COX P.L.L.C. NEWS

OUR INSURANCE COVERAGE TEAM UPDATES OUR CLIENTS ABOUT TEXAS INSURANCE LAWS AND NOTEWORTHY DECISIONS FROM TEXAS STATE AND FEDERAL COURTS.

TEXAS INSURANCE LAW UPDATE

FIRST QUARTER 2025

There were several noteworthy decisions from Texas state and federal courts handed down in the First Quarter of 2025 that may be relevant to your claims handling. This quarter, the courts addressed issues including the application of per person UIM limits in bystander claims; personal jurisdiction over out-of-state insurers; the definition of "physical loss" in COVID-19 business interruption claims; the limits of extra-contractual recovery following appraisal; the scope of the MCS-90 endorsement; and the duty to defend in multi-claimant exposure cases

If you would like to discuss any of the cases in this report in more detail, please reach out to one of our team members at Cox PLLC

PERSONAL AND COMMERCIAL AUTO

COURT OF APPEALS HOLDS BYSTANDER DAMAGES DO NOT TRIGGER SEPARATE UIM LIMIT WHERE ONLY ONE COVERED PERSON SUSTAINS BODILY INJURY

In *Farmers Tex.Cnty. Mut. Ins. Co. v. Blanek.*,[1] the Court of Appeals of Texas for the Fourteenth District (Houston), held that a mother's bystander mental anguish damages, though covered under the policy's UIM provision, were subject to the same $50,000 "each person" limit already paid for her daughter's bodily injury. The Court found the policy language to be unambiguous and reversed the trial court's judgment awarding an additional $50,000.

The dispute was between Melodye Blanek ("Melodye") and Farmer Texas County Mutual Insurance Company. Jamie Blanek ("Jamie"), the daughter of Melodye Blanek, was injured as a pedestrian when struck by an underinsured motor vehicle. Melodye witnessed the accident and claimed mental anguish damage as a bystander. Melodye's insurer paid Jamie the maximum per person limit of $50,000 for uninsured/underinsured motorist bodily injury liability coverage, but denied Melodye's claim for bystander damages since the per person limit was exhausted by the payment of Jamie's claim.

Melody sued in District Court in McLennan County Texas, and the trial court granted summary judgment against Farmers, holding that the policy required Famers to pay an additional per person limit to Melodye. The Court of Appeals reversed and rendered a take nothing judgment. Notably, the parties entered into several stipulations that informed the appellate court's analysis. Among them, Melodye expressly stipulated that she "did not sustain bodily injury as a result of the accident." The stipulations also confirmed that both Jamie and Melodye were covered persons under the policy and, importantly, that Farmers had paid the applicable $50,000 limit to Jamie.

The Appellate Court began its analysis with an interpretation of the relevant policy terms. The Declarations page indicated separate limits of liability for motorist bodily injury and motorist property damage for UM / UIM coverage such that the "per person" or "each person" limit was $50,000. The UIM limit of liability section further stated that the $50,000 limit is "our maximum limit of liability for all damages for bodily injury sustained by any one person in any one motor vehicle accident." Farmers, relying on the common and ordinary meaning of the words used, argued that the word "for" in the clause "for bodily injury" means "resulting from." The Court stated that under Farmers' interpretation, the phrase in question would mean that one $50,000 "each person" limit for UIM coverage applied to all damages resulting from or because of bodily injury sustained by any single covered person in any one motor vehicle accident, regardless of the number of claimants.

Melodye contended that her bystander claim should be independent and not derivative of her daughter's claim, relying on *Haralson v. State Farm Mutual Automobile Insurance Co.*, 564, F.Supp.2d 616 (N.D. Tex. 2008), for support. The Court acknowledged some similarities, such as both cases involving a claim for UIM coverage by a bystander who witnessed a family member injured in an auto accident and identical policy language. In *Haralson*, the Court's holding allowed for a separate "each person" limit to be available to the bystander. However, the *Blanek* Court reasoned that the outcome of Haralson was driven by the fact that the bystander in *Haralson* also suffered a bodily injury, whereas Melodye had stipulated she suffered none. Because Melodye did not suffer a bodily injury, the Court concluded that *Haralson* is not on point.

In conclusion, the Court agreed with Farmers, finding that its interpretation was the only reasonable interpretation:

> If only one covered person sustains bodily injury in an accident with an underinsured motor vehicle, then the "each person" UIM coverage limit applies to all damages resulting from the bodily injury sustained by that person, no matter the number of claimants.

Therefore, the trial court's judgment was reversed and a take-nothing judgment in favor of Farmers was rendered.

COURT OF APPEALS FINDS NO PERSONAL JURISDICTION IN TEXAS OVER A MICHIGAN INSURER AND A FLORIDA POLICY

In an appeal from an interlocutory order overruling an insurer's special appearance, the Court of Appeals of Texas for the First District, Houston in *Auto-Owners Ins. Co. v. Millionder*,[2] dismissed the case against Auto-Owners for lack of personal jurisdiction.

In *Millionder*, Casandra Marie Millionder, a Florida resident, obtained a policy in Florida through a Florida insurance agency. Auto-Owners Insurance Company, or its subsidiary Southern-Owners Insurance Company, issued the policy through Messick Insurance Agency in Florida. During the policy period, Millionder moved to Texas and was involved in a pedestrian versus motor vehicle accident in Harris County, Texas. Millionder filed a UIM claim for over $188,000.00 with Auto-Owners, who denied the claim. Millionder then sued the negligent driver and Auto-Owners for breach of contract, declaratory judgment, underinsured benefits, deceptive trade practices, fraud, negligence, negligent misrepresentation, and negligent hiring, supervision or management for wrongfully denying her UIM claim.

Auto-Owners filed a special appearance for lack of personal jurisdiction, arguing that Millionder's claims did not arise from any activity purposefully conducted by Auto-Owners in Texas, but rather that Millionder, a former Florida resident who had obtained a Florida insurance policy while living in Florida, was now seeking to enforce a Florida policy in a Texas court. Auto-Owners further argued that it lacked minimum contacts with Texas giving rise to either general or specific jurisdiction and even if minimum contacts existed, the exercise of personal jurisdiction over it in Texas would offend traditional notions of fair play and substantial justice. The trial court overruled Auto-Owners' special appearance and Auto-Owners' filed its interlocutory appeal.

On appeal Auto-Owners argued that the court could not exercise specific jurisdiction over it because Millionder's lawsuit did not arise from, or relate to, any activities by Auto-Owners in Texas. Specifically, Auto-Owners argued that Millionder procured a Florida insurance policy while representing herself as a Florida resident and failed to report the change to her vehicle's garaging location, as required by the policy, or produce any evidence imputing knowledge of her Texas residence to Auto-Owners.

Millionder argued that Auto-Owners was subject to specific jurisdiction in Texas because it accepted premiums paid by Texas residents, provided the policy to Texas residents, adjusted claims and hired contractors to adjust claims in Texas, defended previous lawsuits in Harris County, Texas, and "otherwise conduct[ed] business in Texas."

The Court disagreed with Millionder's argument that Auto-Owners was subject to specific jurisdiction in Texas. The Court stated that for a Texas court to exercise specific jurisdiction over a non-resident defendant, that defendant must have purposefully availed itself of the privilege of conducting business in Texas and its purposeful contacts with the forum state must be substantially connected to the operative facts of the litigation or form the basis of the cause of action.

Regarding the payment of premiums, Auto-Owners provided evidence that it did not write policies in Texas and did not seek payment of premiums from Texas residents. The Court cited caselaw that "the making of payments in Texas is not sufficient to establish minimum contacts."[3] The Court held that the mere receipt of premiums in Florida that originated from a Texas address did not establish the type of minimum contacts needed for the Court to have specific jurisdiction over Auto-Owners.

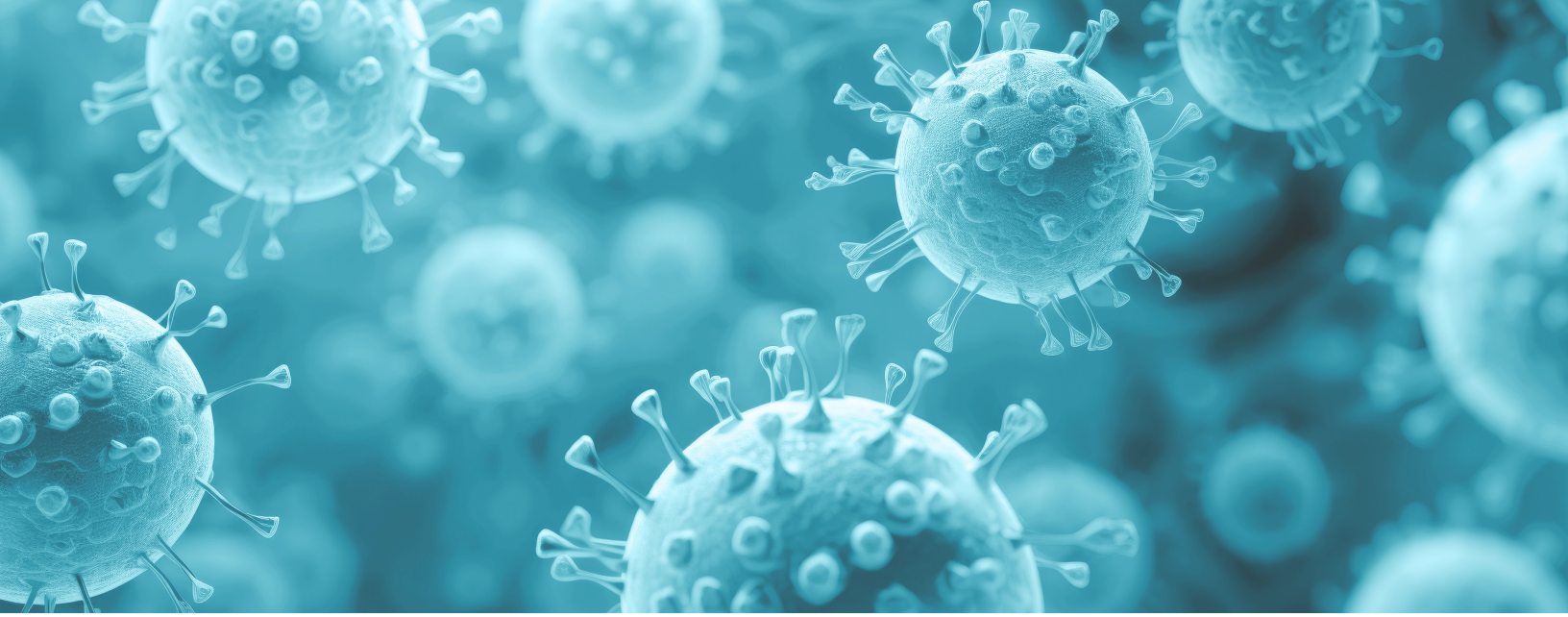
Moreover, the Court relied on caselaw stating that the "mere sale of a product to a Texas resident will not generally suffice to confer specific jurisdiction upon our courts. Instead, the facts alleged must indicate that the seller intended to serve the Texas market." The Court concluded that since Auto-Owners did not sell the policy to Millionder in Texas and there was no evidence that it targeted the Texas market, Millionder's argument was meritless.

Finally, the Court stated that "Auto-Owners' use of independent adjusters in Texas would not subject Auto-Owners to jurisdiction in Texas because the contacts of independent contractors are not attributable to the principal." The Court stated that, with regard to Auto-Owners defending previous litigation in Texas, that such argument would only support general jurisdiction, not specific jurisdiction.

Regarding general jurisdiction, the Court found no basis for exercising it over Auto-Owners. The Court emphasized that Auto-Owners was a Michigan resident with a registered office in Florida for policies issued in Florida. Notably, it was not licensed to transact business in Texas; it was not incorporated under the laws of Texas and did not maintain a registered agent in Texas; it did not maintain officers, places of business, post office boxes, or telephone listings in Texas; it did not having real estate, facilities, bank accounts or other property interests in Texas; it did not have employees, agents or servants in Texas; and it did not advertise, solicit, market or conduct promotional activities in Texas.

Additionally, the Court rejected the argument that Auto-Owners waived its jurisdictional objection by filing a general denial after the trial court overruled its special appearance, citing Rule 120a(4), which preserves such objections post-ruling.

Accordingly, the Court sustained Auto-Owners' issue on appeal, reversed the trial court's interlocutory order overruling Auto-Owners' special appearance and rendered judgment dismissing the case against Auto-Owners for lack of personal jurisdiction.



HOMEOWNERS AND COMMERCIAL POLICY

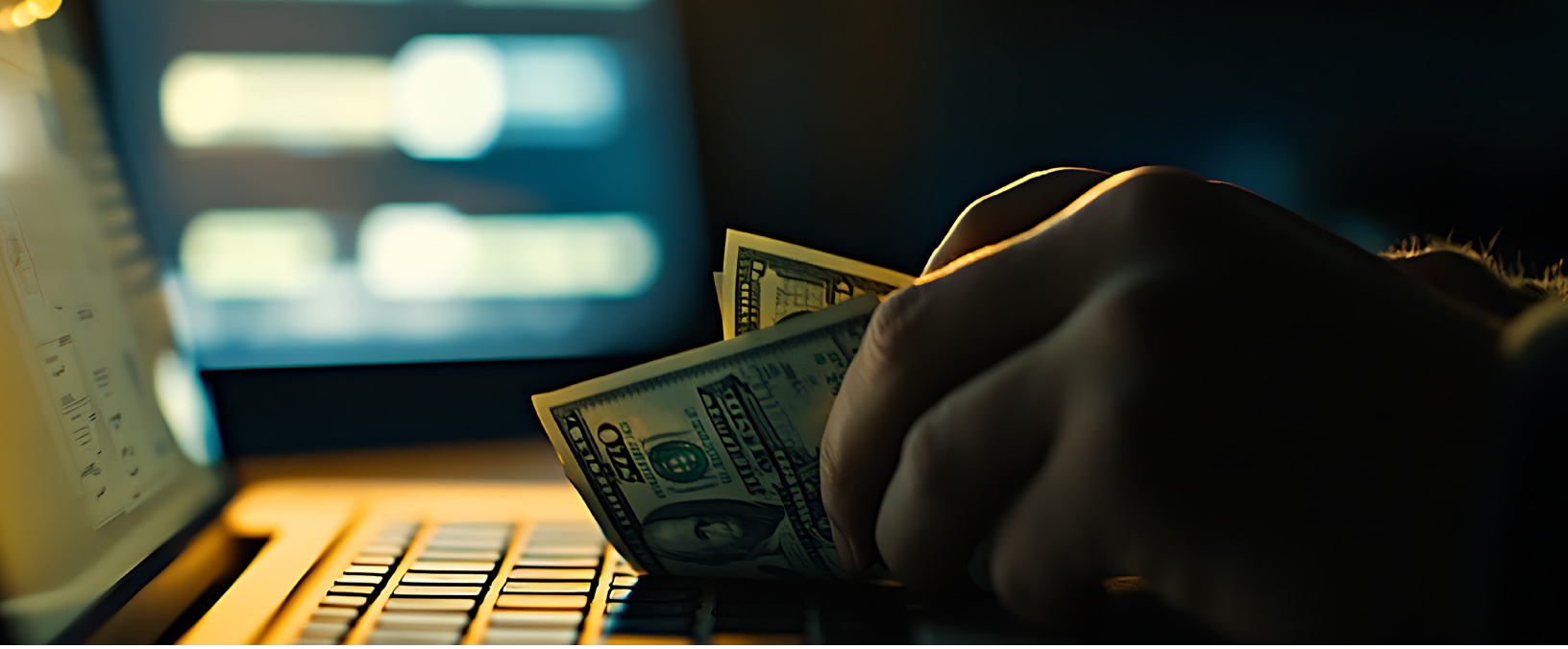
THE HOUSTON 14TH COURT OF APPEALS CONCLUDED THERE WAS NO MORE THAN A SCINTILLA OF EVIDENCE THAT COVID-19 CAUSED PHYSICAL DAMAGE TO THE INSURED'S PROPERTY AND REVERSED THE JUDGMENT BASED ON THE JURY'S VERDICT

In *Lloyd's Syndicate 1967 Subscribing to Pol'y B0180PG1922227 v. Baylor Coll. of Med.*,[4] the issue of first impression before the Houston [14th] Court of Appeals was whether the presence of the SARS-CoV-2 virus caused "direct physical loss of or damages to" the insured property. The court concluded it did not.

Baylor College of Medicine ("Baylor") made a claim for business interruption coverage and for other losses related to the COVID-19 pandemic, which was denied by its insurer. Baylor brought suit against its insurer for breach of contract and other claims. At the conclusion of trial, the jury answered "yes" to the question of whether COVID-19 caused direct physical loss or damage to Baylor's property, and the trial court awarded more than $12 million in damages and attorney's fees to Baylor. The insurer appealed, arguing in part in pertinent part that the evidence was legally insufficient to support the jury's finding of direct physical loss or damage to Baylor's property. The insurer asserted that the policy language required tangible alteration or deprivation of property or injury to property.

Significantly, Baylor did not argue and, the Court did not find, that the policy language was ambiguous. Thus, the Court analyzed the plain meaning of "loss", "damage", and "physical." The Court noted that the Texas Supreme Court addressed the term "physical injury" in a CGL policy in *U.S. Metals, Inc. v. Liberty Mut. Group, Inc.*, 490 S.W.3d 20, 24 (Tex. 2015), and relying on the dictionary definitions of the terms, concluded that a "physical" injury had to be tangible. Moreover, the Court reviewed cases across the country addressing the presence of COVID-19 which required a "tangible alteration or deprivation of property," including the Fifth Circuit in *Terry Black's Barbecue, L.L.C. v. State Auto. Mut. Ins. Co.*, 22 F.4th 450, 456-57 (5th Cir. 2022). The Court noted that under *Terry Black's* the "Texas Supreme Court would interpret a direct physical loss of property to require a tangible alteration or deprivation of property." The Court noted its sister court, the Dallas Court of Appeals, reached a similar conclusion in *Julio & Sons Co. v. Cont'l Cas. Co.*, 692 S.W.3d 877, 883 (Tex. App.—Dallas July 3, 2024, no pet.). Therefore, the Court held that a tangible altercation or deprivation of property is required for a direct physical loss of property or damage to property within the plain meaning of the policy.

The Court noted that the insurer cited to dozens of cases in various jurisdictions that held COVID-19 did not cause a physical loss, and that Baylor did not cite to any case reaching a different conclusion. While Baylor put forth evidence that the virus itself is physical and physically bonded to Baylor's property, the Court noted that the virus did not cause a physical loss of or physical damage to the property. Further, Baylor's witnesses testified that Baylor's property suffered damage because the property was temporarily dangerous to others and, therefore, less valuable. Again, the Court concluded that this was not evidence of a tangible alteration of or deprivation of the property. Moreover, the Court was persuaded by testimony that there was no evidence of the need to discard property and that cleaning the property or waiting for a period of time restored the property to its original condition. The Court observed an appropriate analogy would be Baylor's patrons spilling a small amount of water on the floor that caused no tangible alteration to Baylor's property: while a puddle of water may pose a risk of injury, just because Baylor has to take steps to prevent visitors from stepping in the puddle and choosing to clean up the puddle or let it evaporated did not mean the puddle caused physical damage to the floor. Thus, the Court concluded that there was no more than a scintilla of evidence that COVID-19 caused physical damage or loss to Baylor's property. Therefore, the Court reversed the trial court's judgment and rendered a take nothing judgment against Baylor. A petition for review was filed on March 4, 2025.



TEXAS SOUTHERN DISTRICT COURT GRANTED SUMMARY JUDGMENT IN FAVOR OF THE INSURER FINDING THAT THE DELAYED PAYMENT OF PROCEEDS UNDER THE POLICY DID NOT CONSTITUTE BENEFITS LOST OR AN INDEPENDENT INJURY

In *Dillen v. QBE Insurance Corporation*,[5] the insureds' home was damaged during the February 2021 winter storm that covered Texas. The insureds filed a claim and over the next couple of years, the insureds and the insurer had various estimates made of the damage following which the insurer made multiple payments over time. Ultimately, the insured invoked the policy's appraisal clause and the total appraisal award was $192,292.69, which the insurer paid in total to the insureds.

The insureds filed suit in state court, which was removed to the Texas Southern District Court. The Court noted that for an insured to recover damages for Texas Insurance Code violations, the insured must establish they had a right to policy benefits or compliance with the independent injury rule. Accordingly, the Court stated that the insurer owed no duty to pay once it pays what is contractually owed under the policy unless the insureds qualify based on two exceptions to the general rule: the Benefits-Lost Rule and the Independent-Injury Rule.

As to the Benefits-Lost Rule, if the insurer's conduct caused the insured to lose a contractual right, the insured can recover benefits even where the insured had no right to benefits under the policy.

However, the Court observed that the insureds did not lose a contractual right to any policy benefit. While the insureds argued that the insurer improperly withheld payment, they conceded that the insurer paid what was contractually owed. Citing Fifth Circuit precedent, the Court noted that where an insured has already received all benefits the insured is entitled to, the insured is not entitled to recover under an extra-contractual theory (except for the independent injury rule). Accordingly, the Court concluded the benefits-lost rule was inapplicable.

Regarding the Independent-Injury Rule, the Court noted the Fifth Circuit clarified that the rule limits the recovery of other damages and that an injury is not independent from the right to receive benefits if the injury "flows" or "stems" from the denial of such a right. Accordingly, if an insured seeks damages based on paid benefits, as here, the Independent-Injury Rule applied. The Court noted that the insureds did not suggest how they were injured independently from their right to receive benefits under the policy, nor did they provide any evidence of an injury. While the insureds asserted that they were injured from the withheld payment, they did not provide evidence of damage that did not flow or stem from the denial of benefits under the policy. Further, the Court noted that while the claim may be independent from the contractual dispute, the insureds' alleged injury was not. Thus, the Court granted summary judgment for the insurer on the insureds' Texas Insurance Code claims.

Finally, the Court found that the insureds did not provide any evidence that the insurer acted in bad faith or unreasonably to support their breach of the common law duty of good faith and fair dealing claim. Rather, the evidence showed a claim inspection process yielding multiple payments and an appraisal process that yielded an additional payment. Further, the Court observed that the insureds failed to show any wrong, abuse, insult, or gross negligence on the part of the insurer to give rise to an independent tort. In addition, the Court noted that the only evidence that the insureds provided to show bad faith was the insurer's log which the Court believed showed that the insurer had a reasonable basis for delay based on multiple attempts to reach the insured to no avail.

Because the evidence only showed a coverage dispute, which the Court noted standing alone did not demonstrate bad faith, the Court granted summary judgment for the insurer on the insured's breach of the common law duty of good faith and fair dealing claim.

TEXAS EASTERN DISTRICT COURT FINDS THAT AN INSURED LACKED AN INSURABLE INTEREST IN INSURANCE PROCEEDS BECAUSE THEY WERE TRANSFERRED TO THE LENDER BY THE SECURITY INSTRUMENT UPON FORECLOSURE

In *Walters v. State Farm Lloyds*,[6] the insured property was damaged during a windstorm that occurred on or about April 12, 2022, including damage from a tree that fell on the property. A public adjuster hired by the insured allegedly determined that the damage to the property totaled $136,996.34. However, State Farm paid only $17,333.50 and the insured filed suit against State Farm asserting state law claims for breach of contract, violations of the Texas Insurance Code, breach of the duty of good faith and fair dealing, DTPA violations, and common law fraud. State Farm removed the case to federal court and filed a motion for summary judgment arguing that the lawsuit should be dismissed because the insured no longer owned the property following foreclosure of the property.

Notably, the insured did not dispute that he no longer owned the property. The security instrument executed by the insured upon foreclosure expressly assigned to the lender the insured's rights to any insurance proceeds and any other if the insured's rights under the policy covering the property at issue.

The Court found that the assignment of the insured's rights under the policy after the sale divested him of any interest in the insurance proceeds and, therefore, he no longer had a breach of contract claim against State Farm. Further, the Court concluded that the insured failed to show an issue of material fact related to his remaining extra-contractual claims. Accordingly, the Court granted State Farm's motion for summary judgment.

MOTOR CARRIER

NEW JERSEY APPELLATE COURT HOLDS THE MCS-90 FORM REQUIRES A SPECIFIC FINDING OF NEGLIGENCE AGAINST THE INSURED TO TRIGGER COVERAGE.

The case of *Aurora Terminals Corp. v. G2G Transport, LLC*,[7] concerns an insurance coverage dispute regarding an environmental claim arising out of an oil spill incident involving G2G Transport ("G2G"), a motor carrier, and its insurer, Prime Property & Casualty Insurance, Inc. ("Prime)". The incident occurred on June 1, 2021, when a G2G truck, carrying oil in a trailer-mounted intermodal tank, was maneuvering out of a parking spot at a facility leased by Aurora Terminals Corp. ("Aurora") in Newark, New Jersey. As the truck moved, the tank was punctured by a sharp edge of an adjacent parked truck, causing a significant spill of oil onto the ground and nearby waterway. Surveillance footage captured the event, and the New Jersey Department of Environmental Protection (NJDEP) promptly identified G2G as the responsible party, issuing a Field Directive ordering it to remediate the contamination.

Aurora, as the site operator, engaged environmental firms to conduct remediation and later filed a lawsuit against G2G under the New Jersey Spill Compensation and Control Act ("Spill Act"). The Spill Act imposes strict liability on any party responsible for discharging hazardous substances, regardless of fault or negligence. G2G initially defaulted on responding to the complaint, leading the trial court to enter a default judgment against it. Although G2G later sought to vacate the judgment and filed a third-party complaint against Prime seeking coverage for the environmental response costs under the motor carrier policy issued by Prime. Ultimately, the trial court held G2G was strictly liable for cleanup costs totaling $475,623.87, the Court then trebled this amount under the Spill Act for a total award of $1,426,871.61 against G2G.

Following this judgment, Aurora sought to recover payment from Prime under the MCS-90 endorsement in G2G's insurance policy. The MCS-90 is a federally mandated provision that ensures motor carriers have financial responsibility to cover public liability arising from the insured's negligence in the use of motor vehicles. The trial court also ruled that the MCS-90 endorsement required Prime to pay up to its policy limit of $750,000, despite Prime's argument that its policy excluded coverage for hazardous materials spills.

On appeal, Prime challenged this ruling, arguing that the express terms of the MCS-90 endorsement require G2G's liability to arise from, "negligence in the operation, maintenance or use of motor vehicles." However, the trial court's decision did not assess a finding of negligence because it only contained a finding that G2G was strictly liable under the Spill Act. Therefore, Prime contended that since G2G's negligence had not been established, the endorsement should not have been triggered. The appellate court agreed with Prime, concluding that the lower court failed to determine whether G2G was negligent and, therefore, could not apply the MCS-90 endorsement based solely on a finding of strict liability. The appellate court vacated the summary judgment against Prime and remanded the case for further proceedings to determine whether G2G's actions constituted negligence. Additionally, the appellate court clarified that due to New Jersey's public policy against the insurability of punitive damages, that if Prime were ultimately found liable, it would only be responsible for covering actual cleanup costs ($475,623.87) and not the full treble damages awarded under the Spill Act ($1,426,871.61).

This case highlights the legal distinction between strict liability under environmental statutes like the Spill Act and negligence-based liability required for insurance coverage under an MCS-90 endorsement. Accordingly, insurers handling environmental claims implicating motor carriers should confirm that there has been a clear finding of an insured's negligence to ensure the MCS-90 has been sufficiently triggered. Furthermore, this case also serves as a reminder regarding the significant impact that the controlling jurisdiction's position concerning the insurability of punitive damages can have on an insurer's indemnity obligation.

OHIO APPELLATE COURT HOLDS THAT DISPUTE CONCERNING AMBIGUOUS "PERMISSIVE USER CLAUSE" REGARDING AVAILABLE LIMITS OF LIABILITY ALLOWS FOR CONSIDERATION OF USE OF VEHICLE AT THE TIME OF THE ACCIDENT.

The case *Texas Insurance Company v. Rodriguez*[8] arose from an insurance coverage dispute concerning the appropriate amount of limits of liability for a motor vehicle accident. The underlying accident involved a truck driver, Kenneth Morton, who was driving for hire under Final Touch Logistics, LLC ("Final Touch"), which had a motor carrier liability policy issued by Texas Insurance Company ("TIC"). The dispute centered on whether Morton was an approved driver under the policy and, consequently, the extent of coverage available for the accident. The policy issued by TIC had a limit of liability of $1,000,000 per occurrence. The policy contained a "permissive user clause" which defined a "permissive user" as "users of a covered auto, other than 'insurers', who are not approved in writing by [TIC]". The policy further noted that the "coverage for permissive users is subject to reduction to statutory minimums."

The dispute arose when Corey Sturgill, the owner of Final Touch, requested that Kenneth Morton be added as a covered driver under the policy. Sturgill communicated this request to Scott Bowen, an employee with Kernan Insurance Agency, Inc. ("Kernan") with a photo of Morton's driver's license to facilitate the process. Bowen allegedly checked Morton's driving record and found no immediate issues that would disqualify him from being insured. However, he failed to complete the necessary step of forwarding Morton's information to TIC's underwriters, Rivington Partners, for formal approval as required by the policy. As a result of Morton's information never being forwarded to Rivington Partners, he was never formally approved. Ultimately, TIC sought a declaratory judgment asserting that coverage under the policy should be limited to Ohio's minimum statutory liability limits under Ohio Revised Code (R.C.) 4509.51, which requires limits of only $25,000 per person and $50,000 per accident for bodily injury.

Final Touch argued that the relevant statutory minimums should be those mandated for for-hire motor carriers under Ohio Administrative Code (O.A.C.) 4901:2-13-03 and Ohio Revised Code (R.C.) 4921.09, which requires a minimum of $750,000 in liability coverage for commercial trucking operations. Specifically, Final Touch noted that Morton was operating a for-hire commercial truck weighing over 10,000 pounds and was actively engaged in intrastate commercial trucking at the time of the accident. Therefore, the applicable statutory minimum should align with the statute establishing the minimum limits for-hire motor carrier operating within Ohio. Ultimately, the Court determined that the applicable limits of liability were the $750,000 mandated by Ohio law for-hire motor carriers. In addition, the Court found Kernan liable for the difference between the intended $1,000,000 coverage and the $750,000 coverage, due to its employee's failure to properly process Morton's inclusion under the policy.

The Court reasoned that the term statutory minimums could reasonably be interpreted to mean the minimum financial responsibility required for the type of vehicle and usage in question. Therefore, since Ohio law mandates higher liability limits for for-hire motor carriers, and Morton was operating within that capacity at the time of the accident, TIC Insurance was obligated to provide coverage at the higher statutory level. Additionally, because the insurance policy did not explicitly define statutory minimums to refer solely to the lower general liability limits, the Court ruled that ambiguities in the policy should be interpreted in favor of the insured. The Court also held that Kernan was liable for the shortfall due to its employee failing to ensure that Morton was approved as a scheduled driver to the policy.

Therefore, the Court affirmed the trial court's holding that the applicable statutory minimum for Morton's coverage was $750,000 rather than the $25,000 TIC sought.

This case highlights several important legal principles. First, courts tend to interpret ambiguous terms in insurance policies against the insurer, particularly when the language is broad enough to support multiple reasonable interpretations. Second, the decision reinforces that specialized regulatory minimums—such as those governing commercial trucking—take precedence over general liability minimums when determining the coverage requirements for a specific type of vehicle. Finally, the case underscores the importance of proper insurance underwriting and agent conduct, as the error by Bowen in failing to confirm coverage for Morton coverage resulted in Kernan being liable for the full amount of the shortfall.

OTHER CASES OF GENERAL CONCERN

SUMMARY JUDGMENT IN FAVOR OF INSURED AFFIRMED ON DUTY TO DEFEND, NUMBER OF OCCURRENCES, AND NO RIGHT TO RECOUP DEFENSE COSTS

In *Zurich Am. Ins. Co. v. Burlington N. & Santa Fe Ry. Co.*,[9] the Second Court of Appeals (Fort Worth) had occasion to consider an insurance coverage dispute stemming from over 400 lawsuits filed by current and former residents of Libby, Montana, alleging bodily injury due to exposure to asbestos-contaminated vermiculite transported by Burlington Northern Santa Fe Railway ("BNSF"). In 2012, BNSF and its insurers contributed $18 million to settle over 1,000 claims related to these allegations. BNSF and Zurich American Insurance Company ("Zurich") disputed Zurich's duty to defend BNSF in these lawsuits. BNSF filed a motion for summary judgment asserting that Zurich had a duty to defend it against future claims, while Zurich sought a declaration to recoup defense costs after allegedly exhausting its liability limits through the 2012 settlement. The trial court granted BNSF's motion and denied Zurich's, and Zurich appealed.

The issues on appeal were whether Zurich had a duty to defend BNSF in these lawsuits under the premises-operations insurance policies, whether the claims constituted a single occurrence or multiple occurrences, whether the previous settlement exhausted the policy limits, and whether Zurich was entitled to recoupment of defense costs.

The Court first addressed whether the trial court correctly determined that Zurich had a duty to defend BNSF from and against the claimants in the Libby Lawsuits based on the policy language. The Court conducted an eight-corners analysis, comparing the four corners of the Owners', Landlords', and Tenants' Liability policies ("OL&T policies") to the four corners of the complaints in the Libby Lawsuit (while ignoring the voluminous evidence both sides presented from experts, corporate representatives, and other sources).

The Court noted that Zurich did not argue that the alleged bodily injuries from exposure to asbestos-tainted vermiculite were not "bodily injuries" "caused by accident" or "caused by an occurrence," but rather, Zurich argued that it had no duty to defend because "none of the pending claims against BNSF involve a plaintiff who claimed to have suffered an injury while on the River Loading Facility premises or on land immediately adjoining the premises." Alternatively, Zurich argued against coverage based on the completed operations exclusion and that the alleged allegations of bodily injury were for completed operations and were excluded under the OL&T policies. The Court stated that Zurich failed to point to any individual pleading or group of complaints in which a Libby Lawsuit claimant failed to make such an allegation. The Court concluded that the trial court did not err by determining that the allegations in the Libby Lawsuits fall within the OL&T policies' premises—operations coverage, triggering Zurich's duty to defend.

On the second issue, the Court addressed Zurich's argument that the trial court erred by declaring that each plaintiff's alleged exposure in the Libby Lawsuits constituted a separate accident or occurrence. The question the Court presented was whether the Libby Lawsuits claimants' alleged bodily injury from exposure to asbestos-tainted vermiculite arising out of BNSF's premises operations at the River Loading Facility alleged one or more causative events. The OL&T policies included a $500,000 per-accident or per-occurrence limit of liability and no policy had an aggregate limit of liability. Based on this information the Court looked at two tests for analyzing the number of accidents and occurrences: (1) the cause test, which looks at the cause or causes of damage and (2) the effects test, which looks to the injuries, damages, or effects resulting from the cause.

The Court noted that most states, including Texas, apply the cause test but some courts look at a single proximate cause, while others consider the existence of liability-triggering events. The Court further noted that the Texas Supreme Court has not yet provided guidance on applying the cause test and the difficulty in applying the cause test from case to case, even those involving similar fact patterns emanates from policy language differences and each case's unique factual circumstances. Thus, the Court opined that the appropriate inquiry is whether there is one proximate, uninterrupted, and continuing cause which resulted in all of the injuries and damages. If so, then there would be a single occurrence but if the chain of proximate causation was broken by a pause in the negligent conduct or by some intervening cause, then there would be multiple occurrences, even if the insured's negligent conduct which caused each of the injuries was the same kind of negligent conduct.

Ultimately, the Court applied the cause test in light of the OL&T policies. Analyzing the Policies' language, the Court noted that the policies excluded completed operations coverage and coverage for BNSF's operations and concluded that the coverage afforded under the Zurich policies was limited to the premises operations at the River Loading Facility.

The Court concluded that the sole proximate cause of the Libby Lawsuit plaintiffs' bodily injury claims was BNSF's operations at the River Loading Facility where BNSF continuously conducted its loading and transporting of asbestos contaminated vermiculite, the hazard insured against in the OL&T policies. Accordingly, the Court held that the trial court erred by granting BNSF's summary judgment motion and by denying Zurich's cross-motion on the number of causative events and by declaring that each Libby Lawsuit plaintiff had alleged a separate accident or occurrence.

Next, Zurich argued that the trial court erred concerning whether Zurich's prior 2012 settlement contribution exhausted the $500,000 per-accident and per-occurrence limits of liability. Zurich argued that its $5.4 million contribution toward the overall $18 million funding of the 2012 settlement exhausted the OL&T policies' limits and terminated Zurich's duty to defend BNSF. However, the Court disagreed, stating that Zurich's fundamental problem was that the 2012 settlement agreement that included BNSF and Libby vermiculite claimants did not in itself state what Zurich's contribution was going to be, and it did not limit or otherwise attribute Zurich's settlement payment solely to BNSF's premises operations liability. The settlement agreement stated that the settlement encompassed not only BNSF's alleged contractual liabilities to Libby vermiculite claimants under the OL&T policies, but also potential extra contractual liabilities as defined under the agreement among BNSF, the insurers, and the Libby vermiculite claimants.

The Court determined that the agreement did not attribute or connect Zurich's eventual $5.4 million funding contribution to the exhaustion of the OL&T policies' but instead Zurich expressly agreed that the settlement agreement was intended to be and was a commercial accommodation among the Parties and that it was not meant to be construed as an admission of coverage under the policies issued by Zurich or an admission of liability to the BNSF Claimants or anyone else. As such, the Court held that Zurich failed to offer any evidence that it has exhausted the OL&T policies' limits of liability through the funding of the 2012 settlement agreement and therefore, the trial court did not err by denying Zurich's motion for summary judgment concerning exhaustion and by granting BNSF's motion on the duty to defend.

Finally, Zurich argued that it was entitled to recoup any defense costs paid to BNSF after Zurich's duty to defend ended following Zurich's $5.4 million settlement contribution in 2012. The Court stated that Zurich's argument suffered from two key flaws: (1) that Zurich has a duty to defend BNSF from and against the Libby Lawsuits due to Zurich's failure to show such duty was terminated by exhaustion; and (2) Zurich failed to meet its evidentiary burden on its alleged right to recoupment.

As the Court previously concluded that Zurich had a duty to defend BNSF previously in its opinion, the recoupment analysis focused primarily on whether Montana or Texas law would apply for the purpose of recoupment and the evidence presented to satisfy either state's laws.

The Court determined that regardless of which state's law was applicable, Zurich failed to meet its evidentiary burden under either state's law.

Zurich did not proffer any summary judgment evidence (1) that the OL&T policies expressly allowed for Zurich's recoupment claim (which they did not) or (2) that BNSF had otherwise consented to or was notified of such a claim. Rather, Zurich pointed to a single document: a reservation of rights letter concerning only the 1971 Zurich policy and Libby vermiculite claimant in a separate federal case filed in 2013 whose name was not listed among the claimants in the 400 plus Libby Lawsuits. As such, the Court held that Zurich failed to carry its evidentiary burden on its recoupment claim under both Texas and Montana law and that the trial court did not err by denying Zurich's summary judgment request for recoupment.

Zurich has until Monday April 27, 2025 to file any appeal with the Texas Supreme Court and if the Texas Supreme Court were to take this matter up, it could have major ramifications for how Texas Courts apply the cause test in determining whether alleged damages constitute a single, or multiple occurrences given the varying approaches used by the appellate courts in applying the cause test.

FIFTH CIRCUIT DIRECTS STATE COURT TO DISMISS SUIT AFTER THE INSURED SOUGHT A POST-TRIAL DECLARATORY JUDGMENT CONCERNING A DECLINED STOWERS DEMAND

In *Golden Bear Insurance Co. v.34th S&S, L.L.C.*,[10] the U.S. Court of Appeals for the Fifth Circuit reversed a federal district court's ruling and dismissed the case brought by Golden Bear Insurance Company ("Golden Bear") after it filed a complaint seeking a declaratory judgment. The case centers around Golden Bear's attempt to avoid liability for an excess judgment awarded in a state personal injury lawsuit against its insureds, Concrete Cowboy and its owner, Daniel Wierck. The Fifth Circuit determined that the federal court should not have exercised jurisdiction under the Declaratory Judgment Act, as the case was better suited for state court where the underlying tort and insurance issues had already been litigated.

Golden Bear arises from a New Year's Day 2019 incident at a bar called Concrete Cowboy where Kacy Clemens and Conner Capel, the plaintiffs in the state suit, were injured during an altercation with the bar's bouncer. The police arrested the bouncer, and Clemens and Capel subsequently sued Concrete Cowboy and Wierck in Texas state court, alleging negligence, vicarious liability, and gross negligence, and attaching photos of their injuries.

Initially, Clemens and Capel sought between $200,000 and $1,000,000 in damages. Their attorneys later sent a Stowers *demand letter* to the defense counsel for Concrete Cowboy and Wierck. Golden Bear, which held a $1 million policy covering assault and battery claims for the defendants, declined the settlement offer, claiming the demand letter was too vague. The case proceeded to trial, and the jury returned verdicts of $960,000 for Clemens and $2.28 million for Capel. The court added prejudgment interest, post-judgment interest, and court costs, resulting in a total exceeding Golden Bear's $1 million policy limits. Golden Bear tendered the remaining policy limit after the verdict, leaving the insureds liable for at least $2.24 million.

After a failed post-trial mediation among the parties—where Clemens and Capel asserted that Golden Bear was liable for the excess judgment due to a breach of its *Stowers* duty, Golden Bear filed a complaint in federal court. In this complaint, Golden Bear sought a declaratory judgment that it had no obligation to indemnify the insureds beyond the policy limit, claiming the *Stowers* letter lacked the specificity to trigger its duty. However, Clemens and Capel filed their own lawsuit in state court against Golden Bear, alleging breach of the *Stowers* duty and legal malpractice against defense counsel in an attempt to eliminate diversity jurisdiction and stop the removal to federal court. In federal court, Clemens and Capel moved to stay (or dismiss) Golden Bear's declaratory judgment action, arguing the state court was the more appropriate venue under the *Trejo* abstention factors. The district court denied the motion without explanation.

Golden Bear then moved for summary judgment, asserting the Stowers letter did not meet the legal standard to trigger its duty. Clemens and Capel moved again to dismiss the case, arguing that Golden Bear had not properly invoked the Declaratory Judgment Act. The district court ultimately sided with Golden Bear, granting its summary judgment motion and declaring that it had no duty to pay the excess judgment due to the alleged insufficiency and vagueness of the Clemens and Capel's *Stowers* demand letter.

On appeal, the Fifth Circuit analyzed the case under the *Declaratory Judgment Act*, and held the Act grants federal courts discretion—not obligation—to issue declaratory judgments. Importantly, the Act is designed to allow parties to clarify legal rights *before* wrongful conduct occurs, not afterward. Thus, courts must assess whether the Act is being properly used to resolve a live controversy or being misused to preempt liability in state tort cases. The Fifth Circuit held that Golden Bear misused the Act. Golden Bear's alleged misconduct—failing to settle under its Stowers duty—was already complete, as a final judgment had been issued in state court. Therefore, the federal action was a retrospective attempt to avoid liability rather than a forward-looking clarification of legal rights. Additionally, the court emphasized that the appropriate forum for such negligence-based claims is state court, especially when the core legal issues (duty, breach, damages) stem from Texas negligence law. Federal courts are not intended to allow potential tort defendants, like insurers, to forum-shop for declarations of non-liability and thereby interfere with ongoing state proceedings.

The Fifth Circuit further noted that allowing Golden Bear to proceed with its federal case would contravene the purpose of the Declaratory Judgment Act and unfairly force personal injury plaintiffs to litigate in a forum of the insurer's choosing. The Court warned against letting defendants use the Act as a tool to seek preemptive rulings in negligence cases where liability is already being adjudicated elsewhere.

The Fifth Circuit found that the district court erred in two major respects: (1) by granting Golden Bear's summary judgment motion despite the unresolved factual dispute about the sufficiency of the *Stowers* demand, and (2) by denying the defendants' motion to dismiss when the federal case lacked a proper basis under the Declaratory Judgment Act. Consequently, the appellate court vacated the district court's judgment, reversed both the denial of the Rule 12(c) motion and the grant of summary judgment, and remanded with instructions to dismiss the case.

This decision reaffirms the limited and discretionary nature of federal jurisdiction under the Declaratory Judgment Act and underscores the importance of respecting state court proceedings in insurance-related tort claims.

MISCELLANEOUS

RECENTLY PROPOSED LEGISATION SEEKS TORT REFORM

Senate Bill 30 (SB 30) by Senator Charles Schwertner and House Bill 4806 (HB 4806) by Representative Greg Bonnen are key pieces of legislation recently introduced in Texas to address the issue of "nuclear verdicts excessively large jury awards that have become a growing concern in civil litigation, particularly in personal injury cases. These bills propose significant reforms to the way damages, particularly medical and noneconomic damages, are presented and challenged in court. If passed, they would have substantial implications for insurers, claims professionals, and defense counsel handling litigation in Texas.

One of the primary changes in the legislation involves amendments to Section 18.001 of the Texas Civil Practice and Remedies Code, which governs affidavits used to prove the reasonableness and necessity of medical expenses. Under the current law, defendants wishing to challenge these affidavits must file controverting affidavits within a specific timeframe. The proposed legislation seeks to replace the requirement for a controverting affidavit with a notice of intent to controvert. Importantly, the bills stipulate that this notice must adhere to the existing timelines previously applicable to controverting affidavits. Typically, under the existing framework, a defendant must serve a controverting affidavit no later than 30 days after receiving the plaintiff's affidavit. By maintaining these timelines for the new notice of intent to controvert, the proposed legislation ensures continuity in procedural deadlines, allowing defendants the same period to challenge the reasonableness and necessity of the claimed medical expenses. If passed, a defendant would no longer need to file a controverting affidavit to challenge the reasonableness of medical charges. Instead, a simple notice of intent to challenge the charges would suffice, allowing for greater flexibility in disputing inflated medical costs without the procedural hurdles that currently exist.

Additionally, the bills introduce new limitations on challenging medical expenses by adding Section 18.0011. Under this provision, defendants would be prohibited from contesting the reasonableness of medical charges if the plaintiff's affidavit complies with specific guidelines. These guidelines include reporting either the actual amounts received from all sources (such as insurance, government payors, or other third parties) or an amount that does not exceed 150% of the median payment for similar medical services, as determined by the Texas All Payor Claims Database. This change aims to prevent excessive claims based on artificially inflated medical billing and instead align recovery with real-world medical costs.

The bills also address noneconomic damages by refining legal definitions to reduce ambiguity and prevent exaggerated claims for subjective injuries. For example, future damages would need to be "reasonably probable," a stricter standard designed to limit speculative claims. Future loss of earnings would also require a reasonable probability standard, ensuring that damages awarded for lost wages are based on verifiable evidence. Furthermore, mental or emotional pain and anguish is redefined as "grievous and debilitating angst, distress, torment, or emotional suffering that causes a substantial disruption of the claimant's daily routine," rather than the more loosely interpreted definitions currently in use. Similarly, physical pain and suffering must be tied to an observable injury or impairment and verified through objective medical evaluation or testing. These changes aim to curb excessive jury awards for subjective, difficult-to-quantify injuries. SB 30 and HB 4806 also seek to address jury anchoring, a legal strategy where attorneys suggest arbitrary or excessively high monetary figures to influence juries into awarding inflated damages. This tactic is commonly used in personal injury cases to encourage jurors to set damages based on an attorney's proposed number rather than on actual evidence. The bills specify that it is a reversible error for an attorney to suggest a monetary amount to the jury unless it is directly supported by the evidence presented at trial. This restriction aims to prevent attorneys from artificially inflating jury awards by introducing speculative figures with no factual basis. By limiting what can be suggested to the jury, the legislation seeks to create a more objective and evidence-driven damages determination process.

In addition to prohibiting anchoring, the bills also require mandatory jury instructions that reinforce the principle that noneconomic damages—such as pain and suffering, mental anguish, and loss of enjoyment of life—must be based on actual evidence rather than arbitrary numbers suggested by counsel. These jury instructions will help ensure that jurors understand their responsibility to base their awards on tangible proof rather than emotional appeals. This measure is particularly important in cases where noneconomic damage is highly subjective and prone to significant variation. Furthermore, the bills introduce judicial oversight of noneconomic damage awards by requiring trial courts to articulate the legal and factual reasoning behind any noneconomic damage award that exceeds certain thresholds. If a defendant requests a remittitur (a reduction of an excessive jury award), the court must provide a detailed explanation of why the damages awarded were appropriate given the evidence. This requirement not only increases transparency in judicial decisions but also provides a clear basis for appellate review if a defendant believes the award is unjustifiably high.

SB 30 and HB 4806 also propose amendments to Section 304.102 of the Texas Finance Code, specifically addressing the calculation of prejudgment interest on awards for economic losses in civil cases. Under the current statute, prejudgment interest accrues on amounts awarded for economic losses, but the specific start date for this accrual is not explicitly defined. The proposed legislation seeks to clarify this by stipulating that prejudgment interest on economic losses should be calculated from the date the losses were actually incurred by the claimant. For health care expenses, this means interest would accrue from the date the claimant or their insurer paid the medical bills. For other types of economic losses, such as lost wages or property damage, interest would begin accruing from the date those losses were suffered.

This change aims to more accurately reflect the time value of money lost due to the defendant's actions and to ensure that claimants are compensated for the actual period during which they were deprived of their financial resources. By tying the accrual of prejudgment interest to the specific dates when economic losses occurred, the legislation seeks to promote fairness and precision in the calculation of interest on damage awards. Overall, SB 30 and HB 4806 represent a significant step in Texas' tort reform efforts, aiming to create a more predictable and fair litigation environment while discouraging the kinds of excessive awards that have driven up insurance costs and liability exposure in recent years. If passed, the legislation would significantly limit the ability of plaintiffs' attorneys to use psychological tactics to inflate verdicts, reinforcing the principle that damages should be based solely on the facts and evidence of each case.

1. No. 14-23-00799-CV 2025 Tex. App. LEXIS 589 (February 4, 2025).
2. No. 01-24-00221-CV, 2025 Tex. App. LEXIS 569 (February 4, 2025).
3. 706 S.W.2d 135, 142 (Tex.App.—Dallas 1986, writ ref'd n.r.e.).
4. No. 14-22-00925-CV, 2025 Tex. App. LEXIS 378 (Tex. App.—Houston [14th Dist.] Jan. 28, 2025, pet. filed).
5. No. 4:23-cv-2043, 2025 U.S. Dist. LEXIS 24742 (S.D. Tex. 2025).
6. No. 6:24-cv-53-JDK, 2025 U.S. Dist. LEXIS 29557 (E.D. Tex. 2025).
7. 2025 N.J. Super. Unpub. LEXIS 346 (App. Div. 2025).
8. 2025-Ohio-417, 2025 Ohio App. LEXIS 424 (3d Dist., 2025).
9. No. 02-23-00245-CV, 2025 Tex. App. LEXIS 1741 (Tex. App.—Fort Worth Mar. 13, 2025, no pet. h.).
10. No. 24-20332, 2025 U.S. App. LEXIS 6058 (5th Cir. Mar. 14, 2025).

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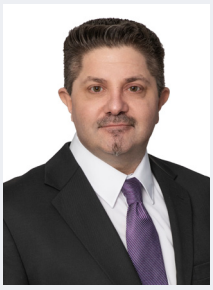

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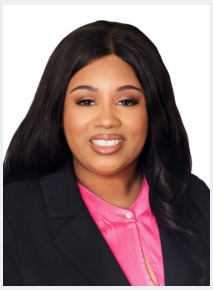

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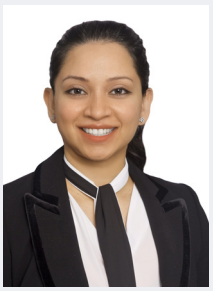

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