currently, only temporary income benefits are subject to re-evaluation. Thus, the Court held that the Division had no jurisdiction to re-open Adcock's determination.

Commentary:

Although it may not be monumental, the Court's decision in *Adcock* certainly is important in the realm of worker's compensation insurance. The Court has never shied away from deferring to the state legislature and *Adcock* is no different. However, it is interesting that the Court acknowledged that an employee could obtain a windfall of LIBs if his medical situation improved over time and, more importantly, the Division and the insurer are powerless to revisit the LIB determination. That being said, one would have to believe that, in most scenarios, the loss of two limbs is not something that typically improves with time. As such, the reopening of LIB determinations likely would be a rare event even if it had been allowed by the Court.

VIII. *Star-Tex Resources, L.L.C. v. Granite State Insurance Co.*, 2014 WL 60192 (5th Cir. Jan. 8, 2014)

Acknowledging a rare exception to Texas's "eight-corners" rule, the U.S. Court of Appeals for the Fifth Circuit looked to extrinsic evidence in its coverage analysis and found that no duty to defend or duty to indemnify was owed by an insurer to its insured. *See Star-Tex Resources, L.L.C. v. Granite State Ins. Co.*, 2014 WL 60192 (5th Cir. Jan. 8, 2014). The court's decision represents an ongoing debate as to the existence of such an exception—one that has never been adopted by the Supreme Court of Texas, but that periodically is utilized in Texas federal courts.

A. Background Facts

The underlying lawsuit giving rise to this appeal stemmed from a tort suit brought by Eddie Siegmund in Texas state court. Siegmund was injured in an automobile collision caused by Mariana Esquivel. Star-Tex, a staffing company, sent Ms. Esquivel to Auto Auction, who employed Siegmund. Esquivel, while allegedly under the influence of drugs, put a car into motion, pinning Siegmund between two cars and injuring him. Siegmund ultimately filed suit against Esquivel and Star-Tex to recover for his injuries. The two defendants sought a defense from Granite State Insurance Co. ("Granite"), which insured Star-Tex under, among other things,

a CGL policy. Granite denied coverage, however, claiming that the policy's "auto" exclusion precluded coverage. *Id.* at *1. The exclusion at issue barred coverage for damages caused by an "insured" arising out of the use of a motor vehicle. More specifically, coverage was barred for the following claims:

> "Bodily injury" or "property damage" arising out of the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft owned or operated by or rented or loaned to any insured. Use includes operation and "loading or unloading."
>
> This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage" involving the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft that is owned or operated or rented or loaned to any insured."

Id. at * 2.

At trial in the coverage lawsuit that resulted, both parties moved for summary judgment. Granite moved for summary judgment on the basis that, under the "eight corners" rule, which generally governs an insurer's duty to defend in Texas, the court must make a reasonable inference that Ms. Esquivel was driving the vehicle that pinned Siegmund to the second vehicle, triggering the policy's "auto" exclusion and negating Granite's duty to defend. Star-Tex and Esquivel moved for summary judgment on the basis that the "eight corners" rule requires the court to construe their claim broadly and expansively, resolving any doubt as to coverage in favor of the insured. Because, according to Granite and Esquivel, Siegmund's underlying complaint asserted a *potentially* covered claim, Granite's duty to defend was triggered. They further reasoned that because the underlying complaint did not state whether Esquivel was *driving* the auto at the time of the accident, the "auto" exclusion could not apply. The trial court granted Granite's motion for summary judgment and the instant appeal followed. *Id.*

B. Analysis by the Fifth Circuit

The Fifth Circuit began its analysis by discussing the "eight corners" rule, noting that "[f]acts outside the pleadings, even those easily ascertained, are ordinarily not material to the determination [of the duty to defend] and allegations against the insured are liberally construed in favor of coverage." *Id.* at *3 (citations omitted). In other words, duty to defend determinations generally are made by only considering the policy and the pleadings and other information, no matter how easily discovered, is not to be considered. Thus, the duty to defend arises only when the facts as alleged in the pleadings, taken as true, *potentially* would state a cause of action falling within the terms of the insurance policy.

In his complaint, Siegmund asserted that he was "seriously injured in an automobile collision caused by the negligence of . . . Esquivel," who was "under the influence of alcohol and/or drugs at the time of the collision." *Id.* at *4. Apart from that, however, the complaint lacked any other factual allegations. On appeal, Granite argued that the "auto" exclusion applied

because it would have been reasonable to infer from the complaint that Esquivel was operating an auto at the time of the accident. Granite also argued that the fact that Siegmund only sued Esquivel and no one else underscored the reasonable inference that Esquivel was operating the auto. The court agreed that the inference was indeed reasonable, but the court noted it was not the *only* reasonable inference that could be made under the facts as alleged. For instance, as argued by Esquivel and Star-Tex, Esquivel could have caused the accident by directing traffic in the auto lot, or while walking through it, causing another vehicle to strike Siegmund. Because the allegations in the underlying complaint, which the court described as "terse," could support multiple reasonable inferences, the court could not determine, based solely upon the pleadings, whether there was a potentially covered claim. *Id.*

Because the pleading was "insufficiently precise to determine coverage," the court concluded that "there is a limited exception to the eight-corners rule that, under the circumstances of this appeal, allows us to consider extrinsic evidence." *Id.* The court noted that while the "[Supreme Court of Texas] has never expressly recognized an exception to the eight-corners rule, other courts have." *Id.* at *5 (citing *GuideOne Elite Ins. Co. v. Fielder Road Baptist Church*, 197 S.W.3d 305 (Tex. 2006); *Northfield Ins. Co. v. Loving Home Care, Inc.*, 363 F.3d 523 (5th Cir. 2004)). The court acknowledged its prior "*Erie* guess" that "if the [Supreme Court of Texas] were to recognize an exception to the eight-corners rule, it would likely do so under [these] circumstances." *Id.* "Specifically, this court has *Erie* guessed that the Texas Supreme Court would recognize an exception to the eight-corners rule 'when it is initially impossible to discern whether coverage is potentially implicated *and* when the extrinsic 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 in the underlying case.'" *Id.* (citing *Northfield*, 363 F.3d at 475–76 (emphasis added)). The court continued, "[i]n *GuideOne*, the Supreme Court of Texas cited this language from *Northfield* with approval, though it held that the circumstances of the case before it did not meet the conditions of the exception." *Id.* Further, the court had previously "suggested that extrinsic evidence is more likely to be considered when an 'explicit policy coverage exclusion clause' is at issue." *Id.*

Granite argued that, if the court were to look beyond the eight corners, it should consider the undisputed extrinsic evidence that Ms. Esquivel was driving the auto, put the vehicle into motion, and pinned Mr. Siegmund between that car and another, thereby triggering the auto exclusion. First, the court asked, based upon the underlying complaint, whether it was "initially possible to discern whether coverage is potentially implicated." *Id.* The court found that it was—the complaint contained one brief sentence describing the facts of the accident. Importantly, that single sentence did not contain a description of *how* Ms. Esquivel caused the collision. Because Granite's duty to defend hinged upon what Ms. Esquivel was doing at the time of the accident "'[s]uch an explanation is critical to the question of coverage' under the policy." *Id.* In this respect, the Fifth Circuit found the magistrate judge's reasoning persuasive:

> Siegmund's petition triggered the potential application of the Auto Exclusion in alleging he was injured in an 'automobile collision.' Had Siegmund's petition alleged only an accident without referencing an automobile or collision, it would have stated a potentially covered claim and the Auto Exclusion would not have applied. Alternatively, had the petition stated Esquivel was 'driving' or 'operating' at the time she negligently caused the collision, this case would fall

> squarely within the Auto Exclusion. Because Siegmund's petition triggers a potential exclusion but omits a fundamental fact—how Esquivel's negligence caused the collision that harmed Siegmund—the first requirement to permit the Court to consider evidence outside the eight corners is satisfied.

Id. at *6.

Second, the court considered "whether 'the extrinsic 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 in the underlying case.'" *Id.* Here, the court concluded that the extrinsic evidence applied to coverage. Specifically, the evidence would establish that Ms. Esquivel was an "insured" under the policy—that is an "employee" of Star-Tex—and that she was operating a vehicle at the time of the accident, triggerng the auto exclusion. Further, the evidence *solely* applied to coverage. That is, the extrinsic evidence did not overlap with the merits of the underlying case because the mere fact that Ms. Esquivel was operating a vehicle did not establish her negligence in causing the injury to Mr. Siegmund or apply to Siegmund's negligent hiring or respondeat superior claims. Moreover, the evidence did not engage in the truth or falsity of any alleged facts. Having reviewed the evidence, the court concluded that the exclusion applied and that Granite owed no duty to defend. Finally, the court noted that the same reasons that negated the duty to defend likewise preclude the duty to indemnify.

Commentary:

As noted above, the Fifth Circuit's adoption of an exception to the "eight corners" rule continues the ongoing debate as to whether an exception actually exists. To date, the Supreme Court of Texas still has not adopted such an exception. Nevertheless, federal courts continue to utilize such an exception where the concerns raised in *Northfield* exist. Of course, not all federal courts—or Fifth Circuit panels—operate the same, as there continues to be a divide even among the federal courts as to whether an exception truly exists. Until such time the issue is certified to the Supreme Court of Texas or works its way through the state court system, insureds and insurers alike may continue to face uncertainty on the issue. Moreover, the resolution of the issue truly may depend on the court and the judge or judges before which the case is pending.

IX. *Ewing Construction Co., Inc. v. Amerisure Insurance Co.*, 420 S.W.3d 30 (Tex. 2014)

In what had been, according to some commentators, the most watched insurance coverage case in the United States in 2013, the Supreme Court of Texas had the task of determining whether the "contractual liability" exclusion should apply to negate coverage for a general contractor where the "property damage" at issue is only to the subject matter of its construction contract. Apparently not wanting to let those commentators be right, the Court waited until 2014 to end the "*Ewing* watch" that had gripped the state—or at least this author's office[3]—for nearly a year. On January 17, 2014, the Court issued a unanimous opinion in favor of Ewing Construction and in favor of coverage under a standard-form CGL policy, finding that

[3] In the interest of full disclosure, the authors were pleased to have represented Ewing Construction in this case throughout its many twists and turns.

the "contractual liability" exclusion did not apply to negate coverage. *See Ewing Constr. Co., Inc. v. Amerisure Ins. Co.*, 420 S.W.3d 30 (Tex. 2014).

A. Background Facts

In 2008, Ewing entered into a standard American Institute of Architects contract with a school district in the Rio Grande Valley wherein Ewing agreed to renovate and build additions to a school in Corpus Christi, including the construction of tennis courts. Shortly after their completion, however, the district complained that the courts were flaking, crumbling and cracking, making them unusable for tennis events. As a result, the district filed suit against Ewing and others under theories of negligence and breach of contract. *Id.* at 31.

Ewing tendered its defense to Amerisure, which had issued a commercial package insurance policy that included CGL coverage, but Amerisure denied coverage. Ewing filed suit, seeking a declaration that Amerisure had breached its contract by failing to defend Ewing in the underlying lawsuit and failing to indemnify it for any damages that may be awarded to the district. Amerisure did not dispute that the insuring agreement of its policy had been satisfied by the allegations in the live pleading of the underlying lawsuit, but it contended that the "contractual liability" exclusion completely negated coverage. Ewing and Amerisure filed cross motions for summary judgment in the Southern District of Texas, where Amerisure prevailed on its argument with the district court relying in large part on the Supreme Court's earlier decision in *Gilbert Texas Construction, L.P. v. Underwriters at Lloyd's London*, 327 S.W.3d 118 (Tex. 2010). *See Ewing*, 420 S.W.3d at 32. The crux of that court's decision was that *Gilbert* "stands for the proposition that the contractual liability exclusion applies when an insured has entered into a contract and, by doing so, has assumed liability for its own performance under that contract." *Id.* (citation omitted). Further, the court ruled that the exceptions to the exclusion did not apply.

Ewing appealed to the U.S. Fifth Circuit Court of Appeals, which initially affirmed the district court's opinion in a 2-1 decision that included a blistering dissent from Judge W. Eugene Davis. *Id.* at 32–33. On petition for rehearing, however, the Fifth Circuit withdrew its initial opinion and certified the following two questions to the Supreme Court of Texas:

1. Does a general contractor that enters into a contract in which it agrees to perform its construction work in a good and workmanlike manner, without more specific provisions enlarging this obligation, "assume liability" for damages arising out of the contractor's defective work so as to trigger the Contractual Liability Exclusion.

2. If the answer to question one is "Yes" and the contractual liability exclusion is triggered, do the allegations in the underlying lawsuit alleging that the contractor violated its common law duty to perform the contract in a careful, workmanlike, and non-negligent manner fall within the exception to the contractual liability exclusion for "liability that would exist in the absence of contract."

Ewing Constr. Co. v. Amerisure Ins. Co., 690 F.3d 628, 633 (5th Cir.2012).

B. The "Contractual Liability" Exclusion

After addressing Texas's long-standing rules on the duty to defend—namely, the applicability of the "eight corners" rule and the necessary focus on the factual allegations of the underlying lawsuit instead of the legal theories asserted—the court turned to the allegations of the underlying lawsuit. *See Ewing*, 420 S.W.3d at 33. The Court reiterated that Ewing contracted to build the tennis courts at issue, noting that all or part of the work had been subcontracted to other parties. After the courts began to flake and fall apart, the school district claimed damages under contractual and negligence theories of liability. *Id.* Importantly, the allegations under each theory were virtually the same. Additionally, the district generally alleged that Ewing breached its duty of ordinary care in performing its contract. *Id.*

Thereafter, the Court turned to the "contractual liability" exclusion relied on by Amerisure, which provided as follows:

> **2. Exclusions**
>
> This insurance does not apply to:
>
> ***
>
> **b. Contractual Liability**
>
> "Bodily injury" or "property damage" for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement. This exclusion does not apply to liability for damages:
>
> (1) That the insured would have in the absence of the contract or agreement; or
>
> (2) Assumed in a contract or agreement that is an "insured contract".

Id. at 34. Noting that *Gilbert* involved the interpretation of a substantively similar exclusion and exception,[4] the Court also pointed out that *Gilbert* involved only the duty to defend, but that the duty to defend and the duty to indemnify both were at issue in *Ewing*. Nevertheless, the Court found that "*Gilbert's* interpretation of the contractual liability exclusion guides our determination." *Id.*

To briefly summarize, the Court in *Gilbert* found that the contractual liability exclusion applied to negate coverage for a breach of contract claim asserted against Gilbert by a third-party entity ("RTR") that owned property near a project Gilbert completed for the Dallas Area Rapid Transit ("DART"). That property was inadvertently flooded during the course of construction, resulting in significant damages. The Court explained that Gilbert undertook two obligations in its contract with DART—one of which extended Gilbert's obligations beyond the general common law. Specifically, the Court stated as follows:

> Gilbert owed RTR a duty under general law to conduct its construction operations with ordinary care so as not to damage RTR's property. In Gilbert's contract with DART, though, it undertook a specific contractual obligation to repair or pay for

[4] The exceptions in *Gilbert* were in the opposite order as compared to those at issue in *Ewing*.

> damage to third-party property resulting from either (1) a failure to comply with the requirements of the contract, or (2) a failure to exercise reasonable care in performing the work. The second obligation—to exercise reasonable care—mirrored Gilbert's duty under general law principles that would have made it liable for damages it negligently caused RTR. Thus, because Gilbert's contractual liability for damages to RTR for failing to exercise ordinary care in performing its work would not have differed from its liability for damages to RTR under general principles of law—such as negligence—Gilbert did not assume liability for damages in its contract under the second obligation sufficient to trigger the policy's contractual liability exclusion.
>
> But the first obligation Gilbert assumed—to repair or pay for damage to property of third parties such as RTR "resulting from a failure to comply with the requirements of this contract"—extended "beyond Gilbert's obligations under general law." Thus, we held that RTR's breach of contract claim "was founded on an obligation or liability contractually assumed by Gilbert within the meaning of the policy exclusion." In other words, Gilbert did not contractually assume liability for damages within the meaning of the policy exclusion unless the liability for damages it contractually assumed was greater than the liability it would have had under general law—in Gilbert's case, negligence. We then considered whether the exception to the exclusion brought Gilbert's liability to RTR back into coverage. In doing so we recognized that the case involved "unusual circumstances" because Gilbert ordinarily could have been liable in tort for damages to RTR absent its contract, but under the facts of the case, the only basis for Gilbert's liability to RTR was RTR's claim for Gilbert's breach of the contract with DART. We held that the exception was inapplicable because Gilbert's only liability for damages was for breach of contract. Because the exclusion applied and the exception did not, there was no coverage.

Id. at 35–36 (internal citations omitted).

With that set out, the Court turned to the facts before it and the dispute between Ewing and Amerisure. Amerisure, relying on the Court's statement in *Gilbert* that the exclusion "means what it says: it excludes claims when the insured assumes liability for damages in a contract or agreement, except when the contract is an insured contract or when the insured would be liable absent the contract or agreement," arguing that the exclusion applies to Ewing because "Ewing contractually undertook the obligation to construct tennis courts in a good and workmanlike manner and thereby assumed liability for damages if the construction did not meet that standard." *Id.* at 36. On the other hand, Ewing contended that the case was different than *Gilbert* because its agreement to perform the work in a good and workmanlike manner did not enlarge its obligations any general common law duty it might have. That is, it did nothing to expand its obligation beyond the requirement that it perform the contract in accordance with its terms and exercise ordinary care in doing so and, therefore, was not an "assumption of liability" within the meaning of the exclusion. *Id.* The Court said: "We agree with Ewing." *Id.*

Acknowledging and reiterating its holding in *Gilbert*, the court restated that the exclusion means what it says: "it excludes liability for damages the insured assumes by contract unless the

exceptions bring the claim back into coverage." *Id.* at 37. But, also as stated in *Gilbert*, the insured has to have "assumed a liability for damages that exceeds the liability it would have under general law" or else "assumption of liability" becomes meaningless. *Id.* (citing *Am. Family Mut. Ins. Co. v. Am. Girl, Inc.*, 673 N.W.2d 65, 80–81 (Wis. 2004) ("The term 'assumption' must be interpreted to add something to the phrase 'assumption of liability in a contract or agreement.' Reading the phrase to apply to all liabilities sounding in contract renders the term 'assumption' superfluous.")). According to the Court, the allegations that Ewing did not perform its work in a good and workmanlike manner was substantively the same as the allegations that it negligently performed its work under the contract. And, as Ewing pointed out in its briefs, "it had a common law duty to perform its contact with skill and care." *Id.* As such, the Court held as follows:

> Accordingly, we conclude that a general contractor who agrees to perform its construction work in a good and workmanlike manner, without more, does not enlarge its duty to exercise ordinary care in fulfilling its contract, thus it does not "assume liability" for damages arising out of its defective work so as to trigger the Contractual Liability Exclusion. We answer the first [certified] question "no" and, therefore, need not answer the second [certified] question.

Id. at 38.

Having held in favor of Ewing, the Court also addressed Amerisure's rehashing of an age-old insurer argument—finding coverage in the scenario presented to the Court converts a CGL policy into a performance bond. *Id.* Having rejected the same argument in *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, 242 S.W.3d 1, 7 (Tex. 2007), the Court again disagreed with the insurer. As it explained in that earlier decision, the underlying allegations of defective construction fell within the broad coverage grant of the CGL policy, but the Court did not address whether any of the policy exclusions negated coverage. *Ewing*, 420 S.W.3d at 38 (discussing *Lamar Homes*, 242 S.W.3d at 10). In fact, in that case, the Court noted specific business risk exclusions that may be applicable in such cases, but did not determine their applicability. *Id.* (citing *Lamar Homes*, 242 S.W.3d at 10–11). The Court concluded: "Because the policy contains exclusions that may apply to exclude coverage in a case for breach of contract due to faulty workmanship, our answer to the first certified question is not inconsistent with the view that CGL policies are not performance bonds." *Id.* at 38–39.

Commentary:

In another landmark victory for policyholders, the Supreme Court of Texas again rejected an insurer's attempt to find that breach of contract claims are not covered by standard-form CGL policies. In doing so, the Court walked a thin line between what constitutes an "assumption of liability" as was found in *Gilbert* and what does not, but reached a clear conclusion: The mere fact that the damages at issue are only to the subject matter of the contract does not mean that coverage does not exist. Possibly more importantly, it seems clear that the Court intended for its holding to apply to both the duty to defend and the duty to indemnify. Notably, a number of cases across Texas have been abated awaiting this opinion, so we should see, in short order, the impact of the Court's decision. Stay tuned . . .

X. Other Cases of Note

A. "Policy Construction": *Bituminous Casualty Co. v. The Travelers Indemnity Co.*, 2013 WL 1722447 (N.D. Tex. Apr. 22, 2013)

On April 22, 2013, the Northern District of Texas, in an opinion issued by Chief Judge Sidney A. Fitzwater, held that a policy endorsement on a business auto policy means what it says. The court held that a policy endorsement that specifically deleted five tractor trailers under the liability coverage of the policy prevailed notwithstanding any alleged ambiguity created by the use of coverage symbols in the policy. In particular, the court rejected Bituminous's claim that the use of coverage symbol "1," which was defined as "Any Auto," meant that the only way to remove a vehicle from coverage was to change the meaning of the symbol or replace that symbol with a more limited coverage symbol. In rejecting the position, the court found that the endorsement deleting the five vehicles was clear and unambiguous and, moreover, under Texas law, when an endorsement and the main coverage form conflict, the endorsement controls the coverage issue.

B. "Examination Under Oath": *Shafighi v. Texas Farmers Insurance Co.*, 2013 WL 1803609 (Tex. App.—Houston [14th Dist.] April 30, 2013, no pet.)

Shafighi arose out of a dispute between a home owners' insurance policyholder and his insurer. The insured filed a claim after fire damaged his home. The insurer requested that the insured submit to an examination under oath as provided for in the policy. Because of various scheduling conflicts, the examination did not take place and, approximately six months after the filing of the claim, the insurer denied coverage. The insured sued and lost at the trial level. The trial court granted summary judgment in favor of the insurer and the insured appealed.

On appeal, the court noted that the policy provides that "as often as [insurer] reasonably requests," the insured must "submit to examinations under oath." However, the penalty for failing to submit to such examination is not a bar to coverage, but abatement of the pending suit until such examination occurs. The court of appeals rejected the insurer's contention that failure to comply with the condition precedent of submitting to an examination under oath is a reasonable basis for denying an insured's claim; thus, overruling the trial court.

C. "Workers' Compensation: Failure to Exhaust Administrative Remedies": *Thomas v. American Home Assurance Co.*, 403 S.W.3d 512 (Tex. App.—Dallas 2013, no pet.)

This case stemmed from a workplace injury suffered by Mr. Thomas. Thomas underwent knee surgery following the injury, paid for by the worker's compensation insurer. Thomas' physician recommended a full knee replacement upon follow up diagnosis, which the insurer rejected after a peer review found the injury to Thomas did not warrant such a surgery. Thomas did not request reconsideration of this decision. The Texas Workers' Compensation Commission, now the Texas Department of Insurance, Division of Workers' Compensation, sent Thomas a letter stating it had received Thomas's request for a benefit review conference, but a conference could not be scheduled because of a lack of documentary evidence supporting the claim. The letter requested that Thomas provide such evidence; however, no indication existed

that this was done. In the meantime, Thomas's physician sent multiple preauthorization requests for knee replacement surgery, to which the insurer replied that an injury was recognized, but advised that compensability of the injury may be disputed. After six requests for knee replacement, the insurer agreed to pay the cost of the replacement surgery.

After undergoing the surgery, Thomas sued the insurer, the claims investigator, and others based on the delay in approving the worker's compensation claim. The insurer replied with a motion to dismiss based on lack of subject matter jurisdiction, claiming that Thomas had failed to exhaust his administrative remedies. The court concluded that Thomas had failed to pursue any of the administrative remedies available to him under the relevant statutory scheme as there was no evidence of such pursuit in the appellate record. As such, the court affirmed the lower court's ruling.

D. "Prejudice Caused by Late Notice": *Starr Indemnity & Liability Co. v. SGS Petroleum Service Corp.,* 719 F.3d 700 (5th Cir. 2013)

The *SGS Petroleum Service* decision arose out of a chemical spill at a chemical plant in Baytown, Texas. The policy at issue was an umbrella policy purchased from Starr Indemnity & Liability Co. ("Starr") by a company that provides services to the petrochemical industry. The insured also was covered by a primary liability policy with $2 million limits. One of the insured's employees accidentally spilled chemicals while conducting unloading operations. Initially, the insured did not inform the excess insurer of the incident, as the total damages appeared to be within the coverage of the primary policy. However, the damages later were found to be substantially over the coverage amount of the insured's primary policy. The insured then, fifty nine days after the incident, informed Starr of the loss. The Starr policy contained the following "buy back" provision which replaced the usual pollution exclusion:

> Notwithstanding anything to the contrary, this policy shall not apply to any claim arising directly or indirectly in consequence of the discharge, dispersal, release, or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials, oil or other petroleum substance or derivative (including any oil refuse or oil mixed wastes) or other irritants, contaminants or pollutants into or upon land, the atmosphere, or any watercourse or body of water. This exclusion ***shall not apply,*** however, provided that the assured establishes that all of the following conditions have been met:
>
> ***
>
> (4) the discharge, dispersal, release, or escape was reported in writing to these underwriters within 30 days after having become known to the assured.

Starr filed a declaratory judgment action, seeking a ruling that its policy did not cover the insured's claim because the insured failed to notify Starr of the chemical release within the requisite thirty-day period. The insured moved for summary judgment alleging that (1) the 30–day requirement must be construed as a covenant and not as a condition precedent; (2) failure to strictly comply with the 30–day requirement did not excuse Starr's performance absent prejudice; (3) Starr was not prejudiced as a matter of law; and (4) in the alternative, the policy was ambiguous and the Court must construe any ambiguity in favor of the insured. The trial

court granted Starr's motion for judgment on the pleadings and denied the insured's motion. On appeal, the court noted that the "buy back" provision was negotiated for by the parties and should be respected. The notice requirement in the negotiated-for provision is "essential to the bargained-for coverage"; thus, Starr was not required to show any prejudice to deny coverage.

E. "Inspection Before Repairs": *Santacruz v. Allstate Texas Lloyds, Inc.*, 2013 WL 3196535 (N.D. Tex. June 25, 2013)

On June 25, 2013, the Northern District of Texas held that an insured was not entitled to coverage under a homeowner's insurance policy. The dispute arose after the insured's home suffered a loss during a windstorm and the insured had to cover the roof with a tarp. The insured made a claim for wind and water damage, and the adjuster told the insured it would not be there for a couple days to investigate. Having already had a roofer on site to replace the roof, the insured moved forward with the repairs. Allstate denied coverage after its adjuster arrived two days later for the inspection and the repairs already had been completed. The court ruled that the insured had violated the terms of the policy because the insured had not complied with its duties after a loss, depriving the insurer of the ability to properly investigate the claim. Thus, coverage did not exist.

F. "Diminution of Value": *Noteboom v. Farmers Texas County Mutual Insurance Co.*, 406 S.W.3d 381 (Tex. App.—Ft. Worth 2013, no pet.)

In *Noteboom*, the insurer disputed that uninsured motorist coverage ("UM") allowed recovery of a vehicle's diminution in value after damages caused by an uninsured driver were repaired. The court of appeals, however, found that the insureds' auto policy unambiguously covered such damage, the amount of which was stipulated by the parties. Accordingly, the court of appeals reversed the trial court and rendered judgment for the insureds.

G. "Directors' and Officers' Liability": *Gastar Exploration Ltd. v. U.S. Specialty Insurance Co.*, 412 S.W.3d 577 (Tex. App.—Houston [14th Dist.] 2013, pet. filed)

An insured filed a lawsuit for declaratory relief against its primary liability insurer and excess liability insurer after the insurers denied coverage for lawsuits filed against the insured during the insurers' respective policy period. At trial, the court denied the insured's motion for partial summary judgment and entered summary judgment in favor of the insurer based upon an a provision in the directors' and officers' liability insurance policy that deemed interrelated claims to have been filed before the policy period because they related back to a series of pre-policy lawsuits. On appeal, the court found that an ambiguity in the policy existed because the "prior or pending litigation" exclusion, which had been modified by endorsement, conflicted with the interrelated claims provision. In particular, the court found that the interrelated claims provision rendered the "prior or pending litigation" exclusion meaningless. Because the provisions conflicted, or at best created an ambiguity, the court construed the policy in favor of coverage under Texas law and reversed and remanded the case to the trial court for further proceedings.

H. "Frozen Plumbing – Duty to Maintain Heat Exclusion": *American National Property & Casualty Co. v. Fredrich 2 Partners, Ltd.*, 408 S.W.3d 610 (Tex. App.—El Paso 2013, pet. denied)

In *Fredrich 2 Partners, Ltd.*, the insured brought a declaratory judgment action against its commercial property insurer, asserting that water damage caused by a frozen water pipe was covered under the policy. The insurer argued that coverage was excluded by virtue of an exclusion that provided as follows:

> 2. We will not pay for loss or damage by or resulting from any of the following:
>
> e. Frozen Plumbing
>
> Water, other liquids, powder or molten material that leaks or flows from plumbing, heating, air conditioning, or other equipment (except fire protective systems) caused by or resulting from freezing, unless
>
> (1) You do your best to maintain heat in the building or structure.

The water pipe at issue burst in an attic of a building containing two units—one of which was occupied and heated and the other of which was vacant and unheated. The insured argued that, by maintaining heat in the occupied unit, it had satisfied the policy's requirement that it "do [its] best to maintain heat in the building or structure." Additionally, the insured argued that even if the "do your best" language was ambiguous, the phrase should be construed narrowly in its favor. Last, the insured argued that even if the vacant unit had been heated the pipe still would have burst and, therefore, the exclusion should not apply. The trial court did not state which argument it relied on in siding with the insured. Accordingly, on appeal, the court noted that the judgment need only be supported by at least one of the asserted claims. The court of appeals found that heat was available by virtue of the insured supplying electricity and gas to the vacant building and that, therefore, the insured had done its part "to do its best to maintain heat in the building." Consequently, the court of appeals affirmed the lower court's judgment for the insured.

I. "Commercial Property Insurance": *Lexington Insurance Co. v. JAW The Pointe, LLC*, 2013 WL 3968445 (Tex. App.—Houston [14th Dist.] Aug. 1, 2013, pet. filed)

This case arose out of a Hurricane Ike claim that was brought by a property management company against its property insurer. At trial, the jury found the insurer had breached its contract with the insured and did so in bad faith. In doing so, the jury awarded the insured statutory damages based on the insurer's violation of certain Insurance Code provisions. On appeal, the court found in favor of the insurer, finding that the insured's policy did not provide coverage where the insured's loss was caused, in whole or in part, by flood. The court rejected the insured's contention that its wind damages alone were sufficient to trigger the ordinance or law coverage under the policy, as those damages arguably exceeded the requisite 50% of the city's market value of the apartments. The court found that the evidence was insufficient to support the insured's position because the damages were not segregated between wind and flood damage and, therefore, the policy's "concurrent causation" language precluded coverage. Moreover, the

insured could not "identify any evidence that the City made its substantial damage determination based on wind damage alone—as opposed to flood damage or a combination of wind and flood damage, both of which are excluded causes of loss. Enforcement of the City ordinance predicated in part on an excluded cause of loss is excluded by the policy's concurrent causation language." Thus, coverage could not exist under the Ordinance or Law endorsement. Similarly, the court found that coverage also did not exist under the policy's Demolition and Increased Cost of Construction endorsement. Having found that the policy did not cover the insured's loss, the court concluded that the insurer had not breached its contract and, in turn, could not be liable under the Insurance Code. Finally, because no evidence existed that the insurer engaged in extreme conduct and because no cause of action for bad faith exists for the failure to timely investigate the insured's claim, the court also found that the insured could not prevail on its statutory bad faith claim either.

J. "Breach of Contract, Good Faith and Fair Dealing": *Marquis Acquisitions, Inc. v. Steadfast Insurance Co.,* 409 S.W.3d 808 (Tex. App—Dallas 2013, no pet.)

The claim in this case arose out of the legal defense provided by an insurer to its insureds. Initially, the insurer issued a reservation of rights letter to it's the insureds, but later in the claims handling process and after a dispute arose as to the appointment of independent counsel, the insurer agreed to provide the insureds an unqualified defense and appointed counsel. Nevertheless, personal counsel for the insured continued to contend that he should be named as counsel because of a conflict of interest. The insureds' attorney, however, did not provide any basis for the alleged conflict. Ultimately, after agreeing that a potential conflict could arise in the future, the insurer agreed to hire separate counsel for one of the insureds but refused to hire that insured's personal counsel to defend the case based on the provision of an unqualified defense. That insured sued its insurer, alleging breach of contract and bad faith, while seeking coverage for the attorneys' fees it incurred in getting the insurer to retain separate counsel. The appellate court upheld the trial court's finding that the insurer's delay in employing separate counsel did not constitute a breach of the insurance contract, and, moreover, the insured had not suffered any harm as a result of the delay. Additionally, the court found that the insurer had not violated the Insurance Code or breached its duty of good faith and fair dealing.

K. "Appraisal": *TMM Investments, Ltd. v. Ohio Casualty Insurance Co.,* 730 F.3d 466 (5th Cir. 2013)

The insured, the owner of a shopping center, brought action in state court against its property insurer, seeking to have an appraisal award regarding hail damage declared invalid. The case was removed to the Eastern District of Texas. At trial, the court entered partial summary judgment in favor of the insured, set aside the appraisal award, found that the insured was entitled to damages and attorney's fees, and denied the insurer's motions for new trial. On appeal, the Fifth Circuit agreed with the insured that an error existed in the award because the umpire lacked the authority to exclude the HVAC damages estimate from the award. Nevertheless, the court found that the error did not justify invalidating the entire award. Further, the court found that the appraisers properly considered causation of the alleged damages as allowed by *State Farm Lloyds v. Johnson*, 290 S.W.3d 886 (Tex. 2009). And, because the award was valid and the insurer paid it in full (included the HVAC amount that had been struck by the

umpire) the court found the insurer complied with the insurance policy. As a result, the court reversed the trial court's decision in its entirety.

L. "Life Insurance Contestability After Policy Reinstatement": *Cardenas v. United of Omaha Life Insurance Co.*, 731 F.3d 496 (5th Cir. 2013)

This case arose after a life insurance company denied benefits under a life insurance policy. The policy was allowed to lapse by the insured but subsequently was reinstated. Thirteen months after the reinstatement, the insured died. As required by the Texas Insurance Code, the policy contained a provision that it would become incontestable if it was in force for two years following its issue date. The policy was silent on any contestability period following reinstatement, but the parties agreed that one existed—although they disagreed on the length of the period where the insured died before the two-year period. The trial court found that the policy never became incontestable because the insured did not survive beyond the two-year period. On appeal, the court upheld the verdict, citing language from the Texas Insurance Code. Specifically, the code provides that "a life insurance policy must provide that a policy in force for two years from its date of issue *during the lifetime of the insured* is incontestable, except for nonpayment of premiums." The court held that that statute applies to both initial policies and reinstatements.

M. "Inverse Condemnation": *City of College Station, Texas v. Star Insurance Co.*, 735 F.3d 332 (5th Cir. 2013)

The City of College Station, Texas brought suit against its commercial liability insurer, seeking to recover defense costs, indemnification, and statutory penalty interest after the insurer refused to defend or indemnify the city in an underlying lawsuit stemming from a dispute over the re-zoning of a tract of land that a real estate developer had hoped to develop into a shopping mall. The policy at issue excluded "any liability . . . actually or allegedly arising out of or caused or contributed to or in any way connected with any principal of eminent domain, condemnation proceeding, [or] inverse condemnation . . . by whatever name called." According to the insurer, the underlying action fell within the inverse condemnation exclusion. Agreeing with the insurer, the trial court granted its motion for summary judgment. Upon appeal, the court noted that a potential for liability existed that was wholly independent of and outside of any inverse condemnation claim. Therefore, the court found that the insurer had a duty to defend its insured and was liable for the insured's defense costs incurred in the underlying lawsuit. Accordingly, the court reversed the lower court's decision and remanded the case to the district court for a determination as to penalty interest that should be awarded under Texas's Prompt Payment of Claims Act.

N. "Commercial Auto Insurance, Effect of Other Insurance": *American States Insurance Co. v. ACE American Insurance Co.*, 2013 WL 6069431 (5th Cir. Nov. 19, 2013)

In this case, a commercial auto insurer, American States, sued a business auto insurer, ACE, seeking defense costs, attorney's fees, and a declaratory judgment that ACE had the sole duty to defend American States' insured, Hook & Anchor, in an underlying action that stemmed from an auto accident in which Hook & Anchor's employee was driving a vehicle owned by

ACE's insured, Chemical Weed Control. The insurers' dispute centered on their respective "other insurance" provisions, as the vehicle was insured by ACE, but the driver also qualified as an insured under American States' policy. At trial, the court held that both insurers were primary insurers and ordered them to share the defense costs on a pro-rata basis. On appeal, the Fifth Circuit disagreed and held that, under Texas law, ownership of the vehicle by Chemical Weed Control required ACE to provide primary coverage for Hook & Anchor, despite the fact that the driver of the vehicle was insured under the American States policy and both policies contained identical "other insurance" provisions. The crux of the court's decision was that each insurer's "other insurance" clause based primary coverage not on the existence of other insurance but on the ownership of the vehicle in question. Accordingly, the clauses did not conflict, and ACE was obligated to provide primary coverage with respect to the underlying lawsuit.

O. "Insurer's Ability to Enforce a Deed of Trust": *Peacock Hospitality, Inc. v. Association Casualty Insurance Co.*, 419 S.W.3d 649 (Tex. App.—San Antonio 2013, no pet.)

This case arose when Peacock Hospitality, Inc. ("Peacock"), the insured under a property policy, sued Association Casualty Insurance, Co. ("Association"), its property insurer, for breach of contract based upon Association's alleged underpayment for water damage to the insured property. The insured property was under foreclosure by Peacock's lender and Association issued payment jointly to Peacock and the foreclosing lender. When a dispute arose concerning the amount of damages to the property, Peacock sued Association, along with the lender and the buyer of the property post-foreclosure. Peacock alleged that Association had breached the insurance contract by not paying the full measure of damages, violated the Prompt Payment of Claims Act, and committed other torts. Association moved for summary judgment, asserting the foreclosure of the property had divested Peacock of any insurable interest; thus, eliminating its rights under the policy. The argument was based on wording in the deed of trust that was signed by Peacock and its lender.

In response to Association's argument, Peacock asserted that an anti-assignment clause in the policy prevented Association from assigning its rights in the policy to the foreclosing lender. Additionally, Peacock argued that, as Association was not a party to the deed of trust, it could not enforce any of its provisions. Association replied that it was not attempting to enforce the provision and that it had only cited the language in the deed in order to demonstrate that the bank could enforce the deed against Association. The trial court agreed with Association.

On appeal, the court found that a material issue of fact existed regarding the breach of contract claim by Peacock as it was unknown if the foreclosure resulted in a deficiency or a surplus. If a deficiency existed, then the mortgagee retains a right to the insurance proceeds, but only to the amount of the proceeds necessary to satisfy the deficiency. On the other hand, where a surplus exists, the mortgagor can retain the insurance proceeds and pursue the insurer for underpayment of the claim. Thus, that issue remained to be resolved.

Further, although Association disputed that it was attempting to enforce the deed of trust, the court found that its entire argument that Peacock had been divested of its rights was based on the deed of trust. As a third party, Association had no entitlement to enforce the deed of trust. Further, because summary judgment on Peacock's prompt payment and tort claims were based

on the trial court's finding that Peacock was divested of its breach of contract claim, the appellate court reversed the summary judgment ruling on those claims as well.

P. "Waiver of Appraisal": *JAI Bhole, Inc. v. Employers Fire Insurance Co.,* 2014 WL 50165 (S.D. Tex. Jan. 7, 2014)

On January 7, 2014, the Southern District of Texas held that an insurer that issued a property policy had waived its right to invoke appraisal. In that case, the insurer had mediated the dispute twice, but the mediations were unsuccessful at least in part because of the insurer's insistence on an accord and satisfaction defense. The court found that the insurer's insistence on its defense, the amount of time that passed (three years) before invoking appraisal and the nearly $40,000 in costs and fees incurred by the insureds resulted in prejudice to the insureds. Thus, under *In re Universal Underwriters of Texas Insurance Co.*, 345 S.W.3d 404 (Tex. 2011), the court denied the insurer's motion to compel appraisal.

Q. "Duty to Indemnify": *National Casualty Co. v. Western World Insurance Co.,* 2014 WL 128610 (5th Cir. Jan. 15, 2014)

National Casualty involved an insurer versus insurer dispute pertaining to the duty to indemnify an insured ambulance company. National Casualty Co. ("National") and Western World Insurance Co. ("Western") both insured the ambulance company, which had been named in a personal injury lawsuit. The National policy covered "all sums an insured must pay as damages because of 'bodily injury' . . . to which this insurance applies, caused by an 'accident' and resulting from the ownership, maintenance or use of a covered 'auto.'" The National policy also contained an exclusion, removing bodily injuries "resulting from the providing or the failure to provide any medical or other professional services" from coverage. The Western policy, on the other hand, covered "those sums the insured becomes legally obligated to pay as damages because of any 'bodily injury' . . . to which this insurance applies caused by a 'professional incident.'" The Western policy contained an exclusion for bodily injury arising out of the use of any auto. In addition, the Western policy provided that it would be excess over "any of the other insurance, whether primary, excess, contingent or on any other basis . . . if the loss arises out of the maintenance or use of . . . 'autos' . . . to the extent not subject" to the auto exclusion.

National sued Western, seeking a declaration that it had no duty to indemnify its insured. Western counterclaimed, seeking its own declaration that National had the sole duty to indemnify the insured, or in the alternative, that Western's coverage was excess to National's coverage.[5] The underlying lawsuit was settled with both insurers contributing to the settlement. At trial in the coverage case, the district court held that National Casualty had no duty to indemnify the insured, as the incident did not occur from the "use" of the auto, but while transporting a patient to it. For this same reason, the trial court also held that the "use of any auto" exclusion in the Western policy did not apply.

On appeal, the Fifth Circuit held that the underlying suit did, in fact, result from the "use of an auto," because the EMTs had reached the ambulance, had placed the gurney into "load"

[5] The district court, in a prior proceeding, found that both insurers had the duty to defend the insured. *See National Casualty Co. v. Western World Insurance Co.*, 669 F.3d 608 (5th Cir. 2012).

position, and had opened at least one ambulance door at the time the injury occurred. Moreover, while the gurney was not touching the ambulance or its doors, one of the EMTs was touching both the gurney and the ambulance and had begun the process of loading the patient into the ambulance when the accident occurred. Nevertheless, after reviewing the pleadings, the Fifth Circuit found that Western had not established that it was entitled to summary judgment, as a fact issue potentially existed as to whether the patient had been properly secured to the gurney before being moved to the ambulance. If the patient's injury resulted from that error, the "use of any auto" exclusion would not apply. Thus, the district court's opinion was vacated and the cause remanded for further proceedings.

R. "Commercial Property Insurance": *United National Insurance Co. v. Mundell Terminal Services, Inc.,* 740 F.3d 1022 (5th Cir. 2014)

A commercial property insurer brought a declaratory judgment action against its insured, a warehouse operator, seeking a declaration that it had no duty to defend or indemnify its insured in an underlying action resulting from the theft of a customer's copper sheeting from an insured warehouse location and that the policy did not cover the stolen copper. At trial, the district court granted summary judgment in favor of the insurer, finding that the policy did not provide a defense obligation to the insured and, moreover, an exclusion, which is commonly referred to as an excess "other insurance" clause, precluded coverage for the claim. The provision at issue provided that "Covered Property does not include: . . . Property that is covered under another coverage form of this or any other policy in which it is more specifically described, except for the excess of the amount due (whether you can collect on it or not) from that other insurance." According to the insurer, a separate policy issued by the customer's insurer provided primary coverage for the stolen copper.

On appeal, the Fifth Circuit addressed the applicability of the "other insurance" provision. The court noted that such clauses apply only where the two policies in question cover the same property and interest against the same risk in favor of the same party. The court found that both policies at issue covered the same interest. In addition, the court agreed that both policies provided insurance in favor of the customer. Thus, the court agreed with the district court that the commercial property policy did not provide any coverage for the stolen copper.

S. "Contestability of a Life Insurance Policy": *Mutual of Omaha Life Insurance Co. v. Costello,* 2014 WL 258213 (Tex. App.—Houston [14th Dist.] Jan. 23, 2014, no pet.)

This dispute arose from the denial of life insurance benefits by an insurer for misrepresentation of health history in the insurance application. At trial, the court granted the life insurance policy beneficiary's motion for summary judgment, finding that the insurer did not contest the policy's validity until filing affirmative defenses in the suit, which occurred more than two years after the policy became effective. The court of appeals reversed, holding that the insured individual died before the policy became incontestable as per the policy language and Texas statutory law. Simply put, in order for a policy to become incontestable, the insured must

survive the two-year contestability period but the insurer need not contest the policy within the same two-year period when the insured dies before the two-year period lapses.

T. "Notice of Policy Cancellation": *Molly Properties, Inc. v. Cincinnati Insurance Co.*, 2014 WL 486521 (5th Cir. Feb. 7, 2014)

This dispute arose after a fire damaged commercial property that had been insured under a property policy. The policy lapsed before the fire occurred as a result of the insured's failure to pay the premium owed. When the insurer denied coverage, the policyholder sued the insurer for breach of contract, alleging that because the insurer failed to notify the property's mortgagee, as required by the policy, the policyholder was entitled to coverage. The trial court found in favor of the insurer. On appeal, the court agreed with the ruling, noting that the promise to provide a cancellation notice to the mortgagee was for the benefit of the mortgagee, not the policyholder. The insurer's ability to cancel the policy was not conditioned on the insurer providing notice of such cancellation to the insured's mortgagee. Therefore, the failure to notify the mortgagee of the cancellation only affects the mortgagee's "independent" contract and is "irrelevant as to the insured's loss of coverage."

U. "Effect of Divorce on Life Insurance Policy": *Branch v. Monumental Life Insurance Co.*, 2014 WL 545617 (Tex. App.—Houston [14th Dist] Feb. 11, 2014, no pet.)

This dispute arose out of a life insurance policy purchased when the insured was married to his spouse. The insured and his spouse subsequently divorced and the insured died six weeks later. The former spouse demanded the funds from the policy, but the insurer refused, arguing that Texas statutory law operates to divest a spouse of any interest in a life insurance policy upon divorce. The trial court found in favor of the insurer and the court of appeals upheld the verdict based on the plain language of the statute. Further, none of the three exceptions to the statute applied to reinstate the former spouse's right to the insurance proceeds.

V. "Application of Texas Anti-Technicality Statute": *W.W. Rowland Trucking Co. v. Max America Insurance Co.*, 2014 WL 685217 (5th Cir. Feb. 24, 2014)

The *W.W. Rowland* case pertains to the theft of video game consoles from an insured trucking company. The loss occurred during shipping, when thieves broke into a trucking terminal—making off with $354,000 in gaming consoles. The property policy at issue contained a provision stating that all insured trucking terminals must be "100% fenced, gated, locked, and lighted for 24 hours per day, 7 days per week" or the coverage is "null and void." The fence surrounding the terminal was missing several sections, but the thieves cut the fence in other locations in order to gain access to the premises. The insurer denied coverage based on the above-quoted provision. The insured sued its insurer, claiming breach of contract, negligence, and violations of the Texas Deceptive Trade Practices Act. At trial, the court applied the Texas Anti-Technicality Statute, TEX. INS. CODE. ANN § 862.054, which states that there must be a causal link between the breach in the policy provision and the loss in order for an insurer to deny coverage under a property insurance policy and held the insurer liable under its policy.

On appeal, the insurer argued that the Anti-Technicality Statute did not apply because the policy in question was a liability policy and not a property policy. Additionally, the insurer argued that statutory penalty interest under the Prompt Payment of Claims Act should not have been awarded because the claim was a third-party claim, not a first-party claim. Finally, the insurer argued that the award of attorneys' fees should be reversed because the insured's initial demand for damages exceeded the policy limits.

Regarding the first argument, the court disagreed, finding that the policy provided coverage for the insured's legal liability for the loss of property of others while in the insured's custody. Such coverage, under Texas law, constituted property insurance, not liability insurance. Further, because the insured had an insurable interest in the consoles that were stolen, the Fifth Circuit found that the Prompt Payment of Claims Act had been properly applied. Finally, the court found that the insured was entitled to its attorneys' fees under the same Act and, therefore, no need existed to address the insurer's argument that fees could not be awarded under Section 38.001 of the Civil Practice & Remedies Code.

W. "Exhaustion of Other Remedies": *Certain Underwriters at Lloyd's of London v. Cardtronics, Inc.*, 2014 WL 943130 (Tex. App.—Houston [1st Dist.] Mar.11, 2014, no pet. h.)

Cardtronics, Inc. arose out of a theft of over $16 million from an ATM operating company, Cardtronics, Inc., by its former armored car services provider. Cardtronics was insured by Lloyd's under an "Automated Teller Machine and Contingent Cash in Transit" insurance policy. The insured filed a claim after the theft of its cash. The insurer initially denied coverage for the loss, arguing that a policy provision required Cardtronics to exhaust all other avenues of recovery before the policy would pay to cover the loss. More specifically, the provision stated that the policy only would pay for the amount of loss for contingent cash in transit that Cardtronics "cannot recover" under its agreement with the armored car provider or under any other insurance policy. After Cardtronics prevailed in the trial court, its insurer appealed. On appeal, the court affirmed the lower court's holding, finding that the policy at issue does not explicitly require Cardtronics to exhaust its remedies against third parties before pursuing its insurer for its unrecovered loss. Rather, the insured need only engage in reasonable steps to secure its insurer's claims against the responsible third parties. Because Cardtronics had performed such reasonable steps and still was unable to recover its full measure of damages from the liable third parties, Cardtronics had the right to pursue coverage from its insurer, who, in turn, could subrogate against the same third parties. As such, the court found Cardtronics was entitled to payment of its claim in full, subject to a credit for amounts previously paid by the insurer.