SPRING 2015 NEWSLETTER

INSURANCE LAW UPDATE

By Jennifer Kelley

CURRENT LEGISLATION REGARDING INSURANCE:

(1) SB 1166 – Recovery of Damages for Delayed Payment of Certain Insurance Claims

SB 1166, filed by Sen. Van Taylor (R - Plano), would amend the "Prompt Payment of Claims" section of the Insurance Code to provide additional instances in which an insurer would not be liable for damages due to a delay in paying on a first party claim. Under SB 1166, the damages-for-delay provisions would not apply if: (1) the amount of damages awarded as a result of arbitration or litigation is less than 80 percent of a settlement offer (as defined by section 42.001 of the CPRC) made by an insurer and rejected by the claimant; (2) a claimant fails to provide an affidavit of damages as defined by SB 1166; or (3) the insurer pays to the claimant the amount of damages awarded as a result of an appraisal no later than the 15th business day after the date the damages are awarded in the appraisal.

The "affidavit of damages" provisions in SB 1166 would require a claimant to provide an insurer with an affidavit containing the dollar amount of all damages the claimant intends to seek in a suit no later than the 30th day before the date the claimant commences the suit against the insurer. However, if a claimant ultimately seeks damages that exceed the amount in the claimant's affidavit, the claimant would be required to provide the insurer with written notice of the excess amount by affidavit no later than the 15th day before the date the claimant files a pleading seeking the excess amount.

Under SB 1166, a claimant could also file a claim seeking damages as a "small claims case" (as provided by section 27.060 of the Government Code) if the disputed amount of the insurance claim does not exceed the maximum amount allowed for a small claims case as determined by the Texas Rules of Civil Procedure. However, the total amount awarded in an action filed as a small claims case may not exceed two times the disputed amount of the claim. If a suit seeking damages is filed as a small claims case as provided by the Government Code, an insurer may elect to waive the insurer's right to appeal no later than the 15th day after the date the suit is filed against the insurer.

Finally, SB 1166 would also amend section 542.060 of the Insurance Code to modify the damages provisions of that section. In addition to paying the amount of the claim, an insurer would be liable for interest only on the "disputed amount" of the claim, for reasonable and necessary attorney's fees, and, in small claims cases, for court costs if the insurer did not waive its right to appeal any judgment entered in the small claims case. SB 1166 would also add the following to the damages section of the "Prompt Payment of Claims" section of the Insurance Code: (1) the court will determine the amount of attorney's fees awarded, but the amount of attorney's fees must bear a reasonable relationship to the damages awarded by the trier of fact based on the disputed amount of the claim; (2) any interest awarded would begin to accrue on the

date the claimant provided the affidavit of damages; and (3) an attorney cannot share attorney's fees awarded with the claimant.

Status of SB 1166: Referred to Business & Commerce on March 17, 2015.

(2) SB 1628 – Insurance Claims and Certain Prohibited Acts and Practices Relating to the Business of Insurance

SB 1628, filed by Sen. Larry Taylor (R - Friendswood), would amend various sections of the Texas Insurance Code to do, among other things, the following:

- In actions relating to certain claims for property damage, an insurer could elect to assume the liability for any act or omission of its employee, agent, representative, or adjuster related to or arising out of the insured's claim, unless an insured can show the court that the insured cannot "reasonably expect to secure complete relief unless the employee, agent, representative, or adjuster is made a party to the action."

- An insured seeking damages in an action against an insurer would be required to provide written notice to the insurer at least 61 days prior to filing suit that includes a sworn statement containing the following information: (1) the specific damage items and the amount alleged to be owed by the insurer; (2) the amount of actual damages, other damages, interest, and expenses, specifically stated for each item, the insured alleges are owed by the insurer; (3) the amount of attorney's fees the insured reasonably incurred in asserting the claim against the insurer; (4) the amount that the insured will accept in full and final satisfaction of the claim; and (5) the name of every person given notice and a brief description of person's relationship to the insured's claim.

- Establish a requirement in which a failure to provide requisite notice prior to filing suit would, in certain circumstances, be subject to abatement.

- Establish that interest on an unpaid amount of a claim at a rate of 18 percent a year together with reasonable attorney's fees is the exclusive remedy when an insurer is in violation of the Prompt Payment of Claims Statute.

- Establish a 2-year statute of limitations for providing notice to an insurer of certain claims for damages to or loss of real property or tangible personal property.

Status of SB 1628: On April 30th, the full Senate passed SB 1628 by a 21-10 vote. It was referred to Insurance (House) on May 4th. (Senate Committee History: Business & Commerce voted a committee substitute for SB 1628 out of committee on April 20, 2015. The committee conducted its first public hearing on SB 1628 on March 31, 2015. Many witnesses either testified (or registered a position without testifying) about the bill. Most of those who testified

were against the bill; most who registered a position without testifying supported the bill. A public hearing on the committee substitute for SB 1628 was conducted on April 14, 2015. Much like the first hearing, many witnesses either testified (or registered a position without testifying) about the bill. On May 21, 2015, SB 1628 was passed by the Insurance Committee in the House.

(3) HB 3697 – Texas Department of Insurance Study of Claims Data and Recovery of Attorney's Fees in First Party Claims

HB 3697, filed by Rep. Brooks Landgraf (R - Odessa), would amend section 542.062 of the Insurance Code and limit the recovery of attorney's fees in first party insurance claims to an amount equal to the recoverable economic damages. Under HB 3697, the Department of Insurance would be required to research and evaluate claims data made in the past five years to compare and establish an understanding between first party claims made, legal actions filed by claimants to recover damages, and complaints made by claimants to the Department, if any.

Bill Status: Referred to Insurance on March 19, 2015. HB 3697 did not make it to the House floor for a vote prior to the close of the legislative session. The bill will die unless the text of the bill is added to another bill via amendment.

(4) HB 3822 – Recovery under Uninsured/Underinsured Insurance Coverage (Companion: HB 3533)

HB 3822, filed by Rep. Garnet Coleman (D - Houston), would amend the Insurance Code by adding provisions that prohibit an insurer from requiring, as a prerequisite to asserting an uninsured/underinsured motorist claim, a judgment or other legal determination establishing the other motorist's liability or uninsured/underinsured status. Further, a judgment or other legal determination would not be a prerequisite to asserting a claim for unfair/deceptive acts or practices or for violations of the prompt payment of claims provisions of the Insurance Code. Under HB 3822, an insurer would be required to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim once liability and damages have become reasonably clear.

Also, under HB 3822, prejudgment interest would begin to accrue on the earlier of: (1) the 180th day after the date the claimant notifies the insurer of the claim; or (2) the date on which suit is filed against the insurer to recover uninsured/underinsured motorist benefits. Further, for purposes of recovering attorney's fees under section 38.002 of the Texas Civil Practice and Remedies Code, a claim for uninsured/underinsured motorist coverage would be considered presented when the insurer receives notice of the claim.

Status of HB 3822: Referred to Insurance on March 23, 2015. HB 3822 did not make it to the House floor for a vote prior to the close of the legislative session. The bill will die unless the text of the bill is added to another bill via amendment.

Status of HB 3533: Referred to Insurance on March 18, 2015. HB 3533 did not make it to the House floor for a vote prior to the close of the legislative session. The bill will die unless the text of the bill is added to another bill via amendment.

SUPREME COURT OF TEXAS CASES:

***JAW The Pointe, LLC v. Lexington Ins. Co.*, No. 13-0711, 2015 WL 1870054 (Tex. Apr. 24, 2015).**

In *JAW,* the Supreme Court of Texas, analyzing the issue of concurrent causation, affirmed the Fourteenth Court of Appeals and refused to reinstate a $3.7 million trial verdict against Lexington Insurance Co. for losses stemming from property damage from Hurricane Ike. In that case, the dispute involved losses the insured incurred as a result of city ordinances triggered by damage to an apartment complex during Hurricane Ike. The parties agreed the insurance policy covered the costs of complying with city ordinances, but only if the policy covered the property damage that triggered the enforcement of the ordinances. The property damage at issue in the case resulted from wind, which the policy covered, and flooding, which the policy expressly excluded. Lexington provided the primary coverage layer, limited to $25 million per occurrence. Hurricane Ike damaged about 135 other complexes also covered by the same policy. The insured initially planned to repair the apartments, but the City of Galveston ordinance required that all apartment complexes that were "substantially damaged" (meaning they sustained damage equal to or exceeding 50% of their market value) must be brought into compliance with current code requirements, which included raising the structures to a base flood elevation. Two months after the hurricane, the insured submitted a permit application to the city and included a third-party consultant's estimate that it would cost $6,256,887 to repair all of the damage the building had sustained. The estimate did not distinguish between damage caused by wind and damage caused by flooding. The city determined that the building was in fact "substantially damaged" because the cost of the damage "equals or exceeds 50 percent of the market value." The city also found that because the building was "substantially damaged," city ordinances also required the insured to elevate the apartments three additional feet.

Lexington's building consultant submitted a report estimating the building sustained wind damage totaling approximately $1,278,000 and flood damage of approximately $3.5 million. Subsequently the insured submitted a proof of loss to Lexington, requesting payment of $817,940, which represented the $1,278,000 in wind damage less an applicable deductible. Lexington promptly paid this claim, but did not pay the additional amounts the insured had claimed as costs incurred to demolish and rebuild the building pursuant to the city's ordinances. The insured claimed that Lexington never formally denied the claims for these ordinance-compliance losses.

The insured filed suit against Lexington in July 2009, asserting claims for breach of the insurance contract and violations of the Texas Insurance Code and the Texas Deceptive Trade Practices Act. Despite the lawsuit, Lexington and the adjuster continued working on the claim. In September 2009, Lexington notified the insured by letter stating it would not pay for flood damage or for costs to comply with the city ordinances. Meanwhile, Lexington continued paying claims associated with the other apartment complexes that its policy covered, and in January 2010 it notified the insured that the policy's $25 million per-occurrence limit had been exhausted.

Prior to trial, Lexington filed two motions for partial summary judgment, one seeking dismissal of the breach of contract claim on the ground that Lexington had exhausted the policy

limits, and the other seeking dismissal of any claims based on flood damage on the ground that the policy expressly excluded coverage for such damage. The insured did not oppose these motions, and the trial court granted them, leaving only the insured's statutory claims for trial. On the remaining claims, the jury returned a verdict finding that Lexington had engaged in "unfair or deceptive acts or practices in the business of insurance" by failing to (a) "attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim when the insurer's liability had become reasonably clear;" (b) provide a reasonable explanation for its coverage denial; and (c) affirm or deny coverage within a reasonable time, and that Lexington had engaged in this conduct "knowingly." The jury found actual damages and expenses of $1,230,000 and awarded additional statutory damages of $2.5 million. Based on the jury's verdict, the trial court entered a judgment awarding these damages plus $170,000 in attorney's fees.

The court of appeals reversed and rendered a take-nothing judgment concluding the policy excluded coverage for the code-compliance losses and therefore Lexington could not be liable for Insurance Code and DTPA violations. Relying on the policy's anti-concurrent-causation clause, the court of appeals held the policy excluded coverage of costs to comply with the city's ordinances because the necessity of compliance resulted at least in part from flooding, expressly excluded from the policy.

On review to the Supreme Court of Texas, the court began by reiterating that, as a general rule, there can be no claim for bad faith when an insurer has promptly denied a claim that is not covered, unless there was some "extreme" conduct causing damages unrelated to the policy claim. For that reason, the supreme court confined its inquiry to whether the policy provided coverage for the claimed costs. First, the supreme court found that the policy expressly excluded coverage for any "loss or damage caused directly or indirectly by any of the" listed causes, "regardless of any other cause or event that contributes concurrently or in any sequence to the loss." Second, it found that the policy specifically lists "flood" as an excluded cause, and the parties agreed the policy does not cover losses caused by flooding. And third, the supreme court found that even though the policy expressly excludes coverage for any losses that result "directly or indirectly" from "[t]he enforcement of any ordinance or law," there were two endorsements that the parties agreed provided coverage for such losses, despite the exclusion.

The supreme court acknowledged that it had not previously addressed an anti-concurrent-causation clause but listed decisions from federal courts and lower courts of appeals that had interpreted and upheld the applicability of virtually identical clauses under Texas law and other states' laws. They concluded the evidence conclusively established that "Hurricane Ike caused both wind damage and flood damage, in a sequence of events, which combined to cause the city to enforce the ordinances against The Pointe". The Court further agreed with the Fifth Circuit that, under Texas law, the anti-concurrent-causation clause and the exclusion for losses caused by flood, "read together, exclude from coverage any damage caused by a combination of wind and water." The supreme court ultimately concluded that because the evidence established that flood damage triggered the enforcement of the city ordinances and thus 'directly or indirectly' caused the insured's losses, the policy excludes coverage for such losses "regardless of the fact that wind damage 'contribute[d] concurrently or in any sequence to the loss." The supreme court, therefore, affirmed and found that the policy did not cover the insured's losses, thus the insured could not recover for its bad faith claim against the insurer for failure to effectuate a prompt and fair settlement of the claim.

***In re Crawford & Co., Crawford & Co. Healthcare Mgmt., Inc., Patsy Hogan and Old Republic Ins. Co.*, No. 14-0256, 2015 WL 859087 (Tex. Feb. 27, 2015).**

In *In re Crawford*, the Supreme Court of Texas determined that a trial court abused its discretion when it refused to dismiss claims over which the Division of Workers' Compensation had exclusive jurisdiction over the insurance company's investigation, handling, and settling of claims for workers' compensation. In that case, Glenn Johnson, an employee of ASARCO, suffered serious injuries at work. Due to the severity of his injuries, Mr. Johnson was entitled to receive lifetime workers' compensation benefits. In 2008, disputes over the amounts of benefits that he was entitled to receive resulted in a contested hearing. Separate from the administrative proceedings, Mr. Johnson and his wife filed an underlying suit against ASARCO's workers' compensation insurance provider. The Johnson's alleged that over a period of 10 years, the insurer engaged in "a battle plan to discourage and deny" benefits that the Johnsons were entitled to receive. The Johnsons pleaded numerous causes of action, in tort and contract, and alleged violations of the statutory duties under the Texas Insurance Code and Texas Deceptive Trade Practices Act.

The insurer filed a plea to the jurisdiction and motion for summary judgment arguing that the Texas Workers' Compensation Act had exclusive jurisdiction over the Johnson's claims because they arose out of the workers' compensation claims-handling process. The Johnsons responded that the Texas Workers' Compensation Act did not require them to pursue their claims through its administrative procedures because the Act's administrative procedures do not apply to some of their claims. Specifically, the Johnson's alleged that the Worker's Compensation Act did not bar their claims because they were seeking damages that were "unrelated" to workers' compensation benefits and based on injuries that are "independent" of harm the Worker's Compensation Act was intended to prevent. The trial court dismissed the Johnson's claims for breach of common law duty of good faith and fair dealing but refused to dismiss any of the other claims. The court of appeals denied the insurer's petition for mandamus relief.

The Supreme Court of Texas determined that the Division of Workers' Compensation has exclusive jurisdiction over the Johnsons' claims as the administrative agency responsible for overseeing the workers' compensation system of Texas. The supreme court further determined that the court of appeals' interpretation of *Texas Mutual Insurance Company v. Ruttiger*, 381 S.W.3d 430 (Tex. 2012) was too narrow. While the supreme court recognized that its holding in *Ruttiger* does not necessarily bar claims for misrepresenting an insurance policy under the Texas Insurance Code, it noted that the holding in *Ruttiger* was based on the fact that "section 541.061 [of the Texas Insurance Code] does not specify that it applies in the context of settling claims." And, because section 541.061 does not evidence intent that it be applied in regard to settling claims, it is not at odds with the dispute resolution process of the workers' compensation system. Clarifying *Ruttiger*, the supreme court noted that instead of assessing whether a claim falls within the Workers' Compensation Division's exclusive jurisdiction, courts must look at the substance of the claim to determine if the Worker's compensation act bars a cause of action. As the supreme court reiterated in this case, "the current [Worker's Compensation] Act with its definitions, detailed procedures, and dispute resolution process demonstrat[es] legislative intent for there to be no alternative remedies."

While the Johnson's alleged that their claims for misrepresentation existed outside of the Worker's Compensation Act—thereby justifying their underlying lawsuit—the supreme court concluded that the Worker's Compensation Division has exclusive jurisdiction over a claim for "misrepresentation of an insurance policy" when the alleged misrepresentation occurs within the claims-settlement context. The Act's comprehensive system for resolving workers' compensation claims encompasses prohibitions against fraud and misrepresentations made within the claims settlement context, and grants the Worker's Compensation Division authority to regulate and sanction any such conduct. Thus, because all of the Johnsons' misrepresentation-based claims complained of misrepresentations that Crawford allegedly made in connection with its investigation, handling, and settling of the Johnsons' claims for workers' compensation benefits, the Workers' Compensation Division had exclusive jurisdiction to address those claims.

***In re Deepwater Horizon,* No. 13-0670, 2015 WL 674744 (Tex. Feb. 13, 2015).**

In *In re Deepwater Horizon*, the Supreme Court of Texas held that the underlying service contract may govern scope of additional insured coverage. At the heart of that case was the question of whether and to what extent a service contract between two parties may control the scope of insurance coverage available to one party as an additional insured under a policy purchased by the other party. Transocean and BP entered into a Drilling Contract which required Transocean to indemnify BP for a certain set of liabilities (above-surface pollution), and required BP to indemnify Transocean for all other pollution risks, i.e., subsurface pollution. The Drilling Contract also required Transocean to obtain insurance and to name BP as an additional insured "for liabilities assumed by [Transocean] under the terms of [the Drilling Contract]." The policies purchased by Transocean extended additional-insured status to any person or entity to whom the insured was obliged by way of an "insured contract" to provide such insurance.

Initially, a federal district court ruled in favor of Transocean and its insurers, holding BP was not entitled to additional-insured coverage under Transocean's policies for the subsurface pollution claims arising from the Deepwater Horizon disaster. On appeal, the Fifth Circuit reversed the district court, relying on *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.,* 256 S.W.3d 660 (Tex. 2008). However, six months later, after rehearing, the Fifth Circuit withdrew that opinion and certified the following two questions to the Supreme Court of Texas:

1. Whether *Evanston Ins. Co. v. ATOFINA Petrochems., 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 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?

The supreme court affirmed its commitment to the traditional Texas principle of "the policy means what it says." While BP argued that under *ATOFINA* the scope of its additional-insured coverage must be determined solely from the four corners of the policy, the supreme

court rather wryly pointed out that if one were to look only at the policy itself, BP would not be entitled to any coverage at all, since BP is not named as an insured of any sort anywhere on the face of the policy. Rather, the policy directs one to look to an "insured contract" to determine BP's status. The supreme court recognized that an insurance policy may incorporate an external document, stating:

> Thus, while our inquiry must begin with the language in an insurance policy, it does not necessarily end there. In other words, we determine the scope of coverage from the language employed in the insurance policy, and if the policy directs us elsewhere, we will refer to an incorporated document to the extent required by the policy. Unless obligated to do so by the terms of the policy, however, we do not consider coverage limitations in underlying transactional documents. … [A]n insurance policy may incorporate an external limit on additional-insured coverage. In such cases, the external limit is, in effect, an endorsement on the insurance policy.

The supreme court distinguished this situation from that previously addressed in *ATOFINA*, stating:

> *ATOFINA*, on the other hand, recognizes that a named insured may gratuitously choose to secure more coverage for an additional insured than it is contractually required to provide. This occurs when the language of the insurance policy does not link coverage to the terms of an agreement to provide additional-insured coverage. In that event, only coverage restrictions embodied in the policy will be given effect.

According to the supreme court "we rely on the policy's language in determining the extent to which, if any, we must look to an underlying service contract to ascertain the existence and scope of additional-insured coverage." In other words, under *Deepwater Horizon*, the general rule of *ATOFINA* remains undisturbed: One must look to the policy to determine coverage. However, if the policy directs one to consult an underlying contract in order to determine coverage, then one not only may do so, but ***must*** do so.

Moving to the language of the Drilling Contract in this case, the court rejected BP's effort to hinge the entire $750 million of coverage on the presence or absence of a comma in the additional-insured provision of the Drilling Contract. BP argued that the phrase "except Workers' Compensation for liabilities assumed by [Transocean] under the terms of this contract" only carved out workers' compensation claims from the Drilling Contract's insurance mandate. Instead, the court stated: "… a carve-out for workers' compensation policies covering Transocean's employees adds nothing and would, therefore, be superfluous and functionally inoperative. We will not construe the absence of a comma to produce an unreasonable construction." Thus, in response to the Fifth Circuit's certified question with regard to whether the rule of *contra proferentum*, or construing a document against the drafter, is amenable to a "sophisticated insured" exception. The court observed that *contra proferentum* only comes into play when there is more than one reasonable construction of the document and, because it had already found there was only one reasonable construction of the policies and Drilling Contract, it declined to answer this question.

TEXAS COURTS OF APPEALS CASES:

***Eoff v. Central Mutual Ins. Co.*, No. 05-14-00035-CV, 2015 WL 1568374 (Tex. App.—Dallas Apr. 7, 2015), *judgment set aside, opinion not vacated* (Apr. 23, 2015).**

In Eoff, the Dallas Court of Appeals discussed a tool that insurers can use in seeking reimbursement for claims paid: the threat of driver's license revocation under the Texas Transportation Code. In that case, an uninsured motorist allegedly caused an automobile accident involving an insured of Central Mutual Insurance Company. After Central Mutual paid its insured for damages related to the accident, Central sought reimbursement from the uninsured motorist, who was not listed as an insured under his own policy. The uninsured motorist agreed to pay Central Mutual $8,969 through installment payments, but defaulted on some of his payments. Central Mutual sued the uninsured motorist for breach of contract, and a jury ruled in Central Mutual's favor.

The Dallas Court of Appeals first addressed the uninsured motorist's contention that the trial court did not have jurisdiction over the case because Central Mutual had failed to exhaust its administrative remedies with the Texas Department of Public Safety. The relevance of the DPS in this case began when the uninsured motorist and Central Mutual agreed to sign Form SR-19, a document issued by the DPS that allows drivers to prevent revocation of their driver's license by showing they have settled a dispute related to an automobile accident. The form in this case was an "Installment Agreement" that obligated the uninsured motorist to make monthly payments to Central Mutual, and this agreement was the contract that Central Mutual claimed the uninsured motorist breached when he stopped making payments. Throughout the litigation, the uninsured motorist argued that his execution of Form SR-19 was not a contractual agreement, but merely an administrative mechanism to maintain his license, and that Central Mutual was therefore required to pursue revocation through the DPS before it sued the uninsured motorist in district court.

In addressing the uninsured motorist's argument, the appellate court discussed Texas Transportation Code Section 601.151.-.153, which provides for suspension of a license and registration if a driver not covered by liability insurance is involved in an accident resulting in bodily injury or death or in damage of at least $1,000 to a person's property. A license-holder may prevent suspension, however, by the timely filing of Form SR-19 with the DPS, described in the regulations as an installment agreement or other similar agreement between the parties. If the license-holder defaults on the agreement, the other party may then file a notice of default through Form SR-73, which will result in suspension of the license.

The Court of Appeals rejected the uninsured motorist's argument that Central Mutual had to exhaust its administrative remedies with DPS before filing suit and obtaining a judgment, noting that other provisions of the Transportation Code expressly allowed for judicial remedies after a driver's default. Specifically, the Code allows a party that obtains a judgment to send the DPS Form SR-42 (a transcript of civil proceedings) and Form SR-62 (notice of unsatisfied judgment). The appellate court concluded that the trial court had proper jurisdiction and that Form SR-19 was a binding contract that obligated the insured motorist to pay Central Mutual $8,069.25 through monthly installments. The appellate court also found that the trial court erred

by entering judgment of this entire amount, holding the uninsured motorist was only liable for past-due amounts of $1,200 because the installment agreement did not contain an acceleration clause and the uninsured motorist had done nothing to repudiate the entire contract.

***Zatorski v. USAA Texas Lloyd's Co.*, No. 01-13-01002-CV, 2015 WL 456474 (Tex. App.—Houston [1st Dist.] Feb. 3, 2015, no pet.).**

In *Zatorski*, the Houston (First) Court of Appeals affirmed summary judgment in favor of an insurer after finding that the agent's alleged statements that the insured was "fully covered" were not actionable when the insurer paid the applicable policy limits for a theft loss, even though the insured sought recovery for substantially larger losses. In that case, the insured purchased a renter's policy seeking "full coverage" but did not review it upon receipt. Armed intruders reportedly broke into the insured's rental home and stole firearms and a safe containing watches, jewelry and cash valued at over $260,000. The insured submitted a claim to USAA which promptly responded paying policy limits of $1,000 for jewelry, $2,000 for firearms, $200 for cash and $1,300 for the safe, or $4,500 total. The insured sued and the trial court granted summary judgment in favor of USAA on all claims.

On appeal, the appellate court examined the nature of the alleged representations by USAA's agent and the disclosures made by the insured as to the value of the items for which he sought coverage. Although the insured testified that the insurance agent reportedly told him he was "covered fully", the evidence did not show that the insured told the agent that "the value of any of the items for which he sought to buy coverage." Noting that "[g]eneral claims by the insurer of the adequacy or sufficiency of coverage . . . are not generally actionable . . . " and that USAA paid the full amount or applicable policy limits for the items lost, the appellate court found no breach of contract. Moreover, because there was no breach of contract, the common law and statutory bad faith claims failed as well, and summary judgment in favor of USAA was affirmed.

FIFTH CIRCUIT CASES:

***Amerisure Mut. Ins. Co. v. Arch Specialty Ins. Co.*, No. 14-20239, 2015 WL 1811843 (5th Cir. April 21, 2015).**

In *Amerisure*, the Fifth Circuit Court of Appeals examined whether defense costs and attorney's fees were "expenses" and whether an endorsement transforms the policy into an "eroding limits" liability policy. In that case, Amerisure issued a Texas Commercial Package Policy to Admiral Glass & Mirror Co. in 2006. The policy afforded coverage in excess of any coverage afforded by a controlled insurance program policy. Arch issued an Owner Controlled Insurance Program ("OCIP") policy to Endeavor Highrise, LP and its contractors and subcontractors for bodily injury and property damage arising out of construction of the Endeavor Highrise. Admiral Glass was a subcontractor insured under the policy. The policy had combined bodily injury and property damage limits of $2,000,000 per occurrence, a general aggregate limit of $2,000,000, and a products-completed operations aggregate limit of $2,000,000. The OCIP policy contained a Supplementary Payments provision which provided that Arch will pay "[a]ll expenses we incur" in connection with any covered claim, and that "[t]hese payments will not reduce the limits of insurance." Endorsement 16 to the OCIP policy expressly deleted and

replaced the statement quoted above with: "[supplementary payments] will reduce the limits of insurance." The OCIP policy also provided that Arch's duty to defend ends "when we have used up the applicable limit of insurance in the payment of judgments or settlements."

Prior to the claim giving rise to this lawsuit, Arch settled three claims under the OCIP policy: a wrongful death suit arising from a worker's fatal fall (settled for $1,555,000.00; attorneys' fees and defense costs of $159,543.160); a toilet leak claim in one of the apartment units (settled for $60,000; attorneys' fees and defense costs of $62,620.18 incurred); and a fire sprinkler leak claim (settled for $880,000; attorneys' fees and defense costs of $31,671.87 incurred). In June 2010, Endeavor sued Admiral and others for faulty work. Amerisure tendered the lawsuit to Arch as the primary insurer. Prior to Arch accepting the defense, Amerisure incurred $23,879 in defense fees. In April 2012, Arch withdrew from defense of the lawsuit asserting that attorneys' fees, defense costs, and settlements of $2,000,000 from defending Admiral and other subcontractor defendants exhausted policy limits. Amerisure took over the defense and incurred additional fees and costs of $114,957 before settling the claims. In total, Arch paid a settlement of $1,555,000 and defense costs of $159,543 under the general coverage limit of the OCIP, and paid settlements totaling $1,472,032 and defense costs of $527,967 under the products-completed operations coverage of the OCIP policy.

Amerisure sued Arch for breach of contract, contending Arch wrongfully refused to defend and indemnify Admiral. Arch removed the case to federal court based on diversity jurisdiction. Amerisure filed a motion for partial summary judgment seeking a declaration that: (1) Arch had not exhausted the policy because defense costs did not erode the policy limits; or (2) Arch had a continuing duty to defend after the policy was exhausted. Arch filed a cross-motion for partial summary judgment on the same issues and a second motion for partial summary judgment seeking a declaration on a third issue: that it had not "wrongfully exhausted" the policy by paying uncovered claims. The magistrate judge determined (1) defense costs and attorneys' fees were "expenses" under the Supplementary Payments provision and therefore eroded the policy limits; (2) though subject to the same policy limits, the duty to defend ended only when the policy limits were exhausted by judgments and settlements alone (i.e., not by defense costs); and (3) coverage existed for the toilet and sprinkler leaks and therefore Arch did not "wrongfully exhaust" the policy limits with payments on uncovered claims. The district court adopted the magistrate's recommendation over both parties' objections and held that Arch did not breach its duty to indemnify, but did breach its duty to defend Admiral.

Arch appealed the finding that it had a duty to defend Admiral that had been breached. Amerisure cross-appealed the part of the judgment holding that Arch had no duty to indemnify Admiral. Turning first to the meaning of the term "expenses," the Fifth Circuit noted: "given it its ordinary meaning, when an insurer pays costs of defense, including attorneys' fees, that is an "expense" to the insurer. Absent some indication that a different meaning is intended, we see no reason to deviate from this ordinary meaning of the term." Turning then to the question of whether "supplementary payments" erode the limits, the court concluded the endorsement transforms the policy into an "eroding limits" policy. The Fifth Circuit further found that the district court's finding that there are two separate policy limits for indemnity and defense essentially "reads the endorsement out of the policy." Finally, the Fifth Circuit turned to the argument that Arch wrongfully exhausted the policy by paying claims that should have been excluded under the "products-completed" coverage. The court questioned whether Amerisure

had the authority to argue that amounts were "wrongfully paid" and whether such a claim even exists and found that even if assuming arguendo that such a claim did exist, it did not apply here. The Fifth Circuit affirmed the district court's judgment regarding the duty to indemnify, reversed the district court's judgment regarding the duty to defend, and rendered judgment for Arch.

***Berkley Regional Ins. Co. v. Philadephia Indemnity Ins. Co.*, Nos. 13-51180, 14-50099, 2015 WL 329421 (5th Cir. Jan. 27, 2015) (unpublished).**

In *Berkley Regional*, the core dispute concerned whether the umbrella policy's notice requirements were satisfied by notice of the claim to the broker who placed the umbrella policy. The Fifth Circuit held it was not because the broker was not an agent for the carrier regarding claim notification and prejudice existed as a matter of law. In that case, Towers of Town Lake Condominiums was sued for premises liability. Towers was insured by a $1,000,000 primary policy with Nautilus Insurance Company and a $20,000,000 umbrella policy with Philadelphia Indemnity Ins. Company. Towers was defended in the underlying lawsuit by Nautilus. During the suit, Towers tendered the petition and notice of the suit to an alleged agent of Philadelphia, Wortham Insurance Group, the broker for the Umbrella policy. Notice never actually got to Philadelphia, and a jury delivered a verdict of $1,654,663 against Towers. With interest and cost, the Judgment was entered for $2,167,300. Nautilus tendered its limits and interest. Towers then gave direct notice to Philadelphia, and demanded they pay the excess. Philadelphia refused to pay based on late notice and prejudice. Nautilus obtained a supersedeas bond on the judgment through Berkley Regional Ins. Co. and Berkley paid the remainder to the insured in exchange for an assignment of the insured's and Towers' rights under the Umbrella Policy. The district court granted summary judgment in favor of Philadelphia based on lack of notice, concluding that notice to the broker did not constitute constructive notice to Philadelphia, and that the lack of notice constituted prejudice to Philadelphia.

On appeal, the Fifth Circuit noted that the Umbrella Policy required Towers to "see to it" that Philadelphia was "notified promptly." This language does not require direct notice to Philadelphia, so the Court looked to the contract between Philadelphia and the broker to see if the broker had authority to receive notice. The court noted: "The claims process is distinct from policy brokering, and even though Wortham may have had authority to broker policies, this authority did not impliedly include authority to accept notice of claims." The Fifth Circuit, therefore, concluded that, although the 2002 Agency Agreement "at least arguably created an agency relationship," the contract expressly provided that the broker had authority to solicit and place business for Philadelphia, but was silent about accepting notice of a claim. The Fifth Circuit also held that notice was not just late, but it was "wholly lacking." Thus, Philadelphia was denied the opportunity to investigate or participate in any aspect of the suit including mediation. Whether Philadelphia would have participated in the trial was deemed irrelevant. The Umbrella Carrier was prejudiced as a matter of law, and summary judgment in favor of Philadelphia was affirmed.

FEDERAL DISTRICT COURT CASE:

***Campuzano v. Sentenel Ins. Co.*, No. H-13-2522, 2015 WL 520901 (S.D. Tex. Feb. 9, 2015).**

In Campuzano, the Federal District Court denied an insurer's motion for summary judgment based on late notice of a first-party theft claim under a business policy. In that case, the insured was a small business owner who operated a booth at an antique and flea market. In November 2011, the insured submitted a claim for theft of approximately $60,000 of inventory from his booth which allegedly occurred in October 2011. After the carrier denied the claim on the ground that the policy was canceled in August due to non-payment of premiums, the insured reported a new claim in December 2011, claiming that an earlier, previously unreported theft of $49,000 worth of inventory had occurred in July 2011—*before the policy was canceled*. Although the insured claimed he had promptly reported the July theft to the police, he was never able to produce a police report for the July theft, instead claiming the police report for the second theft listed all missing items from both thefts.

The carrier moved for summary judgment based on the insured's violation of the policy's prompt notice condition, arguing it had been prejudiced by the lack of prompt notice of the July theft because the insured could not differentiate between the inventory items allegedly stolen during the policy period and those allegedly stolen after the policy was canceled. The carrier argued if it had received timely notice of the July theft, it could have made a site visit to identify the inventory missing versus what was still present, which became impossible due to the insured's delay. The district court rejected this argument holding the accounting of missing inventory could be "easily recreated at trial through documents." The carrier also argued the insured had violated his duty to provide documents. However, the district court observed the insured did provide *some* documents, and the real question was their adequacy to prove the claimed loss. The district court, therefore, concluded that the insured had complied with this duty "to the extent possible given the record-keeping practices of his business," and saw this not as a violation of a policy condition, but as an evidentiary question for the jury. The district court expressed confidence that if the insured could not adequately prove his claim at trial, he would be the one to pay the price, not the carrier.