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.

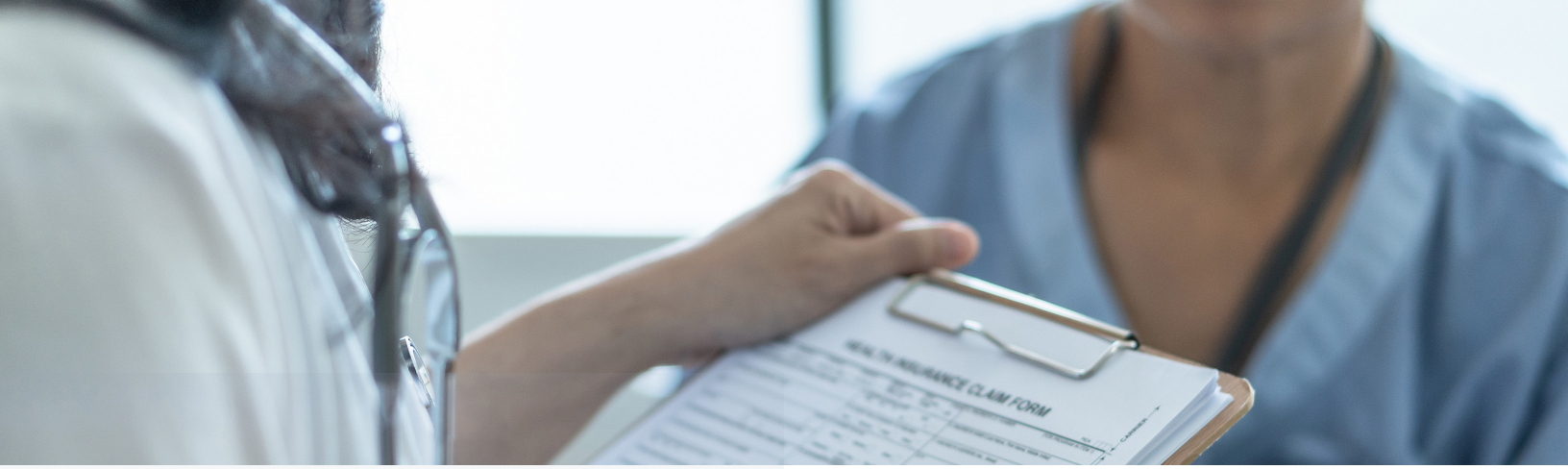
TEXAS INSURANCE LAW UPDATE

FIRST QUARTER 2026

THERE WERE SEVERAL NOTEWORTHY DECISIONS AND RULINGS FROM TEXAS STATE AND FEDERAL COURTS HANDED DOWN IN THE FIRST QUARTER OF 2026 THAT MAY BE RELEVANT TO YOUR CLAIMS HANDLING. DURING THE FIRST QUARTER OF 2026, THE COURTS ADDRESSED VARIOUS COVERAGE ISSUES INCLUDING:

- The duty to defend, the application of several injury to worker exclusions, and whether the Monroe exception applied;
- An insurer's right to subrogation and when the right vests;
- The duty to defend an additional insured where the policy required the court to examine the subcontract which required additional insurance;
- Whether a rideshare driver's Personal Auto Policy and the rideshare company's commercial auto policies provide collision coverage to the driver's vehicle when not en route to pick up a passenger;
- Whether a primary insurer is entitled to equitable contribution from excess carrier for payment beyond Its proportionate share of the liability;
- Whether an undefined "Windstorm or Hail" deductible in a homeowners policy applied to a loss caused by a tornado;
- Whether a homeowner's policy provided coverage for alleged hail damage to a metal roof and resulting interior water intrusion or whether the policy's Cosmetic Damage Endorsement applied;
- Whether a commercial property policy provided coverage for water damage caused by burst frozen pipes or whether a "Frozen Plumbing" exclusion applied;
- Whether a defense was owed under a professional liability policy where lawsuit alleged human trafficking;
- Whether an MCS-90 endorsement created a duty to defend, a duty to indemnify, or a Stowers duty to settle; and
- The impact of an MCS-90 endorsement on a Motor Carrier Liability Policy's "Other Insurance" excess clause.

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



CGL, UMBRELLA, AND EXCESS COVERAGE OPINIONS

THE WACO COURT OF APPEALS FOUND A DUTY TO DEFEND EXISTED AND DENIED THE REQUEST TO CONSIDER EXTRINSIC EVIDENCE UNDER THE MONROE EXCEPTION [1]

Quinton Williams ("Williams") was severely injured while he was working at a manufacturing facility owned by Lippert Components, Inc. ("Lippert"), and operated by Lippert's subsidiaries, Kinro Texas, Inc. ("Kinro") and LCI Industries ("LCI"). After Williams brought suit, Lippert, Kinro, and LCI sought a defense from their CGL insurer, Admiral Insurance Company ("Admiral"). In refusing to provide a defense, Admiral relied on four separate exclusions: (1) the employer's liability exclusion; (2) the injury to leased workers exclusion; (3) the injury to independent contractors exclusion, and (4) the injury to temporary, volunteer, or casual worker exclusion (collectively referred to as the "injury to workers exclusions").

Thereafter, Admiral filed a declaratory judgment action seeking a judgment that Admiral did not have a duty to defend or to indemnify Lippert, Kinro, and LCI as to the Williams personal injury lawsuit. The parties filed cross-motions for summary judgment solely on whether a duty to defend existed. Admiral argued that one of the four exclusions applied to preclude a duty to defend in light of the factual allegations and from reasonable inferences from the allegation that Williams was assigned to work at a facility owned by Kinro, that he was an "invitee," and that he was working with equipment, products, and instrumentalities owned by Kinro.

Lippert, Kinro, and LCI countered that the operative petition controls and, when read liberally in favor of coverage, does not unambiguously place Williams within any category of the policy's "injury to workers exclusion." Specifically, Lippert, Kinro, and LCI note that Williams alleged that he was an employee of Diversified Sourcing Solutions, was denied workers' compensation because he was not an employee of Lippert, Kinro, LCI, or a subsidiary, and that Williams's only relationship with Lippert, Kinro, or LCI was that of an invitee at the Kinro facility—none of which falls within the "injury to workers exclusions" enumerated definition of a worker. In response, Admiral contended that the following factual allegations allege the relationship between Kinro and Williams as employer – employee:

- that Williams was working with equipment, products and instrumentalities owned and provided by Kinro;
- that Williams alleged that Kinro did not subscribe to workers' compensation insurance (i.e., that "[o]nly an 'employer' can be a non-subscriber to workers' compensation, and that such an allegation is only relevant when asserting a claim against an employer.") and
- that Williams alleged that he was assigned to perform work at the Kinro facility

The Waco Court of Appeals disagreed and reasoned that "an equally plausible inference could be made that [Williams] was not working in any excluded capacity for any insured, particularly in light of the allegations that: (a) '[a]t all times material hereto, [Williams] was the employee of Diversified Sourcing Solutions and in the course and scope of [that] employment when he was injured,' and (b) [Williams] 'was expressly denied workers compensation benefits for not being an employee of Lippert Components or its subsidiaries.' " The appellate court also noted that Williams did not allege he was employed by or doing work for Lippert, Kinro, or LCI, nor did Williams allege the existence of a "staff leasing agreement" between Diversified and any insured, and that he did not allege he was a temporary worker, volunteer worker, casual worker, leased worker, or independent contractor, as required for one of the injury to workers exclusions to apply.

Lastly, the Court of Appeals refused to consider extrinsic evidence under *Monroe*[2] as there was no gap in the pleadings which prevented a determination of the duty to defend based on the factual allegations, and because the evidence proffered by Admiral contradicted the liability facts asserted in the lawsuit. As such, the Waco court upheld the trial court's decision and ruled that Admiral had a duty to defend.

THE U.S. DISTRICT COURT FOR THE SOUTHERN DISTRICT OF TEXAS FINDS THAT NO DUTY TO INDEMNIFY EXISTED WHERE A FINAL JUDGMENT WAS ACTUALLY AN INTERLOCUTORY ORDER[3]

Nenita Montgomery ("Montgomery") brought suit against the Greater Houston Transportation Company ("GHTC") alleging that she sustained injuries in an accident on January 2, 2020, when taxicab driver Dawit Afewerki ("Afewerki"), while acting in the course of his employment with GHTC, negligently dropped Montgomery onto her front porch while transporting Montgomery in a wheelchair from a taxicab to her home. GHTC filed an answer, but Afewerki did not. In April 2022, Montgomery filed her third amended petition wherein she alleged that Afewerki had been served but had not filed an answer. At the same time, counsel for GHTC was granted their motion to withdraw as counsel.

Approximately five-months later, Montgomery filed a traditional and no evidence motion for summary judgment against GHTC only. As GHTC was no longer represented by counsel, it failed to respond to the summary judgment motion of Montgomery. The trial court entered an order on August 19, 2022 finding that GHTC was negligent as a matter of law and vicariously liable for the negligent conduct of its employee, Afewerki. However, the August 2022 order did not hold that Afewerki himself was negligent – only that GHTC was negligent and liable for the damages sought by Montgomery.

Thereafter, on February 24, 2023, the trial court filed a notice of intent to dismiss for want of prosecution warning that the matter would be dismissed unless a motion to retain was filed, a default judgment against Afewerki was filed, or Afewerki filed an answer. No one responded to the dismissal notice from the trial court and, as such, on April 26, 2023, the trial entered an order dismissing the lawsuit "for failure to comply with the notice dated February 24, 2023."

In December 2024, counsel for Montgomery sent a letter to Mt. Hawley Insurance Company ("Mt. Hawley") demanding it satisfy the judgment (i.e., the summary judgment order) Montgomery had obtained against GHTC. Mt. Hawley refused and filed a declaratory judgment action against GHTC and Montgomery. The primary argument of Mt. Hawley was that the supposed "final judgment" was not in actuality final at all. Rather, it was, at best, an interlocutory judgment as it did not dispose of all parties and issues in that it did not resolve the claims against Afewerki.

The district court agreed with Mt. Hawley that the "final judgment" was not final and therefore, Mt. Hawley did not have a duty or legal obligation to indemnify GHTC or to pay Montgomery:

> [Montgomery] argues that the Interlocutory Summary Judgment Order is a final judgment because it disposed of all claims and all parties. As such, [Montgomery] argues "there was nothing to sever." In response, Mt. Hawley contends that [Montgomery] "fails to explain how the Interlocutory Summary Judgment Order that granted a motion for summary judgment against only GHTC – and not against Afewerki – could have possibly disposed of all claims and parties in the Underlying Lawsuit, including Montgomery's claims against Afewerki." The Court agrees with Mt. Hawley. In Montgomery's Third Amended Petition, a negligent undertaking cause of action was asserted against Afewerki. However, that claim is not addressed in the Interlocutory Summary Judgment Order.
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> Further, Mt. Hawley argues "if the court intended the interlocutory order to dispose of all parties and claims, the subsequent Notice and Order of Dismissal would not have been necessary." Again, the Court agrees with Mt. Hawley. .
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> Because the Order of Dismissal set aside the Interlocutory Summary Judgment Order, Montgomery did not ultimately attain a final judgment against GHTC. As such, [Montgomery] is not entitled to recover from Mt. Hawley. In light of this, the Court need not reach [Mt. Hawley's] arguments regarding GHTC's failure to (1) pay the self-insured retention and the corridor self-insured retention amounts or (2) take reasonable steps to avoid or minimize liability in the Underlying Lawsuit.

THE U.S. DISTRICT COURT FOR THE WESTERN DISTRICT OF TEXAS HELD THAT THE CGL INSURER WAS ENTITLED TO PURSUE SUBROGATION OR EQUITABLE RELIEF AS THOSE RIGHTS VESTED AT THE TIME DEFENSE COSTS WERE PAID[4]

Hunt Construction Group, Inc. ("Hunt") was the general contractor for the construction of the Manchester Austin Hotel (the "Hotel"). In its capacity as the general contractor, Hunt and subcontractor Shambaugh & Son, L.P., d/b/a Northstar Fire Protection of Texas ("Northstar") entered into a subcontractor agreement (the "Northstar Subcontract"), in which Northstar agreed to design, furnish, and install the fire protection system for the Hotel. Similarly, Hunt and subcontractor Cobb Mechanical Contractors, Inc. ("Cobb") also entered into a subcontractor agreement (the "Cobb Subcontract") (with the Northstar Subcontract, collectively the "Subcontracts"), in which Cobb agreed to design the mechanical and plumbing systems at the Hotel.

The Hotel's owner filed an arbitration asserting claims against Hunt arising out of the alleged negligent design and construction of the Hotel. Hunt filed claims against Northstar, Cobb, and other subcontractors; and Northstar and Cobb asserted cross-claims against Hunt. Hartford Fire Insurance Company ("Hartford") had issued to Hunt a consolidated general liability policy which provided coverage for certain types of damage arising out of the construction of the Hotel ("the Policy").

Northstar and Cobb were both Named Insureds under the Policy; accordingly, Hartford provided a defense to both Northstar and Cobb in the Arbitration. The Arbitration Panel's final award declared Cobb was a prevailing party and ordered Hunt to pay all of the fees Cobb requested that were associated with its defense against Hunt's claims and its prosecution of its own claims (Northstar had previously settled with Hunt). Cobb moved to enforce the Final Award in a confirmation lawsuit and Hartford filed a motion to intervene to recover the costs of Cobb's defense. The presiding judge denied Hartford's request on the basis that Cobb was not seeking to recover any fees paid by Hartford. Thereafter, Hunt and Cobb entered into a settlement agreement and moved to dismiss the confirmation suit with prejudice. The dismissal order stated that "Each party is to bear its own costs, attorneys' fees, and expenses."

Hartford filed a separate lawsuit against Hunt on the basis that the Subcontracts expressly provided that if the parties "proceed to arbitration or to court, that forum shall award to the prevailing party all of its attorney's fees, disbursements or costs . . . incurred in connection with the prosecution or defense of the dispute." Hartford sought to recover the $800,000.00 it had paid to defend Northstar and the $2,128,208.36 in attorneys' fees and defense costs of Cobb. Hunt challenged whether Hartford could legally recover as it did not have a viable subrogation claim because Hunt had settled with Cobb and Northstar.

In support of its position, Hunt argued that the Arbitration Panel's Final Award dismissed with prejudice all claims that Northstar had against Hunt, including any right to attorneys' fees and costs, and that in light of the Northstar Settlement Agreement and the Arbitration Panel's Final Award, Northstar has no right to recover further from Hunt and therefore neither does Hartford. Similarly, Hunt relied on the settlement with Cobb, the language in the dismissal order regarding each party paying their own attorney's fees, and expenses to contend that Hartford did not possess a viable claim for subrogation.

The Western District Court was not persuaded and held that Hartford could recover from Hunt:

> Hartford argues that Northstar and Cobb could not release Hartford's attorneys' fees claims because Hartford exclusively possessed the defense cost reimbursement claims upon paying for Northstar's and Cobb's defenses. After considering the parties' arguments, the court agrees with Hartford.
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> The Policy language supports Hartford's arguments that the right to attorneys' fees and costs was vested in Hartford as soon as either Subcontractor had the right to recover the fees and costs. The Policy states: "If the insured has rights to recover all or part of any payment, including Supplementary Payments, we have made under this Coverage Part, those rights ***are*** transferred to us." (emphasis in original). This language is present tense and not conditional upon any further act by Hartford or the Insured.
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> Case law also supports this position. In *City of Lubbock v. Payne*, 2011 Tex. App. LEXIS 4695 *3 (Tex. App.–Amarillo June 17, 2011), the court held that "once the subrogee's rights become fixed via payment, a change in the subrogor's ability to pursue a cause of action does not affect the subrogee's ability." In other words, "if (1) the subrogor enters into a settlement with and gives a release to the wrongdoer after such payment, (2) while the tortfeasor knows of the subrogee's rights of subrogation, and (3) the subrogee is not party to the settlement, then settlement does not bar the subrogee from enforcing its subrogation right." . . . .
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> Finally, public policy and common sense support this conclusion. Without such a conclusion, an insured could settle all claims, including attorneys' fees paid by the insurer, with a tortfeasor in exchange for a kickback or inflated settlement amount to dismiss the insurer's right to attorneys' fees. The court is not speculating that either Northstar or Cobb did so here, but must consider the possible implications if the court were to follow Hunt's reasoning.
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> The Subcontracts gave the prevailing party in any dispute the right to their defense costs. When the Arbitration Panel's Partial Award found the Subcontractors were "prevailing parties," their right to recover their defense costs came into existence. Under the Policy, because Hartford had already paid those costs, that right was immediately transferred to Hartford. Northstar and Cobb could only settle the rights and claims they had, and they no longer had the right to Hartford's defense costs. As such, neither Subcontractor had any ability, without Hartford's consent, to compromise or settle Hartford's rights. Accordingly, neither the settlement agreements themselves, nor the Arbitration Panel's Final Award including the Agreed Stipulation for Dismissal (in the case of Northstar), nor the court's order confirming the Final Award or dismissal (in the case of Cobb) could affect Hartford's right to recoup its defense costs from Hunt.
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> Consequently, Hartford's right to its defense costs has not been extinguished.

The District Court likewise dismissed the other arguments of Hunt and held that Hartford was entitled to recover the attorneys' fees and defense costs associated with the defense of Northstar and Cobb.

Interestingly, the Magistrate acknowledged that the issue of Hartford's right to subrogation was a challenging issue and intimated that it is likely that Hunt will file an appeal with the Fifth Circuit. We will monitor the matter to see if an appeal is filed.

THE U.S. BANKRUPTCY COURT FOR THE NORTHERN DISTRICT OF TEXAS HELD THAT A CGL INSURER DID NOT OWE AN ADDITIONAL INSURED A DEFENSE FOR CLAIMS BASED ON THE SOLE NEGLIGENCE OF THE ADDITIONAL INSURED[5].

Roofing Designs by JR, LLC ("Roofing Designs") served as the roofing subcontractor for the construction of an apartment complex located at 900 Winston Street in Houston, Texas (the "Apartments"). As part of its work, Roofing Designs subcontracted the labor installation of the roofing system to Bonifacio Tapia, operating through BMTL Roofing Specialist, LLC and BYTL Roofing Solutions, LLC (collectively, "Tapia"). According to Roofing Designs, the subcontract agreement required Tapia to procure commercial general liability insurance naming Roofing Designs as an additional insured, and Tapia obtained that coverage through a policy issued by Kinsale Insurance Company ("Kinsale").

Roofing Designs alleged that in May 2021, the roofing system was substantially complete when the general contractor, Royal American Construction ("RAC"), began reporting roof leaks and asserted a claim against Roofing Designs. In turn, Roofing Designs denied it was at fault and argued that the leaks stemmed from building-related problems such as plumbing, HVAC, and exterior deficiencies, rather than from any defect in the roofing system. Nevertheless, on June 16, 2021, RAC terminated its contract with Roofing Designs and later filed suit in the U.S. District Court for the Southern District of Texas asserting claims relating to Roofing Designs' installation work at the Apartments (the "RAC Lawsuit").

Roofing Designs sought a defense as an additional insured under the policy Kinsale had issued to Tapia ("the Tapia Policy"). In requesting a defense, Roofing Designs took the position that the RAC Lawsuit centered on roofing work performed by Tapia and his crew – even though Tapia was not included as a defendant in the RAC Lawsuit. Kinsale refused to provide Roofing Designs with a defense under the Tapia Policy.

Complicating the matter is the fact Kinsale had also issued a CGL policy to Roofing Designs and was providing it with a defense under that policy subject to a reservation of rights. After Kinsale settled the RAC Lawsuit, Roofing Designs brought suit against Kinsale to recover certain attorneys' fees and defense costs Roofing Designs should have been paid under the Tapia Policy. In the lawsuit, Roofing Designs also asserted claims for breach of contract, common law bad faith, and for violations of the Texas Insurance Code.

The core dispute was whether Roofing Designs should have been afforded coverage under the Tapia Policy as an additional insured and whether Kinsale should have done more to defend Roofing Designs under the Roofing Designs Policy. The initial issue was whether Roofing Designs qualified as an additional insured and then whether the factual allegations in the RAC Lawsuit created a duty to defend. The Tapia Policy included a standard additional insured endorsement which extended insured status to anyone Tapia was required to name as an additional insured – however, the scope of the AI coverage was "for vicarious liability imposed on the Additional Insured" that is "caused by the sole negligent conduct of the Named Insured and proximately caused by" the "Named Insured's work or product."

Thus, the AI endorsement imposed a two-part inquiry: a written contract requirement and a further requirement that the underlying allegations impose vicarious liability on the additional insured for the named insured's sole negligence arising out of the named insured's work for that additional insured. The Bankruptcy Court applied the eight-corners rule and examined the factual allegations in the RAC Lawsuit:

> The RAC Complaint asserted facts and claims ***only*** against Roofing Designs (emphasis in original). The RAC Complaint alleged that Roofing Designs engaged in negligent conduct, including deficient work, improper handling of materials, damage to property outside the scope of work, and negligent supervision and selection of subcontractors. Notably, the RAC Complaint contains no allegations that Roofing Designs was vicariously liable for Tapia's sole negligence. Because the RAC Complaint contained no allegations of negligence against Tapia and no allegations that Roofing Designs' liability was vicarious and caused solely by Tapia's negligence, Roofing Designs did not qualify as an additional insured for purposes of the RAC Lawsuit. Thus, Kinsale owed no duty to defend Roofing Designs under the Tapia Policy as a matter of law.
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> For similar reasons, Roofing Designs has not plausibly alleged any duty to indemnify under the Tapia Policy. As previously discussed, coverage under the Tapia Policy's additional insured endorsement is limited to vicarious liability arising from Tapia's sole negligence. Roofing Designs does not allege facts establishing that any settlement or judgment imposed liability on Roofing Designs solely due to Tapia's negligence.
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> The Roofing Designs Policy presents a different posture. Kinsale defended Roofing Designs in the RAC Lawsuit under the Roofing Designs Policy and resolved RAC's claims against Roofing Designs through settlement. Accordingly, the remaining issues are not whether Kinsale owed a defense under the Roofing Designs Policy, but whether Roofing Designs has plausibly alleged a breach of any contractual or statutory duty based on Kinsale's denial of Tapia Policy coverage or based on litigation strategies such as the pursuit of Roofing Designs' counterclaims or third-party actions.
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> Finally, it cannot be ignored that in opposing dismissal, Roofing Designs relies in part on authorities that are not verifiable or are plainly inapplicable. The Court does not consider citations to non-existent opinions or authorities that cannot be substantiated [and may lead to sanctions against counsel for Roofing Designs].

Of note is the fact the Bankruptcy Court reiterated that Texas law is well settled that a liability insurer's duty to defend "does not include an obligation to pay for or pursue affirmative claims" pointing out that the Fifth Circuit has likewise observed that "[n]o Texas court has ever held that the duty to defend includes the duty to pay legal fees incurred in the course of prosecuting affirmative claims that are inextricably intertwined with the defense." Ultimately, based on the absence of a duty to defend or to indemnify under the Tapia Policy, the Court dismissed all of Roofing Designs' claims against Kinsale.

FEDERAL COURT ANALYZES DUTY TO DEFEND AN ADDITIONAL INSURED FINDING THAT THE SUBCONTRACT WHICH REQUIRED ADDITIONAL INSURANCE WAS NOT IMPERMISSIBLE EXTRINSIC EVIDENCE.

In *Arlanxeo USA, LLC*,[6] the policy providing additional insurance provided same to "any Owner, Lessee or Contractor whom you have agreed to include as an additional insured under a written contract or purchase order, and any other person or organization you are required to add as an additional insured under this contract or purchase order, but only to the extent of the Named Insureds obligation to defend or indemnify pursuant to a written contract that was executed prior to the date of loss." The carrier (ACE) denied the additional insured's tender for defense and indemnity and the additional insured sued. The court concluded the carrier owed a defense to the additional insured (Arlanxeo). To analyze the carrier's duty to defend Arlanxeo, because Arlanxeo was only an additional insured under the policy "to the extent of" the insured's obligations under the contract, the court examined the allegations in the pleading against the contract obligations, concluding that ACE owed a defense to Arlanxeo under the policy's additional insured provisions. The court did not refuse to consider the contract on the basis it was extrinsic evidence. With respect to Arlanxeo's contractual indemnity claim against Turner for defense and indemnity with respect to the underlying bodily injury lawsuit, the court also concluded Turner's contractual duty to defend Arlanxeo was triggered by the pleadings. Turner argued that Arlanzeo improperly relied on extrinsic evidence to trigger the duty to defend, arguing that Arlanxeo cannot refer to other provisions of the agreement because that would be "a request that the court consider extrinsic evidence to determine whether the petition triggers the duty to defend." Arlanxeo responded that other provisions of the agreement are not extrinsic evidence (citing In re Deepwater Horizon). Citing to In re Deepwater Horizon, the court stated that the parties agreed that courts "determine the scope of coverage from the language employed in the insurance policy" and that "if the policy directs [courts] elsewhere, [they] will refer to an incorporated document to the extent required by the policy." The court further stated that the Agreement directs the court to look to Turner's "obligations under this agreement" and that the Agreement's duty to defend incorporates by reference the duties that the Agreement imposes on Turner. The court concluded that Arlanxeo "does not rely on extrinsic evidence to determine Turner's duty to defend" and that its argument is consistent with the Texas Supreme Court's directions on applying the eight-corners rule."

THE EASTLAND COURT OF APPEALS HOLDS THAT NEITHER A RIDESHARE DRIVER'S PERSONAL AUTO POLICY NOR THE RIDESHARE COMPANY'S COMMERCIAL AUTO POLICIES PROVIDE COLLISION COVERAGE TO THE DRIVER'S VEHICLE WHEN NOT EN ROUTE TO PICK UP A PASSENGER.

The case of *Neeley v. Lyft, Inc.*[7] arose from a four-vehicle collision involving a Lyft driver, Neeley. Neeley was logged into Lyft but did not have a passenger in the car when the accident occurred. Neeley received a $30,000 estimate for the repair of his vehicle and submitted a claim to Liberty, his personal insurer and the business auto insurance and business liability carrier for Lyft. Neeley's personal auto policy included an exclusion for a loss that occurred during the period of time the vehicle was being used by a person who is logged into a transportation network platform as a driver, regardless of whether there was a passenger in the vehicle. Lyft's auto policy included an endorsement limiting coverage to situations in which a driver is using the network app, has accepted a request for services, and is in one of four stages of transporting a passenger. Liberty denied Neeley's claim for collision coverage. Neeley sued Liberty and Lyft for breach of contract, Insurance Code violations, DTPA violations, and fraud. Defendants moved for summary judgment, which the trial court granted. Neeley appealed.

The court of appeals affirmed in part and reversed and remanded in part. First, the court addressed Neeley's breach of contract claim. Liberty argued that it didn't breach the policy because there was no evidence that Neeley's claim was covered under his personal auto policy, which excluded coverage when the driver was logged in to the network app, or Lyft's policy, which didn't cover collision coverage when the driver was logged into the network but hadn't accepted a request for transportation services. The court agreed with Liberty and affirmed summary judgment on that claim.

Next came the Chapter 541 bad faith claim. Liberty challenged the damages element, arguing that Neeley couldn't recover for Insurance Code violations because he had no right to benefits under the policies and the independent injury rule didn't apply. As to the first prong, Liberty already conclusively established that Neeley had no right to receive collision coverage benefits from either policy. The question then became whether Neeley pleaded damages for injuries independent of any policy benefits. The court found that all of Neeley's claimed damages flowed directly from the loss of policy benefits, not any independent injury. Liberty thus conclusively negated an essential element of Neeley's bad faith claim and was entitled to summary judgment on that issue.

Moving on to the fraud claim, Neeley argued that Lyft and Liberty had a duty to explain the gap in coverage between the two policies and acted fraudulently by intentionally failing to disclose the information. Under Insurance Code § 1954.101, a transportation network company must disclose in writing the company's insurance coverage and limits and that the driver's personal insurance may not provide coverage when the driver is logged in to the network app. Lyft argued that it followed the law. Neeley argued that Lyft's website led him to believe that he was covered any time the app was engaged. Observing that a website is not a contract, the court nevertheless interpreted the webpage's language according to its plain meaning, concluding that it informed drivers that coverage was only available "once a ride request is accepted, not simply when the app is on." The webpage was thus unambiguous, and Neeley's interpretation was unreasonable. The trial court properly granted summary judgment for Lyft on the fraud claim. But Neeley also pleaded a statutory failure to disclose claim, which Lyft neglected to address in its motion for summary judgment. Because it didn't challenge that pleaded cause of action in Neeley's live petition, the trial court erred in granting summary judgment on that claim.

As to Neeley's fraud and failure to disclose claims against Liberty, Neeley admitted that Liberty never made any disclosures to Neeley, "much less one of misrepresentation." Liberty also proved conclusively that its policies were not ambiguous, and that Neeley's claim in his second amended petition that Liberty mislead him by way of Lyft's allegedly misleading website, didn't create a duty on Liberty's part to disclose anything to Neeley. Insurance company agents "generally [have] no duty to explain policy terms to an insured," and there was no reason to change the law here. Even if the trial court erred in granting summary judgment on Neeley's nondisclosure claim, which Liberty didn't directly address in its summary judgment motion, the error was harmless.

Turning to the DTPA claims, the court observed that Lyft did not specifically address that claim in its summary judgment motion and didn't amend the motion after Neeley added the DTPA claim in his second amended petition. But in this instance, the court determined that the DPTA claims in Neeley's second amended petition were based on the same facts alleged in his first amended petition, i.e. they involved the same "false representations" alleged in Neeley's fraud claim.

The court, consequently, construed Lyft's summary judgment motion as broad enough to cover the DTPA claims as well. And since the record contained no evidence of any false or misleading representation by Lyft, the trial court properly granted summary judgment on those claims. Neeley further pleaded a statutory failure to disclose claim under § 17.46(b)(24), Business & Commerce Code. Because Lyft failed to address this theory in its summary judgment motion and the court could not stretch the motion to cover this theory, the court found error and sent the issue back to the trial court. As to Liberty, however, the trial court properly granted summary judgment on Neeley's DTPA claims because there was no independent injury upon which to base DTPA damages.

A COURT OF THE SOUTHERN DISTRICT OF TEXAS GRANTED A PRIMARY INSURER'S MOTION FOR SUMMARY JUDGMENT AGAINST AN EXCESS INSURER, HOLDING THAT THE PRIMARY INSURER IS ENTITLED TO EQUITABLE CONTRIBUTION FOR PAYMENT BEYOND ITS PROPORTIONATE SHARE OF THE LIABILITY.

Allstate Indem. Co. v. Fed. Ins. Co., involved a declaratory judgment action between Allstate Indemnity Company and Federal Insurance Company.[8] In the underlying lawsuit, Makenzy Cornell sued Kendall Jordan for substantial bodily injury that she suffered in a car crash with Jordan. Cornell demanded $1.25 million to settle the claims against Jordan. Defense counsel strongly recommended that the insurers pay the settlement. Allstate sent multiple letters to Federal to obtain its assent to the settlement and to a pro rata split of the $1 million in excess of the $250,000 primary auto policy limit. Federal never responded. With the settlement deadline imminent, Allstate, unable to coordinate with Federal, paid the $1.25 million for a full release of Cornell's claims. Allstate then sued Federal to recover the $910,000 pro rata share of the settlement agreement that it contends Federal should have paid. Federal argued Allstate's payment was voluntary, but the court found it was involuntary because it was made in good faith to protect the insured based on defense counsel's recommendation and reasonable belief in the settlement's necessity.

The court addressed whether the *Mid-Continent Insurance Co. v. Liberty Mutual Insurance Co.* decision bars Allstate's contribution claim in cases involving conflicting 'other insurance' clauses. The court analyzed conflicting 'other insurance' clauses in Allstate's umbrella policy and Federal's excess policy. The Allstate umbrella policy required coverage only after exceeding 'the sum of' the auto policy and other applicable insurance, while the Federal policy required coverage 'in excess of all underlying insurance.' The court found these conflicting provisions created a common obligation for pro rata contribution, distinguishing the case from Mid-Continent where pro rata clauses limited contribution rights. It concluded that Mid-Continent's limitations do not apply here for three reasons:

1. Federal did not respond to the settlement demand, resulting in the case being more like a case in which coverage is disputed. The court concluded that if the rule of *Mid-Continent* applied in this situation, it would encourage insurers to avoid responding to fair and reasonable settlements in the hopes that the other insurer pays, ultimately frustrating the goals of Texas insurance law;
2. unlike *Mid-Continent*, conflicting "other insurance" clauses bind both Allstate and Federal to pay the entire loss in excess of the primary auto limit. The court acknowledged Federal's argument that there was a genuine factual dispute as to whether the contract's "other insurance" clauses were conflicting but held that Federal's answer conceded that they did conflict; and
3. Allstate's payment was not voluntary. Having determined that Allstate and Federal shared a common obligation, as each of the policies covered the settlement, the only remaining consideration was whether Allstate made a compulsory payment of more than its fair share of that settlement. The court noted that the record shows that Allstate based its decision to settle on counsel's confidence that the $1.25 million settlement would be eminently reasonable given the life care plan and other damages documentation and testimony that would be admitted into evidence that could result in a judgment against the insured far in excess of $1.25 million. Further, defense counsel strongly recommended that the carriers pay the $1.25 million for a full release of the insured. The court held that Federal failed to offer evidence on which a reasonable jury could find the settlement was voluntary. As such, Federal's reliance on *Mid-Continent's* conclusion that the excess payment in that case was voluntary does not alter the court's decision in this matter. The court held that because there were conflicting "other insurance" clauses here, each co-insurer's liability was not confined to only a proportion of the loss.

Federal's final argument claimed its non-breach of *Stowers* duty precluded Allstate's contribution claim. The court rejected this, noting Allstate's tender of policy limits triggered Federal's Stowers duties and that Stowers does not negate Allstate's independent right to contribution. The court stated that even if *Stowers* were relevant, it did not preclude Allstate's contribution claim. The court concluded that Federal's argument failed because Allstate, by informing Federal of the settlement and proffering the primary insurance policy's limits, triggered the excess insurers' Stowers duties.

The court concluded that the undisputed facts entitled Allstate to summary judgment on its contribution claim. Allstate and Federal had a common obligation to insure Jordan against the claims that Cornell brought against him, and Allstate made a fair and reasonable settlement payment to Cornell in service of its legal obligations to Jordan. Because Allstate paid more than its fair share of its legal obligation to settle Jordan's claims, it has a right to pro rata contribution from Federal.

THE SUPREME COURT OF TEXAS HELD THAT A HOMEOWNER'S POLICY DEDUCTIBLE APPLICABLE TO COVERED LOSSES CAUSED BY A "WINDSTORM OR HAIL" UNAMBIGUOUSLY APPLIES TO DAMAGE CAUSED BY A TORNADO AND REINSTATED SUMMARY JUDGMENT FOR THE INSURER

In *Privilege Underwriters Reciprocal Exchange v. Mankoff*, the Supreme Court of Texas addressed whether an undefined "Windstorm or Hail" deductible in a homeowners policy applied to a loss caused by a tornado. The Court held that it did, concluding that the ordinary meaning of "windstorm" unambiguously includes a tornado. The Court reversed the Dallas Court of Appeals and reinstated the trial court's summary judgment in favor of the insurer.

The dispute arose from tornado damage to a residential home owned by Jeff and Staci Mankoff ("Mankoffs" or "insureds") in 2019. After the loss, Privilege Underwriters Reciprocal Exchange ("Privilege Underwriters" or "carrier" or "insurer") paid only a portion of the claim, taking the position that the policy's $87,156 "Windstorm or Hail Deductible" applied. The deductible provided that, for direct physical loss caused directly or indirectly by "windstorm or hail," the insured would bear the deductible amount stated in the declarations for dwelling, other structures, and contents. However, the policy did not define the term "windstorm." The insureds sued for breach of contract, contending that a tornado is a peril distinct from a windstorm and that the carrier therefore improperly reduced the claim payment by applying the windstorm deductible.

The parties filed cross-motions for summary judgment disputing whether "windstorm" as used in the policy encompassed a tornado. The trial court granted summary judgment for the insurer and rendered a take-nothing judgment against the insureds. However, a divided Dallas Court of Appeals reversed the take-nothing judgment, holding the deductible was ambiguous because "windstorm" was undefined and, in that court's view, susceptible to more than one reasonable meaning, including a meaning that excluded tornadoes. The Texas Supreme Court granted review and disagreed.

The Court began with familiar Texas insurance-interpretation principles. Because the policy did not define "windstorm," and nothing in the policy showed the parties intended a technical or specialized meaning, the Court applied the term's plain, ordinary meaning. The Court reiterated that a policy is not ambiguous simply because parties offer competing interpretations. Rather, ambiguity exists only if the language is genuinely susceptible to two or more reasonable meanings, and because the deductible operated as a limitation on coverage, this rule, which clearly favors the insureds, would apply only if ambiguity actually existed.

From there, the Court looked first to dictionary definitions. It noted that standard dictionaries consistently define "windstorm" as a storm marked by high, strong, or violent wind, often with little or no precipitation. The Court reasoned that the common thread in those definitions is the presence of violent or strong wind. It then compared those definitions to dictionary definitions of "tornado," which uniformly describe a tornado as a violent, destructive, rotating column or movement of air. Some dictionaries went even further and expressly defined a tornado as a type of windstorm. Based on those sources, the Court concluded that a tornado falls comfortably within the ordinary meaning of "windstorm."

The insureds attempted to avoid that conclusion by focusing on the "little or no precipitation" wording in the dictionary definitions and arguing that tornadoes are precipitation events. The Court rejected that reasoning. It explained that even if a tornado forms within a broader storm system involving significant precipitation, that surrounding weather event is distinct from the tornado itself. In the Court's view, the relevant question was not whether every larger storm system containing a tornado is itself a "windstorm," but whether a tornado, considered on its own, qualifies as a windstorm. The Court answered that question yes, emphasizing that the broader weather conditions accompanying the tornado does not change the tornado's characteristics as a violent wind event.

The Court was likewise unpersuaded by the insureds' reliance on statutes, media usage, encyclopedia entries, and a meteorologist's opinion. Various Texas statutory provisions listed "windstorm" and "tornado" separately, but the Court held that those lists did not create a specialized ordinary meaning excluding tornadoes from the broader term. The Court also found that the non-dictionary sources cited by the insureds did not show that "windstorm" ordinarily excludes tornadoes. At most, those sources reflected that not all windstorms are tornadoes, not that tornadoes are something other than windstorms.

In reaching its holding, the Court also discussed prior authority. It distinguished the Fifth Circuit's decision in *Landmark American Insurance Co. v. SCD Memorial Place, L.L.C.*, explaining that *Landmark* addressed policy context and covered perils, not the ordinary meaning of "windstorm."[9] By contrast, the Court found support in *Fireman's Insurance Co. v. Weatherman*, a 1946 Texas court of appeals decision approving a definition of "windstorm"broad enough to encompass the whirling features associated with tornadoes and cyclones.[10] According to the Court, that history confirmed that courts and parties have long treated tornadoes as a subtype of windstorm rather than as a categorically different kind of storm.

Accordingly, the Supreme Court of Texas held that the term "windstorm," when undefined in a homeowner's policy, is not ambiguous and that its ordinary meaning includes a tornado. Because the damage to the Mankoffs' property was caused by a tornado, the claim was subject to the policy's "Windstorm or Hail" deductible. The Court therefore reversed the court of appeals' judgment and reinstated the trial court's take-nothing summary judgment for the insurer.

For carriers and adjusters, this opinion reaffirms that, under Texas law, undefined policy terms are given their plain, ordinary meaning and are not ambiguous simply because competing interpretations are offered, particularly where dictionary definitions establish a clear and consistent meaning.

THE U.S. DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS GRANTED SUMMARY JUDGMENT FOR THE INSURER, HOLDING THE COSMETIC DAMAGE ENDORSEMENT IN THE HOMEOWNER'S POLICY BARRED COVERAGE

In *Mike Nguyen v. Allstate Vehicle and Property Insurance Company*,[10] the United States District Court for the Northern District of Texas addressed whether a homeowner's policy provided coverage for alleged hail damage to a metal roof and resulting interior water intrusion. The Court concluded it did not provide coverage. Enforcing the policy's Cosmetic Damage Endorsement and excluding the insured's expert testimony on causation, the Court granted summary judgment for Allstate and dismissed all claims with prejudice.

The claim arose from a May 1, 2022 hailstorm in Hereford, Texas. The insured, Mike Nguyen ("Nguyen" or "homeowner"), reported damage to his property, including water intrusion in the garage. Allstate investigated and acknowledged that hail caused some exterior damage, but concluded that the roof damage was cosmetic and therefore excluded from coverage under the policy. The endorsement excluded "cosmetic damage" to a metal roof caused by hail unless the damage resulted in water leaking through the roof surface.

Although Allstate issued limited payments for covered exterior damage after revising its estimate, it maintained that the roof itself was not covered. The homeowner later submitted a significantly higher repair estimate driven largely by a full roof replacement, and filed suit asserting breach of contract, bad faith, and statutory violations.

The Court first addressed Allstate's Motion to Exclude the homeowner's expert witnesses. The Court excluded the causation opinions of the homeowner's primary expert, finding that the expert failed to connect the alleged roof damage to the May 1 storm or to any specific date within the policy period. While the expert identified signs of hail damage, he did not attempt to date the damage or rule out prior storms, despite there being evidence of multiple hail events impacting the property. Because Texas law requires the insured to establish that covered damage occurred during the policy period, the Court held the expert's causation opinions were irrelevant and inadmissible.[11]

The Court also excluded the insured's rebuttal expert in full, finding that the report did not actually rebut the insurer's experts but instead offered an independent analysis. The court emphasized that rebuttal experts must specifically address and contradict the opposing expert's findings—not simply present an alternative theory of the case.[12]

Turning to the breach of contract claim, the Court reiterated that insurance policy interpretation is a question of law governed by the plain language of the contract. The Cosmetic Damage Endorsement strictly barred coverage for hail-related cosmetic damage unless it resulted in water seeping through the roof surface. Allstate met its burden to establish the applicability of the exclusion through expert testimony opining that the roof damage was purely cosmetic and did not impair the roof's function or cause leakage. Both of Allstate's experts agreed that the interior leak originated from defective flashing—not hail damage.

The burden then shifted to the homeowner to raise a genuine issue of material fact or establish an exception to the exclusion, which he failed to do. Without admissible expert testimony on causation, the homeowner relied primarily on his own lay opinion that hail caused the leak. The Court rejected this evidence, holding that a lay witness is not competent to offer opinions on causation in a complex property damage case.

Because the homeowner failed to produce competent evidence that hail caused non-cosmetic damage resulting in water intrusion, the Court held that the Cosmetic Damage Endorsement barred coverage as a matter of law. Accordingly, summary judgment was granted on the breach of contract claim.

The Court likewise disposed of the insured's extra-contractual claims. Relying on Texas Supreme Court precedent, the court reiterated that there can be no bad faith claim where the insurer properly denies a claim that is not covered. The Court also found no evidence of an independent injury that would allow such claims to proceed under the *Menchaca* precedent.[13] Finally, the court dismissed the homeowner's claim under the Texas Prompt Payment of Claims Act, emphasizing that liability under the statute requires a finding that the insurer is liable under the policy, but because no coverage existed, the statutory claim failed. Accordingly, the court granted Allstate's Motion for Summary Judgment in its entirety and dismissed the case with prejudice.

This case reaffirms the critical role of cosmetic damage endorsements in metal roof claims and highlights the necessity of competent expert testimony to establish causation, especially where multiple potential storm events exist.

THE U.S. DISTRICT COURT FOR THE SOUTHERN DISTRICT OF TEXAS GRANTED SUMMARY JUDGMENT FOR THE INSURER, HOLDING THE FROZEN PLUMBING EXCLUSION BARRED COVERAGE AND PRECLUDED ALL EXTRA-CONTRACTUAL CLAIMS

In *Arturo Barona v. State Farm Lloyds, the United States District Court for the Southern District of Texas* addressed whether a commercial property policy provided coverage for water damage caused by burst frozen pipes. The Court concluded the policy did not provide coverage for the water damage upon applying the unambiguous "Frozen Plumbing" exclusion and its narrow exceptions. The Court held that the insured failed to satisfy the conditions necessary to restore coverage and granted summary judgment in favor of the carrier on all claims.

The dispute arose from a December 24, 2022 freeze event that caused plumbing fixtures at the insured's commercial property to allegedly freeze and burst, resulting in significant water damage. The insured, Arturo Barona ("Barona"), reported the loss to State Farm, which investigated the claim and determined that coverage was barred under the policy's "Frozen Plumbing" exclusion. Notably, during the inspection and later in his deposition, Barona admitted that he intentionally turned off the heat in the building and did not drain the plumbing system or shut off the water supply. State Farm denied the claim on January 24, 2023, citing the exclusion and the insured's failure to meet its exceptions.

The policy provided coverage for "accidental direct physical loss" but expressly excluded damage caused by frozen plumbing unless the insured either (1) used best efforts to maintain heat in the building, or (2) drained the system and shut off the water supply if heat was not maintained. Several months after completing repairs, Barona demanded appraisal and payment exceeding $113,000. State Farm declined to participate in appraisal, asserting that Barona had already repaired the property—thereby making the appraisal unnecessary—and that the dispute concerned coverage, not the amount of loss. Barona then filed suit asserting breach of contract and multiple extra-contractual claims, including bad faith, violations of the Texas Insurance Code, the Deceptive Trade Practices Act, and the Texas Prompt Payment of Claims Act ("TPPCA").

On summary judgment, the Court first addressed evidentiary objections to State Farm's claim file and supporting declaration by overruling Barona's authentication objections and holding that the insurer's business records were adequately supported by a custodian declaration. Importantly, the Court noted that Barona's own deposition testimony independently confirmed the key facts underlying the denial.

When analyzing Barona's breach of contract claim, the Court emphasized that under Texas law, policy terms are given their plain and ordinary meaning and must be enforced as written when unambiguous.[14] The Court found no ambiguity in the "Frozen Plumbing" exclusion or its exceptions. Applying those terms to the undisputed facts, the Court held that Barona could not satisfy either exception. First, Barona admitted he intentionally turned off the heat during freezing conditions, which the court found was the opposite of "doing your best to maintain heat." Second, Barona admitted he did not drain the plumbing system or shut off the water supply after turning off the heat. Because neither exception applied, the exclusion barred coverage as a matter of law.

The Court also rejected Barona's alternative breach theory based on State Farm's refusal to participate in appraisal. Citing Texas Supreme Court precedent, the court reiterated that appraisal clauses are limited to disputes over the "amount of loss," not liability.[15] Here, the dispute centered entirely on whether the policy afforded coverage, not the amount of damages. Accordingly, the Court held that State Farm had no contractual obligation to participate in appraisal.

Having determined there was no coverage, the Court disposed of all extra-contractual claims. Relying on *USAA Tex. Lloyds Co. v. Menchaca* and related authority, the Court reiterated that when coverage is resolved in the insurer's favor, extra-contractual claims generally cannot survive.[16] The Court found that State Farm had a reasonable basis for denying the claim based on the plain policy language and the insured's own admissions. As a result, the bad faith claims, including the insured's claims under Chapter 541 of the Texas Insurance Code and the DTPA, all failed as a matter of law. Finally, the Court dismissed the TPPCA claim, holding that such claims require a showing that the insurer is liable under the policy. Because the Court found no contractual obligation to pay the claim, Barona could not recover under the statute. Accordingly, the Court granted State Farm's motion for summary judgment in its entirety and dismissed the case with prejudice.

For adjusters and carriers, this matter reinforces the importance of clearly worded freezing exclusions and confirms that an insured's failure to comply with straightforward policy conditions—particularly where admitted under oath—can be dispositive not only of coverage but of all related extra-contractual claims.

PROFESSIONAL LIABILITY OPINIONS

THE U.S. DISTRICT COURT FOR THE WESTERN DISTRICT OF TEXAS DENIES SUMMARY JUDGMENT FOR THE INSURER, HOLDING THE UNDERLYING PETITION HUMAN TRAFFICKING CLAIM ALLEGED A POTENTIAL PROFESSIONAL SERVICE AND THAT THE BUSINESS ENTERPRISE EXCLUSION DID NOT APPLY BASED ON A STRICT-EIGHT CORNERS ANALYSIS

The underlying complaint in *Med. Protective Co. v. Mrugeshkumar Shah*[17] alleged that Defendants, including the insured, Shah, a doctor, "conspired together to commit various unlawful predicate acts, including coercion, human trafficking, dealing in controlled substances, and wire fraud" and that the insured, Shah had liability under the Trafficking Victims Protection Act. Specifically, Shah allegedly prescribed controlled substances to the underlying Plaintiff, which is what allowed "[the Defendants] to force [Plaintiff Hubbard] to perform commercial sex acts against her will."

Medical Protective Company ("MedPro") filed a declaratory judgment seeking a determination that it did not owe Shah coverage (defense or indemnity) under his professional liability policy. In pertinent part, MedPro argued that it was entitled to judgment as matter of law because the Plaintiffs did not allege that they have been treated by Shah, and thus, none of their claims are based on "professional services" as defined by the Policy, and that the Business Enterprise exclusion applied. In relevant part, the Policy defined "professional service" as the "rendering of medical, surgical, dental, or nursing services to a patient and the provision of medical examinations, opinions, or consultations regarding a person's medical condition with the Insured's practice as a licensed health care provider. This shall include first aid rendered at the scene of an accident without expectation of monetary compensation." Additionally, the policy included an indemnity only exclusion for damages that are the consequence of the performance of a criminal act or willful tort or sexual act. The Court was not persuaded that there was no "professional service," as the allegations "form the basis or foundation of the claims against him, at least potentially," there being a professional service. Notably, it was alleged that the Plaintiff "visits" Shah who was "prescribing controlled substances." The Court concluded that these allegations were sufficient to allege a professional service. Regarding the Business Enterprise exclusion, it precluded coverage for "[a]ny liability arising from activity of an Insured . . . as a proprietor, shareholder, officer, administrator, committee member, director, or medical director of any hospital, sanitarium, clinic, nursing home, surgicenter, blood bank, commercial laboratory, health maintenance organization, preferred provider organization, or other professional or business enterprise . . . " The court noted that there were no allegations that Shah participated as a "proprietor, shareholder, officer, administrator, committee member, director, or medical director" of the defendants' criminal venture. Thus, the Court denied the Motion for Summary Judgment as to the duty to defend and denied without prejudice to refile as to the duty to indemnify.

MOTOR CARRIER OPINIONS

NORTHERN DISTRICT OF TEXAS HOLDS THAT THE MCS-90 ENDORSEMENT DOES NOT CREATE A DUTY TO DEFEND, A DUTY TO INDEMNIFY, NOR A STOWERS DUTY TO SETTLE.

The case of *Taghavi v. Brooklyn Specialty Insurance Company RRG, Inc.*[18] arose from a prior personal injury lawsuit in the Northern District of Texas in which Plaintiff Maghsoud Taghavi obtained a default judgment of $1,746,017.03, jointly and severally, against defendants Enrique Leblanc, Y&S Trucking, LLC ("Y&S"), and Ignacio Iser. Prior to entry of the default judgment, Taghavi had issued a Stowers demand which was not responded to by Y&S' insurer, Brooklyn Specialty Insurance Company Risk Retention Group, Inc. ("BSIC"). Following entry of that judgment, Taghavi obtained a turnover order from the Court awarding him all rights and title to the judgment debtors' causes of action against BSIC. Armed with that turnover order, Taghavi filed a new lawsuit directly against BSIC, asserting claims for breach of contract, violations of the Texas Insurance Code, Stowers liability, and seeking a declaratory judgment that BSIC was obligated to pay the judgment under the MCS-90 endorsement contained in Y&S's motor carrier policy.

Ultimately, BSIC moved to dismiss all claims arguing that none of the asserted causes of action were legally cognizable under the facts as pleaded. Taghavi responded and simultaneously moved for leave to file an amended complaint. The Court began its analysis by reaffirming the well-established principle that an MCS-90 endorsement is not insurance in the traditional sense. Rather, as the Fifth Circuit has consistently held, the MCS-90 creates a suretyship — a three-party relationship in which the insurer (as surety) undertakes to pay certain final judgments against the insured motor carrier to protect the public, even when the underlying insurance contract would have otherwise excluded coverage.

With regard to the Stowers claim, the Court held that the insurer's duty to settle does not arise under an MCS-90 endorsement. The Stowers duty — which requires an insurer to exercise ordinary care in evaluating and accepting reasonable settlement demands within policy limits — flows from the insurer's contractual obligations to defend and indemnify the insured. Accordingly, the Court held that the rationale underlying the Stowers doctrine simply does not apply in the MCS-90 context. Therefore, the Court dismissed the Stowers claim with prejudice.

Next, the Court similarly found that Taghavi had not plausibly pleaded a cognizable breach of contract claim. Specifically, the Court noted that Taghavi's entire contractual theory rested on the MCS-90 endorsement. However, because the MCS-90 does not itself impose a duty to defend or indemnify, no breach of contract claim could be sustained absent allegations identifying other policy provisions that would independently impose those duties.

Finally, the Court noted that prior Texas case law had held that Chapter 541 remedies are personal and punitive in nature to the insured and, like DTPA claims, cannot be assigned or turned over to a third party. In the present case, the Court reasoned that Taghavi obtained his standing to assert these claims solely through the turnover order, the Chapter 541 claims were unavailable to him as a matter of law. However, with regard to the Chapter 542 claim ("Prompt Payment claim"), the Court noted that the Prompt Payment claim only applied to first-party claims. Accordingly, the Court dismissed Taghavi's Prompt Payment claim because it was entirely based upon payment of the Default Judgment, which unequivocally constitutes a third-party claim for indemnity.

This case serves as an important reminder for motor carrier insurers of the distinct and limited nature of the MCS-90. The endorsement obligates the insurer to satisfy final judgments against the insured motor carrier for the protection of the public — nothing more. The MCS-90 does not create a duty to defend, a duty to indemnify, or a duty to settle pre-judgment demands. Accordingly, motor carrier insurers should not treat a MCS-90 endorsement as expanding an insurer's obligations beyond what the underlying policy otherwise provides. Additionally, this case underscores that Texas Insurance Code Chapter 541 claims solely belong to the insured and cannot be assigned to another party. Finally, this case supports the position that Prompt Payment claims are limited to first-party claims.

SOUTHERN DISTRICT OF OHIO HOLDS THAT A MOTOR CARRIER LIABILITY POLICY COVERS BOTH BROKER AND MOTOR CARRIER LIABILITY, AND THAT AN "OTHER INSURANCE" EXCESS CLAUSE RENDERS A MOTOR CARRIER LIABILITY POLICY EXCESS TO A TRANSPORTATION BROKER POLICY CONTAINING AN ESCAPE CLAUSE WHEN THE INSURED IS ACTING AS A BROKER.

The case of *National Union Fire Insurance Company of Pittsburgh, PA v. TT Club Mutual Insurance Ltd.*,[19] arose from a fatal motor vehicle accident that occurred on March 26, 2019, when a tractor-trailer driven by an employee of Simbad LLC ("Simbad") rear-ended a passenger vehicle on an Ohio highway, killing one occupant and seriously injuring another. Greatwide Dallis Mavis LLC ("Greatwide"), a company offering both broker and motor carrier services, had contracted with Alton Steel, Inc. ("Alton Steel") to haul a shipment of steel from Illinois to Ohio. Greatwide subsequently assigned the load to Simbad to perform the actual delivery.

The victims of the crash filed suit against Greatwide, Simbad, and the driver. Specifically, the victims alleged that Greatwide knew Simbad and its drivers were unsafe and asserting a number claims including a claim for negligence. It should be noted that the allegations by the victims alleged that Greatwide was liable both in its capacity as a broker and as a motor carrier. The underlying lawsuit settled on a 50/50 basis between two of Greatwide's insurers, National Union Fire Insurance Company of Pittsburgh, PA ("National Union") and TT Club Mutual Insurance Ltd. ("TT Club"). In agreeing to pay the settlement, both insurers agreed to reserve their rights to seek recovery from each other in a subsequent coverage lawsuit. In addition, the coverage lawsuit implicated a third insurer, United Specialty Insurance Company ("USIC"), who was never notified of the underlying lawsuit or settlement until it was added to the subsequent coverage lawsuit.

The coverage lawsuit centered on four policies issued to Greatwide: (1) a National Union Motor Carrier Liability Policy ("MCL Policy") with a $2,000,000 per accident limit; (2) a National Union Commercial General Liability Policy ("CGL Policy") with a $1,000,000 per occurrence limit; (3) a TT Club Transporter Operator Policy ("TT Club Policy") covering Greatwide's broker liability with a $5,000,000 per accident limit; and (4) a USIC Commercial Excess Liability Policy with a $5,000,000 per occurrence limit ("USIC Excess Policy). It must be noted that the USIC Excess Policy expressly stated that it is excess over the National Union CGL Policy.

National Union initiated the coverage lawsuit against TT Club, arguing that the MCL Policy was excess to the TT Club Policy and that National Union was therefore entitled to recover its settlement contribution through equitable subrogation or indemnification. TT Club counterclaimed for reimbursement of the $291,605.81 in defense costs it had paid entirely on Greatwide's behalf, arguing that National Union had breached its duty to defend Greatwide under both its MCL and CGL Policies. TT Club also joined USIC as a third-party defendant, arguing that USIC should have contributed to the settlement once the CGL Policy was exhausted. The claims and defenses were provided for the Court's consideration through a series of cross-filed summary judgments.

The first and threshold question before the Court was whether Greatwide acted as a motor carrier or a broker with respect to the Alton Steel load, a determination that was never made in the underlying lawsuit due to settlement. The Court held that a genuine issue of material fact existed on this question. Competing expert reports offered conflicting analyses and testimony from various employees pointed in different directions regarding whether Greatwide was authorized to broker loads and whether that was commonly understood. Because this fact question was outcome-determinative as to which insurer bore primary liability, the Court denied both National Union's and TT Club's cross-motions for summary judgment on the equitable subrogation and indemnification claims.

Before deferring on those claims, however, the Court issued several significant legal rulings on the structure and interaction of the policies. First, the Court held that the National Union MCL Policy covered both broker liability and motor carrier liability. The Court noted that MCL Policy's coverage provision applied to bodily injury and property damage caused by an accident and resulting from the use of a "covered auto," with symbol "61" designating "any auto". The Court analyzed the MCL Policy and found the designation of "any auto" was a broad umbrella term encompassing non-owned autos used in connection with Greatwide's business. Accordingly, the Court found no limiting language in the MCL Policy restricting coverage solely to motor carrier operations and concluded that the tractor-trailer operated by Simbad qualified as a "covered auto" under the MCL Policy. Therefore, the Court held that the MCL Policy provided coverage to Greatwide regardless of whether Greatwide was acting as a motor carrier or broker.

Second, the Court addressed the impact of the MCS-90 endorsement on the MCL Policy's "Other Insurance" excess clause. TT Club argued that the MCS-90 endorsement — which provides that no condition in the policy shall relieve the insurer from liability for any final judgment — rendered the MCL Policy primary as a matter of law, negating the excess clause. The Court rejected this argument. Instead, the Court held that the MCS-90 endorsement did not alter the priority of insurance coverage, and that "Other Insurance" excess clauses remain in full force and effect notwithstanding the MCS-90.

Third, the Court determined that TT Club's "Double Insurance" clause — which provided that TT Club would "exclude any claim to the extent that it is recoverable from the other insurer" — was an escape clause, not an excess clause. The Court noted that under Ohio law, an excess clauses consistently use the word "excess," and that the phrase "to the extent that it is recoverable" more resembles an escape clause. The Court then noted that Ohio law gives effect to excess clauses over escape clauses. Accordingly, the Court held that National Union's MCL Policy's excess clause controlled — meaning the TT Club Policy would be primary and the MCL Policy excess with respect to broker liability, im the event that Greatwide were ultimately found to have been acting as a broker.

Fourth, on the duty to defend, the Court held that National Union breached its duty to defend Greatwide under the MCL Policy. Unlike the CGL Policy's "Other Insurance" clause which expressly stated that National Union's duty to defend was excess, the MCL Policy's "Other Insurance" clause did not specifically reference the duty to defend. Accordingly, the Court found the excess clause was not clearly drafted to apply to National Union's potential defense obligation. Accordingly, National Union was obligated to participate in Greatwide's defense under the MCL Policy and its failure to do so constituted a breach of the MCL Policy. However, the Court declined to award TT Club reimbursement of defense costs at this stage because the genuine issue of material fact regarding Greatwide's role as broker or motor carrier precluded a determination of which insurer was primary at this stage of the coverage lawsuit.

Finally, as to the USIC Policy, the Court granted summary judgment in USIC's favor. USIC had never been notified of the underlying lawsuit or settlement until it was joined in the coverage lawsuit. The USIC Policy contained both a fourteen-day written notice requirement and a voluntary payment provision precluding coverage for payments made without USIC's consent. Citing to Ohio Supreme Court precedent, the Court held that an insurer asserting a coverage defense based on late notice must demonstrate prejudice. The Court found that USIC suffered prejudice because it was denied any opportunity to participate in settlement negotiations, evaluate liability allocation, or influence the outcome. The Court rejected TT Club's argument that USIC's presence at the settlement table would not have made a difference as purely speculative. Instead, the Court reasoned that such speculation cannot overcome a showing of prejudice.

This case provides important guidance on several issues frequently encountered in motor carrier coverage disputes. First, when a motor carrier liability policy uses broad "any auto" language, courts may find that broker-related liability — even involving vehicles owned and operated by a third-party carrier — falls within the policy's coverage, regardless of whether the insured acted as a motor carrier or a broker on the particular load.

Second, the presence of an MCS-90 endorsement in a motor carrier policy does not, under Ohio law, render that policy primary or negate an otherwise enforceable "Other Insurance" excess clause. Third, when evaluating "Other Insurance" clauses across competing policies, the language used matters greatly — courts will heavily scrutinize whether an "Other Insurance" clause truly operates as an excess clause or an escape clause. Fourth, certain jurisdictions, such as Ohio, will hold that escape clauses trump excess clauses. Fifth, insurers must specifically and clearly reference the duty to defend in any "Other Insurance" excess clause if they intend that clause to excuse their defense obligations. Finally, this case underscores the critical importance of timely notice to all potentially implicated insurers, including excess insurers. As this case demonstrates, in certain jurisdictions an excess insurer that is not notified until after settlement has occurred may successfully establish prejudice and avoid contribution obligations, simply on the grounds that it was denied any meaningful opportunity to participate in the defense or settlement process.

MISCELLANEOUS/GENERAL OPINIONS

NORTHERN DISTRICT OF TEXAS COMPELS BROAD DISCOVERY IN FIRST-PARTY BAD FAITH DISPUTE

In *Islamic Services Foundation d/b/a Brighter Horizons Academy v. Philadelphia Indemnity Insurance Company*,[20] the United States District Court for the Northern District of Texas addressed the scope of permissible discovery in a first-party property dispute, providing important guidance on underwriting materials, reserve information, personnel files, and privilege obligations.

The case arises from a hail damage claim in which the insurer denied coverage on the basis that the claimed damage predated the policy period. The insured moved to compel production of various categories of information, including underwriting materials, reserve information, personnel files of claim handlers, and testimony on several corporate representative topics.

The court began by reiterating the broad scope of discovery under Rule 26, emphasizing that information is discoverable if there is "any possibility" it may be relevant to a party's claims or defenses. Against that backdrop, the court addressed four primary areas of dispute.

First, the court compelled testimony regarding claim reserves and how they were established. Relying on authority within the Fifth Circuit, the court confirmed that reserve information is generally relevant in cases involving bad faith allegations because it may shed light on the insurer's evaluation of the claim and settlement practices.

Second, the court required production of underwriting materials and related testimony, rejecting the insurer's argument that such information was categorically irrelevant. Because the insurer denied the claim based on its position that the damage predated the policy, the court found that information regarding the pre-policy condition of the property, inspections, and underwriting practices bore directly on the dispute. However, the court narrowed the scope, limiting discovery to underwriting materials and practices tied to the insured property and the policy at issue, rather than allowing a broader inquiry into all underwriting processes.

Importantly, the court also rejected the insurer's attempt to withhold underwriting materials based on "confidentiality," clarifying that confidentiality alone does not justify withholding discovery where a protective order can address those concerns. The court further emphasized that any documents withheld on the basis of privilege must be supported by a proper privilege log, ordering the insurer to produce one within five days.

Third, the court compelled production of personnel files for individuals involved in adjusting the claim, within a defined time period. The court found that training records, evaluations, and performance materials were relevant to allegations that the insurer failed to conduct a reasonable investigation. While acknowledging concerns about overbreadth, the court concluded that targeted personnel file discovery is routinely permitted in similar bad faith contexts.

Finally, the court denied the motion to compel testimony regarding master service agreements where the insurer unequivocally represented that no such agreements existed. The court declined to require a corporate representative to testify on a topic unsupported by the facts, distinguishing cases where courts were skeptical of similar representations.

Overall, the insured obtained a significant portion of the requested discovery. The court compelled testimony regarding reserves, required production of underwriting materials and related corporate testimony, ordered disclosure of personnel files for claim handlers, and mandated the creation of a privilege log within a short deadline.

By comparison, the court's limitations were more modest, only narrowing the scope of underwriting discovery to the policy and property at issue and declining to require testimony on master service agreements that did not exist. In that sense, the ruling reflects a broad view of discoverability in first-party bad faith cases and serves as a reminder that where claim handling and coverage determinations are at issue, courts are likely to permit expansive inquiry into an insurer's internal processes, even while imposing targeted guardrails at the margins.

NORTHERN DISTRICT OF TEXAS CLARIFIES BURDEN ON INSURERS TO ESTABLISH AMOUNT IN CONTROVERSY FOR REMOVAL

In *Moorman v. Travelers Casualty Insurance Company of America*,[21] the United States District Court for the Northern District of Texas addressed whether a defendant insurer properly removed a first-party insurance dispute based on diversity jurisdiction, focusing on whether the amount in controversy requirement was satisfied.

The case arises from a 2021 fire and subsequent litigation in which the insurer initially provided a defense under a reservation of rights but later withdrew that defense, prompting the insured to file suit for breach of contract, bad faith, and violations of the Texas Deceptive Trade Practices Act. The insured filed suit in state court seeking monetary relief of "$250,000 or less." The insurer removed the case to federal court, asserting diversity jurisdiction, and the insured moved to remand.

The court began by reaffirming the well-established framework governing removal based on diversity jurisdiction, noting that the removing defendant bears the burden of establishing both complete diversity and that the amount in controversy exceeds $75,000. While the parties did not dispute diversity of citizenship, the central issue was whether the amount in controversy requirement had been met.

Turning to the plaintiff's pleading, the court explained that under Texas pleading rules, a request for monetary relief of "$250,000 or less" does not constitute a sum certain. Instead, such a range is considered an indeterminate amount because it could fall either above or below the $75,000 jurisdictional threshold. As a result, the court rejected any argument that the jurisdictional amount was satisfied based solely on the face of the petition.

Because the amount in controversy was not facially apparent, the burden shifted to the insurer to establish by a preponderance of the evidence that the claim exceeded $75,000. The court noted that this burden may be satisfied through summary-judgment-type evidence or by setting forth specific facts supporting the jurisdictional amount. However, the insurer's attempt to aggregate alleged damages, including potential treble damages under the DTPA and attorney's fees, fell short. The court found that while the insurer identified categories of damages, it failed to provide evidence demonstrating that those amounts would more likely than not exceed the jurisdictional threshold.

In particular, the court emphasized that speculative assumptions regarding future attorney's fees or potential damages are insufficient to carry the removing party's burden. Even where it is possible that a claim could exceed $75,000, the removing defendant must show that it is more likely than not that the threshold is met, which the insurer failed to do in this case. Accordingly, the court recommended that the case be remanded to state court, concluding that the insurer had not met its burden to establish federal jurisdiction.

Overall, the decision serves as a reminder that removal based on diversity jurisdiction requires more than generalized assertions regarding potential damages. Where a plaintiff pleads an indeterminate damages range under Texas law, insurers must be prepared to submit competent evidence establishing that the amount in controversy more likely than not exceeds $75,000. Absent that showing, even cases involving bad faith and statutory claims may be remanded to state court.

1. *Admiral Ins. Co. v. Lippert Components, Inc.,* 2026 Tex. App. LEXIS 2332 * (Tex. App.–Waco March 12, 2026, no pet. h.)
2. *Monroe Guar. Ins. Co. v. BITCO Gen. Ins. Corp.,* 640 S.W.3d 195 (Tex. 2022).
3. *Mt. Hawley Ins. Co. v. Aninipok,* 2026 U.S. Dist. LEXIS 37528 (S.D. Tex. February 2, 2026) (Magistrate R. Bennett), adopted, approved, and final judgment entered, 2026 U.S. Dist. 36085 (Justice S. Lake).
4. *Hartford Fire Insurance Company v. Hunt Construction Group, Inc.,* 2026 U.S. Dist. LEXIS 11014 (W.D. Tex. January 21, 2026) (Magistrate M. Lane), adopted and approved, 2026 U.S. Dist. Lexis 54898 (March 17, 2026 (Justice R. Pittman).
5. *Roofing Designs by JR, LLC v. Tapia,* 2026 U.S. Bankr. LEXIS 131 (Bankruptcy N.D. Tex. January 20, 2026).
6. *Arlanxeo USA, LLC v. Turner Indus. Grp., LLC,* Civ. No. H-25-1980, 2026 U.S. Dist. LEXIS 33106,*5-6, 2026 WL 469113 (S.D. Tex. Feb. 18, 2026),
7. *Neeley v. Lyft, Inc.,* No. 11-25-00065-CV, 2026 Tex. App. LEXIS 1389, at *1 (Tex. App.—Eastland Feb. 12, 2026, no pet. h.)
8. *Allstate Indem. Co. v. Fed. Ins. Co.,* No. H-25-3693, 2026 U.S. Dist. LEXIS 33700, at *1 (S.D. Tex. 2026).
9. *Landmark Am. Ins. Co. v. SCD Mem'l Place II, L.L.C.,* 25 F.4th 283 (5th Cir. 2022).
10. *Fireman's Ins. Co. v. Weatherman,* 193 S.W.2d 247 (Tex. Civ. App. 1946).
11. *Seger v. Yorkshire Ins. Co.,* 503 S.W.3d 388 (Tex. 2016).
12. *Rodriguez v. Olin Corp.,* 780 F.2d 491 (5th Cir. 1986).
13. *USAA Tex. Lloyds Co. v. Menchaca,* No. 14-0721, 2016 Tex. LEXIS 737 (Sep. 2, 2016).
14. *Schnell v. State Farm Lloyds,* 98 F.4th 150 (5th Cir. 2024); See also *Coker v. Coker,* 650 S.W.2d 391, 393 (Tex. 1983).
15. *In re Universal Underwriters of Tex. Ins. Co., 345 S.W.3d 404 (Tex. 2011). See also State Farm Lloyds v. Johnson, 290 S.W.3d 886, 890 (Tex. 2009).*
16. *USAA Tex. Lloyds Co. v. Menchaca,* No. 14-0721, 2016 Tex. LEXIS 737 (Sep. 2, 2016).
17. *Med. Protective Co. v. Mrugeshkumar Shah,* No. 5:24-CV-01315-JKP, 2026 LEXIS 35301 (W.D. Tex. Jan. 23, 2026).
18. *Taghavi v. Brooklyn Specialty Ins. Co. RRG, Inc.,* No. 3:25-CV-1735-S-BN, 2026 U.S. Dist. LEXIS 52445 (N.D. Tex. Feb. 9, 2026), adopted by 2026 U.S. Dist. LEXIS 50994 (N.D. Tex. Mar. 11, 2026).
19. *Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. TT Club Mut. Ins. Ltd., Case No. 2:23-CV-3696,* 2026 U.S. Dist. LEXIS 57782 (S.D. Ohio Mar. 19, 2026).
20. *Islamic Servs. Found. v. Phila. Indem. Ins. Co., No. 3:25-CV-1333-L,* 2026 U.S. Dist. LEXIS 19818 (N.D. Tex. 2026).
21. *Moorman v. Travelers Cas. Ins. Co. of Am.,* Civil Action No. 4:25-cv-01315-O, 2026 U.S. Dist. LEXIS 26325 (N.D. Tex. 2026).

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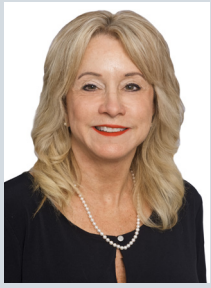

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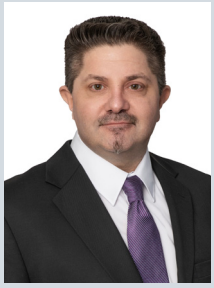

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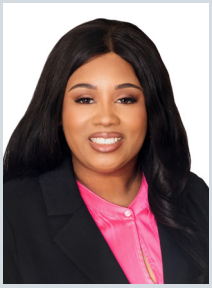

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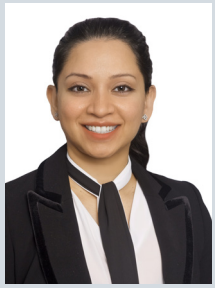

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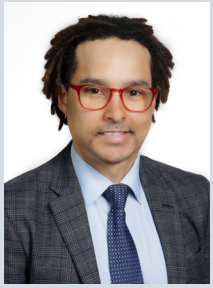

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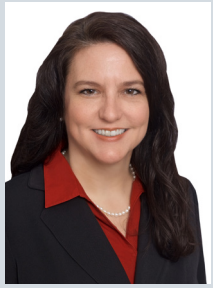

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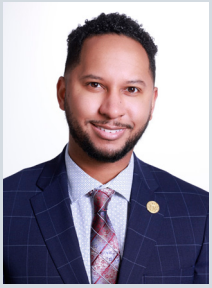

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