SPRING/SUMMER 2012 NEWSLETTER

INSURANCE LAW UPDATE

By Jennifer Kelley

THE SUPREME COURT OF TEXAS

***Evanston Ins. Co. v. Legacy of Life, Inc.*, No. 11-0519, 2012 Tex. LEXIS 569 (Tex. June 29, 2012).**

In *Evanston*, the Supreme Court of Texas answered the following questions certified by the Fifth Circuit:

> (1) Does the insurance policy provision for coverage of "personal injury," defined therein as "bodily injury, sickness, or disease including death resulting therefrom sustained by any person," include coverage for mental anguish, unrelated to physical damage to or disease of the plaintiff's body?
>
> (2) Does the insurance policy provision for coverage of "property damage," defined therein as "physical injury to or destruction of tangible property, including consequential loss of use thereof, or loss of use of tangible property which has not been physically injured or destroyed," include coverage for the underlying plaintiff's loss of use of her deceased mother's tissues, organs, bones, and body parts?

At issue in *Evanston*, was the construction and application of a combined professional and general liability insurance policy issued by Evanston Insurance Company ("Evanston") to Legacy of Life, Incorporated ("Legacy"). Legacy requested a defense from Evanston in a lawsuit in which the plaintiff alleged that she consented to Legacy's harvesting some of her mother's organs and tissues (including corneas, skin, bone, and arterial tissue) after her mother's death because Legacy, a non-profit corporation, represented to her that the harvested tissues would be distributed on a nonprofit basis. However, contrary to these representations, Legacy allegedly transferred the tissues to a for-profit company, which sold the tissues to hospitals at a profit. Ms. Alvarez filed suit against Legacy alleging breach of contract, quantum meruit, civil conspiracy, conversion, fraud, fraudulent misrepresentation, fraudulent inducement, aiding and abetting fraud, civil theft, intentional infliction of emotional distress, and deceptive trade practices. Ms. Alvarez sought recovery of "the reasonable value of the benefits of the tissue and bones provided." She also sought to recover "compensatory damages," "emotional distress damages," "restitution damages," and "punitive or exemplary damages," as well as attorney's fees. There were no allegations in the underlying lawsuit that Ms. Alvarez suffered any physical injury.

Evanston denied Legacy's request for a defense and filed a declaratory judgment that it had no duty to defend Legacy in the underlying lawsuit. The district court disagreed with

Evanston's arguments, holding that personal injury covers extreme mental and emotional distress and that a Texas court could potentially find human tissues to be property.

On certification to the supreme court, the court first looked at whether or not Ms. Alvarez's suit sought damages for personal injury under the terms and conditions of the Evanston policy. The court noted that the policy defined "personal injury" as "bodily injury, sickness, or disease . . . ." The court agreed with Evanston that "bodily" modified "injury," "sickness," and "disease," and therefore an accompanying physical injury was required for coverage to trigger. The supreme court concluded that because Ms. Alvarez did not allege physical injury, her claims against Legacy did not trigger Evanston's duty to defend under the personal injury component of the policy.

Next, the supreme court determined whether or not "loss of use of tangible property" included coverage for Ms. Alvarez's loss of use of her deceased mother's tissues, organs, bones, and body parts. The court first analyzed whether or not the mother's tissues were Ms. Alvarez's property by looking to the common law and statutes. The supreme court noted that the common law (1) gives Ms. Alvarez the right to direct the burial; and (2) allows the next of kin to sue for mental anguish damages when acts are performed on a decedent's body for tissues without the next of kin's consent in certain circumstances. The court also recognized that the Anatomical Gift Act gives the next of kin the right to gift tissues. Despite these rights, the court noted that Ms. Alvarez was missing some of the key rights that make up the bundle of property rights. Specifically, next of kin have no right to (1) possess a body other than for burial or final disposition; (2) use tissues unless they have been designated by the individual as a transplant recipient; (3) transfer tissues other than as set forth in the Anatomical Gift Act; and (4) exclude, other than to seek damages in certain circumstances for acts done beyond their consent. In light of these limited rights, the supreme court concluded that it could not say that human tissues have attained the status of property of the next of kin.

The supreme court next analyzed whether or not the mother's tissues were the property of the estate. In looking at the rights afforded under the Anatomical Gift Act, the court noted that an individual can designate a recipient for their tissues before their death, but once they die, their estate cannot designate a recipient or receive compensation for the tissues. Thus, the court concluded that the estate has fewer rights in tissues than next of kin who may designate a recipient once the individual dies. The supreme court therefore held that loss of use of tangible property did not include the loss of use of the mother's tissues by Ms. Alvarez or her mother's estate.

***In re XL Specialty Ins. Co.*, No. 10-0960, 2012 Tex. LEXIS 568 (Tex. June 29, 2012).**

In *In re XL Specialty Insurance Company*, the Supreme Court of Texas decided whether, in a bad faith action, communications between an employer and an attorney for the employer's workers compensation insurer are protected by the attorney-client privilege. The supreme court held that the privilege did not apply.

The case stemmed from a work-related injury Jerome Wagner suffered while working for Cintas Corp., which obtained workers compensation insurance from XL. XL's third party

administrator, Cambridge Integrated Services Group, Inc., denied Mr. Wagner's claim for benefits. After a contested case before the Division of Workers' Compensation, a hearing officer found that Mr. Wagner sustained a compensable injury and was entitled to medical and income benefits. During the course of that case, XL's outside counsel sent messages about the status and the evaluation of the proceedings to Cambridge and to Cintas.

After the workers compensation dispute was resolved, Mr. Wagner sued XL, Cambridge, and the claims adjuster for breach of good faith and fair dealing and insurance code violations. During discovery, Mr. Wagner sought the communications that went between Cintas and the outside attorney during the workers compensation benefits dispute case. XL and Cambridge argued that the attorney-client privilege protected the communications. After an in-camera inspection, the trial court held that the privilege did not apply. An appeals court then denied a petition from XL and Cambridge seeking mandamus relief.

On appeal to the Supreme Court of Texas, XL argued that communications between the attorney and Cintas were protected by the attorney-client privilege, "and more generally, the insurer-insured relationship". After providing a detailed analysis of the privileges afforded to communications between an attorney and a client, the supreme court noted that it has "not recognized a general insurer-insured privilege". "Nevertheless, the supreme court agreed that, under certain circumstances, communications between an insurer and its insured may be shielded from discovery by the attorney-client privilege." However, the supreme court concluded that XL had failed to show that its lawyer's communications were among those protected by Texas rules.

In reaching its decision, the supreme court noted that the allied litigant doctrine was inapplicable because the communications were not made to a lawyer or a representative of another party in a pending action. For similar reasons, the joint client rule was inapplicable. In reaching its conclusion about the joint client rule, the supreme court recognized that a lawyer could represent both the insurer and the insured, and that an insurer could be a representative of the insured under Rule 503, making some of its communications privileged. XL, however, had failed to plead or prove either of these in the case. Finally, the supreme court noted that Cintas was not a representative of XL because Cintas could not act on XL's behalf. For these reasons, the supreme court concluded that XL had failed to bring the communications within Rule 503's parameters.

***Tex. Mut. Ins. Co. v. Ruttiger*, No. 08-0751, 2012 Tex. LEXIS 501 (Tex. June 22, 2012).**

In *Ruttiger*, the Supreme Court of Texas considered whether Texas' workers compensation statutory reforms in 1989 eliminated the common law duty of good faith and fair dealing owed by workers compensation insurers to their insureds' covered employees, based on a 1988 decision in *Miguel Aranda vs. Insurance Co. of North America*, 748 S.W.2d 210 (Tex. 1988). In a 5-4 decision, the Court overruled its 1988 *Aranda* decision, and concluded that as a result of statutory changes to the workers compensation statutes in 1989, workers compensation insurers no longer owe a common law duty of good faith and fair dealing to their insureds' covered employees. The dissent rejected the idea that Texas lawmakers meant to eliminate the state's common law bad faith remedy when they enacted workers compensation reforms, noting

that "[t]he 1989 act . . . did not repudiate, but rather acknowledged, the viability of extra-contractual claims against workers' compensation insurance carriers".

Texas Mutual Insurance Co. involves a workers' compensation claimant, Ruttiger, who claimed he was injured on the job. Texas Mutual's investigation indicated that Ruttiger may have been injured while playing softball, and it filed a denial of the claim after issuing one income benefit payment. While his claim was still pending before the Texas Workers' Compensation Commission—now known as the Texas Department of Insurance, Division of Workers' Compensation referred to hereafter as "DWC"—and before Ruttiger had reached maximum medical improvement, he sued the insurer and adjuster for alleged violations of the Texas Insurance Code and Deceptive Trade Practices Act, and breach of the common law duty of good faith and fair dealing.

On petition to the Supreme Court of Texas, the Court held that claims against workers' compensation insurers for unfair settlement practices may not be made under the Insurance Code, thus eliminating DTPA claims arising under the Insurance Code as well. However, workers can still pursue claims against insurers under the Insurance Code for misrepresenting provisions of their policies. Additionally, the Court considered whether *Aranda*—case extending the common law action for breach of the duty of good faith and fair dealing to the workers' compensation system—should be overruled, and concluded that it should.

In addressing Ruttiger's Chapter 541.060 Insurance Code claim for unfair settlement practices, the Court drew on its recent discussion of the relationship between a general statutory cause of action and one in which the statute had a more detailed, specific claims resolution process in *City of Waco v. Lopez*, 259 S.W.3d 147 (Tex. 2008) to find that allowing workers' compensation claimants to bring causes of action for unfair settlement practices under the Insurance Code would significantly undermine the Act which has carefully constructed rights, remedies and procedures. The Court also found that the limited definition of "settlement" in the Act does not fit with the construct of section 541.060. Thus, the Court held that Ruttiger may not assert a cause of action under section 541.060. Further, the Court held that the Legislature did not intend for workers' compensation claimants to have a cause of action under section 542.003—a claim that an insurer failed "to adopt and implement reasonable standards for prompt investigation of claims arising under its policies"—for the same reasons the Court found workers' compensation claimants cannot assert a cause of action under section 541.060.

Notably, the Court did not rule out all Insurance Code claims for workers' compensation claimants. The Court held that claims under section 541.061 for misrepresentation of an insurance policy are not at odds with the dispute resolution process of the workers' compensation system because section 541.061 does not specify that it applies in the context of settling claims. However, the Court then went on to find that in Ruttiger's case, there was legally insufficient evidence to support a finding that Texas Mutual misrepresented its policy because the "dispute between Ruttiger and the insurer was over whether Ruttiger's claim was factually within the policy's terms—whether he was injured on the job."

With regard to Ruttiger's DTPA claim, the Court concluded that the viability of the DTPA claim depended on the validity of the Insurance Code claims. Thus, because all of Ruttiger's Insurance Code claims failed, he could not recover on his DTPA claim.

Finally, as to Ruttiger's claim for breach of the duty of good faith and fair dealing, the Court noted that *Aranda*, which allowed a worker to assert claims outside the workers' compensation dispute resolution system, had been decided before the 1989 reforms. In overruling *Aranda*, the Court stated that workers comp reforms had established "meaningful, binding administrative dispute resolution procedures" that eliminated the need for common law recourse against insurers who act in bad faith. The court noted that "[o]ne of the legislature's unquestioned goals was to make decisions about benefits as objective as possible, and thereby reduce disputes and litigation over them". The court therefore held that "[t]he *Aranda* cause of action with its subjective standards for damages is antithetical to such a system, and it has no dispute resolution process other than litigation with its associated delays and expense."

***Tex. Dep't of Ins. v. Am. Nat'l Ins. Co.*, No. 10-0374, 2012 Tex. LEXIS 420 (Tex. May 18, 2012).**

In *Texas Department of* Insurance, the issue for resolution was whether or not ERISA "stop-loss insurers" were subject to state regulation as "insurers". The Supreme Court of Texas concluded that they were, holding that an insurer's sale of stop-loss insurance to a self-funded group health plan is subject to taxes and other regulatory requirements under the Texas State Insurance Code.

American National Insurance Co. and one of its subsidiaries, American National Life Insurance Company of Texas, sold stop-loss insurance to self-funded employee health benefit plans. Employers operating self-funded employee benefit plans assumed the risk of providing health insurance to their employees and purchased the stop-loss policies to limit their financial exposure for catastrophic losses.

The Texas Department of Insurance audited American and concluded that the stop-loss insurance was direct insurance under the insurance code and subject to the department's regulatory authority. American fought the decision, arguing that the self-funded employee health benefit plans were "insurers" under the insurance code and that the stop-loss insurance was "reinsurance," which was not subject to Texas insurance regulations.

On petition for review, the supreme court noted that both "direct insurance and reinsurance reallocate risk with the principal distinction being the nature of the purchaser. Insurance consumers reallocate their risk by purchasing direct insurance … while insurance companies reallocate the risks they assume by purchasing reinsurance." While the supreme court agreed that self-funded employee health-benefit plans operate like insurers, it noted that the insurance code does not include health-benefit plans "because they [were] not regulated like insurance companies."

The supreme court continued by noting that ERISA Section 514 preempts state laws that relate to employee benefit plans but does not provide an exemption from state insurance laws. Section 514 further provides that "an employee benefit plan … shall not be deemed to be an insurance company … for purposes of any law of any State purporting to regulate insurance companies". Thus, relying on ERISA's "insurance savings clause," the supreme court concluded that Texas could regulate American's insurance contracts with self-funded employee health

benefit plans. Having concluded Texas could regulate stop-loss policies, the supreme court next assessed whether Texas chose to regulate stop-loss policies.

The supreme court determined that the insurance code was ambiguous because the legislature did not define the terms "reinsurance" or "stop-loss insurance." The supreme court noted, however, that in cases of ambiguity, it frequently deferred "to administrative agencies' statutory interpretations. . . . so long as the construction [was] reasonable and [did] not contradict the plain language of the statute". Taking that into consideration, the supreme court recognized that the insurance department had promulgated regulations "instructing that stop-loss . . . policies like American's are in the nature of direct health insurance, not reinsurance, and subject to assessment" under the insurance code. The supreme court concluded that the regulation was "reasonable . . . formally promulgated, and [was] not expressly contradicted by the Insurance Code."

THE FIFTH CIRCUIT

***State Farm Fire and Cas. Co. v. Lange,* No. 11-20396, 2012 U.S. App. LEXIS 13567 (5th Cir. July 3, 2012).**

In *State Farm Fire and Casualty Company*, the issue to be decided was whether or not a son "primarily resided" with his parents in their home and therefore qualified as an insured under the parent's personal liability umbrella policy. Based on the evidence, the Fifth Circuit concluded that the son did not "primarily reside" in his parent's home and therefore was not an insured under the policy.

In 2009, Matthew Lange was involved in an automobile accident in which two of the passengers in Lange's vehicle were killed. A coverage dispute arose as to whether or not Lange was covered under his parent's personal liability umbrella policy, which defined "insured" to mean "you [the named insureds, Lange's parents] and your relatives whose primary residence is your household." The district court, concluding that Lange's primary residence was an apartment and not his parent's home, granted the insurer's motion for summary judgment.

The evidence showed that Lange had lived in his parent's house while attending high school, but that he moved into an apartment with friends in 2005. The evidence further showed that Lange moved into his own apartment in 2007 and that the apartment was located 45 minutes from his parent's house. Lange stated in his deposition that he moved into the apartment to be closer to work and to school. The evidence showed that the apartment was furnished with basic furnishings (bed, couches, and tv), and that Lange slept at the apartment during the week and at his parent's house most weekends. The evidence also showed that Lange's childhood bedroom had been maintained for him in his parent's house, and that his "prized possessions" were stored at his parent's house. There was evidence that Lange had a key to his parent's house and could come and go as he pleased. There were documents, including bills, credit applications, and loan documents listing the apartment as Lange's present address. When interviewed by the insurer after the accident, Lange stated that his primary residence was his apartment. When deposed almost a year later, however, Lange testified that his parent's house was his primary residence at the time of the accident. When interviewed, Lange's mother told the insurer that she thought her

son's move to the apartment was permanent, and that she did not consider him to be a resident of her home at the time of the accident. Lange's father told the insurer that he thought Lange was living at the apartment at the time of the accident, but that he considered the house to be Lange's permanent residence.

In affirming the district court's ruling, the Fifth Circuit noted that the term "primary residence" was not defined in the policy. However, the court agreed with other state courts' conclusions that the term is unambiguous. Believing that the Texas Supreme Court would agree that the term is unambiguous, the Fifth Circuit stated that "primary" means "first or highest in rank or importance," "chief," or "principal." Thus, a "primary residence" is ones chief, principal, and most important residence. Based on this definition and the evidence presented, the Fifth Circuit concluded that the apartment was Lange's primary residence at the time of the accident. As such, Lange was not an "insured" under his parent's policy.

***Downhole Navigator v. Nautilus Ins. Co.*, No. 11-20469, 2012 U.S. App. LEXIS 13342 (5th Cir. June 29, 2012).**

In *Downhole Navigator*, the issue before the Fifth Circuit was whether or not an insured was entitled to reimbursement for its costs in hiring independent counsel after rejecting its insurer's offer to defend subject to a reservation of rights. The Fifth Circuit concluded that Texas law did not require the insurer to reimburse its insured for hiring independent counsel.

After being sued in a negligence action, Downhole Navigator sought a defense from Nautilus, its general liability insurer. When Nautilus agreed to defend subject to a reservation of rights, Downhole rejected Nautilus's offer, claiming that the reservation of rights created a conflict with respect to the selection of counsel, thereby forcing Downhole to retain its own representation. In subsequent coverage litigation, the parties filed cross motions relating to Nautilus's duty to reimburse the cost of Downhole's Independent counsel. The court awarded summary judgment to Nautilus.

In reaching its conclusion, the Fifth Circuit noted that under Texas law, a policyholder is entitled to conduct its own defense when there is a conflict of interest between the insurer's duty to defend and its interest in avoiding coverage. The Fifth Circuit further noted that no such conflict existed in the present case because "[n]o finding in the [underlying] suit [would] control the outcome of the coverage issue." The underlying case turned on a finding of negligence, whereas the coverage issues, as framed by the reservation of rights letter, pertained primarily to the scope of various exclusions, including a professional services exclusion. Thus, because no conflict of interest existed, the insurer did not have to fund its insured's choice of independent counsel.

***Ewing Constr. Co. v. Amerisure Ins. Co.*, No. 11-40512, 2012 U.S. App. LEXIS 12154 (5th Cir. June 15, 2012).**

At issue in Ewing was whether or not a CGL policy's contractual liability exclusion applied to preclude the insurer's duties to defend and indemnify its insured. The Fifth Circuit

held that the CGL policy's contractual liability exclusion applied to preclude the insurer's duty to defend, but that it was premature to apply the exclusion to the insurer's duty to indemnify.

Ewing, who was insured by Amerisure, was sued on February 25, 2010 by the Tuloso-Midway Independent School District for damages caused by allegedly deficient construction of a tennis facility in Corpus Christi, Texas. Ewing had contracted with the school district to serve as general contractor on the project. Ewing tendered the lawsuit to Amerisure for a defense and indemnity, but Amerisure denied the duty to defend. As a result, Ewing filed suit against Amerisure seeking a declaration that Amerisure had an obligation to defend Ewing, and that in failing to do so Amerisure breached its duty to defend and also violated Texas' Prompt Payment of Claims Act. Amerisure counterclaimed, seeking a declaration that it had no duty to defend or indemnify Ewing.

On appeal to the Fifth Circuit, the court noted that the parties agreed that the alleged defects constituted property damage caused by an occurrence that took place in the coverage territory as required under the terms and conditions of the subject policy. The issue on appeal, was whether or not coverage was excluded by the contractual liability exclusion in the policy and whether or not an exception applied to reinstate coverage if excluded.

The Fifth Circuit noted that the Supreme Court of Texas' opinion in *Gilbert Texas Construction, L.P. v. Underwriters at Lloyd's London*, 327 S.W.3d 118 (Tex. 2010), principally stands for the proposition that a CGL policy's contractual liability exclusion excludes coverage for property damage when "the insured assumes liability for . . . property damage by means of contract . . . ." As a result, because the school district's complaint against Ewing was contractual in nature, whether implied or express, the court held that the CGL policy's contractual liability exclusion applied to exclude coverage.

In reaching its decision, the Fifth Circuit acknowledged that *Gilbert* contained some rather opaque language, and that its particular facts made for imperfect comparisons to the case at hand. However, the court emphasized that *Gilbert* furnishes the Texas Supreme Court's approach to the contractual liability exclusion and that approach is to apply the plain language of the exclusion, rather than grafting additional language to it. Thus, the court concluded that Ewing's position that the phrase "assumption to liability in a contract" means "assumption of a duty to repair third party property, but not assumption of implied contractual duties," was contrary to the Supreme Court of Texas' approach.

Having determined the contractual liability exclusion applied, the Fifth Circuit turned to Ewing's argument that the exception for liability that "the insured would have in the absence of the contract or agreement" applied to reinstate coverage and thus a duty to defend. In particular, Ewing argued that because claims for negligence also existed alongside the breach of contract claims in the underlying lawsuit, liability existed in the absence of the contract.

The Fifth Circuit disagreed, noting that the school district's use of the term "negligence" was not dispositive. Instead, the court emphasized that it is the substance of the petition that must be assessed—that is, whether the allegations are for actions in contract, tort, or both. In looking at the underlying allegations, the court concluded that Ewing's contract with the school

district was the source of its potential liability, and that the damage alleged by the school district was damage to the subject matter of the contract and not to any other property. As such, the Fifth Circuit held that the school district's claim sounded in contract, and the exception did not apply to reinstate coverage.

After holding there was no duty to defend, the court then analyzed whether the exclusion applied to preclude Amerisure's duty to indemnify. Concluding that it was premature to decide the issue, the court noted that the duty to indemnify is ordinarily not justiciable until after the underlying lawsuit has been resolved because coverage may turn on facts that are proven, even if those facts were not pled. The court pointed out that the school district could potentially prove in the underlying lawsuit that Ewing's performance damaged property other than the tennis courts, thus triggering tort liability and the exception to the contractual liability exclusion.

Finally, the court held that because Amerisure owed no duty to defend, it had not violated Texas's Prompt Payment of Claims Statute. However, with respect to Amerisure's duty to indemnify, the court noted that the issue was not justiciable at that time.

***Firman v. Life Ins. Co. of N. Am.*, No. 11-20451, 2012 U.S. App. LEXIS 12232 (5th Cir. June 15, 2012).**

In *Firman*, the issue was whether or not an administrator of an ERISA plan had abused its discretion by denying benefits to its insured. The Fifth Circuit, adopting the district court's opinion, held that the claims administrator (LINA) had abused its discretion by determining that the participant's death was not accidental under controlling law.

Gilberto Espinoza, who was covered under two employer-sponsored ERISA Accidental Death Plans, died in a single vehicle crash. The evidence showed that his vehicle veered to the right off the highway upon entering a left curve, Espinoza overcorrected, and his vehicle rolled over when it swerved back to the left side shoulder of the road. Espinoza was partially ejected and fatally crushed by the vehicle. The accident occurred around noon, the weather was clear, and the road was dry. Espinoza's blood-alcohol level was .20% at the time of the accident. The investigating officer noted that the curve where the accident occurred was dangerous and that he had investigated numerous accidents at the site.

Life Insurance Company of North America ("LINA"), who had issued the ERISA plans, denied AD&D benefits to Espinoza's widow on the ground that the death was not accidental because death resulting from driving while intoxicated is publicly known and a foreseeable event. Neither plan defined "accident," but LINA interpreted the term to mean "a sudden, unforeseeable event." The district court found the insurer's decision, even under an arbitrary and capricious standard, to be an abuse of discretion. In reaching its decision, the district court applied the two-step inquiry used by the Fifth Circuit in reviewing a benefit denial for abuse of discretion: first, the court asks whether the plan administrator's determination was legally correct. If so, there can be no abuse of discretion. If not, the court determines whether the plan administrator abused its discretion in making its determination.

To answer the first question, the court asks whether the plan administrator's interpretation is consistent with a fair reading of the plan. Although LINA had made similar interpretations in the other cases, the district court held that the application of a *per se* rule that death resulting from driving while intoxicated is never an accident was inconsistent with controlling law. Specifically, the district court noted that the Fifth Circuit applies the following standard when "accident" is not defined in the policy: a death is deemed accidental if the insured had a subjective expectation of survival that was objectively reasonable, from the perspective of the insured. The test is whether death or serious injury is "highly likely" to occur. Accordingly, the district court concluded that LINA's interpretation was legally incorrect in that it focused on whether death resulting from driving while intoxicated was merely foreseeable, rather than on whether it was highly likely. The court then found that LINA had abused its discretion in denying benefits because no evidence showed that the participant's death was foreseeable. In fact, LINA had repeatedly misrepresented the only evidence that the participant was intoxicated by comparing his urine alcohol level to the legal limit for blood alcohol concentration.

TEXAS COURTS OF APPEALS

***Allstate Ins. Co. v. Spellings*, No. 01-11-01065-CV, 2012 Tex. App. LEXIS 5154 (Tex. App.—Houston [1st Dist.] June 28, 2012, no pet. h.).**

In *Allstate Insurance Company*, the Houston [First Dist.] Court of Appeals addressed the issue of whether an insurer could recover payments from a responsible party on a claim for equitable subrogation. The court concluded that because the payments were voluntary, the insurer could not recover payments from a responsible party under equitable subrogation.

Amber Jeffrey, who was seventeen years old, lost control of her vehicle and struck another vehicle being driven by the Haywoods. Amber died as a result of her injuries. It was revealed through an autopsy that Amber was legally intoxicated at the time of the accident. The insurer for Amber and her father paid the Haywoods $1,350,973 in damages. The Haywoods signed releases in favor of the insurer and Amber's father, Mr. Jeffrey.

At some point near to or after the releases were signed, Mr. Jeffrey filed a wrongful death suit against the Spellings who were the parents of Amber's best friend and who had allegedly provided Amber with alcoholic beverages on the night of the accident. Mr. Jeffry's insurer filed a plea in intervention asserting a claim for equitable subrogation against the Spellings. The Spellings, in turn, filed a motion for summary judgment as to the equitable subrogation claim arguing that the insurer had conducted an "extensive investigation" into the accident and concluded that Amber was the "sole cause" of the accident. The trial court granted the Spellings' motion for summary judgment.

On appeal, the insurer argued that its equitable subrogation claim was based on it standing in the shoes of the Haywoods, and not in the shoes of Mr. Jeffry. Thus, the insurer contended that by standing in the shoes of the Haywoods it was allowed to equitably subrogate against other responsible parties. The court of appeals disagreed, noting that a party seeking equitable subrogation must show that it involuntarily paid a debt primarily owed by another. The court then went on to distinguish the facts in the instant case from those in *Frymire Eng'g Co.,*

Inc. v. Jomar Int'l, Ltd., 259 S.W.3d 140 (Tex. 2008). The court noted that the Texas Supreme Court in *Frymire* expressly noted that the insurer was bringing suit "through" its insured. Moreover, Frymire had a legal duty to satisfy its contractual indemnity obligation and, in so doing, it involuntarily extinguished a debt primarily owed by another. In the instant case, the Houston [First Dist.] Court of Appeals noted that the insurer did not dispute that its liability policy provided for liability payments to the Haywoods based on the fault of its insured. Thus, to the extent the insurer made any payments exceeding the amounts owed in proportion to the fault of its insured, such payments were voluntary. The court of appeals therefore held that the insurer was not entitled to recoup the payments it made to the Haywoods by intervening in Mr. Jeffrey's wrongful death suit and bringing an equitable subrogation claim against the Spellings.

***Markel Am. Ins. Co. v. Lennar Corp.*, 342 S.W.3d 704 (Tex. App.—Houston [[14th Dist.] 2011, pet. granted).**

In *Markel American Insurance Company*, the Houston [14th Dist.] held that an insured's failure to separate the amount it paid for covered portions of its claim from the amount it paid for uncovered portions of its claim, as explicitly required by an earlier appellate order, precluded coverage for the entire claim. On June 8, 2012, the Supreme Court of Texas granted the insured's petition for review.

From 1992 to 1998, Lennar Corporation ("Lennar") and its predecessor built homes using an imitation stucco siding called an Exterior Insulation and Finish System ("EIFS"). It was later discovered that the EIFS trapped moisture, which resulted in damage to the EIFS and to the building materials beneath it.

After a national television program televised a story on the moisture problems caused by EIFS, Lennar began receiving phone calls from concerned homeowners. In response, Lennar developed a "voluntary business plan" to inspect and repair the EIFS on many of the homes. When the repairs failed to solve the moisture problems, Lennar decided to remove the EIFS on all of the homes and replace it with conventional stucco, regardless of whether any particular home had suffered water damage.

Lennar filed suit against its liability insurers, including Markel American Insurance Company ("Markel"), which issued excess coverage. The trial court granted summary judgment in favor of Markel, holding that coverage did not exist for Lennar's losses. The Houston [14th Dist.] Court of Appeals reversed the judgment and held that the costs to repair water damage and the costs to remove EIFS to repair underlying water damage were covered, but held that the costs to remove and replace EIFS as a preventative measure on homes that had not yet suffered water damage were not covered. The Houston court remanded the case to the trial court, and specifically instructed Lennar to apportion its loss among those costs that were covered and those that were not.

On remand to the trial, Lennar argued that it could not determine if water damage had occurred without first removing the EIFS. It asked the jury to award damages for the costs to remove the EIFS on all homes, without regard to whether any home had actually sustained damage. Lennar did not offer any evidence of the costs it incurred to remove EIFS solely from

the damaged portions of homes. After a jury trial, the trial court awarded Lennar nearly $3 million in actual damages. Markel appealed, arguing that it did not owe coverage for any of the damages because Lennar failed to apportion the covered portion of the judgment from the uncovered portion.

The Houston [14th Dist.] Court of Appeals agreed with Markel's argument, reasoning that because Lennar bore the burden to establish the amount of covered damages under the Markel policy, it had the burden of presenting evidence from which the jury could allocate between covered and uncovered damages at trial. Thus, because Lennar failed to do so, it failed to meet its burden to prove what damages were covered. Consequently, the appellate court held that coverage was barred for the entire claim.

The appellate court also held that Lennar had failed to establish that any of the costs it incurred fell within the definition of "ultimate net loss" under the Markel policy. The policy defined "ultimate net loss" as "the total amount of damages for which the insured is legally liable in payment of . . . 'property damage.'" The policy provided that "ultimate net loss" could be established "by adjudication, arbitration, or a compromise settlement to which we [Markel] have previously agreed in writing." Because there had not been any adjudication or arbitration of any claims, and because Lennar had settled the claims without Markel's written consent, the appellate court held that the payment of the losses did not satisfy the definition of "ultimate net loss." Accordingly, the court held that the losses were not covered on this basis too.

Although the jury had found that the settlements had not prejudiced Markel, the court held that prejudice was immaterial. The court had earlier held in a prior appeal that Markel would need to establish prejudice in order to prevail on a coverage defense based on a breach of the voluntary payment clause in the conditions section of the policy. The court, however, ruled that prejudice was not required to be shown when an insurer challenges whether the claim falls within the grant of coverage to begin with, that is, whether the losses fell within the definition of "ultimate net loss." The court held that injecting a prejudice requirement into the analysis of "ultimate net loss" would require the court to rewrite the policy, which Texas law prohibits.

***Columbia Lloyds Ins. v. Mao*, No 02-10-00063-CV, 2011 Tex. App. LEXIS 2180 (Tex. App.—Fort Worth Mar. 24, 2011, pet. denied).**

In *Columbia Lloyds Insurance*, the Fort Worth Court of Appeals analyzed whether or not there was sufficient evidence to support competing summary judgments that (1) the vacancy clause in the subject policy applied to preclude coverage or (2) the vacancy clause in the subject policy did not apply to preclude coverage. The appellate court concluded that the evidence did not support granting of summary judgment on either grounds. On March 30, 2012, the Supreme Court of Texas denied petition for review.

Columbia Lloyds issued a Texas Dwelling Policy to Mao, which covered a rental house and a detached garage. The policy contained a vacancy clause, which stated,

> During the policy term, if an insured building is vacant for 60 consecutive days immediately before a loss, we will not be liable for a loss by the perils of fire and

lightning or vandalism or malicious mischief. Coverage may be provided by endorsement to this policy.

After a fire occurred in the house on October 28, 2006, Mao submitted a claim to Columbia Lloyds, which in turn denied coverage based on the vacancy clause. Mao filed suit against Columbia Lloyds, alleging claims for breach of contract, breach of the duty of good faith and fair dealing, common law fraud, violations of the Deceptive Trade Practices Act, violations of the insurance code, and violations of the PPCA. The parties eventually filed competing motions for summary judgment. Mao argued, among other things, that as a matter of law the insured dwelling was not vacant at the time of the fire as the term "vacant" is defined by Texas law. Columbia Lloyds, on the other hand, argued, among other things, that as a matter of law the property was vacant for sixty consecutive days prior to the fire. The trial court granted Mao's motion.

On appeal, Columbia Lloyds argued that the trial court erred by granting Mao's motion for summary judgment and by denying its motion. The Fort Worth Court of Appeals agreed in part, holding that a genuine issue of material fact existed on the applicability of the Policy's vacancy clause, and disagreed in part, holding that said genuine issue of material fact also prevented the granting of Columbia Lloyd's motion for summary judgment. In reaching its conclusion, the court noted that there was evidence that: (1) the adjuster's photos documented that there were contents in the detached garage but not in the actual dwelling; (2) the claims manager testified that she did not have any information that the insured had abandoned the property, but she did know that the insured was remodeling the property to try and sell it; (3) the insured testified that prior to the fire, all of the tenant's furniture had been moved out and the property was "completely vacant"; (4) the remodeler testified that he began remodeling the property on July 12, 2006 and that he finished the job a little over a month before he discovered the house had burned; (5) the remodeler also testified that there was a refrigerator and a stove in the actual dwelling; (6) the insured testified that the dwelling was being renovated until September 2006 but that it was not complete at the time of the fire because the remodeler still needed to put in new windows; and (7) the insured testified that she showed the home to potential buyers approximately twice a week, that she had been to the home the week before the fire, and that she went to the home at least once a week.

Because the policy did not define "vacant" or "vacancy", the appellate court turned to the case law for a definition. "The term vacant has been defined by case law as an entire abandonment, deprived of contents, empty, that is, without contents of substantial utility." Thus, based on the evidence stated above, the court concluded that reasonable and fair-minded people could differ in their conclusions on whether or not the dwelling was vacant for sixty consecutive days prior to the fire.