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Insurance Law

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I. EXTRACONTRACTUAL LIABILITY AND REMEDIES

EXTRACONTRACTUAL liability and alternative theories of recovery from insurers figured prominently during the *Texas Survey* period. While the actual number of cases involving the breach of the duty of good faith and fair dealing appears to have declined in recent years, insureds and their insurers continue to struggle with the complexities of their legal relationship.

A. THE *STOWERS* DOCTRINE

1. Assumption of Settlement Duties

Because Texas does not recognize a cause of action for breach of the duty of good faith and fair dealing in the context of third party liability claims,[1] insureds increasingly have turned to the common law doctrine created under *G.A. Stowers Furniture Co. v. American Indemnity Co.*[2] Under *Stowers*, Texas insurers have a duty to exercise ordinary care in attempting to settle liability claims because of the insurers' right to take complete and exclusive control of the insured's defense. Several significant *Stowers* decisions were published during the *Texas Survey* period.

In *Rocor International, Inc. v. National Union Fire Insurance Co.*,[3] an insured trucking company sued its excess liability carrier for bad faith. In 1989, one of Rocor's employees killed two highway patrol officers while driving while intoxicated. Rocor's insurance consisted of a $1 million deductible it carried on itself, a $1 million primary policy, under which the employer retained the right to defend itself at trial, and an $8 million excess policy with National Union. The National Union policy did not include a duty to defend the employer in the event of a lawsuit. Rocor, through the efforts of its own attorney, determined that it was liable for the subsequent action brought by the families of the deceased officers, and began negotiating with the plaintiffs. When Rocor's liability became apparent, National Union took over settlement negotiations but did not reach a settlement until two years later. National Union directed that mediation efforts be halted and that no offer be made. National Union delayed settling the case for more than a year after it had assumed responsibility for settlement. The case ultimately settled in 1991 for almost exactly the estimate made by Rocor's attorney in 1990.[4]

Rocor sued National Union for the defense expenses it incurred during the settlement negotiations, claiming National Union had engaged in unfair insurance practices and made material misrepresentations regarding the settlement. The jury found that National Union had settled negligently and in bad faith and awarded Rocor $123,000 in damages plus in-

1. *See* Maryland Ins. Co. v. Head Indus. Coatings & Serv., Inc., 938 S.W.2d 27, 28 (Tex. 1996).
2. 15 S.W.2d 544 (Tex. Comm'n App. 1929, opinion adopted).
3. 995 S.W.2d 804 (Tex. App.—San Antonio 1999, pet. granted).
4. *See id.* at 807.

terest and attorney's fees.[5] The trial court later granted National Union's motion for judgment *non obstante verdicto*.[6] The original appellate opinion was withdrawn.[7]

After an *en banc* rehearing, the court of appeals issued a plurality opinion. While five of the seven justices agreed that the insured had a common law cause of action against the excess carrier for negligently assuming control of settlement negotiations when it had no duty to defend, four of the seven justices disagreed that the insured had a cause of action under the Texas Insurance Code.[8]

Rocor first argued that National Union violated the Texas Insurance Code by not attempting in good faith to execute a fair settlement once liability was reasonably clear.[9] Citing *Vail v. Texas Farm Bureau Mutual Insurance Co.*,[10] the court agreed, acknowledging the insured's right to expect that, once all parties agreed on liability and damages, settlement would follow with reasonable promptness and the insured's financial interests would be protected, especially since National Union took over the settlement negotiations and negotiated with the insured's funds and those of the primary carrier.[11] The court rejected National Union's use of *Allstate Insurance Co. v. Watson*,[12] which bars a third-party claimant from having a cause of action as a third-party beneficiary of an insurance policy for unfair settlement practices, by plainly stating that Rocor was not a third-party claimant.[13] The court noted, however, that "*Vail* and *Watson*, taken together, allow first-party claimants who qualify as consumers to bring causes of action based on the DTPA [Deceptive Trade Practices Act], as it incorporates provisions of the Insurance Code and the first-party plaintiffs who do not qualify as consumers under the DTPA to bring suit under the Insurance Code and the reasoning supplied in *Vail*."[14] Because Rocor did not qualify as a "consumer" under the DTPA since its assets exceeded $25 million, the court treated the claim as one by an insured seeking direct damages incurred as a result of the insurance company's mishandling of a third-party claim.[15] After determining that Rocor was entitled to the protection of the Insurance Code, the court held that the insured's evidence was sufficient to prove that National

5. *See id.* at 806.

6. *See id.*

7. *See* Rocor Int'l, Inc. v. National Union Fire Ins. Co., 966 S.W.2d 559 (Tex. App.—San Antonio 1998, opinion withdrawn and motion for *en banc* rehearing granted May 13, 1998).

8. *See Rocor Int'l, Inc.*, 995 S.W.2d at 804.

9. *See id.* at 808.

10. 754 S.W.2d 129 (Tex. 1988).

11. *See Rocor*, 995 S.W.2d at 809.

12. 876 S.W.2d 145 (Tex. 1994).

13. *See Rocor*, 995 S.W.2d at 809.

14. *Id.* at 810 (citing Webb v. International Trucking Co., 909 S.W.2d 220, 226 (Tex. App.—San Antonio 1995, no writ) (stating that both the Insurance Code and DTPA grant relief for unfair practices)).

15. *See id.* at 810-11.

Union engaged in unfair settlement practices.[16]

The court then considered Rocor's claim that it had a common law negligence cause of action against National Union by virtue of the *Stowers* doctrine. Although National Union argued that *Stowers* did not apply because it had no duty to defend under the terms of the excess agreement, the court noted that National Union assumed the duty to fairly settle the claim against the insured when it took over the negotiations, including negotiations involving funds that it did not control.[17] Noting that the Rocor situation did not fall neatly into the *Stowers* doctrine, the court found that National Union's assumption of the exclusive right to negotiate a settlement gave rise to the special relationship upon which the *Stowers* doctrine rests.[18] The court held that even though National Union had no duty to defend Rocor, once it took over settlement negotiations in the case it assumed the duty to fairly settle the claims against the insured.[19] The Texas Supreme Court granted writ in this case on January 2000, and set submission of the case for March 2000.

2. *No Duty to Consider Non-Covered Claims*

The Fifth Circuit recently considered whether carriers must consider non-covered claims during settlement negotiations. In *St. Paul Fire & Marine Insurance Co. v. Convalescent Services, Inc.* (CSI),[20] Schultz was a patient at a nursing home owned by CSI. After Schultz developed various medical conditions requiring hospitalization, surgery and skin grafts, he sued CSI for actual and punitive damages, alleging a variety of negligent acts and omissions that resulted in his serious personal injuries and near death. St. Paul insured CSI, but its policy excluded coverage for punitive damages. While St. Paul was defending CSI in the underlying claim, Schultz made a settlement demand of $250,000, which was well within CSI's policy limits. At the time, Schultz's medical expenses alone were $80,000, but St. Paul rejected the offer and made a counteroffer of $35,000. The case did not settle, and at trial a jury awarded Schultz $380,000 in actual damages and $850,000 in punitive damages against CSI.[21] St. Paul paid the actual damages award against CSI, but refused to pay the punitive damages award based on the policy exclusion.

CSI then pursued a *Stowers* action against St. Paul for its negligence in the settlement negotiations. St. Paul sought a declaratory judgment for a determination of no coverage for the punitive damages award in the same suit. The trial court entered a judgment on the pleadings that St. Paul did

16. *See id.* at 811. The court rejected, however, Rocor's assertion that National Union's alleged misrepresentations concerning the settlement negotiations was actionable under Insurance Code article 21.21 §4 on grounds that the misrepresentations were not the producing cause of Rocor's injuries. *See id.* at 814.

17. *See id.* at 812.

18. *See id.* at 812.

19. *See id.* at 813.

20. 193 F.3d 340 (5th Cir. 1999).

21. *See id.* at 341.

not breach its *Stowers* duty to CSI.[22] The court also found that St. Paul had no liability for the punitive damages award.[23] On appeal, CSI argued that St. Paul's *Stowers* duty was triggered in this case because St. Paul knew or had reason to know that CSI was willing to pay its share of any demand for non-covered damages in order to avoid exposure to a large award of punitive damages based on CSI's payment of $100,000 of its own money the year before in settlement of an unrelated suit that posed a large risk of punitive damages.[24] Relying on the Texas Supreme Court's holding in *American Physicians Insurance Exchange v. Garcia*[25] that an insurer has no duty to settle a claim that is not covered under its policy, the Fifth Circuit rejected CSI's argument that St. Paul had a duty to take into consideration CSI's potential exposure to uncovered punitive damages during settlement negotiations of covered claims.[26]

CSI also argued that regardless of *Stowers*, St. Paul had an independent duty to accept reasonable settlement demands, based on the broad language of *Ranger County Mutual Insurance Co. v. Guin*,[27] which extends an insurer's duty of care to investigation, preparation for the defense of the lawsuit, trial of the case, and reasonable attempts to settle. The Fifth Circuit noted that the Texas Supreme Court's decision in *Garcia* had "drastically curtailed" the broad language of *Guin*.[28] The Fifth Circuit also rejected CSI's reliance on cases from other jurisdictions which had imposed a similar duty because those cases were founded in part on an insurer's duty of good faith and fair dealing, a duty which the Texas Supreme Court expressly declined to extend to third-party claims in *Maryland Insurance Co. v. Head Industrial Coatings & Services, Inc.*[29] Finally, the Fifth Circuit noted that because Texas does not impose a duty upon insurers to consider other covered claims when faced with a settlement demand by one claimant,[30] there is no duty for the insurer to consider claims that are not covered by the policy during settlement negotiations involving one claimant.[31]

3. *Demand Within Policy Limits*

Texas courts repeatedly reject *Stowers* claims that fail to meet the crite-

22. *See id.* at 341-42.
23. *See id.* at 342.
24. *See id.*
25. 876 S.W.2d 842 (Tex. 1994).
26. *See St. Paul*, 193 F.3d at 343.
27. 723 S.W.2d 656 (Tex. 1987).
28. *See St. Paul*, 193 F.3d at 344.
29. 938 S.W.2d 27 (Tex. 1996).
30. *See* Texas Farmers Ins. Co. v. Soriano, 881 S.W.2d 312 (Tex. 1994).
31. *See St. Paul*, 193 F.3d at 345.

ria set out in *Garcia*.[32] The Houston Court of Appeals[33] rejected excess insurer Westchester's claim for equitable subrogation against American Contractors for breach of its *Stowers* duty when the initial settlement demand exceeded the primary carrier's policy limits. In this case, Phillips 66 had a $250,000 primary policy with American Contractors. Westchester was the third-level excess carrier, responsible for amounts between $2 million and $4 million. Cooper, a U.S. Contractors employee working at a Phillips 66 refinery, suffered severe injuries to his hand. Cooper sued Phillips 66 for negligence. American Contractors believed Phillips 66 could prevail at trial by showing U.S. Contractors was responsible for Cooper and that Cooper was more than fifty percent at fault in the accident.

American Contractors' attorney estimated Cooper had as much as a fifty percent chance of obtaining a negligence verdict, with damages likely to range from $990,200 to $1.9 million. Cooper demanded $1.8 million to settle the claim. American Contractors offered $5,000. At mediation, American Contractors again offered the $5,000 and declined to increase it; the mediation ended before Cooper made a counteroffer. At trial, Cooper obtained damages of $5.1 million, plus $2.5 million in prejudgment interest. The case settled for $4.3 million, after Westchester contributed $1.3 million.[34] Westchester then sought reimbursement for the amount it paid under a theory of equitable subrogation against American Contractors. American Contractors obtained summary judgment.[35] On appeal, Westchester contended a primary insurer should not be permitted to engage in misconduct in settlement negotiations but the appeals court refused to extend *Stowers*.[36] Instead, relying on the fact that Cooper's demand exceeded American Contractor's policy limits, the appeals panel affirmed summary judgment.[37] Although technically correct, the *Westchester* case is disturbing because of the propensity of primary carriers or self-insureds with low limits to "gamble" with the excess carrier's money.[38]

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32. The Supreme Court of Texas states that

> The *Stowers* duty is not activated by a settlement demand unless three prerequisites are met: (1) the claim against the insured is within the scope of coverage, (2) the demand is within the policy limits, and (3) the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment.

Garcia, 876 S.W.2d at 849.

33. *See* Westchester Fire Ins. Co. v. American Contractors Ins. Co. Risk Retention Group, 1 S.W.3d 872 (Tex. App.—Houston [1st Dist.] 1999, no pet.).

34. *See id.* at 873.

35. *See id.* at 873.

36. *See id.* at 872.

37. *See id.* at 874.

38. *See, e.g.*, International Ins. Co. v. Dresser Indus., Inc., 841 S.W.2d 437 (Tex. App.—Dallas 1992, writ denied). In *American Centennial Ins. Co. v. Canal Ins. Co.*, the Texas Supreme Court reasoned that if excess carriers were not subrogated to the claims of their insureds, primary insurers would have less incentive to settle within their policy limits and might be tempted to "gamble" with excess carriers' money when potential judgments

4. Implications of Soriano in Stowers

The Fifth Circuit provided a comprehensive analysis of the insurer's dilemma when faced with a settlement of one insured's claims that leaves its remaining insureds without protection under the policy.[39] Travelers issued three insurance policies to Wright Petroleum, a wholesaler and retailer of petroleum products, a business auto policy, a catastrophe umbrella policy, and a comprehensive general liability policy. Citgo had a franchise agreement with Wright, and the three policies named Citgo an additional insured by endorsement. Both the business auto and umbrella policies contained provisions giving Travelers the discretion to settle claims and allowing Travelers to terminate its duty to defend upon exhaustion of the policy limits.

The underlying case arose from a collision involving one of Wright's tanker trucks. Both the Wright employee and the driver of the other vehicle were killed. At the time of the accident, the truck was carrying petroleum products for Citgo. The survivors of the other driver sued Wright, but did not initially sue Citgo. Travelers defended Wright.

The plaintiffs presented a settlement demand. Eventually, a release was executed releasing Wright, the estate of the tanker truck driver, and all others who were then named defendants in the lawsuit, in exchange for Travelers tendering the full policy limits—$1.5 million—of both the auto and the umbrella policies to the plaintiffs. Citgo, which at that time was not and had never been named a defendant in the lawsuit and as to which plaintiffs had not made any offer to settle, was not included in the release. The plaintiffs then amended their complaint, adding Citgo, and asserting negligence in its continued dealings with Wright. Citgo demanded a defense and indemnity from Travelers and Travelers refused, citing in part the exhaustion of policy limits.

Travelers then brought a declaratory judgment action, and Citgo counterclaimed. The court acknowledged that *Stowers* requires that an insurer accept an offer on behalf of its insured "when an ordinarily prudent insurer would do so . . . ."[40] The problem with that duty, the court acknowledged, is when an insurer settles pursuant to that duty and then exposes itself to claims by insureds excluded from the settlement.

The court noted that this dilemma was resolved by the Texas Supreme Court in situations involving multiple claimants. In *Soriano*, "evidence that a larger claimant was willing to settle within policy limits (but had not then made an offer) was deemed irrelevant in the absence of evi-

approach the primary insurers' limits. 843 S.W.2d 480, 483 (Tex. 1992). At some point, the Texas Supreme Court may be forced to develop a hybrid *Canal/Stowers* cause of action in order to resolve the complicated indemnity issues facing primary and excess carriers. Recently, the Fifth Circuit in *General Star Indem. Co. v. Vesta Fire Ins. Corp.*, reversed a Federal Rule of Civil Procedure12(b)(6) motion to dismiss, finding an excess insurer is legally entitled to assert a *Stowers* claim against the primary insurer via equitable subrogation principles. *See* 173 F.3d 946, 951 (5th Cir. 1999).

39. *See* Travelers Indem. Co. v. Citgo Petroleum Corp., 166 F.3d 761 (5th Cir. 1999).

40. *Id.* at 764.

dence that the settlement reached with the other claimant, considered alone, was unreasonable."[41] In situations involving multiple insureds, rather than multiple claimants, the court noted that only two cases construing Texas law have addressed this problem. In the first case, the court held that duties to additional insureds terminated when the settlement exhausted the policy limits.[42] In the second case, *Vitek, Inc. v. Floyd,*[43] the court allowed for the possibility that a co-insured might have an action against the insurer for breach of good faith under these circumstances. But the *Citgo* court noted that Texas "has since indicated that in such a context an action for breach of good faith against the insurer cannot be maintained."[44]

Citgo charged that when multiple insured parties, rather than multiple claimants, are involved, the *Soriano* approach discourages settlement as a partial settlement obtained under the *Arnold* rule does not prevent continued litigation against the exposed co-insured.[45] The court rejected Citgo's position, noting that under such a rule "the only rational course for insurers would be to formally or informally make all their insureds parties to any settlement negotiations. No insurer would settle at its policy limits with potential excess liability to a disgruntled co-insured lurking in the background."[46] The court opined that "mandatory interjection of new parties and new issues into settlements that Citgo's rule would likely produce seems calculated to increase the cost of negotiations and decrease the likelihood of their ultimate success."[47] The court ultimately followed the *Arnold* rule that an insurer is not subject to liability for proceeding on behalf of a sued insured with a reasonable settlement once a settlement demand is made, even if the settlement eliminates or reduces limits of liability to a level insufficient for further settlement coverage for a co-insured as to whom no demand has been made.[48] The *Citgo* decision follows those jurisdictions holding that a carrier need only act in good faith in securing a settlement and may settle on behalf of less than all insureds.

The Fifth Circuit then reconsidered the same issue in a second case, in which a house fire resulted in the deaths of five people.[49] The plaintiffs in the underlying suit initially only sued Sparks, the property manager. To resolve that claim, the excess insurer paid $500,000 of a $520,000 settlement. The primary carrier paid the balance. At that time, the primary

41. *Id.* at 765 (citing Texas Farmers Ins. Co. v. Soriano, 881 S.W.2d 312, 314-15 (Tex. 1994)).

42. *See* American States Ins. Co. v. Arnold, 930 S.W.2d 196 (Tex. App.—Dallas 1996, writ denied).

43. 51 F.3d 530 (5th Cir. 1995).

44. *Citgo,* 166 F.3d at 766 (citing Maryland Ins. Co. v. Head Indus. Coatings and Servs., Inc., 938 S.W.2d 27, 28 (Tex. 1996)).

45. *See id.* at 766.

46. *Id.* at 767, n.5.

47. *Id.* at 767.

48. *See id.* at 768.

49. *See* Western Alliance Ins. Co. v. Northern Ins. Co., 176 F.3d 825 (5th Cir. 1999).

and excess insurers agreed they would resolve their differences over coverage and allocation at the conclusion of all litigation arising out of the house fire. Following the settlement of the claims against the property manager, the plaintiffs in the underlying lawsuit sued the FDIC, the property owner. The primary carrier ultimately tendered its policy limits. In the insurance litigation that followed, the primary carrier argued that its payment of policy limits to settle the FDIC claims precluded its liability for any portion of the *earlier* Sparks settlement. The Fifth Circuit disagreed:

> [A]t that time Sparks was the only insured party named in the action, and the primary policy limits were not exhausted. If the facts were sufficient to trigger the duty to indemnify, that duty included the immediate payment of a settlement of up to $1 million. Northern's decision to subsequently extend the policy limits on behalf of the FDIC cannot alter the fact that it may be liable to Sparks for the full value of a settlement within policy limits. Under the facts of this case, we hold that the exhaustion of Northern's primary policy liability in a subsequent proceeding could not serve to excuse Northern's asserted earlier breach of its duty to indemnify.[50]

Although the Fifth Circuit could not completely resolve the coverage questions (due to an incomplete record) it reviewed the record and articulated its belief that the excess insurer was entitled to reimbursement from the primary insurer and stated its belief regarding the excess insurer's entitlement to summary judgment if the missing pages from the record did not deviate from the factual findings made by the court.[51]

B. Breach of the Duty of Good Faith and Fair Dealing

Denise Castañeda's father applied for medical insurance with Provident American in May 1991 to cover his entire family.[52] During the application process, her father failed to disclose that just two days before he applied for the policy, his son received medical attention for jaundice, anemia, and suspected hepatitis. Denise received medical treatment for jaundice and hepatitis several years before her brother. Provident American issued a policy to the family effective June 17, 1991, but with two relevant limitations. First, the policy did not cover expenses resulting from a sickness that manifests within thirty days of the policy's effective date. Second, the policy excluded diseases or disorders of certain internal organs, including the gallbladder, unless the loss occurred more than six months after the policy's effective date. Shortly thereafter, the Castañedas learned that another family member had been diagnosed with hemolytic spherocytosis ("HS"), a hereditary condition causing misshapen red blood cells, and commenced HS screening for the rest of the family. On July 20, 1991, the third day after the thirty day period, Cas-

50. *See id.* at 828-29.
51. *See id.* at 833.
52. *See* Provident Am. Ins. Co. v. Castañeda, 988 S.W.2d 189 (Tex. 1999).

tañeda and her brother were diagnosed with HS. In August, she and her brother each had their spleen and gallbladder removed. The Castañedas submitted the claims to Provident American, which denied it on the basis of the six-month policy exclusion for internal organ disorders. After Castañeda's father explained that removal of the gallbladder was only secondary to HS, Provident American reopened the claim, but later denied it on the ground that the HS disorder had manifested within thirty days of the policy's effective date. Provident American yet again promised Castañeda that it would reconsider her claim, but failed to respond later.

Castañeda sued the carrier, claiming violations of the DTPA and the Code. The trial court entered judgment for Castañeda on the jury's verdict, awarding $50,000 in actual damages based on a broad-form jury question that allowed the jury to combine damages for lost policy benefits and past loss of credit.[53] The jury also awarded $100,000 in additional damages—a twelve percent penalty under the Code on the lost benefits, attorney's fees, and prejudgment interest.[54] The court of appeal reversed the twelve percent penalty, but otherwise affirmed the trial court's judgment.[55]

On appeal, the Texas Supreme Court considered three issues: (1) whether Provident American denied the claim without a reasonable basis or after liability had become reasonably clear; (2) whether there was a misrepresentation about the policy; and (3) whether Provident American engaged in unfair claims settlement practices. The court noted that during the claim dispute, Provident American gave varying reasons for denying Castañeda's claim, but all were grounded in a common nucleus of facts.[56] The court pointed out that even if Castañeda's condition manifested outside of the thirty day period, that fact, standing alone, would not constitute evidence of a bad faith denial of her claim.[57] The Castañeda siblings had exhibited symptoms even before their father applied for the policy. In order to support a verdict, the court stated, Castañeda was required to show some evidence that

> no reasonable insurer could have believed that the condition had manifested before the end of the thirty-day period (an objective prong of the "no reasonable basis" definition of bad faith) and that Provident American knew or should have known that it had no reasonable basis for denying the claim based on the thirty-day waiting period (the second prong).[58]

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53. *See id.* at 192.

54. *See id.*

55. *See* Provident Am. Ins. Co. v. Castañeda, 914 S.W.2d 273 (Tex. App.—El Paso 1996), *rev'd*, 988 S.W.2d 189 (Tex. 1999).

56. *See id.* at 193.

57. *See Castañeda*, 988 S.W.2d at 194. A bona fide coverage dispute does not demonstrate that there was no reasonable basis for denying a claim. *See id.* (citing State Farm Lloyds v. Nicolau, 951 S.W.2d 444, 448 (Tex. 1997); Transportation Ins. Co. v. Moriel, 879 S.W.2d 10, 17 (Tex. 1994); National Union Fire Ins. Co. v. Dominguez, 873 S.W.2d 373 (Tex. 1994).

58. *Castañeda*, 988 S.W.2d at 195-96 (citing *Dominguez*, 873 S.W.2d at 376).

The court emphasized that a finding of coverage "is not the equivalent and cannot be the only evidence of bad faith."[59]

The court also addressed whether denial of Castañeda's claim was improper under the six-month exclusion. Clearly, there was confusion even within Provident American as to its applicability once one of Castañeda's physicians opined that the removal of her gallbladder was secondary to her HS condition. But the court declined to find that the confusion over the exclusion amounted to evidence that no other reasonable insurance company would have denied coverage in light of other facts.[60] Even though one of Provident American's employees testified that it was improper to deny the claim based on the gallbladder exclusion, no employee believed that the claim was payable based on the thirty-day provision.[61] Relying on its previous holding in *Republic Insurance Co. v. Stoker*,[62] the *Castañeda* court observed that even if Provident American's reliance on the gallbladder exclusion was misplaced, there were ample facts to support reliance on the thirty-day exclusion at virtually every stage of the claim.[63] As a result, the court found that there was no evidence that Providence American's liability under the policy was reasonably clear when it denied coverage or that it had no reasonable basis for denying coverage.[64]

Castañeda also contended that she was entitled to recover damages equivalent to policy benefits because Provident American failed to acknowledge communications about the claim or failed to adopt reasonable standards for investigating claims. The court noted that the "failure to properly investigate a claim is not a basis for obtaining policy benefits," but might be a basis for damages "to the insured other than policy benefits or damages flowing from the denial of the claim if the insurer mishandled the claim."[65] The court also rejected Castañeda's claim that Provident American's preapproval of her surgery was an acknowledgment of coverage, and its subsequent failure to pay her claim was a violation of the Code and the DTPA.[66] While the court declined to hold that preapproval of medical procedures can never constitute an actionable representation under article 21.21 or the DTPA, the court found that adopting "Castañeda's position . . . would impose strict liability on carriers that are not given pertinent facts before a procedure is pre-approved and who later learn that they have a good faith, reasonable basis for denying coverage."[67] The court also noted that there was no evidence that Castañeda relied on the preapproval to her detriment and would have

59. *Id.* at 196.
60. *See id.* at 197.
61. *See id.*
62. 903 S.W.2d 338, 340 (Tex. 1995).
63. *See Castañeda*, 988 S.W.2d at 197.
64. *See id.*
65. *Id.* (citing *Stoker*, 903 S.W.2d at 341).
66. *See id.* at 199.
67. *Id.* at 200.

foregone the surgery if there had been no preapproval.[68]

Finally, the court rejected Castañeda's claim that Provident American's conduct was unconscionable under the DTPA. The court observed that there was no evidence that Provident American took advantage of the lack of knowledge, ability, experience or capacity "of Castañeda to a grossly unfair degree or that its conduct resulted in a 'gross disparity between value received and consideration paid.'"[69] The court noted that even if the policy did not cover the HS claim, the policy was not "valueless," as Castañeda contended, because "it covered a myriad of other illnesses Castañeda could have contracted while the policy was in effect."[70] Because the judgment against Provident American was not supported by legally sufficient evidence, the court reversed the decision of the court of appeals and rendered that Castañeda take nothing.[71]

II. GENERAL LIABILITY INSURANCE

A. DUTY TO DEFEND

In a recent case, the Department of Transportation ("DOT") sued St. Paul, the general liability insurer of a highway construction contractor, for a declaration that its policy covered DOT as an additional insured against claims arising out of flooding caused by the highway.[72] The DOT contended that St. Paul owed it a defense under an additional insured endorsement that provided coverage for injury or damage resulting from the contractor's work for DOT, or the DOT's general supervision of the work. St. Paul argued that it had no duty to defend the DOT because the underlying petition failed to allege facts or claims for damages that would trigger a duty to defend, or at most it was only obligated to defend certain covered claims.

The court of appeals examined the underlying petition in light of the "eight corners" rule.[73] The petition alleged the DOT and the contractor designed, scheduled, constructed, and supervised the construction of the highway and its drainage channels. The court noted that this allegation could be read to allege that the contractor failed to construct the highway with adequate flood-control measures, the DOT supervised the construction, and the acts of both the contractor and the DOT caused the plain-

68. *See Castaneda*, 988 S.W. 2d at 200.
69. *Id.* at 200-01.
70. *Id.* at 201.
71. *See id.*
72. St. Paul Ins. Co. v. Texas Dep't of Transp., 999 S.W.2d 881 (Tex. App.—Austin 1999, writ denied).
73. *See id.* at 884-85. An insurer's duty to defend is determined by the allegations in the pleadings and the language of the insurance policy. National Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc., 939 S.W.2d 139, 141 (Tex. 1997); Trinity Universal Ins. Co. v. Cowan, 945 S.W.2d 819, 821 (Tex. 1997); American Physicians Ins. Exch. v. Garcia, 876 S.W.2d 842, 847-48 (Tex. 1994). This is known as the "eight corners" rule. *See National Union*, 939 S.W.2d at 141. The "eight corners" rule is also sometimes called the "complaint allegation" rule. *See Cowan*, 945 S.W.2d at 821; *Garcia*, 876 S.W.2d at 847-48.

tiffs' injuries.[74] The court specifically rejected St. Paul's argument that vicarious liability had to be alleged against DOT before the provisions of the additional insured endorsement were triggered.[75] The court noted that it was plain from the endorsement that an allegation of the DOT's direct negligence was sufficient to trigger a duty to defend.[76]

St. Paul also maintained that the policy's intentional injury exclusion precluded coverage for gross negligence or intentional torts. The court observed, however, that the negligent supervision allegations against the DOT could naturally be read to encompass ordinary negligence, as well as gross negligence or intentional torts.[77] In spite of the fact that the petition alleged legal theories of gross negligence and intentional torts, the facts alleged were controlling over the legal theories.[78]

B. Occurrence

Unpublished decisions are generally not recognized as authority by courts, especially when such decisions are generated from a lower court. But the next opinion is significant because of its apparent acknowledgment of the difficult task of interpreting the term "occurrence" in insurance policies. McKinney was sued by two homeowners who were informed that their houses encroached on neighboring lots.[79] After McKinney assumed responsibility, the homeowners sued alleging negligence in misplacing the houses, negligence in hiring surveyors, misrepresentation and fraud. McKinney sought defense and indemnity from Nationwide under its general liability and umbrella policies. Nationwide denied coverage, asserting the fact that McKinney mistakenly built the houses on the wrong spots did not constitute an accident or occurrence.

As support, Nationwide relied on *Argonaut Southwest Insurance Co. v. Maupin*[80] and *Hardware Mutual Casualty Co. v. Gerrits*.[81] In *Maupin*, the Texas Supreme Court held that the insured was not entitled to coverage for a suit alleging trespass for the insured's acts of removing borrow material from property.[82] The *Maupin* court acknowledged that while the insured's mistaken belief regarding the identity of the owner of the property arguably indicated no intent by the insured to injure, the act itself, the removal of the borrow material, was intentional, deliberate and, thus, not an accident.[83] The *Maupin* court relied in part on *Gerrits*, in which the insured used an erroneous property survey to construct a house

74. *See St. Paul Ins. Co.*, 999 S.W.2d at 884-85.
75. *See id.* at 885-86.
76. *See id.* at 886.
77. *See id.* at 887.
78. *See id.*
79. McKinney Builders v. Nationwide Mut. Ins. Co., No. 3:97-CV-3053-R, 1999 U.S. Dist. LEXIS 12559, at *4-5 (N.D. Tex. Aug. 11, 1999).
80. 500 S.W.2d 633 (Tex. 1973).
81. 65 So.2d 69 (Fla. 1953).
82. *See Maupin*, 500 S.W. 2d at 635.
83. *See id.*

which was later discovered to encroach upon a neighboring lot.[84] The *Gerrits* court found the resulting suit was not covered, holding that a "mistake of fact" occurred and the resulting encroachment was the "natural and probable" consequence of the erroneous survey.[85] Therefore, the *Gerrits* court concluded, there was no accident.[86] The *McKinney Builders* court rejected *Maupin* and *Gerrits* as sound precedent because the Florida Supreme Court has since modified its position on the term "accident."[87] The *McKinney Builders* court concluded that the underlying complaint alleged an "occurrence" because the alleged damages were undesigned or unexpected from the standpoint of McKinney.[88]

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84. *See id.*

85. *See Gerrits*, 65 So.2d at 70-71.

86. *See id.* at 71.

87. *See McKinney Builders*, 1999 U.S. Dist. LEXIS 12559, at *15. In *State Farm Fire and Cas. Co. v. CTC Dev. Corp.*, the Supreme Court of Florida held that the term "accident" in an insurance policy "includes not only 'accidental events,' but also damages or injuries that are neither expected nor intended from the viewpoint of the insured." 720 So. 2d 1072 (Fla. 1998). Arguably, there are two lines of "occurrence" cases in Texas. The line of cases following *Maupin* pertains to coverage of claims against an insured for damage caused by its alleged intentional torts. *Maupin*, *supra* note 80. According to this body of law, damage that is the natural result of voluntary and intentional acts is deemed not to have been caused by an occurrence, no matter how unexpected, unforeseen, and unintended that damage may be. *See, e.g.*, State Farm Fire & Cas. Co. v. Brooks, 43 F.Supp. 2d 695, 702 (E.D. Tex. 1998) (concluding that a claim brought against an insured for damages resulting from "unconsenting sexual acts" is a claim for damages resulting from an intentional act which is not a covered "occurrence"); Metropolitan Property & Cas. Co. v. Murphy, 896 F. Supp. 645, 648 (E.D. Tex. 1995) (concluding that a woman's claim against Murphy, for secretly watching her shower, bathe, dress, and sleep through holes he had drilled in her bathroom and bedroom walls, was based on allegations of intentional conduct that did not satisfy the policy's definition of "occurrence"); Trinity Universal Ins. Co. v. Cowan, 945 S.W.2d 819, 828 (Tex. 1997) (concluding that a photo lab clerk's intentional act of replicating photographs of a woman and showing them to friends was not an "accident" within the meaning of the clerk's homeowners' liability policy, even though the clerk did not intend to cause harm to the woman, because the injury of which the woman complained—the invasion of her privacy—could be reasonably anticipated from the clerk's conduct); Baldwin v. Aetna Cas. & Sur. Co., 750 S.W.2d 919, 921 (Tex. App.—Amarillo 1988, writ denied) (denying plaintiff's claim for damage incurred when his insurer refused to defend him in a suit brought by the state for alleged repeated and intentional highway size and weight violations). In cases involving claims against an insured for damage arising out of his alleged negligence, however, a second line of cases has developed following *Massachusetts Bonding & Ins. Co. v. Orkin Exterminating Co.*, 416 S.W.2d 396 (Tex. 1967). *See, e.g.*, Lafarge Corp. v. Hartford Cas. Ins. Co., 61 F.3d 389, 395 (5th Cir. 1995) (holding that unintended damage to a pipeline caused by the defective coating supplied by insured's subsidiary was caused by an "occurrence" within the meaning of the liability policy); Hartford Cas. Co. v. Cruse, 938 F.2d 601, 604-05 (5th Cir. 1991) (concluding that extensive damage to plaintiffs' home caused by insured's defectively performed foundation leveling services was unexpected and unintended and, therefore, was caused by an "occurrence" within the meaning of the policy); Travelers Ins. Co. v. Volentine, 578 S.W.2d 501, 503 (Tex. Civ. App.—Texarkana 1979) (concluding that the destruction of an entire engine as the result of the malfunction of one repaired valve was unexpected and unintended); Employers Cas. Co. v. Brown-McKee, Inc. 430 S.W.2d 21, 24 (Tex. Civ. App.—Tyler 1968) (concluding that manufacturer's alleged improper construction and repair of concrete grain storage elevator was an "accident" for the purposes of insurance coverage and defense because it brought about damage that was "an unexpected, unforeseen or undesigned happening or consequence from 'either a known or unknown cause.").

88. *See McKinney Builders*, 199 U.S. Dist. LEXIS 12559 at *19-20.

Nationwide also asserted the underlying allegations of diminution in value of the homes did not constitute "property damage" because it was a purely ecnomic loss.[89] The *McKinney Builders* court found the underlying complaint alleged property damage because it claimed loss of use, which was covered under both policies.[90] Moreover, "encroachment" constitutes property damage, the court held.[91]

Finally, the court rejected Nationwide's application of two exclusions to the case. The court found the "your work" exclusion inapplicable because the underlying complaint alleged property damage based on physically injured property.[92] Construing the allegations as property damage to "impaired property" created an ambiguity that should be construed against Nationwide, the court added.[93] In addition, the court applied its finding to Nationwide's argument that the exclusion for failure to perform barred coverage.[94]

C. Assault and Battery Exclusion

In *Scottsdale Insurance Co. v. Texas Security Concepts & Investigation*,[95] the Fifth Circuit upheld the applicability of an assault and battery exclusion in a general liability policy issued to a security company. Two women alleged that they were falsely imprisoned and sexually assaulted at a Houston apartment complex. The women sued Texas Security for negligently failing to provide proper security at the complex. Scottsdale, Texas Security's general liability carrier, filed a declaratory judgment action against its insured and the women. After the insureds failed to answer the suit and defaulted, the trial court granted summary judgment in

89. *See McKinney Builders*, 199 U.S. Dist. LEXIS 12559 at *21. The CGL policy defined "property damage" as "physical injury to tangible property, including all resulting loss of use of that property; or loss of use of tangible property that is not physically injured." *Id.* at *22. The umbrella policy defined the term as "physical injury to or destruction of tangible property which occurs during the policy period, including all resulting loss of use of that property[; or] loss of use of tangible property which has not been physically injured or destroyed provided such loss of use is caused by an occurrence during the policy period." *Id.*

90. *See McKinney Builders*, 1999 U.S. Dist. LEXIS 12559, at *27-30.

91. *Id.* at *23-24 (*citing* Saks v. Nicosia Contracting Corp., 215 A.D.2d 832, 625 N.Y.S.2d 758, 760 (N.Y. App. Div. 1995) ("'There can be little doubt that the real property on which the [misplaced] house encroaches sustained damage, and we are of the view that there was corresponding damage to plaintiffs' real property because of the encroachment.'")).

92. *Id.* at 27-28. This exclusion, exclusion (m), excluded "'[p]roperty damage' to 'impaired property' or property that has not been physically injured, arising out of: a defect, deficiency, inadequacy or dangerous condition in 'your product' or 'your work'; or a delay or failure by you or anyone acting on your behalf to perform a contract or agreement in accordance with its terms." *Id.* at *27.

93. *See id.* at *30.

94. *See id.* The failure to perform exclusion precludes coverage for loss of use of tangible property which has not been physically injured or destroyed, resulting from a delay or lack of performance by the insured or the failure of the insured's products or work performed by the insured or on the insured's behalf to meet the level of performance warranted. *See id.*

95. 173 F.3d 941 (5th Cir. 1999).

favor of Scottsdale and against the women.[96] On appeal, the women contended that (1) the assault and battery exclusion was void since it was against Texas public policy and (2) some of their claims fell outside the exclusion.

The Texas statute regulating the licensing of private security agencies at the time required that the licensing board verify that each security agency seeking a license held a general liability policy which would provide coverage for the security business activities of the agency.[97] The women contended that because the attachment of the assault and battery exclusion is counterproductive to the mandate of the statute, the assault and battery exclusion is void as a violation of Texas public policy. The Fifth Circuit agreed, however, with Scottsdale that the security agency's failure to procure the appropriate insurance was an issue between the security company and the regulating agency.[98] Noting that the statute was regulatory in nature, the court held that the statute did not affirmatively establish a public policy of the state which would override the contractual agreement between the security agency and the insurance company.[99]

The Fifth Circuit also rejected the women's claim that their underlying personal injury suit implicitly stated claims for false imprisonment which were not subject to the assault and battery exclusion. The court stated that "[w]hen an exclusion precludes coverage for injuries 'arising out of' described conduct, the exclusion is given a broad, general, and comprehensive interpretation."[100] Accordingly, the court determined that a claim need only bear an incidental relationship to the described conduct for the exclusion to apply.[101] Noting that "the rape, assault, and unlawful restraint all occurred concurrently and as a part of the same sequence of events," the Fifth Circuit held that the false imprisonment claims of the women by the assault and battery exclusion.[102]

D. Pollution Exclusion

In *Kelley-Coppedge Inc. v. Highlands Insurance Co.*,[103] KCI, an oil and gas pipeline independent contractor, inadvertently struck a Mobil Oil pipeline while laying pipe along an easement. The act caused 1,600 barrels of crude oil to spill and damage a third party's land upon which the easement was located. Highlands, KCI's general liability insurer, paid to repair the pipeline and paid for the lost oil, but refused to pay KCI's clean-up costs under its policy. KCI sued Highlands for a declaration of the carrier's coverage obligations. The trial court found that Highlands'

96. *See id.* at 942.
97. *See id.* at 942. Tex. Rev. Civ. Stat. art. 4413(29bb), § 40(a) (1998) (repealed 1999).
98. *See id.* at 943.
99. *See Scottsdale*, 173 F.3d at 943.
100. *Id.*
101. *See id.*
102. *Id.* at 944
103. 980 S.W.2d 462 (Tex. 1998).

pollution exclusion did not exclude clean-up costs and granted summary judgment for KCI on damages of $435,000.[104] On appeal, however, the court reversed and rendered judgment for Highlands, finding that the policy excluded coverage for the clean-up costs.[105]

The Texas Supreme Court considered whether the pollution exclusion in the contractor's policy excluded coverage for the clean-up costs. In one section of the policy, coverage was excluded for property damage arising out of the discharge or release of pollutants "[a]t or from any premises, site or location which is or was at any time owned or occupied by, or rented or loaned to, any insured[.]"[106] Another section of the policy excluded coverage for any cost or expense arising out of a request that the insured clean up, neutralize or in any way respond to the effects of pollutants.[107] The court noted that the case turned on whether or not the phrase "occupied by" encompassed KCI's activities on the easement.[108]

Highlands argued that "occupied by" meant "to take up space." KCI, on the other hand, contended that something more than mere presence was necessary. The court examined *Tri County Service Co. v. Nationwide Mutual Insurance Co.*,[109] the only Texas case to address the issue. In *Tri County*, the court found that the ordinary meaning of "occupied" did not necessarily mean ownership and that the term was broad enough to include the insured's activities on a parking lot that the insured had been subcontracted to pave.[110] The court also compared the *Tri-County* decision with *United States Fidelity & Guaranty Co. v. B & B Oil Well Service Inc.*,[111] in which the court held that an oil well contractor was not an occupier of the premises on which it had contracted to rework some wells, and with *Gregory v. Tennessee Gas Pipeline Co.*,[112] where the court interpreted "occupy" as "to keep or hold for use." Ultimately, the *Kelley-Coppedge* court held that the *Tri-County* interpretation of "occupy" would render the second part of the pollution exclusion meaningless.[113] Instead, the court held that the first section of the pollution exclusion refers to operations on premises owned or controlled by the contractor and the second section refers to operations on a third party's premises.[114] Thus, the court held that coverage for KCI's cleanup costs was provided.[115]

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104. *See id.* at 463.
105. *See id.* at 463-64.
106. *Id.*
107. *See id.* Because Highlands failed to preserve error regarding this provision, the court declined to decide whether this provision would have excluded coverage for KCI's clean up costs. *See id.* at 467.
108. *See id.* at 464.
109. 873 S.W.2d 719 (Tex. App.—San Antonio 1993, writ denied).
110. *See id.* at 721-22.
111. 910 F. Supp. 1172 (S.D. Miss. 1995).
112. 948 F.2d 203 (5th Cir. 1991).
113. *See Kelley-Coppedge, Inc.*, 980 S.W.2d at 467.
114. *See id.*
115. *See id.*

A lower court also considered a more recent version of the pollution exclusion. In *Mid-Continent Casualty v. United States Fire Insurance Co.*,[116] the plaintiffs filed two lawsuits against Southbend Municipal Utility District (MUD) claiming that they were injured by drinking water MUD furnished to them. MUD was insured by both Mid-Continent and U.S. Fire. Mid-Continent provided a defense and successfully defended MUD in both suits. U.S. Fire declined Mid-Continent's demand that U.S. Fire participate in MUD's defense, citing the pollution exclusion in its policy. Mid-Continent sued U.S. Fire for defense costs of the two suits against MUD, but U.S. Fire ultimately obtained a summary judgment declaring that its pollution exclusion applied to the MUD suits.[117]

On appeal, the court rejected Mid-Continent's argument that the U.S. Fire exclusion required pollutants to originate from a site owned or otherwise under the control of MUD.[118] Instead, the court noted that the exclusion applied to the "discharge, disbursal, release or escape of pollutants" from a site where MUD or those working on its behalf were "performing operations."[119] The underlying petition alleged that either MUD or its contractor operated the facilities on behalf of MUD.[120] Additionally, the court noted that the polluted or contaminated drinking had to have been "'discharged, disbursed, or released' from a site where Southbend MUD or those working on its behalf were 'performing operations'" in order for MUD to provide the drinking water to the underlying plaintiffs in the first place.[121] Therefore, the court held that the absolute pollution exclusion applied, and upheld U.S. Fire's summary judgment.[122]

In a recent environmental liability case, the insured, Gulf Metals, sold materials for more than forty years to a chemical company in South Carolina that manufactured fertilizer, but did not know, or have any reason to know, that its customer's fertilizer-manufacturing operations had serious adverse environmental effects.[123] Throughout the time of the sales, fertilizer-manufacturing operations were not believed to have serious environmental ramifications to neighboring property and groundwater. However, the soil and groundwater at the site of the chemical company's fertilizer plant were later determined to be contaminated. In 1994, the EPA issued an administrative order requiring the insured to participate in the cleanup of the site and to reimburse the EPA for existing cleanup costs. South Carolina's state environmental agency issued a similar order to Gulf Metals in 1997.

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116. 1 S.W.3d 251 (Tex. App. – Corpus Christi 1999, no pet. h.).

117. *See id.* at 252.

118. *See id.* at 253.

119. *Id.* at 252. The reader should note that most pollution exclusions use the term "disperse" over the term "disburse."

120. *See id.* at 253.

121. *Id.*

122. *See id.*

123. Gulf Metals Indus., Inc. v. Chicago Ins. Co., 993 S.W.2d 800, 802 (Tex. App.—Austin 1999, pet. denied).

The insured sought coverage under a succession of liability policies it purchased beginning in 1958. From 1970, most of the policies contained a pollution exclusion that excluded coverage for "bodily injury or property damage arising out of the discharge, dispersal, release; or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials or other irritants, contaminants or pollutants into or upon land, the atmosphere or any watercourse or body of water" *unless* "such discharge, dispersal, release or escape is sudden and accidental."[124]

Gulf Metals sought a declaration that the limited pollution exclusion did not preclude coverage for the environmental claims at the South Carolina fertilizer plant. The insured focused on the exception for "sudden and accidental" discharges and argued that the word "sudden" could reasonably be interpreted to mean "unexpected." Under this reading, the "sudden and accidental" exception to the pollution exclusion would reinstate coverage as long as the underlying event was unexpected and unintended from the standpoint of the insured. Chicago Insurance moved for summary judgment, responding that "sudden" necessarily contains a temporal element requiring that any discharge of pollutants be swift or abrupt for the exception to the exclusion to apply.

The district court held that (1) the insured had the burden of proving that the facts of its polluting events fell within the "sudden and accidental" exception of the pollution exclusion; (2) there was neither patent nor latent ambiguity in the phase "sudden and accidental;" (3) that the term "sudden," as used in the policy, contained a temporal element; and (4) that the phrase "sudden and accidental" meant "rapid and unexpected.[125] Concluding that the insured could not meet its burden of proving that the pollution exclusion did not bar coverage, the district court granted the insurer's motion for partial summary judgment.[126]

In affirming, the court of appeals emphatically rejected Gulf Metals' contention that the pollution exclusion was patently ambiguous.[127] The insured had relied on dictionary definitions of "sudden" and the diversity of judicial opinion on the meaning of the pollution exclusion as evidence of the exclusion's patent ambiguity.[128] The court refused to give weight to either form of evidence, noting that both unduly restrict the ability of courts to engage in "meaningful contextual analysis of contract terms."[129] Interpreting the word "sudden" in the context of the policy, "[t]he court reasoned that the use of both words together reflected two separate requirements. Because 'accidental' describes an unforeseen or unexpected event," the court observed, to ascribe the same meaning to "sudden" would render the terms redundant and "violate the rule that each word in

124. *Id.* at 803.
125. *Id.* at 803-04.
126. *See id.* at 804.
127. *See id.* at 805.
128. *See id.* at 805-06.
129. *Id.* at 807.

a contract be given effect."[130] "The court stated that 'sudden' therefore must contain a temporal element meaning abrupt or brief."[131]

The court also found nothing in the circumstances surrounding promulgation of the policies' pollution exclusion that demonstrated a latent ambiguity in the exclusion.[132] The only evidence proffered by the insured related to the Texas State Board of Insurance's understanding of the exclusion. Although acknowledging that "surrounding circumstances" may be considered in determining whether an insurance policy is ambiguous, the court held that the relevant circumstances are those surrounding the making of the contract, not those present when a regulatory body approves or promulgates a policy form.[133]

E. Advertising Injury

The central issue in *Bay Electric*[134] concerned whether claims of trademark infringement and trade dress infringement constitute an "advertising injury" under Texas law. An underlying action by a competitor, ACB, claimed that Bay Electric and FAE sold circuit breakers bearing trademarks and configurations allegedly identified with and owned by ACB. Travelers carried general liability insurance covering Bay Electric from April 1995 to April 1998. FAE was added as a named insured to the coverage in September 1995. ACB sued in July 1997, and the insureds' broker notified Travelers of the suit in December 1997.

The court held that the claims of trademark and trade dress infringement constituted the "misappropriation of advertising ideas or style of doing business," one of the elements of the policy's "advertising injury" definition.[135] The court rejected the Sixth Circuit's and Travelers' argument that the clause indicating that "misappropriation of advertising ideas or style of doing business" refers only to offenses falling under the common law tort of misappropriation.[136] The court noted that if the drafters of the policy had wanted to limit exposure this common law tort, they could have done so.[137] Interestingly, the court then stated:

> Further, under Texas law, the Court is to look to the understanding of the average insured, and the Court does not believe that the average insured is required to know the obscure distinctions between common law business torts; instead the burden to identify such distinctions and incorporate them into the policy should fall upon the

130. *Id.* at 805.

131. *Id.*

132. *See id.* at 808.

133. *See id.*

134. *See* Bay Elec. Supply Inc. v. The Travelers Lloyds Ins. Co., 61 F. Supp. 2d 611 (S.D. Tex. 1999).

135. *Id.* at 616.

136. *Id.* at 617.

137. *See id.* at 617 (citing Industrial Molding Corp. v. American Mfrs. Mut. Ins. Co., 17 F. Supp. 2d 633, 638 (N.D. Tex. 1998); Union Ins. Co. v. Knife, 897 F. Supp. 1213, 1216 (W.D. Ark. 1995)).

insurer.[138]

After observing that there is disagreement on the meaning of the phrases "advertising ideas" and "style of doing business," the court noted these phrases were ambiguous.[139] Because the insured proposed an objectively reasonable interpretation of the policy language that had been accepted by courts in other jurisdictions, the court adopted the insureds' construction of the terms.[140]

The court found further support for its conclusion in the drafting history of the standard ISO CGL form. In 1986 the standard CGL form was revised to eliminate "unfair competition" as a covered class of advertising injuries in favor of the misappropriation of advertising ideas and style of doing business, and also removed the trademark, service mark and trade name exclusions from the policy; thus the court held that an insured "could reasonably infer that claims related to trade dress would not be excluded from the CGL policy."[141]

The court rejected Travelers' argument that no advertising injury occurred because the insureds' marketing consisted primarily of mailing or faxing price sheets to customers.[142] Looking solely to the underlying ACB complaint, the court found that Bay Electric and FAE had successfully shown that allegations of the complaint alleged an advertising injury.[143] Travelers' attempted application of the knowledge of falsity exclusion because it failed to carry its burden of proof on the knowledge element of the exclusion.[144] As the court pointed out, "knowledge is not a requirement for a finding of liability in the underlying action . . . [t]he conduct alleged by ACB could have been found to be merely negligent or reckless."[145]

The prior publication exclusion was also found inapplicable by the court. Although the inception of sales of the allegedly infringing circuit breakers occurred in August 1995, when FAE (arguably the real party in interest) was not covered under the policy, the court determined that ACB's cause of action against Bay Electric and FAE did not arise until ACB registered its trademarks in 1997.[146]

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138. *Id.* The court cites no authority for this proposition, and so it is difficult to determine if the court is using a form of the "reasonable expectations" doctrine. Texas generally does not adhere to such a doctrine, but has acknowledged it in limited circumstances. *See, e.g.*, Kulubis v. Texas Farm Bureau Underwriters Ins. Co., 706 S.W.2d 953, 955 (Tex. 1986) (permitting innocent victim whose property has been destroyed to collect under insurance policy for loss "reasonably expected" to be covered).

139. *See id.* at 617.

140. *Id.* (citing American States Ins. Co. of Texas v. Arnold, 930 S.W.2d 196, 200 (Tex. App. – Dallas 1996, writ denied); Nationwide Property & Cas. Ins. Co. v. McFarland, 887 S.W.2d 487, 492 (Tex. App.—Dallas 1994, writ denied)).

141. *Id.*

142. *See id.* at 618.

143. *See id.*

144. *See id.* at 617-18.

145. *Id.* at 619.

146. *See id.*

Finally, the court rejected Travelers' late notice defense. Travelers claimed that although Bay Electric and FAE knew of the ACB suit in July 1997 they did not notify Travelers until December 1997. Since Travelers' denial of coverage was not originally based on late notice, Travelers would have denied coverage regardless of the timing of the notice.[147] As a result, the court found that Travelers was not prejudiced by the untimely notice.[148]

F. Additional Insured

In *Admiral Insurance Co. v. Trident NGL, Inc.*,[149] Santos, an employee of K-D Oilfield Services ("KD"), was assigned by KD to assist Trident in performing preventive maintenance on a compressor. Santos was unloading Trident's tools from Trident's truck when the compressor exploded, seriously injuring Santos. It was undisputed that neither Santos nor anyone employed by KD performed any act that caused the compressor to explode. Trident and KD had previously entered into an agreement for KD to service facilities owned by Trident, under which KD was required to purchase CGL insurance and to include Trident as an additional insured. The additional insured endorsement added Trident "but only with respect to liability arising out of the named insured's [KD's] operations."[150] The endorsement defined operations as "oil or gas well servicing . . . to include materials, parts or equipment furnished in connection therewith."[151] Admiral maintained that, absent an affirmative act by KD that caused or contributed to the explosion, the additional insured endorsement in the policy did not provide coverage. The court flatly rejected Admiral's position, based on the majority position that if the accident is directly related to the contractor's work, then the additional insured clause is satisfied and the policy extends coverage to the additional insured.[152] The court held that, because the accident occurred to a KD employee while the employee was on the premises for the purpose of performing preventive maintenance on the compressor that exploded, the alleged liability arose out of KD's operations and, therefore, was covered by the additional insured provision.[153]

147. *See id.* at 620.
148. *See id.*
149. 988 S.W.2d 451 (Tex. App.—Houston [1st Dist.] 1999, pet. denied).
150. *Id.* at 454.
151. *Id.*
152. *See id.* at 454-55 (citing Merchants Ins. Co., Inc. v. U.S. Fidelity & Guar. Co., 143 F.3d 5 (1st Cir. 1998); McIntosh v. Scottsdale Ins. Co., 992 F.2d 251 (10th Cir. 1993); Saavedra v. Murphy Oil U.S.A., Inc., 930 F.2d 1104 (5th Cir. 1991). For a discussion of these cases, see Douglas R. Richmond, *The Additional Problems of Additional Insureds*, 33 Tort & Ins. L.J. 945, 956-65 (1998).
153. *Id.* at 455.

III. HOMEOWNERS INSURANCE

A. INNOCENT SPOUSE'S RECOVERY OF INSURANCE PROCEEDS

In *Texas Farmers Insurance Co. v. Murphy*,[154] the court found that an innocent spouse may recover insurance proceeds when the other co-insured spouse intentionally destroyed the covered community property. One week before Robert and Daisy Murphy's house burned to the ground, Robert obtained a binder on a standard homeowners policy with Texas Farmers covering both the home and its contents. Texas Farmers concluded after its fire investigation that Robert intentionally caused the fire. The carrier filed suit seeking a declaration of nonliability under the policy, based on a public policy prohibition against arsonists recovering their losses. Robert counterclaimed for breach of contract and insurance code violations and Daisy subsequently intervened with her own claim for policy benefits.

Although the Texas Supreme Court had previously held that the illegal destruction of jointly-held property by one co-insured does not bar recovery under an insurance policy by an innocent co-insured, the court explicitly declined to decide whether the principle extended to community property.[155] Noting that many decisions from other jurisdictions were based on public policy, the court stated that contractual interpretation was actually the first step in insurance analysis.[156] Even though the Texas Farmers policy contained a condition barring coverage for all insureds if any one of them commits a fraud or intentionally conceals or misrepresents a material fact, the court found that since Texas Farmers failed to obtain a jury finding on the condition, it could not be used as a defense to coverage.[157]

In a discussion of the public policy implications of its decision, the court noted that in order to prevent an arsonist from having a community interest in any recovery, Texas courts generally have "conditioned an innocent spouse's recovery on whether and when the community interests in the insurance policy have been severed."[158] The court stated that it was unfair to require an innocent spouse to obtain a partition or divorce before the claim was filed or denied because its assumes that partition can be obtained before the insurer denies the claim.[159] The court also expressed dissatisfaction with such a rule because it encourages an innocent spouse to "hastily partition or divorce, even though a jury may later acquit the suspected spouse of any alleged wrongdoing."[160] The court reaffirmed the public policy forbidding an arsonist from benefitting from

154. 996 S.W.2d 873 (Tex. 1999).
155. *See* Kulubis v. Texas Farm Bureau Underwriters Ins. Co., 706 S.W.2d 953, 955 (Tex. 1986) (permitting innocent victim whose property has been destroyed to collect under insurance policy for loss "reasonably expected" to be covered).
156. *See Murphy*, 996 S.W.2d at 875.
157. *See id.* at 879-80.
158. *Id.* at 880 n.45.
159. *See id.* at 881.
160. *Id.* at 881.

his fraud by denying recovery of the arsonist's own one-half interest in the claim against the insurer.[161] But the court held that public policy did not trump the innocent spouse's contractual right to recover his or her one-half interest in the policy benefits.[162]

B. FOUNDATION CLAIMS

Withrow v. State Farm Lloyds[163] involved a claim for foundation damage against both the builder of the residence and the homeowner's insurer. Withrow, the homeowner, sued the builder of her house and engineering consultants for alleged negligence in failing to inspect the soil, failing to properly design the foundation, and failing to properly build the foundation. When the home subsequently suffered substantial damage due to the movement of soil below the foundation, Withrow sued State Farm for breach of contract, breach of the duty of good faith and fair dealing, negligence, and not fully honoring her claim for foundation damage. State Farm obtained a summary judgment from the trial court based on exclusions in the policy. Based upon the allegations in Withrow's pleadings, the court of appeals held the "inherent vice exclusion"[164] precluded coverage for the foundation claim.[165] The court also held the "foundation exclusion"[166] applied.[167] Based upon this policy language, the court concluded State Farm was entitled to summary judgment on plaintiff's breach of contract and bad faith causes of action.[168]

IV. LIFE AND HEALTH INSURANCE

In *Vega v. National Life Insurance Services, Inc.*,[169] the Vegas were the sole owners of a corporation which sponsored an employee group medical plan. The plan was administered by a subsidiary of the insurer that issued the policy. The husband was enrolled in the health plan as an employee and the wife was enrolled as a dependent of her husband. In filling out the application for his wife, the husband stated that his wife had not received any advice or consultation for any medical condition during the preceding six-month period; but the plan administrator discovered a notation in the wife's earlier medical records which referred to posterior repair. The administrator called the wife's doctor and was informed that the wife had earlier asked the doctor about the surgical procedure. The administrator subsequently denied the claim on the basis that the hus-

161. *See id.*
162. *See id.*
163. 990 S.W.2d 432 (Tex. App.—Texarkana 1999, writ denied).
164. The exclusion excluded coverage caused by "wear and tear, deterioration or loss caused by any quality in the property that causes it to damage or destroy itself." *Id.* at 437.
165. *See id.*
166. The exclusion precludes coverage for any loss "caused by settling, cracking, bulging, shrinkage, or expansion of foundations . . . ." *Id.* at 437.
167. *See id.*
168. *See id.*
169. 188 F.3d 287 (5th Cir. 1999).

band and wife failed to accurately answer the question about the wife's prior medical history.

Instead of pursuing an administrative appeal, the wife retained an attorney who sued the insurer in state court. The insurer removed the case to federal court, asserting that the case was governed by ERISA. The district court granted summary judgment for the insurer, concluding that National Life had not abused its discretion in denying the claim and that ERISA applied.[170] The court also ruled that the wife was not permitted to present as evidence her doctor's testimony that the surgery was not contemplated before she was enrolled in the plan because that evidence was not available to the plan administrator.[171]

On appeal, a panel of the Fifth Circuit ruled that because a conflict of interest existed between the interests of the wife and those of the plan administrator, the administrator had a duty to conduct a reasonable, good-faith investigation of the claim.[172] In determining whether that duty had been met, it was proper to consider the doctor's testimony.[173] Relying heavily on that evidence, the panel concluded that the insurer violated its duty to conduct a reasonable, good-faith investigation of the claim.[174]

The *en banc* Fifth Circuit, however, disapproved the panel's decision.[175] The court found that ERISA controlled the suit because the husband could properly be characterized as an employee of the corporation he co-owned with his wife.[176]

The court then set about to determine the standard to which an administrator of an ERISA plan will be held when reviewing the denial of benefits.[177] The court noted the existence of a conflict of interest between Pan American, the insurer, and National Life, the administrator and a subsidiary of Pan American.[178] Acknowledging the varying results among the other circuit courts faced with the issue, the Fifth Circuit ultimately adopted the "sliding scale" standard under which the court applies an abuse of discretion standard, but gives less deference to the administrator in proportion to the administrator's apparent conflict.[179] The court then held that "when confronted with a denial of benefits by a conflicted administrator, the district court may not impose a duty to reasonably investigate on the administrator."[180]

Finally, the court determined that the administrative record in the case

170. *See id.* at 288.
171. *See id.*
172. *See id.*
173. *See id.*
174. *See id.*
175. *See Vega*, 188 F.3d at 302.
176. *See id.* at 294.
177. *See id.*
178. *See id.* at 295.
179. *See id.* at 296.
180. *Id.* at 299.

contained no evidence that would support denying the claim.[181] As a result, the court reversed and rendered on the finding of no liability and remanded the proceeding to the district court for a determination of damages.[182]

In *Benefit Life Insurance Co. v. Mizell*,[183] Mizell's major medical policy provided health benefits only for a condition which "first manifests itself more than thirty days" after the inception of the policy.[184] Thirty-one days after the effective date of the policy, Mizell was examined by a physician with complaints of a knot in the muscle of his right arm. Mizell admitted to his physician that he had first noticed the swollen condition three days earlier. The knot was subsequently determined to be a form of cancer. Benefit Life denied coverage for the subsequent cancer treatment because of its belief that the condition had manifested itself within the thirty days of the effective date of the policy. Mizell disagreed because the medical diagnosis did not take place until after thirty days following the issuance of the policy.

On appeal, the court focused on the manifestation of the actual illness, in contrast to the manifestation of symptoms or conditions leading Mizell to seek an ultimate diagnosis. The court held that the verb "manifest" in the policy requires that the information available for diagnosis be restricted to what the physician could "readily perceive by the senses especially by the sight" and similarly "what is apparent, obvious or plain" to the doctor.[185] The court held that the results of invasive surgery of a patient are not "apparent, obvious, or plain" or from what the diagnosing physician sees.[186] Because the cancer did not manifest within thirty days of the effective date of the subject policy, the court determined that policy covered the cancer.[187]

V. AUTOMOBILE INSURANCE

A. UNINSURED/UNDERINSURED MOTORIST

1. Recovery of PIP Benefits

In two cases consolidated for oral argument, the Texas Supreme Court held valid and enforceable a provision barring duplication of uninsured/underinsured (UM/UIM) and personal injury protection (PIP) benefits that would result in a double recovery for the insured. In *Mid-Century Insurance Co. of Texas v. Kidd*,[188] while driving his own car, Kidd was involved in an accident with an uninsured driver who was at fault for Kidd's property damage and serious personal injuries. The policy issued

181. *See Vega*, 188 F.3d at 300.
182. *See id.* at 302.
183. 2 S.W.3d 423 (Tex. App.—Tyler 1999, pet. denied).
184. *Id.* at 424.
185. *Id.* at 427.
186. *See id.*
187. *See id.*
188. 997 S.W.2d 265 (Tex. 1999).

by Mid-Century to Kidd contained UM limits of $100,000 and PIP coverage of $10,000. Mid-Century paid Kidd the $10,000 PIP benefits. A jury later determined that Kidd had $13,000 in past medical expenses from the accident. Mid-Century moved for an offset against the $10,000 for PIP benefits already paid. Both the trial court and the court of appeals rejected Mid-Century's request for an offset because Kidd was the owner and operator of the car. In *Nationwide Mutual Insurance Co. v. Gerlich*,[189] Gerlich was driving her vehicle when she was hit by an uninsured motorist. Gerlich's Nationwide policy included both PIP and UM coverage and contained a contractual offset in the UM coverage. Nationwide initially paid Gerlich $2,200 in PIP benefits. After later settling her UM claim for $3,500, Nationwide claimed it was entitled to a credit for the PIP benefits it had previously paid to Gerlich and issued a check to for $1,300 for the UM settlement. The appellate court held that Nationwide had the burden of proving that without the offset, Gerlich would obtain a double recovery.[190] The parties had stipulated that the UM settlement was $3,500, but did not stipulate that Gerlich's actual damages were $3,500. The court of appeals seized upon this distinction in holding that Nationwide was not entitled to an offset.[191]

The Texas Supreme Court noted that in previous cases it had held UM/UIM offsets invalid to the extent that such offsets prevented the recovery of actual damages or reduced UM protection below the minimum limits required by statute.[192] But nothing in the previous holdings, the court explained, rendered the offsets ineffective if they prevented only excess recoveries.[193] The language of the offset expressed in its preamble the intent to withhold only "payments in excess of actual damages sustained."[194] The operative language of the offset stated that the carrier was only liable for "covered damages." The offset, by its terms, was also subject to the policy limits. The court rejected arguments by the insureds that the UM and PIP statutes' silence on recovery in excess of actual damages permitted a double recovery.[195] Specifically, the court held that it could not read an intent in the statutory offset provisions to favor double recoveries in situations where they were not expressly excluded.[196] The court also held that the insureds' payment of separate premiums for the UM/UIM and PIP coverages did not entitle them to double benefits; instead, this was a matter for rate adjustment by the Texas Department of Insurance.[197]

189. 997 S.W.2d 265 (Tex. 1999).
190. *See id.* at 268.
191. *See id.* at 267.
192. *See id.* at 269-70 (citing American Liberty Ins. Co. v. Ranzau, 481 S.W.2d 793 (Tex. 1972); American Motorists Ins. Co. v. Briggs, 514 S.W.2d 233 (Tex. 1974); Westchester Fire Ins. Co. v. Tucker, 512 S.W.2d 769 (Tex. 1974)).
193. *See Nationwide Mut. Ins. Co.*, 997 S.W.2d at 270.
194. *Id.* at 271.
195. *See id.* at 270.
196. *See id.* at 271.
197. *Id.* at 275.

2. Use of the Auto

The Texas Supreme Court recently evaluated the availability of UM motorist benefits to cover damages arising out of a drive-by shooting.[198] In order to trigger UM benefits, the liability of the uninsured driver "must arise out of the ownership, maintenance or use of the uninsured motor vehicle."[199] The Court agreed with State Farm's interpretation that this language was intended to protect against auto accidents, "not against criminal nor intentional acts that have a mere incidental relationship to the vehicle."[200] The Court found the shooting to be an independent and intentional act which is not covered under the UM policy because the "use" of the vehicle was "incidental to the shooting."[201]

In contrast, the majority in *Mid-Century Insurance Co. of Texas v. Lindsey*[202] found a nine-year old boy's accidental discharge of a shotgun while entering the cab of a pickup truck (through the truck's sliding rear window) constituted an "accident" which arose out of the "use" of the vehicle thus entitling the injured insured to UIM benefits.[203] With minimal analysis, the majority came to the conclusions that the child's accidental discharge of the shotgun while entering the truck was an "auto accident" even though there was no collision between vehicles.[204] The majority also found that entering a locked pickup truck from a sliding rear window did involve the "use" of the vehicle, even though such a method of entry was very unorthodox.[205]

The dissent in *Lindsey* found the majority's decision completely inconsistent with a prior decision by the court in *National Union Fire Insurance Co. v. Merchant's Fast Motor Lines*,[206] in which the court held that the negligent discharge of a fire arm does not produce an injury caused by the "use" of a covered auto.[207] The dissent compared the facts in this case and the facts in *Merchant's* and found them to be virtually identical.[208] Both cases involved the negligent discharge of a firearm from a vehicle, both injuries were incidental to the use of the vehicle, and both claims lacked a causal nexus between the vehicles and the accident.

3. Prejudgment Interest

The Amarillo Court of Appeals held a claimant seeking UIM benefits who prevailed at trial was not entitled to prejudgment interest.[209] The

198. State Farm Mut. Auto Ins. Co. v. Whitehead, 988 S.W.2d 744 (Tex. 1999).
199. *Id.* at 745 (quoting State Farm Insurance Policy).
200. *Id.*
201. *Id.*
202. 997 S.W.2d 153 (Tex. 1999).
203. *Id.* at 164.
204. *Id.* at 154-55.
205. *Id.*
206. 939 S.W.2d 139 (Tex. 1997).
207. *Id.* at 139.
208. *See Lindsey*, 997 S.W.2d at 164-65.
209. Henson v. Texas Farm Bureau Mut. Ins. Co., 989 S.W.2d 837 (Tex. App.—Amarillo 1999, pet. pending).

court noted that a UIM claimant is required by the policy to show that he is "legally entitled to recover" from the underinsured tortfeasor *before* the UIM carrier owes any policy benefits.[210] The insured must also establish his legal entitlement to recover against the tortfeasor as a condition precedent to the recovery of UIM benefits.[211] This condition precedent is satisfied when the insurer acknowledges coverage and compensability.[212] If the UIM insurer does not believe the claim is compensable, UIM coverage is triggered when a factfinder judicially determines liability and damages.[213] The court found that neither the filing of the UIM claim with the carrier nor the insured's repeated demands for policy benefits satisfied the conditions precedent.[214] Because the UIM insurer timely paid the UIM benefits immediately following the jury verdict, the court decided that the insured had not lost the use of money which the insured was entitled to receive.[215] As such, pre-judgment interest was not available.[216]

4. Competing UIM Claims

The Texarkana Court of Appeals held a UIM carrier was not subject to contractual or extracontractual damages because it paid partial UIM benefits to one insured even though it decreased the available UIM benefits available to another UIM insured.[217] This case arose out of physical injuries received by a minor and the subsequent UIM claims advanced by his divorced parents. State Farm offered to split the $20,000 UIM benefits equally between the divorced parents. The father accepted. After discovering that some of the UIM benefits had been depleted, the mother sued State Farm.

Relying upon *Soriano*,[218] the court held that a UIM carrier could not face contractual or extracontractual liability for settling reasonable claims with one of several claimants even though such a settlement reduced or exhausted the policy proceeds available to any remaining claimants.[219] Because the court found State Farm's tender of some of the UIM benefits to the father was reasonable, it affirmed State Farm's summary judgment on the contract and bad faith causes of action, but remanded because of the existence of fact issues regarding the PIP claims and misrepresentation claims under article 21.21.[220]

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210. *See id.* at 839.
211. *See id.* at 840.
212. *See id.*
213. *See id.*
214. *See id.*
215. *See Henson*, 989 S.W.2d at 840.
216. *See id.*
217. Lane v. State Farm Mut. Auto Ins. Co., 992 S.W.2d 545 (Tex. App.—Texarkana, 1999, no pet.).
218. Texas Farmers Ins. Co., v. Soriano, 881 S.W.2d 312 (Tex. 1994).
219. *See Lane*, 992 S.W.2d at 553.
220. *See id.* at 554.

B. ARTICLE 21.55

In *Dunn v. Southern Farm Bureau Casually Insurance Co.*,[221] following an automobile accident, Dunn submitted a claim for PIP benefits, which Southern Farm handled in compliance with article 21.55. As the PIP claim was pending, Dunn also made a claim for UM benefits. The PIP benefits were timely paid. When the parties could not reach an agreement on the value of the UM claim, Dunn sued for policy benefits and article 21.55 damages in the amount of eighteen percent. Dunn won at trial but did not receive the eighteen percent penalty or attorney fees provided under article 21.55.

On appeal, the court held the requirements of article 21.55 applied *separately* to Dunn's UIM claim and to her PIP claim.[222] Even though an insurer complies with the statute in handling one claim, a related but separate claim still must comply with article 21.55.[223] The court also rejected Southern Farm's argument that the statute should not apply to UM claims because coverage for UIM benefits is not readily ascertainable until a jury determines that the claimant is entitled to recover damages from the uninsured tortfeasor.[224] Southern Farm argued its contractual liability did not materialize until the tortfeasor's liability and the claimant's actual damages were ascertained. The court disagreed because the statute requires certain activities in the handling of a claim must be done "promptly."[225] The court concluded that the insured was entitled to an eighteen percent penalty on the contractual damages found at trial *plus* pre-judgment interest on the contractual damages.[226]

VI. AGENCY

In *Crown Life Insurance Co. v. Casteel*[227] the court addressed whether an independent insurance agent had standing to sue an insurer under article 21.21 of the Insurance Code. Casteel was an independent agent of Crown Life who sold modified vanishing premium policies. One of the policies sold by Casteel led to a lawsuit by policyholders against Casteel and Crown Life. In that lawsuit, Casteel filed a cross-claim against Crown Life. On appeal, Crown Life sought to determine whether Casteel, who alleged that he was injured by the unfair and deceptive practices of Crown Life, had standing to sue Crown Life under Insurance Code article 21.21; and whether that standing extends to article 21.21 claims that allow recovery for DTPA violations.

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221. 991 S.W.2d 467 (Tex. App.—Tyler, 1999, pet. pending).
222. *See id.* at 467.
223. *See id.* at 472.
224. *See id.* at 474.
225. *Id.*
226. *See id.* at 478.
227. 42 Tex. Sup. Ct. J. 945 (July 1, 1999), opinion withdrawn (Jan. 27, 2000); Substituted Opinion on Grant of Rehearing in Part, 43 Tex. Sup. J. 348 (Jan. 27, 2000).

Initially, the court considered whether Casteel, as an insurance agent, was a person with standing to sue Crown Life under article 21.21, and whether Casteel must also be a consumer to have standing to recover under article 21.21's incorporated DTPA violations. The court observed that it was consistent with the legislature's express objective to regulate all insurance trade practices to conclude that an insurance agent is a person with standing to sue an insurance company when the agent is damaged by company practices that violate article 21.21.[228] Not permitting such standing, stated the court, "would allow an insurer to deceive its agent with impunity, despite knowing that the misinformation would eventually reach the public."[229]

An insurance agent is a person as defined under article 21.21, §2(a), for purposes of determining standing under article 21.21, §16(a).[230] Thus, when an agent meets the other required elements for a cause of action under Art. 21.21, §16(a), sustaining actual damages caused by another's engaging in an act or practice declared unfair or deceptive, the agent has standing to bring that claim.

Only a consumer can maintain a cause of action directly under the DTPA. A consumer is defined as one who seeks or acquires by purchase or lease, any goods or services.[231] Although Casteel admitted that he was not a consumer, he argued that consumer status is not required of him because his DTPA-based causes of action arose through article 21.21, not the DTPA itself. "While article 21.21 incorporates the DTPA laundry list of deceptive acts, it does not incorporate the entire DTPA."[232]

Casteel's claims arose from Crown Life's alleged misrepresentations of policy illustrations prepared by Crown Life and presented by Casteel to his clients. The court pointed out that Casteel did not acquire or seek to acquire the policies; he was merely the conduit for information. The misinformation at issue did not concern goods or services purchased or leased by Casteel.[233] Instead, Crown Life's alleged misrepresentations to Casteel involved internal product information for Casteel's use in the sales of policies.[234] The court held that because Casteel was not a consumer of Crown Life's goods and services, he could not state a cause of action under article 21.21 for DTPA violations which require consumer status.[235]

Thus, the court found Casteel was a person with standing to sue Crown Life for violations of article 21.21 of the Insurance Code, but he did not have standing to sue Crown Life for violations of those DTPA provisions

228. *See Casteel*, 43 Tex. Sup. Ct. J. at 4.
229. *See id.*
230. *See id.* at 6.
231. *See id.* (quoting TEX. BUS. & COM. CODE ANN. § 17.45(4) (Vernon 1987 & Supp. 2000)).
232. *Id.*
233. *See id.* at 7.
234. *See Casteel*, 43 Tex. Sup. Ct. J. at 7.
235. *See id.*

incorporated within article 21.21 that, by their terms, required Casteel to be a consumer.[236] The court also determined that Crown Life was entitled to summary judgment on Casteel's common-law claims.[237] The court reversed and rendered the court of appeals' judgment in favor of Casteel on his article 21.21 claims for DTPA violations.[238] The court reversed and remanded Casteel's other article 21.21 claims to the trial court for proceedings consistent with its opinion.[239]

VII. MISCELLANEOUS

A. FRAUDULENT JOINDER

In *Griggs v. State Farm Lloyds,*[240] the Fifth Circuit comprehensively analyzed fraudulent joinder contentions arising in the context of a breach of contract and bad faith claim brought against State Farm and its agent, Blum, through whom the homeowner's policy had been secured. Griggs, the insured under the homeowners' policy, claimed an insured loss in excess of $1 million from burglaries of sports memorabilia. Ultimately, State Farm provided Griggs with notice that it was denying his claim based on a failure to comply with his contractual duties to provide a sworn proof of loss, to produce an accurate and itemized inventory of the items stolen, and to permit reasonable access to records and documentation in support of his claim.

Griggs filed suit against State Farm Lloyds and Blum in Texas state court. State Farm Lloyds removed the case alleging diversity of citizenship jurisdiction and the fraudulent joinder of Blum. Blum and Griggs were both Texas citizens. The federal district court found that Blum was fraudulent joined, entered an order dismissing Blum, and denied Griggs' motion to remand.

The Fifth Circuit affirmed the denial of the motion to remand after an extended review of Texas law on claims against insurance agents. Griggs' original and amended petitions named Blum as a defendant but did not allege any actionable facts specific to Blum. Blum was never served. The court noted that both Griggs' "factual allegations and his articulation of the legal claims focused solely upon State Farm Lloyds' conduct in the processing and ultimate denial of this claim."[241] The Fifth Circuit also noted that it was undisputed that Blum had no claims processing responsibility and no decision-making authority with respect to the processing of Griggs' claim or with respect to State Farm Lloyd's ultimate denial of Griggs' claim.[242] Accordingly, there was no basis for Griggs' claim alleg-

236. *See id.*
237. *See id.* at 10.
238. *See id.* at 12.
239. *See id.*
240. 181 F.3d 694 (5th Cir. 1999).
241. *Id.* at 699.
242. *See id.*

ing that Blum breached the insurance contract.[243] Furthermore, the court observed that Griggs had not alleged that his relationship with Blum was "governed or created by" any contract, or that his relationship with Blum was otherwise imbued with special characteristics that would give rise to the "special relationship" required to impose a duty of good faith and fair dealing.[244] Accordingly, there was no basis for Griggs' claim against Blum for breach of duty of good faith and fair dealing.[245]

Finally, the court commented that Texas courts have recently recognized that the statutory language of the Insurance Code is broad enough to permit in the appropriate circumstances a cause of action against an insurance agent who engages in unfair or deceptive acts or practices.[246] Blum's pre-purchase statements that State Farm Lloyds would handle Griggs' claim professionally, as well as her post-claim assurances that she would monitor the progress of Griggs' claim, were determined by the court to be more in the nature of puffery than actual representations of specific material fact. The court held that Blum's general, undocumented and non-specific statements fell short of actual representations under Texas law.[247] In addition, Griggs' Insurance Code and DTPA claims failed because there is no conceivable basis in law or fact upon which Blum's non-specific statements can be construed as actual representations that caused the injury alleged by Griggs.[248]

B. UNAPPROVED POLICIES

In *Urrutia v. Decker*,[249] Penske, a truck leasing company, had a commercial business auto policy that provided $1 million of liability protection. The policy's definition of "insured" included "[b]oth lessees and rentees of covered autos . . . but only to the extent and for the limits of liability agreed to under contractual agreement with the named insured."[250] Urrutia leased a truck from Penske, which agreed to provide liability protection to Urrutia limited to the minimum coverage required by the state's financial responsibility law.[251] Urrutia was subsequently involved in an accident while operating the leased truck. The driver of the other vehicle, Decker, was seriously injured, but agreed to settle his claims against Urrutia and Penske for $20,000, the amount of liability protection provided to Urrutia under the lease terms and the amount that Decker assumed was the only insurance available.

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243. *See id.* at 700.
244. *Id.* at 701.
245. *See id.* at 702.
246. *See Griggs*, 181 F.3d at 701 (citing Liberty Mut. Ins. Co. v. Garrison Contractors, Inc., 966 S.W.2d 482 (Tex. 1998)).
247. *See id.*
248. *See id.* at 702.
249. 992 S.W.2d 440 (Tex. 1999).
250. *Id.* at 441.
251. *See id.* at 442; *see also* TEX. TRANSP. CODE ANN. § 601.072 (Vernon 1999).

When Decker learned of Penske's $1 million policy, he sought to reopen his personal-injury suit against Urrutia and Penske. The defendants moved for, and the trial court granted, summary judgment on the ground that Decker had signed the settlement and released his claims. On appeal, however, the court reversed and remanded, concluding that the parties had made a mutual mistake of fact by reading the rental agreement to limit coverage to $20,000.[252]

Upon review, the Supreme Court found under the terms of the policy, the liability limit in this case was $20,000.[253] The court noted that the terms of the rental agreement were sufficiently written into the terms of the policy covering Penske.[254] It disagreed with the court of appeals' holding that the rental contract was void as an endorsement because it was not in a form approved by the State Board of Insurance.[255] While the court agreed that the rental agreement did not have board approval for use as an insurance contract, it observed that the terms of the rental agreement did not conflict with the approved standard form or the terms of the commercial business auto policy.[256] Furthermore, to void the provisions in the rental agreement because it was not in an approved form, the court held, would leave an innocent insured without protection.[257] The court held, "[b]ecause insurance sold through an unapproved policy is voidable, the insured may, upon learning that the insurance is unapproved, elect to rescind it. If the insured elects to accept the insurance, however, he must do so under the agreed terms."[258]

The court held that Urrutia accepted the terms of the rental agreement insurance and, therefore, the court of appeals erred in voiding those insurance provisions in the rental agreement merely because they were not in a form prescribed by the board.[259] The liability insurance sold by Penske to Urrutia was merely voidable, not void, the court observed, and limited the liability protection extended to Urrutia to the $20,000 recovered by Decker.[260]

In *Republic Western Insurance Co. v. State*,[261] U-Haul of Texas offered its customers "Safe Protection" insurance packages for the rental of mov-

252. *See Urrutia*, 992 S.W.2d at 442.
253. *See id.* at 444.
254. *See id.* at 443.
255. *See id.*
256. *See id.*
257. *See id.*
258. *Urrutia*, 992 S.W.2d at 443-44 (citing Imperial Premium Fin., Inc. v. Khoury, 129 F.3d 347, 350 (5th Cir. 1997) (insured cannot select the good and discard the bad); Hertz Corp. v. Pap, 923 F. Supp. 914, 922 (N.D. Tex. 1995) (insured cannot chose to void unfavorable language and retain remainder of unapproved policy), *aff'd*, 98 F.3d 1339 (5th Cir. 1996); McLaren v. Imperial Cas. & Indem. Co., 767 F. Supp. 1364, 1376 (N.D. Tex. 1991) (insured must take or leave the policy in its entirety), *aff'd*, 968 F.2d 17 (5th Cir. 1992), *cert. denied*, 507 U.S. 915; *cf.* Mutual Life Ins. Co. of N.Y. v. Daddy$ Money, Inc., 646 S.W.2d 255, 257 (Tex. App.—Dallas 1982, writ ref'd n.r.e.) (when policy has board approval but conflicting endorsement does not, insurer cannot enforce endorsement)).
259. *See Urrutia*, 992 S.W.2d at 444.
260. *See id.*
261. 985 S.W.2d 698 (Tex. App.—Austin 1999, pet. dism'd w.o.j.).

ing equipment, towing equipment, and storage spaces. "Safestor," the storage insurance package, provided additional protection against various dangers posed to items while stored in U-Haul storage facilities. U-Haul had coverage with Republic Western, which permitted U-Haul to add its customers to its own policy as additional insureds. Any premium paid by the customer went directly to Republic Western. After an investigation by and subsequent settlement efforts with the Texas Department of Insurance, U-Haul filed a declaratory judgment action seeking a declaration from the court that its activities did violate the Insurance Code. The trial court ultimately held that U-Haul of Texas, U-Haul International and Republic Western were all engaged in the unauthorized business of insurance in violation of Insurance Code article 1.14-1.[262] The trial court further determined that U-Haul was acting as an unlicenced local recording agent for Republic Western in violation of Insurance Code article 21.14.[263]

In affirming the trial court's decision, the court of appeals held that since U-Haul did not dispute that U-Haul was not statutorily authorized to engage in the insurance business, U-Haul's conduct violated the plain meaning of the terms in article 1.14-1 that define "doing an insurance business."[264] The court distinguished an offer to procure insurance from U-Haul's activities. Specifically, U-Haul's customers entered into a contract with and paid a premium to U-Haul in exchange for the benefit of being insured under its policy with Republic Western. The court, in determining that U-Haul was a local recording agent for Republic Western under article 21.14, decided that while binding Republic Western to insurance risks on its rental customers might not be its primary business, the statute does not require any specific proportion of insurance activity.[265] The court specifically observed:

> The evidence in the record establishes that UHI receives the premium on the insurance packages sold by U-Haul and then remits the funds to Republic Western , its sibling corporation. . . . In so doing, UHI violates article 1.14-1 by assisting U-Haul in the solicitation, procurement and effectuation of insurance; in the dissemination of information as to coverage and rates; and in the delivery of insurance contracts.[266]

The court also held that Republic Western, the insurer actually issuing the master policy, was also in violation of the Insurance Code even though it was a licensed insurer.[267] Republic Western violated of article 1.14-1 section 6[268] by issuing master policies designed to provide addi-

262. *See id.* at 700; *see also* TEX. INS. CODE ANN. art. 1.14-1 (Vernon 1981) (subsequently was recodified as art. 101.051).
263. *See Republic Western*, 985 S.W.2d at 700.
264. *Id.* at 702.
265. *See id.*
266. *Id.* (citing TEX. INS. CODE ANN art. 1.14-1, § 2(a)(6) (Vernon Supp. 1999).
267. *See id.*
268. Currently, TEX. INS. CODE ANN. art. 1.14-1, § 101.051(6) (Vernon 1981 & Supp. 2000).

tional insured protection to U-Haul's rental customers, for which it received premium payments from U-Haul through UHI.[269] The court specifically focused on the fact that the U-Haul customers, who were to be additional insureds under master policies, entered into a contract with U-Haul and paid a premium to U-Haul in exchange for the benefit of being insured under U-Haul's master policies with Republic Western.[270]

VIII. STATUTORY CHANGES

The Texas Legislature also enacted various revisions to the Texas Insurance Code during the *Texas Survey* period. Statutory provisions regulating viatical settlements[271] were amended to include life settlements.[272] Persons who engage in this business are required to register with the Texas Insurance Commission.[273] The insurance commissioner shall adopt rules governing the registration of individuals who engage in the business of life settlements, as well as viatical settlements, and to approve the contract forms they use in order to prevent unfair discrimination.[274] If the insurance commissioner finds that a licensed individual has willfully violated these provisions of the Insurance Code or any rules or regulations dealing with viatical or life settlements, the commissioner may suspend or revoke the license of the individual.[275]

Article 3.77, regulating the Texas Health Insurance Risk Pool, was amended to make it easier for individuals to obtain insurance through the Pool.[276] An individual now need only provide to the pool evidence of rejection or refusal to issue a health insurance policy by one insurer, rather than the two previously required.[277] The individual may also obtain a certificate (on a form to be developed by the Board of Insurance) from an agent or salaried representative of an insurance company stating that the agent or salaried representative is unable to obtain substantially similar individual insurance with any state-licensed insurance company

269. *See Republic Western*, 985 S.W.2d at 702.
270. *See id.*
271. A viatical settlement is
> an agreement that is solicited, negotiated, offered, entered into, delivered, or issued for delivery in this state under which a person pays compensation or anything of value that is less than the expected death benefit of a policy insuring the life of an individual who has a catastrophic or life-threatening illness or condition in return for the policy owner's or certificate holder's assignment, transfer, sale, devise, or bequest of the death benefit under or ownership of the policy.

TEX. INS. CODE ANN. art. 3.50-6A § 1 (2) (Vernon 1981 & Supp. 2000).
272. A life settlement is an agreement under which one person pays compensation that is less than the expected death benefit of a life insurance policy insuring the life of an individual who does not have a catastrophic or life-threatening illness or condition, in return for the policy owner's transfer of the death benefit or ownership of the life insurance policy. *See id.* at § 1(3).
273. *See id.* at § 2.
274. *See id.* at § 3.
275. *Id.*
276. *See* TEX. INS. CODE ANN. art. 3.77 §1 (Vernon Supp. 2000).
277. *See* TEX. INS. CODE ANN. art. 3.77 § 10 (a)(1) (Vernon Supp. 2000).

because the individual will be declined for coverage as a result of a medical condition pursuant to the underwriting guidelines of the insurer.[278]

The rate of premium tax on those insurance companies regulated by article 4.10 was reduced from 3.50 percent to 1.60 percent,[279] and the premium tax on title insurance was reduced from 2 percent to 1.35 percent.[280] Provisions allowing insurance carriers owning Texas investments to reduce the premium tax imposed by article 4.10 to 1.60 percent, and the provisions in article 9.59 which allowed title insurance companies to pay at a tax rate of 1.30 percent were repealed.[281] Accordingly, all title insurance companies doing business in Texas now pay a premium tax of 1.35 percent, and all insurance companies subject to article 4.10 now pay a premium tax of 1.60 percent.[282] The premium tax on life, health, and accident insurance companies remains at 2.50 percent, subject to being reduced to 1.80 percent if the insurance company owns a certain percentage of Texas investments.[283]

A five percent premium discount applies to a personal motor vehicle insurance policy for the completion of a drug and alcohol awareness program approved by the Texas Education Agency.[284] This discount will not apply if any person covered under the policy has, within the seven years preceding the date on which the person enrolled in the drug and alcohol driving awareness program, been convicted of an offense related to the operation of a motor vehicle under Chapter 49 of the Penal Code or Chapter 106 of the Alcoholic Beverage Code.[285] This premium discount is in addition to the other premium discounts provided for anti-theft devices, academic achievement, and certain youth group members.[286]

Owners of single family or multi-family dwellings, apartment owners, or condominium owners are eligible for a premium reduction for homeowners insurance coverage if the owner has correctly installed a stovetop fire suppression device approved by the State Fire Marshal.[287] A stovetop fire suppression device refers to a device that is mounted on the venthood over a residential stovetop cooking surface and that protects against one or more hazards by suppressing or extinguishing fires.[288]

The Texas Health Maintenance Organization Act was amended to provide that each HMO shall ensure that each healthcare plan includes well-child care from birth, as required by the Public Health Services Act,[289]

278. *See id.* at § 10(a)(2).
279. *See* TEX. INS. CODE ANN. art. 4.10 § 10 (Vernon 1981 & Supp. 2000).
280. TEX. INS. CODE ANN. art. 9.59 § 4 (Vernon 1981 & Supp. 2000).
281. *See* TEX. INS. CODE ANN. art. 4.10 §7-9; TEX. INS. CODE ANN. art. 9.59 § 13-14 (Vernon 1981 & Supp. 2000).
282. *See* TEX. INS. CODE ANN. art. 9.59 § 4 (Vernon 1981 & Supp. 2000); TEX. INS. CODE ANN. art. 4.10 § 10 (Vernon 1981 & Supp. 2000).
283. *See* TEX. INS. CODE ANN. art. 9.59 § 4 (Vernon 1981 & Supp. 2000).
284. *See* TEX. INS. CODE ANN. art. 5.03-4(a) (Vernon Supp. 2000).
285. *See id.* at art. 503-4(b).
286. *See* TEX. INS. CODE ANN. art. 5.03-5 (Vernon Supp. 2000).
287. *See* TEX. INS. CODE ANN. art. 5.33C (Vernon Supp. 2000).
288. *See id.* at § 1(1).
289. *See* 42 U.S.C. § 300e, *et seq.* (1994)

and the rules and regulations adopted by the Texas Department of Health.[290] HMO's are required to provide immunizations for children up to age six, including diphtheria, influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunizations required by law.[291] These immunizations also are required to be provided by individual and group insurance companies.[292] HMOs and individual and group plans are also required to provide a screening test for hearing loss for a child up to thirty days old and the necessary diagnostic follow-up care related to the screening test from birth through the date the child is twenty-four months old.[293] This applies to every health benefit plan that provides coverage for benefits for residents of the state of Texas.[294]

In addition, HMOs must pay a claim submitted by a medical provider within forty-five days after receiving a completed claim, as determined by the Department of Insurance.[295] If the claim is not paid in full within the forty-five day period, the HMO must notify the physician or medical provider in writing of why the claim will not be paid.[296] An HMO that violates this provision is liable to the physician or medical provider for the full amount of billed charges submitted, plus reasonable attorney's fees.[297] Finally, if an HMO desires to withdraw from writing coverage, it must now comply with article 21.49-2C,[298] requiring an insurer to file with the commissioner a plan for orderly withdrawal. The plan must contain provisions for meeting the insurer's contractual obligation, providing service to its policyholders and claimants, and meeting any applicable statutory obligations.[299]

An insurance company must also give a written statement concerning the reason(s) for cancellation, declination or nonrenewal of a general liability insurance policy, professional liability insurance policy other than medical professional liability commercial automobile policy, commercial multi-peril coverage, and property and casualty insurance.[300] The explanation must fully explain a decision which adversely affects the applicant or the policyholder, including the precise incident, circumstance or risk factor applicable to the applicant or policyholder that violates the insurer's underwriting guideline; the source of the information; and any other information deemed relevant by the Commissioner.[301] In addition, applicants for insurance under the Texas Medical Liability Insurance Un-

290. *See* TEX. INS. CODE ANN. art. 20A.9(E) (Vernon Supp. 2000).
291. *See* TEX. INS. CODE ANN. art. 20A.9(F) (Vernon Supp. 2000).
292. *See* TEX. INS. CODE ANN. art. 21.53F (Vernon Supp. 2000).
293. *Id.* at § 4.
294. *See id.* at § 4(c).
295. *See* TEX. INS. CODE ANN. art. 20A.18(B) (Vernon Supp. 2000).
296. *See id.* at (c)(3).
297. *See id.* at (f)-(g).
298. *See* TEX. INS. CODE ANN. art. 21.49-2c (Vernon Supp. 2000).
299. *See id.* at (a)(1); *see also* TEX. INS. CODE ANN. art. 20A.26 (Vernon Supp. 2000).
300. *See* TEX. INS. CODE ANN. art. 21.49-2E (Vernon Supp. 2000).
301. *See id.*

derwriting Association now have the right to be notified of their appeal rights at the same time that they receive notice from the association that their application has been denied.[302]

Group health benefit plans that (1) provide coverage for medical or surgical expenses incurred as a result of a health condition, (2) cover prescription drugs, and (3) use one or more drug formularies, are now required to specify which prescription drugs the plan will cover.[303] Group health benefit plans are required to provide each enrollee in plain language in the coverage documentation (1) notice that the plan uses one or more drug formularies, (2) an explanation of what a drug formulary is, (3) a statement regarding the method the plan uses to determine which prescription drugs are included or excluded, (4) a statement of how often the plan reviews the contents of the drug formulary, and (5) a notice that the enrollee may contact the plan to find out if the prescription drug is on a particular drug formulary.[304] The plan must also disclose to any individual on request, not later than the third business day after the date of the request, whether a specific drug is on a particular drug formulary.[305]

The provisions of the Insurance Code dealing with coverage of treatment for diabetes has been amended to provide for nutritional counseling.[306] The health benefit plan must provide coverage for a diabetes self-management training program recognized by the American Diabetes Association; diabetes self-management training given by a multi-disciplinary team; or training provided by a diabetes educator certified by the National Certification Board of Diabetes Educators.[307]

A health benefit plan providing coverage for mastectomy is now required to provide coverage for reconstruction of the breast upon which the mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prosthesis and treatment of physical complications.[308] A health benefit plan may not (1) offer a financial incentive for a patient to forego breast reconstruction; (2) condition, deny, or limit the eligibility of enrollees to enroll in the health benefit plan or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this coverage; (3) reduce or limit the reimbursement or payment, or otherwise penalize, an attending physician; or (4) provide financial incentives or other benefits to an attending physician to induce the physician to encourage an enrollee to forego reconstruction.[309] Health benefit plans are required to provide notice of the availability of this coverage to each enrollee.[310]

302. *See* TEX. INS. CODE ANN. art. 21.49-3 § 7 (Vernon Supp. 2000).
303. *See* TEX. INS. CODE ANN. art. 21.52J (Vernon Supp. 2000).
304. *See id.* at § 3.
305. *See id.*
306. *See* TEX. INS. CODE ANN. art. 21.53G § 1 (Vernon Supp. 2000).
307. *See id.* at § 4.
308. *See* TEX. INS. CODE ANN. art. 21.53I § 3 (Vernon Supp. 2000).
309. *See id.*
310. *See id.*

Administrators of health benefit plans that provide pharmacy benefits must issue a pharmacy identification card to each covered individual.[311] The commissioner will adopt rules requiring standard information to be included on the identification cards.[312] A pharmacy benefit manager may not sell a list of patients containing information through which the identity of the individual patient is disclosed.[313] All data identifying a patient maintained by the pharmacy benefit manager must maintained in a confidential manner.[314]

Coverage for off-label drug use is now regulated.[315] This article applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket or franchise insurance policy, or insurance agreement.[316] A health benefit plan that provides coverage for drugs must provide coverage for any drug prescribed to treat an enrollee for a covered chronic, disabling, or life-threatening illness if the drug has been approved by the Federal Drug Administration and is recognized for treatment of the indication for which the drug is prescribed in a prescription drug reference compendium or substantially accepted peer-reviewed medical literature.[317] Coverage of a drug required under this article shall include coverage for medically necessary services associated with the administration of the drug.[318]

Coverage for craniofacial abnormalities must be provided by a health benefit plan that provides benefits to a child who is younger than 18 years of age.[319] The plan must define reconstructive surgery for craniofacial abnormalities to include surgery to improve the function of, or to attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.[320]

Article 21.58A which regulates health care utilization review agents, now requires, in the event of an adverse determination, that the utilization review agent's written notice to the policyholder include (1) the principal reason for the adverse determination; (2) the clinical basis for the adverse determination (3) a description or the source of the screening criteria that were utilized as guidelines in making the determination and (4) a description of the procedure for the complaint and appeal process.[321] The description of the procedure for the complaint and appeal

311. *See* TEX. INS. CODE ANN. art. 21.07-6 (Vernon Supp. 2000); *see also* TEX. INS. CODE ANN. art. 21.53L (Vernon Supp. 2000).
312. *See id.* § 19A.
313. *See id.* § 19B.
314. *See id.*
315. *See* TEX. INS. CODE ANN. art. 21.53M (Vernon Supp. 2000).
316. *See id.* § 2.
317. *See id.* § 3.
318. *See id.*
319. *See* TEX. INS. CODE ANN. art. 21.53W § 3 (Vernon Supp. 2000).
320. *See id.*
321. *See* TEX. INS. CODE ANN. art. 21.58A § 5 (Vernon Supp. 2000).

process must include (1) notification to the enrollee of his right to appeal an adverse determination to an independent review organization; (2) notification to the enrollee of the procedures for appealing; and (3) notification to an enrollee who has a life-threatening condition of his right to an immediate review by an independent review organization and the procedure to obtain that review.[322] Within five working days from receipt of the appeal, the utilization review agent must send the appealing party a letter acknowledging the date of the utilization review agent's receipt of the appeal and a list of the documents that the appealing party must submit for review.[323] A utilization review agent is prohibited from requiring the observation of a psychotherapy session or the submission or review of a mental health therapist's notes or progress notes as a condition for treatment.[324]

The Amusement Ride Safety Inspection Act[325] now requires persons operating amusement rides in Texas to maintain an accurate record of any governmental action taken in any state relating to any particular amusement ride, including an inspection resulting in the repair or replacement of equipment used in the operation of the amusement ride.[326] The operator is required to file a quarterly report with the commissioner on a form designed by the commissioner.[327] A report is not required in any quarter in which no reportable government action was taken.[328] The operator of the amusement ride is to maintain these reports for at least two years.[329] The commissioner is authorized to adopt rules requiring operators of mobile amusement rides to perform inspections of the rides, including rules requiring daily safety inspections.[330]

322. *See id.*
323. *See id.* § 6.
324. *See id.* at § 4(o).
325. *See* TEX. OCCUATIONAS CODE ANN. § 2151.001 (Vernon Supp. 2000).
326. *See id.* at § 2151.101.
327. *See id.*
328. *See id.*
329. *See id.*
330. *See id.*