TADC INSURANCE LAW UPDATE

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This newsletter is intended to summarize significant cases impacting the insurance practice since the Fall 2019 newsletter. It is not a comprehensive digest of every case involving insurance issues during this period or of every holding in the cases discussed. This newsletter was not compiled for the purpose of offering legal advice. Any opinions expressed herein are those of the authors and do not necessarily reflect the views of Akerman LLP.

Insured Lacked Standing to Sue for Difference Between Provider's List and Negotiated Rates in Personal Injury Protection (PIP) Dispute.

Farmers Tex. Cty. Mut. Ins. Co. v. Beasley, 598 S.W.3d 237 (Tex. 2020).

At issue in this Texas Supreme Court decision is whether an injured plaintiff has standing to bring suit against his Personal Injury Protection ("PIP") policy insurer after the insurer has paid the incurred medical expenses pursuant to the negotiated rate rather than the provider's listed rate. The Texas Supreme Court held that a plaintiff did not.

In 2007, appellee Beasley was injured in a car accident and incurred medical bills, the listed rates of which totaled $2,662.54. Beasley's health insurance, BlueCross BlueShield ("BCBS"), had negotiated reimbursements with Beasley's medical providers, and paid a total of only $1,068.90 pursuant to those negotiated rates. Beasley was not personally responsible for any out-of-pocket medical costs.

In addition to health insurance, Beasley purchased and filed a claim through his PIP policy insurer, Farmers Texas County Mutual Insurance Company (Farmers). The relevant policy language specifies that such PIP benefits consist of "[r]easonable expenses incurred for necessary medical and funeral services." Beasley brought suit when Farmers agreed to pay the $1,068.90, the amount BCBS had negotiated with Beasley's providers, instead of the $2,662.54 as provided in the providers' listed rates.

In 2006, the Texas Supreme Court in a *per curiam* decision, confronted an issue nearly identical to the one presented here. In *Allstate Indemnity Co. v. Forth*, 204 S.W.3d 795 (Tex. 2006), plaintiff Forth, like Beasley, was covered by a PIP policy, and the insurer settled Forth's medical bills for less than the medical providers' listed rates. Forth then sued her insurer, Allstate, for injunctive and declaratory relief, which led to the Supreme Court dismissing her claims for lack of standing on grounds that Forth failed to assert that Allstate's settlement caused Forth any injury.

On appeal, Beasley unsuccessfully attempted to distinguish his claim from that of Forth by asserting that he was seeking monetary

damages whereas Forth sought injunctive and declaratory relief. The Texas Supreme Court noted that, while the relief Forth and Beasley sought differed, the issue of standing turned on their ultimate claim in bringing their lawsuit, which was the same. According to the Court, the dispute common to both plaintiffs centers around the legal position "that their PIP policies entitled them to recover reasonable medical expenses that the plaintiffs incurred." Drawing no meaningful distinction from the Court's precedent in *Forth*, and rejecting Beasley's final contention that Farmers' consideration of negotiated discounts in this case implicated the collateral source rule under *Haygood*, the Court held that Beasley did not have standing to bring his PIP claim against Farmers for the same reasons provided in *Forth*.

Texas Law Does Not Allow Policy-Language Exception to Eight-Corners Rule.

Richards v. State Farm Lloyds, 597 S.W.3d 492 (Tex. 2020).

The issue certified from the Fifth Circuit to the Texas Supreme Court was whether the eight-corners rule, as applied to an insurer's duty to defend, is dependent on the presence of a policy-language exception. The Texas Supreme Court held that it does not.

This insurance coverage dispute between insured Janet and Melvin Richards and their homeowner's insurance provider State Farm Lloyd's ("State Farm") arose from a fatal ATV incident involving the insureds' grandson. The Richards sought defense and indemnity coverage under State Farm's policy after a lawsuit was filed by the child's mother. State Farm denied coverage under the policy's "motor-vehicle exclusion," which excludes any bodily injury that arises from the operation of a motor vehicle while off an insured location. In support of this exclusion, State Farm submitted evidence that the bodily injury arose from the use of the grandparents' ATV on a public recreational trail, not on the grandparents' property. Additionally, State Farm asserted that the minor constituted an "insured" excluded under the policy because the minor was under the care of the Richards at the time of the accident.

In response to the Richards' objections that consideration of State Farm's extrinsic evidence is impermissible under a standard Eight-Corners Rule analysis, State Farm argued that the district court in the proceedings below had previously articulated that such Rule only applied to insurance policies that explicitly require the insurer to defend "all actions against its insured no matter if the allegations of the suit are groundless, false, or fraudulent." Since the policy at issue did not include such a "groundless-claims clause," the eight-corners rule did not apply. The district court granted summary judgment, and upon appeal, the Fifth Circuit certified the following question to the Texas Supreme Court:

"Is the policy-language exception to the eight-corners rule articulated in *B. Hall Contracting Inc v. Evanston Ins. Co.*, 447 F.Supp.2d 634 (N.D. Tex. 2006), a permissible exception under Texas law?"

The Texas Supreme Court held it is not. It first observed that the *B. Hall* exception has not been previously applied by the Fifth Circuit or any Texas court. Instead, a different exception to the Eight-Corners rule has been recognized by Texas case law and only allows for extrinsic evidence when (1) it is initially impossible to discern whether coverage is potentially implicated, and (2) the extrinsic evidence goes solely to a

fundamental issue of coverage which does not overlap with the merits of or engage the truth or falsity of any facts alleged in the underlying case" (the "*Northfield* exception"). Without opining on the merits of the *Northfield* exception, the Texas Supreme Court instead noted that the Texas courts of appeal have consistently applied the Eight-Corners rule for many decades, without regard to whether the policy expressly required the insurer to defend against groundless, false, or fraudulent claims. Thus, the Court found nothing within its jurisprudence which would suggest that the Eight-Corners Rule is contingent on a groundless-claims clause.

In answering the certified question that the *B. Hall* exception is not a permissible exception under Texas law, the Texas Supreme Court reaffirms that the eight-corners rule acknowledges, in the context of common duty-to-defend clauses, that only the petition and policy are relevant to the initial inquiry of coverage. If the petition is silent on facts necessary to determine coverage, the Texas Supreme Court acknowledged, but did not expressly approve as some had hoped, that some courts have permitted consideration of extrinsic evidence on coverage issues that do not overlap with the merits of the case in order to determine whether the claim is for losses covered by the policy.

Extrinsic Evidence Not Admissible On Duty To Defend

National Liability & Fire Ins. Co. v. Young, ___ F.Supp.3d ___, 2020 WL 2519630 (May 12, 2020).

Extrinsic evidence was not admissible to contradict allegations in the petition and the *Avalos* exception permitting evidence of collusive or fraudulent conduct on the part of the insured did not apply here.
National Liability & Fire Insurance Company ("National") issued a commercial auto policy to Young that covered scheduled autos, as well as temporary substitute autos. To be a temporary substitute, an auto must be used by the insured with the permission of the owner as a temporary substitute for one of the insured's covered autos while that covered auto is out of service for repairs or service.

The petition in the underlying lawsuit alleged that the auto involved in the accident was temporarily rented to Young and was being used temporarily as a substitute for one of his permanent vehicles that was being repaired or serviced at the time of the accident. National sought to introduce extrinsic evidence that the auto involved in the accident was leased from Enterprise Rent-A-Car continuously from August 2018 through February 2019 and none of the autos scheduled on the policy were undergoing repairs or service at the time of the accident.

After initially determining that the eight-corners rule implicated coverage, the district court considered whether the exceptions to the prohibition against considering extrinsic evidence announced in *Northfield Insurance Company v. Loving Home Care, Inc.,* 363 F.3d 523, 531 (5th Cir. 2004), and *Loya Insurance Co. v. Avalos,* ___ S.W.3d ___, 63 Tex. Sup. Ct. J. 969, 2020 WL 2089752 (May 1, 2020), applied.

The court noted that the Fifth Circuit has applied an exception to the eight-corners rule when: (1) "it is initially impossible to discern whether coverage is potentially implicated"; and (2) "the extrinsic evidence goes solely to a fundamental issue of coverage which does not overlap with the merits of or engage the truth or falsity of any facts alleged in the underlying case." The court held that the

Northfield exception did not apply in this case because it was not impossible to discern whether coverage was implicated by the pleadings, and the extrinsic evidence National sought to introduce engaged the truth or falsity of the allegations in the petition.

The court next determined that the narrow exception recently recognized by the Texas Supreme Court in *Avalos* did not apply because, while National attacked the "gamesmanship of the underlying plaintiffs in amending their original petition after this coverage action was filed," National had no evidence that its insured, Young, conspired to manipulate or assert groundless or fraudulent claims.

Accordingly, the court denied National's motion for summary judgment on the duty to defend and gave notice under Federal Rule of Civil Procedure 56(f) that, after giving National an opportunity to respond, it would consider granting summary judgment in favor of Young on the duty to defend.

Texas Supreme Court creates exception to eight corners rule based on collusive fraud between an insured and a suing party.

Loya Ins. Co. v. Avalos, __ S.W.3d __, 2020 WL 2089752 (Tex. 2020).

In this case, the Texas Supreme Court carved out an exception to the "eight-corners rule," which generally precludes an insurer from determining a duty to defend outside of the four corners of the pleadings and the policy, holding that "courts may consider extrinsic evidence regarding whether the insured and a third party suing the insured colluded to make false representations of fact in that suit for the purpose of securing a defense and coverage where they would not otherwise exist."

Loya Insurance Company ("Loya") had issued an automobile liability insurance policy (the "Policy") to Karla Flores Guevera ("Guevera"). The Policy expressly excluded coverage for Guevera's husband, Rodolfo Flores ("Flores"). The underlying incident occurred while Flores was operating Guevera's car and collided with another car carrying Osbaldo Hurtado Avalos and Antonio Hurtado (the "Hurtados"). At the scene of the accident, the Hurtados, Guevera, and Flores agreed to tell the investigating officer and Loya that Guevera had been operating the car at the time of the collision, not Flores.

After suit was filed and during the discovery process, Guevera disclosed to her attorney that she was the actual driver of her vehicle. Loya responded to this information by withdrawing from Guevera's defense. The trial court subsequently granted the Hurtados' motion for summary judgment and awarded the Hurtados $450,343.34 in damages. Guevera assigned her rights against Loya to the Hurtados who then filed suit against Loya, alleging breach of contract and bad faith claims. Loya counterclaimed for breach of contract, fraud, and a declaratory judgment that it owed no duty to defend or indemnify Guevera because Flores, an excluded driver, was driving the vehicle at the time of the accident. Loya deposed Guevera, and she confirmed under oath that Flores was the driver. Loya then moved for summary judgment on its declaratory judgment claims. The trial court granted the summary judgment, but the court of appeals reversed based on a strict application of the eight-corners rule.

In its analysis, the Texas Supreme Court recognized the general rule that extrinsic evidence is not allowed to be used in determining whether an insurer owes a

defense to its insured, even when the allegations against the insured are groundless, false or fraudulent. However, it also noted that in two prior cases it had hinted at an exception to this general rule when the insured colludes with the injured parties to make false allegations that would cause a duty to defend to be invoked. Appealing to the contractual foundations of the eight-corners rule, the court reasoned that while an insurer has agreed to defend its insured against fraudulent allegations "*by third parties*," it has "not agreed to undertake, and the insured has not paid for, a duty to defend the insured against fraudulent allegations brought about *by the insured* itself." (emphasis in original). Thus, because the insurer presented conclusive evidence of collusive fraud between the Hurtados, Guevera, and Flores, the collusive fraud exception to the eight-corners rule applied, and Loya did not owe a defense or indemnity to Guevera.

The Hurtados then argued that even under the collusive fraud exception, the court should hold that an insurer cannot withdraw its defense until the insurer files a declaratory judgment action and obtains a judgment that it owes no duty to defend its insured. The court refused to impose such a requirement, reasoning that in such a situation there may be no justiciable controversy between the insurer and its insured, and that in any event, the substantial contractual and bad faith damages and attorneys' fees that an insurer could be subject to if it breaches its duty to defend provided sufficient incentive for an insurer to only withdraw from a defense without securing a declaratory judgment in "clear-cut cases."

Accordingly, the Court reversed the court of appeals' judgment and reinstated the trial court's summary judgment for the insurer.

Payment of an appraisal award does not automatically entitle an insurer to summary judgment on an insured's extra-contractual claims.

Alvarez v. State Farm Lloyds, 601 S.W.3d 781 (Tex. 2020).

The insured, Juan Alvarez ("Alvarez"), made a claim with his insurer, State Farm Lloyds ("State Farm") stemming from wind and hail damage to his residential property.

After its first inspection, State Farm determined that the property's damages fell below Alvarez's deductible. After a second inspection, however, State Farm observed additional damage, revised its estimate, and issued payment. However, Alvarez remained dissatisfied with State Farm's valuation and filed a lawsuit. In response, State Farm successfully moved the trial court to compel appraisal. The appraisal award surpassed State Farm's prior estimates, State Farm paid the award and thereafter moved for summary judgment on all of Alvarez's claims. The trial court granted State Farm's motion and the court of appeals affirmed, holding that payment of an appraisal award entitles an insurer to summary judgment on all of the insured's contractual and extra-contractual claims.

The Texas Supreme Court held that under *Barbara Technologies* and *Ortiz*, the court of appeals erred in concluding Alvarez could not maintain his TPPCA claim due to State Farm's payment of the appraisal award. Accordingly, the Texas Supreme Court reversed the judgment of the court of appeals and remanded the case to the trial court to consider Alvarez's TPPCA claim in light of those holdings.

An insurer's payment of appraisal value does not foreclose TPPCA damages, but the trial court may consider whether payment of an appraisal award under a unilateral appraisal clause bars breach of contract and bad faith claims absent an independent injury.

Biasatti v. GuideOne National Insurance Co., 601 S.W.3d 792 (Tex. 2020).

Properties owned by Steven Biasatti and Paul Gross ("Biasatti") and insured by GuideOne National Insurance Company ("GuideOne"), sustained wind and hail damage. GuideOne conducted its initial inspection and determined the loss fell below Biasatti's $5,000 deductible. Biasatti requested a second inspection, which was performed and yielded the same findings. Thereafter, GuideOne declined a third inspection and Biasatti asked to invoke the policy's appraisal process. GuideOne refused, explaining the policy contained a unilateral appraisal clause and GuideOne considered appraisal unnecessary. Biasatti sued GuideOne and brought contractual and extra contractual causes of action. GuideOne obtained an order compelling appraisal. Through the appraisal process, the loss was determined to amount to $168,808.00. GuideOne paid the award and thereafter moved for summary judgment. Biasatti also moved for summary judgment. The trial court denied Biasatti's motion and granted GuideOne's, rejecting all Biasatti's claims based on GuideOne's payment of the appraisal award.

The Seventh Court of Appeals affirmed, holding that (1) payment of an appraisal award entitled GuideOne to summary judgment on Biasatti's contractual claims and (2) Biasatti's bad-faith and TPPCA claims failed because the insureds did not allege an injury independent from the policy benefits and did not demonstrate policy benefits were withheld after the appraisal award was paid. Biasatti appealed.

Concerning its claims for breach of contract and bad faith, Biasatti argued the court should create an exception to the independent injury rule noted in *Ortiz*. Specifically, it urged that insureds need not establish independent injury to recover for breach of contract and bad faith where an insurer relies on a unilateral appraisal clause to force the insured to file suit, compels appraisal, and then pays the appraisal award. In that situation, Biasatti argues, the appraisal award itself constitutes actual damages.

The Texas Supreme Court held an insurer's payment of appraisal value does not foreclose TPPCA damages under section 542.060. Further, the Court held that, under *Ortiz,* an insured's claims for breach of contract and bad faith are generally barred under these circumstances. However, the Court noted *Ortiz* did not involve a unilateral appraisal clause, and the court advised the trial court could consider that question on remand. Thus, whether payment of an appraisal award under a unilateral clause would bar breach of contract and bad faith claims absent and independent injury has not been determined by the Texas Supreme Court.

Payment of an appraisal award does not automatically entitle an insurer to summary judgment on an insured's extra-contractual claims.

Lazos v. State Farm Lloyds, 601 S.W.3d 783 (Tex. 2020).

The insured, Roberto Lazos ("Lazos") made a claim with his insurer, State Farm Lloyds ("State Farm") stemming from wind and hail damage to his residential property.

After two inspections, State Farm determined the loss fell below Lazos's deductible. Lazos believed State Farm undervalued the damages and filed suit. In response, State Farm successfully moved the trial court to compel appraisal. The appraisal award exceeded State Farm's prior estimates, accordingly, State Farm paid the award and thereafter moved for summary judgment on all of Lazos's claims. The trial court granted State Farm's motion and the court of appeals affirmed, holding that payment of an appraisal award entitles an insurer to summary judgment on all the insured's contractual and extra-contractual claims.

The Texas Supreme Court held that, under *Barbara Technologies* and *Ortiz*, the court of appeals erred in concluding Lazos could not maintain his TPPCA claim due to State Farm's payment of the appraisal award.

Accordingly, the Texas Supreme Court reversed the judgment of the court of appeals and remanded the case to the trial court to consider Lazos's TPPCA claim in light of those decisions.

A court may not deny an insured's TPPCA claim without first determining liability.

Joseph Lambert and Susan Lambert v. State Farm Lloyds, No. 02-17-00374-CV, 2019 WL 5792812 (Tex. App.—Fort Worth Nov. 7, 2019, no pet. hist.).

The Lamberts submitted a claim for damages under their homeowner's insurance policy. After the first inspection, State Farm Lloyds ("State Farm") found the damages fell below the policy's deductible and thus, did not issue payment to the Lamberts. Then, the Lamberts requested a reinspection. State Farm complied and found damages that amounted to $10,000, which turned into issuance of a $1,700 payment to the Lamberts, after subtracting for depreciation and the deductible. The Lamberts believed their claim was undervalued and filed suit against State Farm, alleging contractual and extra contractual causes of action. The parties engaged in appraisal, which set the amount of loss to be $99,112.72 on a replacement cost basis and $70,965.54 on an actual-cash basis. Two days after learning of the award and making the appropriate deductions, State Farm issued payment and filed a motion for summary judgment.

State Farm argued that because it had paid the amount of loss as determined by appraisal and because the Lamberts had not alleged an independent injury separate from their rights under the policy, State Farm was entitled to a take-nothing judgment in its favor. The Lamberts moved for partial summary judgment on their TPPCA claim, specifically claiming that they were entitled to statutory interest and attorney's fees under Section 542 of the Texas Insurance Code. The trial court granted State Farm's motion and denied the Lamberts' motion for partial summary judgment. The Lamberts appealed.

The court of appeals found that because the Lamberts provided no evidence of actual damages independent of benefits paid under their policy, the trial court did not err by granting State Farm's summary judgment motion regarding the extracontractual claims that sought damages for policy benefits that State Farm paid following the appraisal process.

Further, the Lamberts alleged that State Farm failed to follow the TPPCA's prompt-payment deadlines and thus they were entitled to statutory interest and attorney's fees. The court of appeals pointed out that in *Barbara Tech*, the Texas Supreme Court held that payment of an appraisal award does not

bar a TPPCA claim as a matter of law. Specifically, in *Barbara Tech* the Texas Supreme Court noted that an insured could be entitled to a recovery by showing that (1) the insurer was initially liable for the claim under the policy and (2) the insurer violated a TPPCA provision.

The Lamberts further noted that in *Barbara Tech*, the insurer had not accepted liability under the policy and had not yet had its liability adjudicated one way or another, thus the Texas Supreme Court remanded the case for the trial court to first determine liability and then sort through TPPCA timing requirements. The Lamberts argued their TPPCA claim should similarly be remanded because much like in *Barbara Tech*, the issue of liability had not been determined.

Accordingly, the Second Court of Appeals overruled the part of the Lamberts' second issue arguing that they were entitled to summary judgment on their extracontractual claims, sustained the Lamberts' second issue regarding their TPPCA claim, reversed the part of the trial court's order granting summary judgment for State Farm on the Lamberts' second issue regarding their TPPCA claim and remanded the case on that claim.

Unambiguous Interrelated Claims Provision in the claims made policy precluded coverage for claims made during the policy that were related to claims made prior to the policy.

Uni-Pixel, Inc. v. XL Specialty Ins. Co., No: 14-18-00828-CV, 2020 WL 1528098 (Tex. App. – Houston [14th Dist.] 2020 no pet.).

In this wrongful denial of coverage appeal, the Fourteenth Court of Appeals held that coverage was properly denied to a besieged technology company because an enforcement action by the Securities and Exchange Commission ("SEC") related to a pending federal investigation, which commenced prior to the claims-made policy period.

Appellants Uni-Pixel, Inc., as well as several of its former officers, (collectively "Uni-Pixel") sued appellee insurer XL Specialty Insurance Company ("XL") for wrongful denial of coverage under a directors and officers liability policy (the "XL Policy"). Uni-Pixel was a technology company that developed and sold display and touchscreen technologies for use in phones, tablets, and other electronic devices. Following several years of publicity in which Uni-Pixel's stocks rose and fell, Uni-Pixel was ultimately unable to bring its main product, UniBoss, to market by the anticipated timeline of late 2013.

Uni-Pixel's shareholders filed a class action lawsuit in June 2013 alleging securities fraud by (1) misleading investors about UniBoss's commercial prospects for 2013; (2) using secrecy with respect to its license agreements; and (3) using unusual accounting to provide a veneer of progress. Later in 2013, the SEC sent Uni-Pixel a "Formal Order of Private Investigation." In February 2014, Uni-Pixel's shareholders filed a derivative action, and in June 2015, the SEC sent "Wells Notices" followed by a SEC Enforcement Action in March 2016.

Uni-Pixel purchased the XL Policy for claims first made against the insured between April 1, 2015 through April 1, 2016. In July 2015, two years after the SEC initiated its investigation, Uni-Pixel sought coverage under the XL Policy for the SEC's Wells Notice. XL denied coverage on the basis that the "interrelated claims" first arose prior to the coverage period. Upon suit, XL sought summary judgment on Uni-Pixel's breach of

contract action, which was granted by the trial court.

The XL Policy's "Insuring Agreements" provided:

> (A) The Insurer shall pay on behalf of the Insured Persons Loss resulting from a Claim first made against the Insured Persons during the Policy Period or, if applicable, the Optional Extension Period, for a Wrongful Act or Employment Practices Wrongful Act, except for Loss which the Company is permitted or required to pay on behalf of the Insured Persons as indemnification.
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> (B) The Insurer shall pay on behalf of the Company Loss which the Company is required or permitted to pay as indemnification to any of the Insured Persons resulting from a Claim first made against the Insured Persons during the Policy Period, or if applicable, the Optional Extension Period, for a Wrongful Act or Employment Practices Wrongful Act.
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> (C) The Insurer shall pay on behalf of the Company Loss resulting solely from any Securities Claim first made against the Company during the Policy Period, or if applicable, the Optional Extension Period, for a Company Wrongful Act.

Additionally, under the "General Conditions" section of the XL Policy, the "Interrelated Claims" provision stated that "[a]ll Claims arising from the same Interrelated Wrongful Acts shall be deemed to constitute a single Claim …"

On appeal, the court of appeals held that the Wells Notices and the SEC Enforcement Action were all "Claims that arose from the same 'Interrelated Wrongful Acts' as the Class Action, the Derivative Suit, and the SEC Formal Investigation." Therefore, Uni-Pixel did not satisfy their burden to establish coverage. As the court noted, "[a]ll of these Claims stem from the same wrongful acts arising out of the same series of related facts, namely, Appellants' statements and representations regarding UniBoss." Further, the court noted that the SEC's Formal Investigation, which had begun prior to 2015, was also premised on the alleged false statement of fact regarding the viability and revenue potential of Uni-Pixel's product. Thus, the court concluded that "[a]ccording to the terms of the XL Policy, these Claims constitute a single Claim that arose before the April 1, 2015 commencement of the XL Policy Period and are outside the scope of the XL Policy's coverage."

Finally, the appeals court rejected Uni-Pixel's argument that the XL Policy must be read in Uni-Pixel's favor to encompass coverage because such a reading is only warranted when the policy is susceptible to more than one reasonable interpretation. Such a presumption did not apply here because the XL Policy is subject to only one reasonable interpretation. Given that the "Interrelated Claims" provision and the Policy's broad definition of "Interrelated Wrongful Acts" combined the SEC action into a single "Claim" under the policy, Uni-Pixel was not entitled to coverage for such claims occurring prior to the policy period.

Turnover order of insured's legal malpractice, DTPA and Chapter 541 claims was void as against public policy.

Goin v. Crump, No. 05-18-00307-CV, 2020 WL 90919 (Tex. App.—Dallas Jan. 8, 2020, no pet).

John Goin ("Goin") was employed by MICA Corporation ("MICA"). While working on an out-of-town assignment, Goin met Hope

Crump and drove his company truck to Crump's home for dinner. While at Crump's house, Goin's foreman telephoned and instructed Goin to return to the hotel. Crump accompanied Goin on his return trip, during which the two were involved in a rollover accident, resulting in significant injuries to Crump.

In March 2012, Crump sued Goin and MICA in Anderson County. MICA was the named insured under two commercial policies, an auto policy issued by Travelers Property Casualty Company of America ("Travelers") (the "Travelers Policy"), and an umbrella policy issued by Great American Insurance Company ("Great American"). The Travelers Policy extended insured status to anyone while using, with MICA's "permission," an auto that had been "own[ed], hire[d], or borrow[ed]" by MICA. In light of this provision, Travelers agreed to provide a defense to Goin subject to reserving its rights to deny coverage if it was determined that Goin was using the company vehicle without MICA's permission. Travelers retained attorney Michael Dunn ("Dunn") and his firm, Smead, Anderson, & Dunn ("SAD") to defend Goin.

The State charged Goin with intoxication assault. Dunn and Travelers attended the criminal trial in order to assist with the civil defense. Goin claims that, in reality, Dunn and Travelers had worked to develop testimony favorable to Travelers' coverage defense that Goin was not using the company vehicle with MICA's permission. Goin was eventually convicted and sentenced to twelve years in prison. Dunn allegedly never communicated with Goin again.

In January 2013, Crump non-suited her civil case and refiled in Dallas County (the "Crump Lawsuit"), naming Goin, MICA, and Ford Motor Company as defendants. Travelers settled the claims against MICA and Ford was dismissed through summary judgment, leaving Goin as the remaining defendant. Goin claims that he was not served with process, and the court issued a notice of hearing concerning a pending dismissal of Crump's case for want of prosecution. Goin alleged that Crump's counsel visited him in prison and urged him to sign a handwritten answer that was then allegedly filed by Crump's counsel.

In October 2014, Travelers retained new counsel for Goin in the Crump Lawsuit. By then, Goin claimed he had been unrepresented in discovery, including multiple depositions. The case went to trial and the jury awarded $18,745,000 to Crump and found Goin sixty percent responsible for the damages. Goin initially appealed, but then voluntarily dismissed the appeal.

In April 2015, Goin filed suit against Travelers, Great American, and MICA (the "Goin Lawsuit"), asserting various causes of action, including claims against the insurers for violations of the DTPA and the Insurance Code. In June 2015, Crump filed a motion in the Crump Lawsuit, seeking a turnover of Goin's causes of action in the Goin Lawsuit, which Goin did not oppose. The court granted Crump's motion, turning over to a Receiver, among other things, Goin's causes of action against MICA, Travelers, and Great American, and requiring Goin to execute an irrevocable assignment of the claims to the Receiver. The order also directed the Receiver to pay Crump ninety percent of any gross proceeds received from Goin's causes of action and ten percent to Goin net all costs incurred by the Receiver. Travelers then deposited the rest of its indemnity limits into the court's registry, in partial satisfaction of Crump's judgment.

Goin continued to prosecute his claim in the Goin Lawsuit, dropping Great American as a defendant and adding a malpractice claim against Dunn and SAD. Crump and the Receiver also filed petitions in intervention in the Goin Lawsuit. In the Crump Lawsuit, the court approved a settlement among Great American, MICA, Crump, and Goin, and Crump withdrew the remaining proceeds of the Travelers Policy from the court's registry. In December 2017, Crump filed a motion in the Crump Lawsuit seeking clarification as to whether the turnover order transferred ownership of all causes of action in the Goin Lawsuit, including the claims against Travelers and the malpractice claim. Goin filed a competing motion to modify the turnover order, arguing that the turnover of the DTPA, Insurance Code, and malpractice claims were not assignable and void. Goin also sought a modification of the order so that it transferred the net proceeds of any judgment rendered in his favor to the Receiver and not the claims themselves. The trial court granted Crump's motion to clarify and denied Goin's motion to modify. Goin then filed a "Notice of Appeal/Mandamus" with respect to the court's order.

The court of appeals first addressed validity of the turnover of Goin's malpractice claim against Dunn and SAD at length, holding that such turnover was against public policy.

Next, the court reviewed Goin's claim that the turnover of the DTPA claims against Travelers, Dunn, and SAD was also void as against public policy. The court reviewed precedent from the Texas Supreme Court in which the Court held that DTPA claims could not be assigned, concluding that "the personal and punitive aspects of DTPA claims cannot be squared with a rule allowing them to be assigned as if they were mere property," and that therefore "assigning DTPA claims would defeat the primary purpose of the statute—to encourage individual consumers to bring such claims themselves." *PPG Indus., Inc. v. JMB/Houston Ctrs. Partners, Ltd*., 146 S.W.3d 79, 82 (Tex. 2004). Comparing the specific reasons for this conclusion in *PPG* with the circumstances of this case, the appellate court agreed with Crump that, unlike *PPG*, transferring the DTPA claims to a court-appointed receiver did not pose the same serious risks of collusion between an injured party and the assignee, and it did not create a potential for role reversal in a lawsuit. Further, transferring a DTPA claim pursuant to a post-judgment transfer order did not pose the same risk, namely that an unwitting consumer might be duped into transferring the claim for little or no value.

However, the court disagreed with Crump that Goin's remaining ten percent interest in the net proceeds of any recovery would satisfy the "personal and punitive" nature of the DTPA claim when the Receiver had full possession of the claim itself and authority to settle and release the claim, upon court approval. Further, Goin's actual continued involvement in the case did not mitigate this concern, as the turnover order incentivized the Receiver to obtain a settlement which could be inconsistent with Goin's interest in obtaining treble damages, and the turnover order similarly did not require the Receiver to pursue Goin's claims for his "maximum benefit."

Turning to Goin's Chapter 541 claims, the court noted that chapter also provides remedies that are "personal and punitive" in nature, that the Insurance Code makes no provision for assignability, and that every policy argument articulated in *PPG* applied with equal force to a Chapter 541 claim. The court distinguished a prior case allowing a turnover of an insured *Stower's* claim on the grounds that a *Stowers* action generally limits

damages to the amount of the underlying judgment, whereas Chapter 541 allows for extra-contractual damages upon findings of false, deceptive, or unfair acts. This distinction highlighted the same potential conflict of interest addressed under the DTPA claim, namely, that the turnover order would incentivize the Receiver to satisfy Crump's judgment, whereas Goin would be incentivized to obtain treble damages.

Finally, the court addressed Goin's claim under Chapter 542. Reasoning that a violation of Chapter 542 was "not of the same character" as a violation of Chapter 541, that damages for violation of Chapter 542 were limited to the amount of the claim plus interest and attorney's fees, and that such claims were not susceptible to the same sorts of "gamesmanship or strategic maneuvering" that would be inherent in DTPA or Chapter 541 claims, the court held that the turnover of Goin's Chapter 542 claim was valid.

Accordingly, the court, among other things, granted Goin's petition for writ of mandamus with respect to Goin's DTPA and Chapter 541 claims, and denied his petition for writ of mandamus with respect to his Chapter 542 claim.

Insured's Failure to Submit Sworn Proof of Loss Prevented Recovery of Certain Benefits

City of Spearman v. Tex. Mun. League Intergovernmental Risk Pool, 601 S.W.3d 72 (Tex. App.—Amarillo 2020, pet. filed).

The City of Spearman, Texas (the "City") sued the Texas Municipal League Intergovernmental RiskPool ("TML"), a governmental self-insurance fund, for breach of contract after TML allegedly underpaid its property insurance claim. The City had previously submitted a "Claims Notice" for purported hail damage to TML. TML investigated the damage and then sent the City a "Sworn Proof of Loss" to sign, which was never returned by the City. Nor did the City file any other sworn proof of loss. The City later submitted additional damages, which TML investigated but ultimately denied.

The City thereafter filed a lawsuit against TML for improperly denying coverage and for underpaying the claim. TML answered the lawsuit and filed a traditional and no-evidence summary judgment motion claiming that there was no breach of contract, which was granted. An Amarillo appellate court affirmed the summary judgment rendered in favor of TML, holding that by failing to tender a proof of loss as required, the City did not satisfy a condition of recovery, and thus the trial court had before it at least one ground upon which to grant the summary judgment.

The court of appeals only addressed the sworn proof-of-loss issue, as it was dispositive. TML asserted that the City's failure to submit a proof of loss, which was a condition precedent to recovery, prevented it from recovering any additional self-insurance benefits as a matter of law. The Policy contained the following "Proof of Loss" requirement:

> It shall be necessary for the Member to render a signed and sworn proof of loss to [TML] or its appointed representative, within 60 days, stating the place, time, and cause of the loss, damage, or expense, the interest of the Member and of all others, the value of the property involved in the loss, and the amount of loss, damage, or expense.

The appellate court also noted that under the same subsection, the policy provided that "[a]ll adjusted claims shall be due and payable no later than 60 days after presentation and acceptance of proofs of loss by [TML] or its appointed representative." No proof of loss, sworn or otherwise, was filed by Spearman. The appellate court iterated that according to the Texas Supreme Court, a proof of loss is a condition precedent to recovery on the policy. Having failed to tender a proof of loss as required by the policy at bar, the insured also failed to satisfy a condition to recovering on the policy.

The City argued that this outcome should be avoided because the policy provided no deadline to submit the proof of loss; instead, the provision merely states it must be filed within 60 days. The appellate court indicated that it was unclear as to what the insured was attempting to say, but nevertheless analyzed what procedure was required by the terms of the policy after a loss is suffered. The court reasoned that the suffering of a loss is the first toppling domino that leads to the toppling of the others. The court then deduced that the parties to the policy intended the contractual 60-day period within which to submit a sworn proof of loss to begin with the toppling of the first domino, *i.e.*, the point an insured suffers a loss. The appellate court therefore rejected the insured's supposition that the policy contained no starting point triggering the time period to file a notice of loss.

The City also reasoned that its omission was important only if it prejudiced TML. The appellate court stated it was aware of the recent Texas Supreme Court precedent reading such an element into an insured's delay of reporting a loss or suit. However, the court differentiated between a clause requiring a timely notification of a loss with a sworn proof of loss. A sworn proof of loss differs given that it provides *prima facie* evidence of a loss, as opposed to simply informing an insurer of a purported loss.

Abatement of statutory extra-contractual claims was proper because the insured must first establish the insurer is liable on the contract.

In Re Colonial County Mut. Ins. Co., No. 01-19-00391-CV, 2019 WL 5699735, at *1 (Tex. App. – Houston [1st Dist.] Nov. 5, 2019).

Abigail Shelger filed a personal injury lawsuit against Lisselotte Ortiz for damages arising from a motor vehicle accident. Shelger later added her insurer, Colonial County Mutual Insurance Company ("Colonial"), as a defendant asserting Colonial failed to pay uninsured/underinsured motorist benefits under her policy. Shelger asserted causes of action against Colonial for breach of contract, as well as extra-contractual causes of action for breach of the common law duty of good faith and fair dealing, and violations of the Texas Insurance Code and Texas Deceptive Trade Practices Act.

Colonial filed a motion to sever and abate Shelger's extra-contractual claims from her underlying UIM claim. Shelger filed a response agreeing that severance and abatement of her common law bad faith claims was proper but requested that her claims for statutory violations only be severed and not abated. The trial court granted Colonial's motion in part, signing an order severing the extra-contractual claims but abating discovery only as to Shelger's common law bad faith claim. The order provided that discovery was not abated as to the severed causes of action for violations of the Texas Insurance Code and Texas Deceptive Trade Practices Act.

On petition for writ of mandamus, the First Court of Appeals held that the trial court abused its discretion in denying abatement of discovery regarding the severed statutory extra-contractual claims. In reaching this conclusion, the First Court of Appeals reasoned:

> An insured must first establish that the insurer is liable on the contract before the insured can recover on extra-contractual causes of action against an insurer for failing to pay or settle a UIM insurance claim. Thus, our Court and others have required extra-contractual claims to be severed and abated until the UIM breach of contract claim is determined. The rationale for requiring severance and abatement of these types of claims is that they may be rendered moot by a determination of underlying liability. (citations omitted).

Accordingly, the First Court of Appeals conditionally granted Colonial's petition for writ of mandamus and directed the trial court to vacate the portion of its order denying abatement of the severed statutory extra-contractual claims.

Prejudice Required to Deny Coverage Based on Settlement Without Consent

Davis v. State Farm Lloyds, Inc., No. 05-18-00969-CV, 2019 WL 5884405, at *1 (Tex. App.—Dallas Nov. 12, 2019).

Curtis Davis was involved in a motor vehicle collision with Jose Manuel Vicencio-Hernandez. Davis was covered by a State Farm insurance policy at the time. Vicencio-Hernandez was underinsured, and Davis notified State Farm that he anticipated presenting a UIM benefits claim.

Davis's policy with State Farm did not provide UIM coverage if he "settle[d] the claim without [State Farm's] written consent." State Farm sent Davis a letter informing him, among other things, of the policy's settlement without consent provision. Nevertheless, evidence was introduced showing that Davis settled with Vicencio-Hernandez for $30,000, his insurer's policy limits, without first obtaining State Farm's written consent to do so.

Davis later sued State Farm asserting claims for UIM benefits, breach of contract, insurance code violations, and a declaration of his rights and duties under the policy. State Farm answered Davis's suit and filed a motion for summary judgment on the ground that Davis's settlement without State Farm's consent triggered the policy's exclusion, which the trial court granted.

On appeal however, the Fifth Court of Appeals reversed the trial court's grant of State Farm's motion for summary judgment because State Farm produced no evidence that it was prejudiced by Davis's settlement without its consent. Pointing to the Texas Supreme Court's opinion in *Hernandez v. Gulf Group Lloyds,* 875 S.W.2d 691 (Tex. 1994), the Court of Appeals reasoned that, in the UIM context, an insured's failure to comply with a consent-to-settlement clause is treated as a potential prior material breach that requires the insurer conclusively proving it was prejudiced by the same. Accordingly, because this was not done by State Farm, the appellate court reversed the trial court's summary judgment and remanded the case for further proceedings.

Testimony and evidence regarding UIM coverage irrelevant because insured previously settled with his UIM carrier

In Re Geico County Mut. Ins. Co., No. 05-20-00259-CV, 2020 WL 2537249 (Tex. App.—Dallas May 19, 2020).

Adam James Ray rear ended Keith Payne in a 2017 automobile collision. Payne was injured and sued Ray, but Ray did not appear or answer the lawsuit. Payne obtained a default judgment against Ray and subsequently sought to recover the amount of the judgment from Geico, Ray's liability insurance carrier. Payne pleaded causes of action for breach of contract, negligence, breach of the duty of good faith and fair dealing, and violations of the Texas Insurance Code and Texas Deceptive Trade Practices Act. Payne alleged that when he obtained a final judgment against Ray for damages, he became a third-party beneficiary under Ray's policy.

Payne had his own insurance policy from Geico as well that provided UIM coverage. However, Payne did not allege any claims against Geico under that policy because he had presented and settled his UIM claims and was not seeking UIM benefits in his lawsuit. Nevertheless, Payne served a notice to depose a Geico representative with a subpoena duces tecum, requesting information on both Ray's liability coverage and Payne's own UIM coverage. Geico filed a motion to quash the notice and for a protective order, which was subsequently denied by the trial court.

However, the Dallas Court of Appeals granted mandamus release to Geico holding that the trial court abused its discretion in permitting discovery relating to Payne's UIM coverage. As the Court of Appeals noted:

> Payne expressly conceded that his coverage under his UM/UIM insurance policy is not at issue in this case. His sole claim is under Ray's liability policy. Consequently, discovery relating to Payne's UM/UIM coverage does not relate to any claim or defense of either party to [Payne's] lawsuit.

Timely payment of an appraisal award does not entitle the insurer to summary judgment on TPPCA claims.

Alcala v. Republic Lloyds, 13-18-00026-CV, 2020 WL 830840 (Tex. App.—Corpus Christi Feb. 20, 2020, no pet.).

The lawsuit arose from the Alcalas' claim for storm damage under his policy with Republic Lloyds and their disagreement over the damages and value of the claim. The Alcalas filed suit, alleging: (1) statutory bad faith claims under both chapter 541 of the insurance code and the Deceptive Trade Practices Act (DTPA); (2) violations of the Texas Prompt Payment of Claims Act (TPPCA); and (3) common law bad faith and fraud claims. Thereafter, the parties entered into the appraisal process, the appraisers agreed on an amount, and Republic Lloyds issued payment. Republic Lloyds filed a motion for summary judgment arguing their timely payment of the appraisal award negated liability for all of the Alcalas' claims as a matter of law. The trial court granted Republic Lloyds' motion for summary judgment and the Alcalas appealed the ruling with respect to their TPPCA claim.

The Alcalas argued that an insurer's payment of an appraisal award does not as a matter of law bar an insured's claim under the TPPCA. The court agreed. Thus, because Republic Lloyds moved for summary judgment solely

on the basis of its timely payment of the appraisal award and such fact does not excuse Republic Lloyds from liability for TPPCA damages in it of itself. Accordingly, the Corpus Christi Court of Appeals reversed the trial court's order with respect to the Alcalas' TPPCA claim.

A Stowers' Cause of Action *May* Arise Without a Final Judgment

In re Farmers Tex. County Mut. Ins. Co., 604 S.W.3d 421 (Tex. App.—San Antonio 2019, *application for mandamus filed*).

The most salient issue addressed by the court was whether an insured had a *Stowers* cause of action against her insurance company when the case settled pre-trial and the insured paid a portion of the settlement as a result of the insurer refusing to pay the entirety of the settlement demand. The San Antonio court of appeals found that the trial court properly refused to dismiss the *Stowers* claim.

Following a 2016 motor vehicle accident, Gary Gibson ("Gibson") sued Cassandra Longoria ("Longoria") for injuries he allegedly suffered in the accident. Gibson sought damages in the amount of $1 million, which exceeded Longoria's $500,000 policy limits. Two years later, the partiers engaged in mediation. The mediator recommended the case settle for $350,000. Gibson sent a *Stowers* demand to Farmers Texas County Mutual Insurance ("Relator") advising the insurance company that he would accept the proposed settlement of $350,000, but Relator rejected the proposal and offered only $250,000. Gibson withdrew the offer to settle and stated he intended to go to trial but continued to engage in settlement negotiations. Gibson then restated he would settle for $350,000. Because Relator again offered only $250,000 and Longoria was facing a trial on the merits, Longoria offered to pay the $100,000 balance. Gibson accepted the offer, and Gibson and Longoria entered into a settlement and release agreement. Relator paid $250,000 and Longoria paid $100,000. Longoria then sued Relator alleging it unreasonably refused to settle Gibson's claim.

In regards to the issue of whether Longoria had a *Stowers* cause of action against Relator when the case settled pre-trial and Longoria paid a portion of the settlement because Relator refused to pay the entirety of the demand, the appellate court concluded that Relator was not entitled to mandamus relief on the *Stowers* claim, but did not take a firm position. The court reasoned that originally, *Stowers* damages arose from a judgment in excess of policy limits. Subsequently, the Texas Supreme Court extended *Stowers* to include a settlement in excess of policy limits in the context an excess carrier's cause of action against a primary carrier. In the case at hand, the court of appeals stated that the principal of law on which Relator relied—that a *Stowers* claim always requires an excess judgment—was not so clearly established "as to be free from doubt." The appellate court, in reaching its conclusion that Relator was not entitled to mandamus relief on Longoria's *Stowers* claim, stated that the viability of the claim pled by Longoria has not been clearly rejected by Texas law.

The court also held that Relator's decision to settle underlying action, which required Longoria to pay a portion of the settlement personally, did not breach its contractual duty to settle or defend. The court stated that Relator elected to settle, thus fulfilling its obligation to "settle or defend" Gibson's claims against Longoria.

"Special Relationship" gives rise to new duty to protect insured from physical harm during claim investigation

Kenyon v. Elephant Ins. Co., ___ S.W.3d ___, 2020 WL 15404392 (Tex. App. – San Antonio April 1, 2020, pet. filed) (en banc).

Lorraine Kenyon was involved in a one-car accident when she lost control of her car and struck a guardrail. She called her husband, Theodore, who came to the scene. Her second call was to her auto insurer, Elephant Insurance Company. Elephant's policy required its insureds to report any accident within 24 hours or as soon as practicable and to cooperate in the insurer's investigation.

As in this case, Elephant's first notice of loss representatives often received calls from insureds at the scene of an accident. Elephant's representatives encouraged its insureds to take photographs of the involved vehicles at the scene and Elephant's representative instructed Lorraine to "go ahead and take pictures." Lorraine asked Theodore to take photographs and while he was doing so, another car's driver lost control on the wet road and struck Theodore, resulting in fatal injuries.

Lorraine, individually and as executrix of her husband's estate, brought suit against Elephant asserting causes of action for misrepresentations under the Texas Insurance Code and DTPA, for common law negligence, negligent undertaking, negligent training and gross negligence and failure to timely pay the Kenyons' UIM claim. Elephant moved for summary judgement on various theories on all claims other than the untimely payment claim. The trial court's order granting summary judgment in favor of Elephant specified that the sole basis for rendering partial summary judgment was that Elephant owed "no duty" to the Kenyons. The trial court granted permission to appeal the order but limited the appeal to the negligence claims. Kenyon's petition for permissive appeal was limited to the existence of a legal duty. The San Antonio Court of Appeals accepted the permissive appeal. The first panel dismissed the appeal in part and affirmed in part. Kenyon's motion for panel rehearing was denied. Kenyon was allowed to file a motion for en banc reconsideration, which was ordered by the court.

The majority held that the "special relationship" between an insurer and its insured gave rise to a duty of good faith and fair dealing, which imposed a duty on the insurer to exercise reasonable care in providing post-accident guidance to the insured so as not to increase the risk of physical harm to the insured. However, in the instant case, the majority stated that the court could only consider the existence of a duty and not whether a duty was breached. For example, the majority rejected Elephant's argument that Kenyon did not have a viable claim for its alleged failure to exercise reasonable care by instructing Kenyon to take photographs because that argument went to the breach of the duty, not the existence of the duty. On the other hand, the majority appeared to give particular weight to the testimony of a police officer stating that people taking photographs at an accident scene increased the risk to first responders, which seems to address whether an instruction to take photographs failed to meet the standard of care, not whether a duty existed in the first place.

Justice Marion and Justice Rodriguez wrote strong dissents. A petition for review has been filed.

Partial Payment of Insured's Claim Did Not Constitute Admission of Liability

Pulley v. Safeco Ins. Co. of America, 800 Fed. Appx. 292 (5th Cir. 2020) (*per curiam*).

In an insurance coverage dispute, the Fifth Circuit affirmed the district court's grant of summary judgment to Safeco Insurance Company ("Safeco") holding that a partial payment in response to Pully's claim did not constitute an admission of liability.

Plaintiff Sandford Pulley's ("Pulley") insurance claim arose out of damage sustained to a house that Pulley owned. The district court initially granted summary judgment on Pulley's claims on the grounds that Pulley's status as a landlord, rather than as a resident, precluded coverage under his policy, and additionally, that Pulley had violated his policy's prompt-notice requirement. Pulley argued that summary judgment was improper because liability was not in dispute, given that Safeco had sent Pulley a check in response to his claim. According to Pulley, the check was insufficient to offset his repair costs and the only issue in dispute was the amount of damages. However, the Fifth Circuit noted that Pulley failed to provide any legal authority for his contention that Safeco's partial payment is an admission of liability and further failed to address the district court's bases for dismissal on appeal.

In addition, the Fifth Circuit denied Pulley's request to file a fourth amended complaint, noting that Pulley's proposed fourth amended complaint and his operative third amended complaint both stated identical claims with respect to Safeco. Since Safeco did not admit liability on partial payment, Pulley's appeal was dismissed.

No Duty to Defend Wrongful Death Suit Pursuant to "Covenant Not to Execute" as Settlement Under Primary Policy.

Aggreko, L.L.C. v. Chartis Spec. Ins. Co., 942 F.3d 682 (5th Cir. 2019).

In this multi-party insurance dispute, the Fifth Circuit held that under an *Erie* analysis applying both Texas and Louisiana law, payments of policy limits in exchange of a "Covenant Not to Execute" may constitute a "settlement" under the primary policy discharging the primary carrier's duty to defend.

This insurance dispute originated from an underlying lawsuit in which the parents of a rig worker, Brenek, brought suit against Aggreko LLC ("Aggreko"), which had leased the generator involved in the accident to Guichard Operating Company ("Guichard"), a drilling subcontractor who was the deceased worker's employer. At the time of the accident, Guichard had a primary commercial liability policy issued by The Gray Insurance Company ("Gray") with an excess commercial liability policy issued by Chartis Specialty Insurance Company ("ASIC"). Aggreko had a primary insurance policy issued by Indian Harbor Insurance Company ("Indian Harbor") and was recognized as an additional insured under the Gray policy. AISC, on the other hand, refused to qualify Aggreko as an additional insured under its excess policy to Gray.
Regardless of ASIC's coverage position, Gray – in its tendered defense of Aggreko – agreed to pay the Brenek plaintiffs $950,000, which represented Gray's policy limits, in exchange for the Breneks' agreement to execute any subsequent judgment as to Aggreko only against available remaining insurance. Further, the parties' "Covenant Not to Execute" provided for a proportional reduction of damages and agreed that the

Breneks would no longer be able to enforce any judgment against the assets of Aggreko or its officers. After the "Covenant Not to Execute," Gray took the position that its policy limits were exhausted and subsequently withdrew from the defense of Aggreko.

Indian Harbor, Aggreko's primary carrier, sued Gray seeking a declaration that Gray's duty to defend was not exhausted by the "Covenant Not to Execute" with the Breneks. The trial court granted Gray's motion, holding that under Texas law, Gray's payment in exchange for the "Covenant Not to Execute" constituted a settlement against policy limits which exhausted Gray's remaining obligations to defend.

The Fifth Circuit agreed. Under an *Erie* application of Texas law, the Fifth Circuit believed that the Texas Supreme Court, based on court of appeals precedent, would have concluded that a valid settlement was entered into between Gray and the Breneks. Specifically, the Fifth Circuit noted that under the "Covenant Not to Execute," Aggreko received the full benefit of resolution of a portion of monetary claims against it and a step towards a full release, including an agreement not to execute any judgment directly against Aggreko. Additionally, the Texas Supreme Court in *Soriano* and its progeny specifically allowed for an insurer to enter into a reasonable settlement with one of the several claimants even though such settlement may exhaust or diminish the proceeds available to satisfy other claims. While the absence of multiple, independent claimants distinguished this case from *Soriano*, the Fifth Circuit interpreted *Soriano* as an inclination from the Texas Supreme Court to allow an insurer to reasonably exhaust its duties to its insured under the terms of its policy, including its duty to defend, even though it has not resolved all pending liability claims against the insured.

Finally, the Fifth Circuit also made an *Erie* guess under Louisiana law and concluded that the same result would apply. While this decision allows a primary carrier to exercise some leverage over an excess carrier in settlement negotiations, the Fifth Circuit cautioned that:

> [W]e recognize that, in some instances, insurers may be compelled to improperly and hastily hand over their policy limits to rid themselves of the duty to defend their insured. We reiterate that such a situation is not before us, as there is no suggestion or indication in the record that the Breneks' damages do not exceed the Gray policy limit or that Gray did not properly investigate the Breneks' claim on behalf of Aggreko. Thus, our decision should not be construed as in any way limiting remedies to insureds under Texas or Louisiana law against insurers who have improperly or in bad faith handled their claims.

Higher Windstorm Deductible Trumps Flood deductible when damage is flooding caused by a named windstorm

Pan Am Equities, Inc. v. Lexington Ins. Co., 959 F.3d 671 (5th Cir. 2020).

This case arises out of damage to two of Pan Am's Houston buildings caused *solely* by flood after Hurricane Harvey. Lexington admitted the claim was covered but argued that the higher Windstorm deductible instead of the Flood deductible applied. Pan Am, on the other hand, argued that the Flood deductible applied because there was no wind damage and the anti-concurrent causation clause stated that the Flood deductible

applied to Flood damage regardless of any contributing cause.

The Fifth Circuit Court of Appeals held that based on the policy's plain language, the Windstorm deductible applied because the accompanying Named Storm provision expanded what constituted a loss due to Windstorm to also include Hurricane Harvey's flood damage to Pan Am's buildings. Further, even if both the Windstorm and Flood deductibles applied, the Anti-Stacking imposed the largest deductible applicable, so the Windstorm deductible would still apply. The court reasoned that to read the policy so that flood losses caused by a named storm fall exclusively under the Flood deductible would render the Named Storm provision a nullity.

Vague Reference to "Other Services" in Complaint Did Not Preclude Application of Professional Services Exception

Project Surveillance, Inc. v. Travelers Indemnity Co., Civ. No. 4:19-CV-03324, 2020 WL 292247 (S.D. Tex. 2020) (mem. op.).

At issue in this insurance coverage dispute is whether a vague allegation that the insured provided "other services" precluded application of a professional services exception to a Commercial General Liability policy.

Project Surveillance, Inc. ("Project Surveillance") is a company specializing in safety supervision and other services for construction projects. In 2017, various plaintiffs sued Project Surveillance in state court, alleging Project Surveillance failed to provide for the safety of a construction site leading to the death of a worker (the "*Tajada* Pleadings"). At the time of the accident, Project Surveillance was covered by a Professional Liability Insurance Policy issued by RLI Insurance Company ("RLI") and a Commercial General Liability ("CGL") policy issued by Travelers Indemnity Co. ("Travelers"). RLI agreed to defend pursuant to a reservation of rights, but Travelers declined coverage based on the Professional Services Exclusion in the CGL Policy. The Professional Services Exclusion applies to any bodily injury arising out of the rendering or failure to render any "professional services," which includes "any service requiring specialized skill or training."

Project Surveillance filed suit against Travelers, seeking a declaratory judgment that Travelers has a duty to defend and indemnify. Travelers moved for a motion to dismiss, asserting that the allegations against Project Surveillance precluded coverage under the Policy's professional services exception. Project Surveillance did not dispute that its provision of safety supervision is a professional service but argued that "the vague allegation [in the '*Tajada* Pleadings'] that Project Surveillance provided 'other services' precludes application of the exclusion." According to Project Surveillance, because it is impossible to determine whether the *Tajada* pleadings asserted claims related to professional services or some 'other services,' there was potentially a case under the complaint within the coverage of the policy.

Rejecting Project Surveillance's contentions, the court found that the *Tajada* allegations do not, in fact, potentially support a covered claim. The court noted that the *Tajada* pleadings listed six specific allegations of negligence, which even when construed liberally, arose out of claims of failure to provide safety supervision. As indicated, the *Tajada* allegations described failures "to inspect ... the project", "to warn ...", "to

assure ... [safety]", "to verify ...", "to report or require ...", and "to stop work when adequate ...". According to the court, this language was, at least in substance, very similar to the examples given in the Traveler's CGL exclusions, which additionally brings it within the Professional Services Exclusion.

Earth Movement And Defective Work Exclusions Preclude Defense and Indemnity in Construction Defect Claim.

Mid-Continent Cas. Co. v. McCollum Custom Homes, Inc., Civ. No. 4:18-CV-4132, 2020 WL 3549830 (S.D. Tex. 2020).

This insurance coverage dispute involves an underlying construction defect suit between Thomas and Jodie Mark (the "Mark Family") and the insured, McCollum Custom Homes, Inc. ("McCollum"), who purchased a commercial general liability insurance policy ("Policy") from Mid-Continent Casualty Company ("Mid-Continent"). The Mark Family alleges that McCollum, who was the general contractor in the construction of their home, constructed the building in a defective manner which led to "leaking windows; hundreds of dry-wall, mortar, and brick cracks; and extensive foundation movement." According to the Mark Family, the root cause of these issues is a defective foundation caused by McCollum's failure to properly assess risks relating to moisture levels in the soil when removing the trees prior to construction. McCollum sought defense coverage from Mid-Continent, which denied coverage based on the following two exclusions. The first "Earth Movement" exclusion provides that:

> This insurance does not apply to any "bodily injury" or any "property damage", that is directly or indirectly caused by, involves, or is in any way connected or related to any movement of earth, whether naturally occurring or due to manmade or other artificial causes.
>
> Movement includes, but is not limited to, settlement, cracking, contraction, compaction, compression, consolidation, subsidence, shrinking, expansion, heaving, swelling, caving-in, erosion, vibration, shock, earthquake, landslide, mudflow, wind-driven, freezing, thawing or any other movement of earth, regardless of the cause.
>
> Earth includes, but is not limited to any dirt, soil, terrain, mud, silt, sediment, clay, rock, sand, fill material or any other substances or materials contained therein.

The second "Defective Work" exclusion precludes coverage for "any and all costs associated with the removal or replacement of the defective, deficient, or faulty work." Work is defined as:

> "Your Work":
>
> a. Means:
>
> (1) Work or operations performed by you or on your behalf; and
>
> (2) Materials, parts or equipment furnished in connection with such work or operations.
>
> b. Includes:
>
> (1) Warranties or representations made at any time with respect to the fitness, quality, durability, performance or use of "your work"; and
>
> (2) The providing of or failure to provide warnings or instructions.

> "Defective Work" means "Your Work" that is defective, deficient, non-conforming, not in accordance with plans and specifications, fails to satisfy applicable building code(s), fails to meet industry practice standards, is not fit for its intended use, not performed in a workman like manner or is faulty, and is included in the products-completed operations hazard.

After Mid-Continent denied coverage, it filed a declaratory judgment seeking a declaration that its Policy imposes no duty to defend or indemnify.

In reviewing the Mark Family's factual allegations under Texas's Eight-Corners Rule, the court assessed the complaint's allegations in three categories: (1) defects in the crowning of the floors and the unacceptable marks on the floor planks caused by allegations of mishandling of the flooring material by McCollum and its agents; (2) allegations of leaks from the window and roof leading to damages to walls, bricks, roofs, windows, doors, flooring and pool resulting from alleged foundation issues, and (3) alleged pool damages which McCollum claims are due to actions of an unrelated third party.

As to the floor damage, the court found that the defects in floor crowning and unacceptable floor plank marks fall within the Defective Work exclusion. The alleged causes of those defects, the court noted, could only be attributed to McCollum's work on the floors being "defective, deficient, non-conforming," or "fail[ing] to meet industry practice standards." In addition, they would also fall within the property damage exclusion since the "flooring must be repaired or replaced due to McCollum's allegedly shoddy work." Thus, those defects were properly excluded from coverage under the Policy.

Second, the court found that the damages to the walls, bricks, and other foundational structures were properly excluded by the Earth Movement Exclusion under the core theory that McCollum and/or its agents failed to conduct a proper risk assessment prior to building the home's foundation. Applying the plain language of the Earth Movement Exclusion, the court did not interpret, as McCollum did, that the complaint incorporated alternative theories for the alleged other defects other than issues related to the foundation. Further, the court distinguished McCollum's reliance on *Wilshire Ins. Co. v. RJT Constr.*, LLC, 581 F.3d 225 (5th Cir. 2009) by holding that RJT's policy specifically precluded coverage for "earth moving" actions resulting from the insured's own operations, whereas Mid-Continent's Earth Movement exclusion contained no such requirement. Thus, the court rejected McCollum's argument that because it did not physically cause the soil to move, the Earth Moving exclusion cannot apply.

Finally, addressing McCollum's evidence that a duty to defend is a necessary predicate in order to show that a third-party was actually responsible for the alleged pool defects, the court held that under the Eight-Corners Rule, the only inference from the underlying petition suggested that the damage allegedly resulted from the foundation movement and from the defective work performed, not from actions of any third party. Because there was no allegation relating to the alleged negligence by a third party, the court could not consider extrinsic evidence in evaluating Mid-Continent's duty to defend.

Because the court held that Mid-Continent did not have a duty to defend, there was correspondingly no duty to indemnify.

Following the district court's decision, an appeal of this case has been filed with the Fifth Circuit by McCollum.

Abstention Factors Did Not Warrant Dismissal of Insurer's Federal Declaratory Action.

Cincinnati Spec. Underwriters Ins. Co. v. Henry Z. Roofing, LLC, Civ. No. 3:20-CV-0606-D, 2020 WL 2745656 (N.D. Tex. 2020).

In a federal declaratory action filed by Cincinnati Specialty Underwriters Insurance Company ("Cincinnati"), the Northern District of Texas declined to exercise its discretionary authority to dismiss based on an evaluation of the abstention factors and further denied the defendants' requests for Rule 11 sanctions.

Cincinnati issued a commercial general liability policy to Henry Z. Roofing, LLC ("HZR"). On June 1, 2018, Ruth and Clinton Gantt (collectively the "Gantts") sued HZR, its owner Henry Zrubek ("Zrubek"), and the Gantts' homeowner policy insurer Safeco Insurance Company of Indiana ("Safeco") for damages related to the alleged destruction of the Gantts residence by fire on December 15, 2017. Gantts also brought claims for negligence and for violation of the DTPA, alleging, in pertinent part, that HZR caused the fire by using a torch while repairing the roof but did not possess a fire extinguisher. Cincinnati defended HZR and Zrubek under a reservation of rights, but sought a declaratory judgment that it had no duty to defend or indemnify based on the Policy's "Roof Limitation Endorsement," which purports to preclude coverage for applicable work when the insured fails to maintain a fire extinguisher. The Gantts moved to dismiss, requesting that the federal court decline to exercise jurisdiction under its discretionary powers to hear declaratory actions, and further requested sanctions and fees under Rule 11.

Addressing the Rule 11 issue first, the court held that Gantts's request for reimbursement of costs and fees is procedurally defective because (1) the Gantts did not file a separate Rule 11 motion, instead impermissibly requesting such sanctions in their reply brief, and (2) the Gantts did not wait for the 21-day "safe harbor" period to elapse before filing their motion. Substantively, the court also rejected the Gantts's arguments that Cincinnati violated a local rule requiring attachment of related cases along with Cincinnati's complaint, and that Cincinnati purportedly engaged in forum shopping by seeking a declaratory judgment in federal court when a state court action is pending. Neither, in the court's view, merited Gantts's request for sanctions.

Moving to Gantts's request for abstention in response to Cincinnati's declaratory judgment, the court first noted that Cincinnati's duty to indemnify is not ripe because the underlying tort suits against HZR are pending. However, the court found it should not abstain from adjudicating Cincinnati's declaratory judgment action on the issue of the duty-to-defend based on the seven, nonexclusive factors, set forth in *St. Paul Ins. Co. v. Trejo*, 39 F.3d 585 (5th Cir. 1994) ("*Trejo* factors") as follows:

> (1) whether there is a pending state action in which all of the matters in controversy may be fully litigated;

(2) whether the plaintiff filed suit in anticipation of a lawsuit filed by the defendant;

(3) whether the plaintiff engaged in forum shopping in bringing the suit;

(4) whether possible inequities in allowing the declaratory plaintiff to gain precedence in time or to change forums exist;

(5) whether the federal court is a convenient forum for the parties and the witnesses;

(6) whether retaining the lawsuit would serve the purposes of judicial economy; and

(7) whether the federal court is being called on to construe a state judicial decree involving the same parties and entered by the court before whom the parallel state suit between the same parties is pending.

On the first *Trejo* factor, the court concluded that the issues involved in the declaratory judgment action will not be fully litigated in the underlying state proceedings because Cincinnati is not, and cannot, be joined as a party to either state court action. Thus, the federal court's ruling as to Cincinnati's contractual obligations has no direct bearing on the underlying state cases which address the liability of HZR and Zrubek independent and separate from Cincinnati's contractual duties.

As to the second and third factors, the court noted that Cincinnati filed the instant lawsuit based on diversity jurisdiction after the state court suits were filed, and that the declaratory judgment action will apply Texas law. Thus, the risk of forum shopping is low.

The fourth and fifth factors also weigh against abstention, as the court found that Cincinnati will not gain precedence if the case continues, and the Northern District of Texas will be a convenient forum as the Gantts reside within the forum and are unlikely to need witnesses who may live elsewhere.

Finally, the court noted that this federal litigation is not unduly burdensome or duplicative on top of the state court litigation because the court will address, as discussed in factors 1 and 2 above, an issue not reached by the state court. Finally, factor seven also weighs against abstention as the federal court was not being asked to construe a state judicial decree involving the same parties.

Thus, the federal court declined to dismiss the declaratory judgment action by Cincinnati, but deferred its adjudication of the duty to indemnify until the state court proceedings have concluded.

Genuine Dispute over Concurrent Causes of Storm Damage Precludes Summary Judgments in Insurance Coverage Dispute

Ironwood Building II, Ltd. v. AXIS Surplus Ins. Co., Civ. No: SA-19-CV-00368-XR, 2020 WL 1234641 (S.D. Tex. Mar. 3, 2020).

Applying the concurrent-cause doctrine, a Western District of Texas court denied competing summary judgment motions based on a factual dispute over independent causation.

In 2016, a hailstorm damaged the Plaintiffs' office building, which was insured at the time by Liberty Mutual Fire Insurance Company ("Liberty"). Plaintiffs did not repair the roof, as the building continued to function without any water leakage. However, Liberty under

its policy tendered $188,275.00 to the Plaintiffs, which per policy represented the replacement cost less deduction for depreciation.

A year later, Plaintiffs entered into a new insurance policy with AXIS Surplus Insurance Company ("AXIS"), which offered a similar replacement cost coverage for the building. On February 19, 2017, a tornado severely damaged the building, which led to leaking and extensive interior damage. Even though the assessed replacement cost was $470,957.64, AXIS only tendered $232,682.64, discounting, after applicable policy deductible, the $188,275.00 already paid by Liberty to fix or replace the roof a year prior.

Plaintiffs brought suit against AXIS and disputed on summary judgment the narrow issue of whether AXIS could be held liable for breach of contract when it deducted the $188,275.00 already paid by Liberty a year prior from the total estimate costs. While the parties centered their dispute around contract interpretation, the court noted that this issue in fact turned on the application of the concurrent-cause doctrine. Under the doctrine, an insured may recover if he or she suffers damages from both a covered and non-covered peril, but only in proportion to the extent of damages caused solely by the covered peril. The insured must then produce evidence that will afford a reasonable basis for estimating the amount of damages or proportionate part of damages caused by a covered risk. However, where the loss is caused by both a covered and excluded peril, each of which constituted an independent cause of the loss, the insurer is liable. Thus, the concurrent-cause doctrine applies to limit recovery only when the loss is caused by two concurrent causes instead of two independent causes.

Unresolved in the parties' summary judgment motions was whether the 2016 hailstorm and the 2017 tornado constituted concurrent or independent causes of the $470,957.64 total damage. AXIS's position was that both perils combined to create the loss, and therefore segregation was necessary. In response, Plaintiffs have raised a fact issue as to whether the causes were independent by pointing out that the roof did not leak after the 2016 hailstorm. The court denied both parties' summary judgment motion to conduct additional discovery on this causation issue.

Insurer has right to cancel policy for any reason other than insured being elected to political office.

Smith v. State Farm Lloyds, No. 2:18-CV-210-Z-BP, 2020 WL 2832393 (N.D. Tex. June 1, 2020).

Beginning in 2012, Smith insured her house with State Farm. In 2017, State Farm paid Smith for hail damage to the roof, but Smith did not immediately repair the roof. In February 2018, State Farm wrote a letter to notify Smith that it would not renew the policy because Smith delayed repairing the roof. The Nonrenewal Letter stated that coverage would expire on March 14, 2018. A fire destroyed the house on May 1, 2018, and Smith filed an insurance claim for the loss.

State Farm denied the claim because it claimed that no valid insurance contract existed when the house burned down. Smith claimed she never received the Nonrenewal Letter. The court, comparing the Nonrenewal Letter to the difference between completing and mailing an income tax form, held that State Farm’s business records affidavit supported that it generated the Nonrenewal Letter, not that it mailed it. Such additional

evidence could include an affidavit stating the Nonrenewal Letter was mailed, a certified mail return receipt, or other method.

The court also rejected State Farm's argument that Smith's nonpayment of premiums constituted an automatic nonrenewal because State Farm never billed Smith for the premiums it intended not to renew. However, the court agreed with State Farm that it could decline to renew the policy due to Smith's delay in building the roof because an insurer has a right to not renew a policy for any reason other than the insured's being elected to political office.

Strict compliance with sending a proof of loss containing all information listed in a Standard Flood Insurance Policy ("SFIP") is a condition precedent to coverage.

Morgan v. Texas Farmers Ins. Co., No. 2:18-CV-401, 2020 WL 553570 (S.D. Tex. Feb. 4, 2020).

The court in this case held that strict adherence to all terms of the SFIP is required to trigger coverage when the federal treasury is responsible for paying flood claims. Plaintiffs Frank Hilton Morgan, Jr. and Nancy Lawson Morgan (collectively, "Plaintiffs") disputed Defendant Texas Farmers Insurance Company's ("Defendant") valuation of flood damage to their home after Hurricane Harvey. Unable to resolve the issue, Plaintiffs hired Thomas M. Furlow ("Furlow") to handle their flood insurance claim.

Furlow submitted a proof of loss dated August 25, 2018, the last day of the one-year deadline extended by the Federal Emergency Management Agency ("FEMA") but did not attach any supporting documents. Defendant argued that Plaintiffs' proof of loss failed to include an "inventory of the damaged property showing the quantity, description, actual cash value, and amount of loss" and "specifications of damaged buildings and detailed repair estimates" as required under the SFIP. Plaintiffs contended they properly supplemented their proof of loss at a later date when they provided a line-item estimate of damage to the home in their initial disclosures and a list of individuals who performed work at the home in their responses to Defendant's interrogatories and requests for production.

The court found the supplementation was untimely and was not considered part of the proof of loss's supporting documentation. The line-item estimate was calculated on September 5, 2018 and not provided to Defendant until April 5, 2019, and the list of individuals who performed work was not provided until May 3, 2019. Accordingly, the court held that Plaintiffs' proof of loss did not comply with the requirements of the SFIP.

The existence of a bona fide coverage dispute precludes a finding of bad faith to support an insured's extra-contractual claims against the insurer.

Alvarez v. State Farm Lloyds, No. SA-18-CV-01191-XR, 2020 WL 1033657 (W.D. Tex. Mar. 2, 2020).

After Alvarez filed a claim for damage to his roof due to hail and windstorms, State Farm immediately sent an adjuster, Gilbert Santos ("Santos"), to inspect the roof. Santos did not identify any wind or hail damage to the roof. Instead, he discovered design defects to the tiles and issued a denial letter to that effect, advising Alvarez to contact the tile manufacturer or distributor to address the damage. State Farm subsequently issued a check for $370 for a tile a State Farm

representative damaged during the inspection.

Thereafter, Alvarez hired Ricky McGraw of McGraw Property Solutions ("McGraw") to inspect the roof. McGraw informed State Farm that he believed the roof was damaged by wind and hail and estimated the cost to replace the roof at $289,404.93. Santos then hired Armando Selva ("Selva"), a professional engineer of ProNet Group, Inc. to provide a second opinion. Selva concluded that the damaged tiles were a result of deficient installation means and methods, corroded tile nails, expansion and contraction of the tiles, and foot traffic. However, Selva noted several dents on the roof vent caps were caused by hail. As a result, State Farm issued a second denial letter, providing an estimate to replace four roof vent caps at $460.93, which was below the $25,324 deductible under the policy.

Alvarez filed suit against State Farm for breach of contract and three extra-contractual claims (violations of the DTPA and its tie-in statutes, violations of the Texas Insurance Code, and breach of the common-law duty of good faith and fair dealing). Because extra-contractual claims all share the same predicate for recovery—a showing of common-law bad faith—the court granted summary judgment in favor of State Farm on all of the extra-contractual claims because State Farm had a reasonable basis to deny coverage. To prevail on a bad faith claim, an insurer must show there were no facts that would justify denial of the claim, but a bona fide dispute is sufficient a reason for an insurer to not promptly pay a claim. In fact, as long as the insurer has a reasonable basis to deny or delay payment of a claim, even if that basis is eventually determined by the fact finder to be erroneous, the insurer is not liable for the tort of bad faith.

The court found State Farm conducted a reasonable investigation into Alvarez's claim, and the fact that experts on both sides disagreed about whether damage to the roof was caused by hail and wind is further evidence that there was a bona fide dispute. Consequently, the court concluded the facts of the case did not rise above a bona fide dispute even if a jury eventually sides with Alvarez and finds the damage was caused by hail.

A failure to provide a complete and sworn proof of loss as required by the Standard Flood Insurance Policy ("SFIP") relieves the insurer from paying what otherwise may be a valid claim, and even substantial compliance is not enough.

Blue v. Wright Nat'l Flood Ins. Co., No. 1:18-CV-499, 2020 WL 975367 (E.D. Tex. Feb. 10, 2020).

On or about August 25, 2017, Hurricane Harvey flooded Eric Blue and Katrina Blue's (collectively, "Plaintiffs") home for several days. Wright National Flood Insurance ("Wright") sent an adjuster to inspect Plaintiffs' home and prepare a proof of loss. Plaintiffs claimed they felt forced to sign and submit the adjuster-prepared proof of loss in order to receive an initial damage assessment payment. Thereafter, Plaintiffs filed suit against Wright for breach of contract.

The court held that a sworn proof of loss was a condition precedent to filing suit. Because the federal treasury is responsible for paying flood claims, all provisions of the SFIP, including the proof of loss requirement, are strictly construed and enforced. In this case, Plaintiffs had until August 29, 2018, one year from the date of loss to file a compliant proof of loss. Wright received the proof of loss on September 20, 2018, but the proof of loss was

purportedly signed and dated by Katrina Blue on August 25, 2018. However, in her deposition, Katrina Blue testified that she did not sign the proof of loss until August 31, 2018. Thus, the proof of loss was untimely.

Additionally, the proof of loss made a claim for $372,507.49, but Katrina Blue testified in her deposition that she was only seeking a claim for amounts paid to two contractors totaling $45,620. She also admitted she never signed a sworn proof of loss correctly setting the amount of damages she sought under the policy. Therefore, Plaintiffs were not seeking benefits specified in the proof of loss. The court concluded that Plaintiffs' failure to submit a proper proof of loss barred them from seeking damages under the SFIP.

A determination of whether an insurer has a duty to defend constitutes a justiciable controversy under the Texas Declaratory Judgment Act ("TDJA") to defeat an argument of improper joinder and support remand for lack of subject matter jurisdiction based on diversity.

Boy Scouts of Am. v. Hartford Accident & Indem. Co., 443 F. Supp. 3d 753 (N.D. Tex. 2020).

In this case, the court denied the motion to remand although the parties did not have complete diversity of citizenship because the court had "related to" jurisdiction due to the pending Chapter 11 bankruptcy case. On June 5, 2018, the Boy Scouts and local councils filed their Original Petition in state court, seeking a declaratory judgment among other claims. On May 31, 2019, Hartford Accident and Indemnity Company and First State Insurance Company (collectively, "Hartford") filed a notice of removal, arguing that Connecticut Yankee Council ("Connecticut Council") was improperly joined to defeat diversity jurisdiction (both defendants were also citizens of Connecticut).

While removal is only proper in cases with complete diversity of citizenship, a non-diverse defendant may be disregarded in analyzing complete diversity if the non-diverse defendant was improperly joined. The removal party bears a heavy burden to establish improper joinder. In order to establish improper joinder, Hartford must demonstrate that Connecticut Council had no possibility of recovery, which it could not do. During discovery, Hartford claimed it discovered that Connecticut Council had not incurred defense costs and that such costs were born by the Boy Scouts, which rendered Connecticut Council's declaratory judgment claim not justiciable. Based on the eight-corners rule, however, Connecticut Council had a justiciable claim that Harford was obligated to defend Connecticut Council. The relevant policies listed Connecticut Council as an insured and obligated Hartford to defend Connecticut Council against personal injury claims, which the petition alleged. Even considering evidence outside the eight-corners, which the parties referred to extensively, the court found the evidence did not conclusively show that Connecticut Council had not incurred defense costs because the state court suit was ongoing. The inability to make the requisite decision in a summary manner itself pointed to an inability of the removing party to carry its burden.

Therefore, the court concluded that Connecticut Council was not improperly joined and there was not complete diversity amongst the parties. However, federal courts have "related to" subject matter jurisdiction over litigation arising from a bankruptcy case if the proceeding could conceivably affect the estate being administered in bankruptcy. Because the outcome of the Texas coverage

action would undoubtedly have a substantial effect on the Boy Scout's estate, the court denied the motion to remand without prejudice pending a second motion to remand based on the court's "related to" jurisdiction and other matters.

The focus in determining whether the operation exception to the Aircraft, Auto, or Watercraft exclusion (the "Auto exclusion") applies is on the injury arising from the operation of the equipment, not the injury arising from operation of self-propelled vehicles with permanently attached equipment.

Markel Ins. Co. v. 2 RJP Ventures, LLC, No. 4:19-cv-41-ALM-KPJ, 2020 WL 1465893 (E.D. Tex. Mar. 26, 2020).

A piece of equipment, a gasoline-powered portable inverter-generator, was left running in Ross Powell's van, killing both him and his father with carbon monoxide. The father's two surviving daughters filed suit against 2 RJP, which was defended by Markel, and received a large jury verdict. Markel then filed suit in federal court, seeking a declaration that it had no duty to defend or to indemnify 2 RJP.

The parties agreed that the Auto exclusion applied, but Markel argued that the operation exception, which stated that the Auto exclusion does not apply to bodily injury arising out of "[t]he operation of any of the machinery or equipment listed in Paragraph f.(2) or f.(3) of the definition of 'mobile equipment'" did not apply. Markel contended that because the prefatory language of Paragraph f provided that "self-propelled vehicles with the following types of permanently attached equipment are not 'mobile equipment' but will be considered 'auto,'" the operation exception only applied to the extent the generator was permanently attached to a self-propelled vehicle. However, the subject generator was not permanently attached to the 2 RJP van.

Finding the reasoning in cases from other circuits persuasive, the court concluded that the equipment in the operation exception did not need to be permanently attached for the exception to apply. The correct way to interpret the exception was to look to injury arising from the operation of the equipment, not injury arising from operation of self-propelled vehicles with permanently attached equipment. Thus, Markel had a duty to defend and indemnify 2 RJP.

Courts apply the *Hensgens* factors to decide whether to deny joinder of non-indispensable parties that occur after an action is removed or to permit it and remand the action.

Ramadanovic v. Reyes, No. 3:20-CV-0297-B, 2020 WL 1529022 (N.D. Tex. Mar. 31, 2020).

After removal from state court, Plaintiff Aida Ramadanovic ("Plaintiff") sought to amend her complaint to substitute Government Employees Insurance Company ("GEICO") with GEICO County Mutual Insurance Company ("GEICO County") because she sued the wrong insurance company. Because Plaintiff is also a citizen of Texas, replacing GEICO, a Maryland citizen, with GEICO County, a Texas citizen, would destroy the federal court's subject matter jurisdiction.

Defendants Constantino Reyes, Liberty Freight Co., and GEICO (collectively, "Defendants") opposed Plaintiff's motion on the ground that GEICO County was a fraudulently joined party. However, the fraudulent joinder doctrine does not apply to

joinders that occur after an action is removed. Instead, the court applied the four factors in *Hensgens v. Deere & Company* from the Fifth Circuit to determine whether to deny joinder. The factors are: (1) the extent to which the purpose of the amendment is to defeat federal jurisdiction, (2) whether plaintiff has been dilatory in asking for amendment, (3) whether plaintiff will be significantly injured if amendment is not allowed, and (4) any other factors bearing on the equities.

The court concluded that only one *Hensgens* factor weighed in favor of Plaintiff—that she was not dilatory because she sought to amend one day after removal. The remaining factors favored denying Plaintiff's motion to remand. The court noted the fact that Plaintiff waited until after removal to join GEICO County suggested that the purpose of the amendment was to defeat the court's subject matter jurisdiction, and that Plaintiff would not be significantly injured if the court denied her request for an amendment because Plaintiff could still pursue her claim against GEICO County in state court. Additionally, the court found that Defendants had an enhanced interest in the federal forum because they were seeking consolidation of the case with another case before the court, involving the same car accident and both Reyes and Liberty Freight.

Conflicting evidence regarding the amount of damages, the cause of the damage, and the insured's handling of the claim support the existence of a bona fide dispute to defeat extra-contractual claims based on bad faith but not a breach of contract claim at the summary-judgment stage.

Mt. Javed Ventures, Ltd. v. Mt. Hawley Ins. Co., No. 1:18-CV-519, 2020 WL 2045550 (E.D. Tex. Apr. 7, 2020).

Plaintiff Mt. Javed Ventures, Ltd.' ("Plaintiff") filed an insurance claim with Defendant Mt. Hawley Insurance Company ("Defendant") for damage its property sustained as a result of Hurricane Harvey. Defendant retained Vericlaim, Inc. ("Vericlaim") to inspect the property; Vericlaim only found minor damage totaling $6,139.39, which was less than Plaintiff's $25,000 deductible. Plaintiff hired BNRB Construction ("BNRB") to provide a second opinion; BNRB found $482,096.47 in damages caused by wind and water.

In response, Defendant hired independent adjusters with Engle, Martin & Associates to reinspect the property, but the adjusters found no damages caused by Hurricane Harvey. Plaintiff then filed suit for breach of contract, violations of the DTPA and its tie-in statutes, violations of Chapters 541 and 542 of the Texas Insurance Code, and breach of the duty of good faith and fair dealing. Defendant moved for summary judgment on all causes of action.

The court found Plaintiff provided sufficient evidence to defeat summary judgment for the breach of contract claim. In fact, Defendant's own claim showed that Vericlaim found wind damage to the property, which contrasted Vericlaim's final assessment report. Also, Plaintiff's expert found evidence of severe storm damage to the roof, and Plaintiff also provided testimony that no water stains were noticed prior to Hurricane Harvey. The court concluded that lay testimony was sufficient to support a finding that a storm caused property damage in insurance coverage cases and denied summary judgment on this claim. In the same vein, the court could not grant summary judgment on the claim for

wrongfully delaying payment under Chapter 542 of the Texas Insurance Code, which was dependent on Defendant's liability under the breach of contract claim.

Conversely, the court found that Defendant acted reasonably under the circumstances to grant summary judgment on the claims for breach of the duty of good faith and fair dealing and violations of Chapter 541 of the Texas Insurance Code and DTPA. Evidence establishing only a bona fide dispute precludes liability for breach of the duty of good faith and fair dealing and violations of the Texas Insurance Code and DTPA. Therefore, the court held that the existence of conflicting evidence on the amount of damages, the cause of the damage, and Defendant's handling of the claim showed that liability had not become reasonably clear.

On motion to remand, any ambiguities are construed against removal and in favor of remand.

Project Vida v. Phila. Indem. Ins. Co., EP-20-CV-00082-DCG, 2020 WL 2220193 (W.D. Tex. May 7, 2020).

After a hailstorm, Plaintiffs Project Vida and P.V. Community Development Corporation (collectively, "Plaintiffs") filed several claims to Defendant Philadelphia Indemnity Insurance Company ("Defendant") for their multiple properties, including the Pera Property and the Maxwell Property. Defendant hired Robert L. Betts ("Betts") as the adjuster for the Pera Property, which was insured under policy no. PHPK1458047 (the "8047 Policy"). The Maxwell Property was insured under policy no. PHPK1779181 (the "9181 Policy").

The parties disputed the costs and cause of damage to the properties, and Plaintiffs hired counsel to demand payment for damages to the properties, including the Pera Property and Maxwell Property. In response, Defendant sent a letter to Plaintiffs under § 542A.006(a) of the Texas Insurance Code to inform of its election to accept Bett's liability to Plaintiffs. Plaintiffs filed suit against Defendant and Betts for their alleged mishandling of the Pera Property claim. Defendant removed the suit to federal court on diversity jurisdiction, arguing that Betts was improperly joined because it already notified Plaintiffs that it accepted Bett's liability.

The court acknowledged that under Texas House Bill 1774, also known as the "hailstorm" bill, the court must dismiss a suit against an agent whom the insurance company elected to accept whatever liability the agent may have to the claimant by providing written notice to the claimant. However, the letter Defendant sent to Plaintiffs provided the Maxwell Property claim number and date of loss and referenced the 9181 Policy, but the lawsuit centered on the Pera Property claim.

Defendant attempted to argue that the letter listed the address of the Pera Property and mentioned inspection reports on the Pera Property, which should provide adequate notice to Plaintiffs. But at a minimum, this showed Defendant's letter presented an ambiguity as to whether the election was made for the Pera Property claim or Maxwell Property claim. The court also disregarded Defendant's argument that if the case was remanded, it would adopt Bett's liability and remove the case again. Finding the fact that district courts within the circuit were split on whether an election made after a lawsuit commences but before removal renders the adjuster improperly joined once again created

an ambiguity that must be resolved in favor of remand, the court granted Plaintiffs' motion to remand.

Exclusion under property policy applied despite concurrent cause of loss that was not excluded

Dillon Gage Inc. of Dallas v. Certain Underwriters at Lloyd's, 440 F. Supp. 3d 587 (N.D. Tex. 2020) (appeal filed March 10, 2020).

This case arose out of fraudulent checks and a gold heist. A criminal used a stolen identity and two fraudulent checks to pay for roughly $1.2 million worth of gold coins from a wholesale buyer of bullion coins and precious metals, Dillon Gage Incorporated of Dallas ("Dillon Gage"). The criminal then altered the UPS delivery instructions and intercepted the packages. Dillon Gage filed an insurance claim under its all risk policy, and the insurers ("underwriters") determined only minimal coverage existed under an exception to an exclusion for fraudulent payments. Dillon Gage sued the underwriters.

The policy generally covered loss of insured property, including shipping coverage for coins and money, but it also contained the following Invalid Payments Exclusion:

> Notwithstanding anything contained herein to the contrary, this contract excludes any claim in respect of the property insured hereunder, where the loss has been sustained by the Insured *consequent upon* handing over such Insured property to any third party against payment by:
>
> - Cheque ... where such Cheque ... shall prove to be false, fraudulent or otherwise invalid or uncollectible for any reason whatsoever. (emphasis added by the court).

Coverage under the policy turned on the meaning of "consequent upon" in the exclusion. The underwriters contended it meant either 1) results "occasioned by" the initiating factor or 2) "functionally closely related significant cause or contributing factor". As a result, the underwriters argued that Dillon Gage would have never shipped the coins without nonfraudulent payment, so the loss was "consequent upon" the fraudulent payment and therefore excluded. Dillon Gage argued that "consequent upon" means proximate cause, claiming that because the coins were taken without permission, the loss was not consequent upon the fraudulent checks.

Explaining that underwriters' interpretation was too broad and Dillon Gage's too narrow, the Court concluded the proper interpretation of "consequent upon" is "a consequence of" or "because of"—in other words: but-for causation. The court noted Black's Law Dictionary defines "consequent" as "[o]ccurring as the natural result or necessary effect of a particular action, event, or situation; following as a natural result, a necessary effect, or a logical conclusion." Recognizing there can be more than one but-for or actual cause of the loss, the court further stated that the fraudulent checks were a but-for cause of the loss. Dillon Gage only shipped the two orders of coins after (and because) the bank checks cleared. And it did so pursuant to a company policy of ensuring checks clear before shipping to new customers.

Dillon Gage further argued that, in addition to the fraudulent checks, the criminal redirecting packages was also a cause of loss, and, therefore, the policy should cover the

loss. But the court explained that the Texas Supreme Court made clear:

> [W]hen "excluded and covered events combine to cause" a loss and "the two causes cannot be separated," concurrent causation exists and "the exclusion is triggered" such that the insurer has no duty to provide the requested coverage. But when a covered event and an excluded event "each independently cause" the loss, "separate and independent causation" exists, "and the insurer must provide coverage despite the exclusion."

This common-law default can be confirmed or displaced by contract with an anti-concurrent-causation clause. But the exclusion at issue here did not contain such a clause, unlike numerous other exclusions contained in the policy. Thus, the common-law rule controlled here. The fraudulent checks, once they cleared, led Dillon Gage to ship the coins. As a result, the fraudulent checks and the interception of the packages combined to cause Dillon Gage's injuries and were connected and interrelated. Because the causes of the loss (the fraudulent checks and the intercepting of the packages of coins) were concurrent, the exclusion was triggered, absent an applicable exception.

The exclusion contained an exception, which provided:

> Notwithstanding the Invalid Payment Exclusion Clause contained herein, it is understood and agreed that coverage hereunder is extended to cover physical loss of insured interest as a direct result of any fraudulent or dishonest payment(s). Underwriters liability hereunder is limited to USD $12,500 each and every loss and in the aggregate during the policy period and subject to a deductible of USD 1,000 each and every loss or series of losses.

Underwriters acknowledged this exception prior to litigation, conceding the policy provided $12,500 in coverage for the loss. Dillon Gage rejected that coverage and filed suit. When underwriters moved for summary judgment, Dillon Gage neglected to brief this issue and meet its burden of proving the exception, thereby waiving its right to coverage under that provision. Thus, underwriters were entitled to summary judgment.

Declaratory Judgment was not ripe while insurer and insurer renegotiated terms pursuant to provision in policy requiring renegotiation

Gemini Ins. Co. v. Choice Expl., Inc., 3:18-CV-01393-X, 2020 WL 1064844, at *1 (N.D. Tex. Mar. 4, 2020).

The federal district court dismissed the declaratory judgment action as unripe because the insured had not yet incurred any costs eligible for reimbursement and the insurer had not yet breached any obligation under the policy.

Gemini Insurance Company ("Gemini") issued Choice Exploration, Inc. ("Choice") a policy for the Kent Spradley #1 Well (the "Well"), which experienced a control event during the policy period (the "occurrence"). The policy provided certain coverage on a reimbursement basis for costs to regain control of the well. Due to the occurrence, Choice incurred costs to regain control of the well, which Gemini reimbursed. The parties did not dispute this coverage.

The parties' dispute arose out of Section I.B of the policy, which provided coverage on a reimbursement basis for restoration or redrill of the well. The policy provided that Gemini

agreed to "reimburse" for "actual costs and/or expenses reasonably incurred to restore or redrill a Well" or to "permanently plug and abandon the lost or otherwise damaged Well." The policy further obligated Gemini to negotiate with Choice new terms for providing coverage for redrilling or restoring the well as follows:

> The Assured agrees to advise the Company if restoration or redrill has not commenced within 540 days from the date of accident, cancellation or expiry of this Policy, whichever shall occur last and such restoration or redrill shall be held covered at terms, rates and conditions to be agreed by the Company.

In this case, the policy expired on April 15, 2016—776 days before Gemini commenced the lawsuit. At that time, the parties were doing exactly what the policy required: negotiating new coverage terms for redrilling or restoring a well that suffered an occurrence during the policy period, but the work to restore or redrill had not commenced within 540 days of the policy's expiration. Choice satisfied its obligation to advise Gemini accordingly, but at the time suit was filed, Gemini had not yet breached its contractual duty to negotiate new reimbursement terms. Thus, the case was not yet ripe, and Gemini's motion for summary judgment was premature. The policy still controlled the parties' relationship, but there was no contract for reimbursement at that time. Rather, the parties had a contract simply *to contract* new reimbursement terms.

In an attempt to avoid ongoing obligations under the policy, Gemini argued that the policy no longer controlled the parties' relationship because Choice's coverage ended when it transferred its interest in the Well in 2017. The court disagreed, noting that coverage under the occurrence-based policy turned on the occurrence taking place during the policy period. Because the parties did not dispute that was the case here, nothing regarding the transfer of Choice's interest in the Well after the policy's expiration date affected or eliminated the policy's coverage of occurrences that happened during the policy period.

Insurer's cancellation of policy was effective despite premium finance company's failure to comply with cancellation notice requirements in the Texas Insurance Code

Scottsdale Ins. Co. v. All Citizens Transp., LLC, 4:19-CV-010-SDJ, 2020 WL 1974253 (E.D. Tex. Apr. 24, 2020).

Provisions of the Texas Insurance Code and Administrative Code requiring premium finance companies to comply with certain notice requirements when a policy is canceled do not impose any obligations on insurers, and a premium finance company's failure to comply with those requirements does not prevent policy cancellation.

Insured, All Citizens Transportation, LLC ("All Citizens") was habitually late in repaying the premium finance company that financed its commercial auto policy, Capital Premium Financing, Inc. ("Capital") leading Capital to send notices of cancellation and subsequent requests for reinstatement. Capital sent the final Notice of Cancellation to all parties on December 4, 2014, stating the policy was canceled effective November 30, 2014. On December 14, 2014, a van that had been a covered vehicle under the policy was involved in a collision in which two passengers were fatally injured. All Citizens' insurer, Scottsdale Insurance Company ("Scottsdale"), denied coverage for the collision because the policy was canceled

effective November 30, 2014 and filed a declaratory judgment action seeking a declaration of no coverage.

The judgment creditors who sought to recover on the underlying judgment argued Scottsdale was not entitled to summary judgment in the declaratory judgment action because it failed to meet certain statutory obligations related to policy cancellation. Specifically, the judgment creditors pointed to section 651.161 of the Texas Insurance Code, which requires premium finance companies like Capital to "mail to the insured a written notice that the company will cancel the insurance contract because of the insured's default in payment unless the default is cured at or before the time stated in the notice." Tex. Ins. Code Ann. § 651.161(b). The judgment creditors also pointed to section 25.59(a) of the Texas Administrative Code, which implements section 651.161's provisions requiring premium finance companies to provide notice of cancellation because of default.

It was undisputed in this case that Capital failed to meet the requirements of these sections when it sent the cancellation notice without first sending notice of intent to cancel to All Citizens. But section 651.161, by its plain terms, only regulates premium finance companies and not insurers; reading additional requirements applicable to insurers would "torture" the ordinary meaning.

The judgment creditors also argued that Insurance Code section 651.161(f) and Administrative Code section 25.59(a) require the insurer to provide notice of cancellation to the insurance agent. The court disagreed, explaining:

> Section 651.161(f) states that any existing "statutory, regulatory, or contractual restriction that provides that an insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party" applies to section 651.161. Section 651.161(f) goes on to provide that, if such notice must be made, the insurer will provide the notice to the third party and will "determine the effective date of cancellation." As its text reveals, the notice requirement in section 651.161(f) does not create any new duty for insurers. . . . Instead, section 651.161(f) ensures that previously existing notice requirements apply equally in the context of a cancellation effectuated by a premium finance company.

Because sections 651.161(c) and (e), as well as section 25.59(a) of the Texas Administrative Code, unambiguously impose the obligation to provide applicable cancellation notifications to both the insured and the insurance agent on the premium finance company, not the insurer, Scottsdale met its burden of establishing that the policy cancellation was effective November 30. 2014, and there was no coverage for the December 14, 2014 collision.

Voluntary-Involuntary Act rule prohibited removal when insurer accepted liability of non-diverse adjuster after suit was filed

The cases in this section stand for the proposition that post-suit acceptance of liability of a non-diverse adjuster does not create diversity sufficient to allow removal because dismissal of the adjuster from suit is not a "voluntary" act by the plaintiff.

(1) *Hebert v. United Property and Casualty Insurance Co.*, Case No. 1:19-CV-00234-MAC, 2019 WL 5617023(E.D. Tex. Oct. 30, 2019).

A court in the Eastern District of Texas affirmed a magistrate's recommendation that remand be granted where an insurer accepted responsibility for an adjusters' actions post-suit.

The magistrate recommended that the court grant the plaintiff's Motion to Remand on grounds that the state court's dismissal of the adjusters in the case was an "involuntary act" as to the plaintiff.

United Property and Casualty Insurance, Company ("UPC") objected and argued that because it elected liability for the adjusters after suit was filed, the case was removable. The court, however, held that the case was not removable on its face because the adjusters were citizens of the forum, and thus, there was no complete diversity.

In so holding, the court underscored that pursuant to the voluntary-involuntary rule, a case can generally become removable only by an affirmative act by the plaintiff. The court considered UPC's election of post-suit liability an involuntary act with regard to the plaintiff. Additionally, the magistrate determined that the improper joinder exception to the voluntary-involuntary rule did not apply.

To show improper joinder, the removing party must demonstrate either (1) actual fraud in the pleadings or jurisdictional facts, or (2) inability to establish a cause of action against the non-diverse party in state court. Under the second prong, the court held that an insurer's post-suit election of liability did not retroactively render adjusters improperly joined parties. The plaintiff needed only to have stated valid claims against the adjusters when suit was initially filed for the parties to be properly joined.

The court recognized that there are conflicting opinions in the Southern, Western and Eastern Districts of Texas regarding removability following post-suit election of liability. However, this court ultimately granted remand.

(2) *Macari v. Liberty Mutual Insurance Co.*, Civil Action No. H-19-3647, 2019 WL 5595304 (S.D. Tex. Oct. 30, 2019).

Plaintiffs filed suit in Harris County against Liberty Mutual Insurance Company ("Liberty") and the Liberty adjuster assigned to their claim. Following the filing of Plaintiffs' suit, Liberty gave written notice of its election pursuant to Chapter 542A of the Texas Insurance Code to assume liability for the adjuster. Liberty then removed the case to federal court. However, the Southern District court, similar to *Hebert*, held that Liberty's election, made after the lawsuit was filed, did not retroactively render the adjuster an improperly joined party.

(3) *Shenavari v. Allstate Vehicle and Property Insurance Co.*, 448 F. Supp. 3d 667 (S.D. Tex. March 2020).

A court in the Southern District of Texas determined than an insurer's post-suit acceptance of responsibility under Chapter 542A was insufficient to show improper joinder of an in-state adjuster.

Plaintiff, Mohammad Shenavari, alleged that his home suffered extensive property damage during Hurricane Harvey in August 2017. An adjuster employed by Allstate Vehicle and Property Insurance Company ("Allstate"), inspected the property and recommended an insurance payment of $5,000. Plaintiff then sued Allstate and the adjuster, alleging multiple violations of the Texas Deceptive Trade Practices Act.

Allstate filed an Election of Legal Responsibility for the adjuster under Section 542A.006 of the Texas Insurance Code. Allstate then removed the action to federal court on the basis of complete diversity. Allstate argued that the adjuster was improperly joined because Allstate elected responsibility for the adjuster after the lawsuit was filed, but before it was removed. Additionally, Allstate asserted that Plaintiff's boilerplate pleadings failed to state a claim against the adjuster.

The court noted a split in authority between courts regarding the timing of assuming responsibility for an adjuster and improper joinder which the court further noted had not been addressed by the Fifth Circuit. The court reviewed one line of cases that concludes that an election made after a lawsuit but before removal renders the in-state adjuster improperly joined because the election requires the adjuster to be dismissed with prejudice. The other line of decisions concludes that the touchstone of improper joinder is whether the parties were improperly joined at the time of joinder, and thus, an insurer's election after the lawsuit has commenced does not by itself establish improper joinder. The court agreed with the reasoning set forth in the latter cases. As such, the court found that because Allstate's election of responsibility did not occur until after Plaintiff filed the lawsuit, the election did not by itself establish that the adjuster was improperly joined.

As the court also disagreed with Allstate's second argument and found that the complaint sufficiently stated a claim under either the Texas Insurance Code or Deceptive Trade Practices Act, the court held that the suit was not properly removable and must be remanded.

Flood endorsement sublimit inapplicable to business-interruption losses caused by flood damage

Alley Theatre v. Hanover Ins. Co., 436 F. Supp. 3d 938 (S.D. Tex. 2020).

This is a post-Hurricane Harvey first-party property-damage insurance dispute over policy coverage and amounts for flood damage to Houston's downtown repertory theater, the Alley Theatre ("Alley"). Plaintiff Alley was insured under an all-risk commercial-property insurance policy issued through Hanover Insurance Company ("Hanover") at the relevant time of loss. The Hanover policy issued to Alley covered "risks of direct physical loss unless the loss is limited or caused by a peril that is excluded." The policy's schedule of coverages listed a $156,890,000 Catastrophe Limit. The Income Coverage Part of the policy had a coverage limit of approximately $5 million. The policy excluded "loss or damage caused directly or indirectly by one or more of the following excluded causes or events." Flood is listed as an excluded peril, except that the policy does "cover the resulting loss if fire, explosion, or sprinkler leakage results." The policy also contained a separate Flood Endorsement that overrode the excluded peril language on flood. The Flood Endorsement provided blanket flood coverage, limited to $3 million per occurrence, for "direct physical loss to covered property at 'covered locations' caused by 'flood.'" The policy included a Named Storm Deductible Endorsement as part of the Commercial Output Program. The Endorsement created a one percent deductible and imposed a 96-hour waiting period for business income and extra-expense recovery when the damage resulted from a named storm. Pre-suit, Hanover paid almost $7 million for Alley's claim, but denied its obligation to pay additional sums for business-interruption

losses or for "property damage covered as sprinkler leakage and named storm in the property coverage part."

The parties cross-moved for partial summary judgment, presenting three issues: (1) whether the Alley's claim of lost-business income is subject to the Policy's $3 million Flood Endorsement Limit or to the $5 million Income Coverage Limit; (2) whether water damage caused by a sprinkler system that was broken when an interior wall collapsed due to the storm flood waters is subject to the Policy's $3 million Flood Endorsement Limit or to the almost $157 million Catastrophe Limit; and (3) whether the $3 million Flood Endorsement Limit applied if the damage was caused by a named storm, such as "Hurricane Harvey," or whether the Catastrophe Limit applied.

Regarding the issue of which limit applied to the Alley Theater's claim of loss-business income, the federal court sitting in the Southern District of Texas ruled that as a matter of law, the Policy's $3 million Flood Endorsement Limit did not apply to the Alley's business-interruption claim. Instead, the $5 million Income Coverage Limit applied. The court stated that to apply the Flood Endorsement Limit to losses caused by flood, but not covered by the Flood Endorsement, would give the Flood Endorsement Limit a broader scope than the Flood Endorsement's coverage. The court granted the Alley's motion for summary judgment on this point.

The court then addressed whether the sprinkler-system damage was subject to the flood damage limit. The court determined that as a matter of law, flood was a proximate cause of the sprinkler-leakage damage, making the Policy's $3 million Flood Endorsement Limit applicable to those damages. The court denied the Alley's motion for summary judgment and granted Hanover's motion for summary judgment on this point.

Finally, the court addressed whether the Flood Endorsement Limit applied if the damage was caused by a named storm. Citing Fifth Circuit precedent, the court concluded that the Named Storm Deductible Endorsement does not create a separate covered peril, making the Policy's $3 million Flood Endorsement Limit applicable to direct physical loss caused by flood, even if the loss resulted from a named storm. The court denied the Alley's motion for summary judgment on this point and granted Hanover's motion for summary judgment.

Plaintiffs' failure to file proof of loss for the amount sought under flood policy barred recovery

Legaspi v. Allstate Ins. Co., CV H-18-3957, 2020 WL 759425 (S.D. Tex. Feb. 14, 2020).

The issue before the district court was whether the plaintiffs' failure to submit a signed and sworn Proof of Loss for the damages being sought in the lawsuit before they filed the action prevented them from recovering the amount sought. The federal court sitting in the Southern District of Texas concluded that the plaintiffs failed to demonstrate that before filing the lawsuit they submitted a signed and sworn Proof of Loss for the damages being sought in the action, and thus, no genuine dispute of material fact existed as to whether plaintiffs could recover in the action.

Defendant Allstate Insurance Company ("Allstate") is a Write-Your-Own ("WYO") Program carrier participating in the United States Government's National Flood Insurance Program ("NFIP") pursuant to the

National Flood Insurance Act of 1968, as amended ("NFIA"), 42 U.S.C. § 4001, *et seq*. As a participant in the NFIP, Allstate issues and services Standard Flood Insurance Policies ("SFIP") and handles all aspects of flood insurance claims filed against SFIPs that it issues. Plaintiffs Javier and Claudia Legaspis ("Plaintiffs") held a Dwelling Form Standard Flood Insurance Policy ("SFIP") issued by the Defendant for a building located in Houston Texas. The SFIP was in full force and effect when Hurricane Harvey hit the Houston metroplex.

On August 28, 2017, Plaintiffs reported a claim under their SFIP for damages to the property as a result of a flood that occurred on August 26, 2017. Allstate acknowledged the claim and assigned the loss to an independent adjuster, who in turn provided an estimate of the damages. Allstate thereafter determined the covered and payable amount of the claim pursuant to the SFIP, and the independent adjuster issued Proof of Loss documents dated November 22, 2017 to Plaintiffs for that amount. Plaintiffs signed those documents and Allstate sent letters to the Plaintiffs conveying payment for damages to their building that were covered and payable.

Plaintiffs purportedly then submitted an additional proof of loss to Allstate on July 30, 2018, along with a construction professional's estimate of the additional necessary repairs and replacement costs for Plaintiffs' flood damaged property. Allstate denied the proof of loss. Plaintiffs thereafter filed an action for breach of contract against Allstate on October 21, 2018, alleging breach of their SFIP as a result of Allstate's alleged failure to pay the claim. Allstate filed a motion for summary judgement, alleging that Plaintiffs failed to submit a proper Proof of Loss supported by sufficient documentation of the loss in compliance with the requirements set forth in the SFIP and that, as a result, Plaintiffs failed to satisfy the conditions precedent to filing a legal action as stated in the SFIP.

The district court granted Allstate's motion for summary judgment, determining that Plaintiffs did not show prior compliance with the terms and conditions of the SFIP prior to filing suit. In reaching this holding, the district court acknowledged that disputes arising out of NFIP policies are governed by federal common law. The court stated that because NFIP claims are paid through treasury funds, the Fifth Circuit has long recognized that the terms and conditions of SFIPs must be strictly construed and enforced. The relevant SFIP stated that a claimant "may not sue [ ] to recover money under this policy unless [the claimant has] complied with all the requirements of the policy." The court held that Plaintiffs cited no summary judgment evidence capable of refuting Allstate's assertion that Plaintiffs did not file a Proof of Loss for the amount sought prior to filing the lawsuit.

While Plaintiffs did attach documentation purporting to show an additional Proof of Loss that Plaintiffs submitted with Allstate, the evidence did not show that the purported Proof of Loss was submitted prior to the Lawsuit.

No case or controversy in declaratory judgment action where only parties in privity with insured were dismissed from lawsuit

Cincinnati Specialty Underwriters Ins. Co. v. US Polyco, Inc., No. 3:19-CV-00421-X, 2020 WL 2114820 (N.D. Tex. May 4, 2020).

The issue addressed in this case is whether an insurer can bring a declaratory judgment suit

to declare its rights under an insurance contract when the insureds in privity with the insurer have been dismissed.

Cincinnati Specialty Underwriters Insurance Company ("Cincinnati Specialty Underwriters"), a liability insurer, brought a declaratory judgment action in the Northern District of Texas against defendants US Polyco Inc. ("Polyco"), Jared Joseph Miguez (Miguez), Justin Chambers, and Crystal Chambers, seeking to declare its rights under an insurance contract. Defendants Polyco and Miguez are the insured defendants who had privity with Cincinnati Specialty Underwriters through the insurance contact. The declaratory judgment action relates to an action filed by Justin and Crystal Chambers in Ellis County, Texas, a case in which Justin and Crystal Chambers alleged that Justin Chambers was injured while working as an employee of another company that had been hired by Polyco and while acting with the consent of Miguez, Polyco's Plant Safety Manager. That suit remains pending.

After filing the motion for summary judgment in the declaratory judgment action against all four of the defendants, Cincinnati Specialty Underwriters filed an agreed motion to dismiss its claims against defendants Polyco and Miguez.

Accordingly, the court dismissed without prejudice the declaratory judgment action. The court reasoned that a declaratory judgment suit can be brought against an insured because the insurance policy puts it in privity with the insurer. An injured plaintiff is not in privity with the insurer and so can only be brought in such a suit because it is in privity with the insured due to the derivative nature of the injured plaintiff's recovery under the policy. Accordingly, if there is no privity among the remaining parties, the suit no longer presents a case or controversy under Title III of the Constitution and the Declaratory Judgment Act and so must be dismissed for lack of subject matter jurisdiction.

Prompt Payment provisions applied to Crime Policy

RealPage Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, No. 3:19-CV-1350-B, 2020 WL 1550798 (N.D. Tex. Apr. 1, 2020).

A federal court out of the Northern District of Texas denied a partial 12(b)(6) motion to dismiss filed by National Union Fire Ins. Co. of Pittsburgh, PA ("National Union"), holding that two insuring agreements under a "Commercial Crime Policy" (the "Policy") did not constitute fidelity bonds, and thus, the insured, RealPage, Inc. ("RealPage"), had stated a plausible claim under the Prompt Payment of Claims Act ("PPCA") after its insurance claim was partially denied by National Union.

RealPage provides services to the real estate industry, including the collection, management, and transfer of rent payments from residents to RealPage's client-properties. To accomplish this transfer, a subsidiary of RealPage uses a third-party software application that transfers the rent payments to a bank clearing account and then to the appropriate client's bank account. The application also directs transaction fees to RealPage for its processing services.

In May of 2018, RealPage was the victim of a phishing scheme in which the perpetrator obtained and altered the account credentials of a RealPage employee, which then allowed the perpetrator to access the third-party software application and change certain bank account disbursement instructions. Through

this scheme, RealPage ultimately lost more than $6,000,000.

RealPage then submitted a claim under the Policy, which contained three relevant insuring agreements. Under the "Computer Fraud" insuring agreement, National Union agreed to pay for loss or damage "resulting directly from the use of any computer to fraudulently cause a transfer" from within RealPage or its bank to a place outside of RealPage or its bank. Under the "Funds Transfer Fraud" insuring agreement, National Union agreed to pay for loss "resulting directly from a 'fraudulent instruction' directing a financial institution to transfer, pay or deliver 'funds' from" RealPage's accounts. Under the "Employee Theft" insuring agreement, National Union agreed to pay for loss or damage "resulting directly from 'theft' committed by an 'employee,' whether identified or not, acting alone or in collusion with other persons."

National Union denied most of RealPage's claim, concluding that the Policy only covered RealPage's loss of transaction fees, not the loss to RealPage's clients. RealPage then brought suit, alleging, among other things, violations of the PPCA. National Union argued that the PPCA did not apply to the Policy because it was a fidelity bond, which is expressly excepted from the PPCA.

Reviewing first the language of the PPCA, the court noted that PPCA is to be "liberally construed to promote the prompt payment of claims," and that the PPCA applies broadly to "any insurer," but does not apply to "fidelity, surety, or guaranty bonds[.]" TEX. INS. CODE §§ 542.052-.054. Because the PPCA does not define "fidelity bond," the court turned to Black Law's Dictionary, which defines "fidelity bond" as "[a] bond to indemnify an employer or business for loss due to embezzlement, larceny or gross negligence by an employee or other person holding a position of trust." BLACK'S LAW DICTIONARY (11 ed. 2019).

Using this definition, the court held that the Computer Fraud and Funds Transfer Fraud insuring agreements were not fidelity bonds because "neither mentions insuring RealPage against the misconduct of an employee or an individual in a position of trust—a distinctive feature of fidelity bonds." This point was bolstered by the fact that the third insuring agreement at issue, the Employee Theft insuring agreement, specifically did insure against losses suffered due to employee misconduct. The court also did not find it significant that the Policy contained a "Crime & Fidelity" heading, stating that the heading simply suggested the Policy "offer[ed] fidelity coverage along with other, additional coverage."

Accordingly, the court found that RealPage had a plausible claim for relief under the PPCA and denied National Union's motion to dismiss.

Public policy prohibited insurer from paying punitive damage award in drunk driving accident

Frederking v Cincinnati Ins. Co., 447 F. Supp. 3d 577 (W.D. Tex. 2020).

Ever since *Fairfield Insurance Company v. Stephens Martin Paving, LP,* 246 S.W.3d 653 (Tex. 2008), practitioners have been looking for guidance concerning the "special circumstances" that will prohibit an insurer from covering exemplary damages. Before *Frederking,* only two Texas cases had addressed the issue. However, both *American International Specialty Insurance Company v. Res-Care, Inc.,* 529 F.3d 649 (5th Cir. 2008) and *Minter v. Great American*

Insurance Company, 394 F.Appx. 47 (5th Cir. 2010), involved such egregious conduct that the public policy issue was clear. Unfortunately, the facts in *Frederking* do nothing to lower the bar as to the degree of an insured's misconduct that will invoke the public policy bar.

Frederking was injured in an automobile accident caused by Sanchez, an employee of Advantage Plumbing Services. As a result of this accident, Sanchez pled guilty to driving while intoxicated, his fifth DWI conviction. When Advantage assigned its vehicle to Sanchez, Sanchez told Advantage that he had a valid driver's license, but it had in fact been suspended. Advantage did not ask to see the license or check Sanchez's driving record.

Frederking sued Sanchez for negligence and gross negligence and Advantage for respondeat superior and negligent entrustment. Cincinnati defended both Sanchez and Advantage. The trial court granted partial summary judgment for Advantage on the respondeat superior theory on the grounds that Sanchez was not in the course and scope of his employment. The jury awarded Frederking compensatory damages in the amount of $137,025 and exemplary damages against Sanchez in the amount of $207,550. Cincinnati paid the compensatory award but refused to pay the exemplary damage award. Frederking sued.

The district court previously granted Cincinnati's motion for summary judgment on the grounds that the collision was not an "accident" because Sanchez made the conscious decision to drink and drive. At that time, the district court did not reach the issue of whether it was against public policy to insure against exemplary damages. The Fifth Circuit reversed and remanded. Accordingly, in this opinion, the court addressed the public policy issue.

While noting that *Minter* was an unpublished decision and thus not binding on the court, the court found that decision instructive. *Minter* held that it would violate public policy to allow an insurer to cover exemplary damages against a commercial truck driver for an accident that resulted in his third DWI conviction. As noted above, the accident in *Frederking* resulted in Sanchez's fifth DWI conviction. Accordingly, the court held, "But the exemplary damages awarded against Sanchez to punish and deter his own grossly negligent conduct must be borne by Sanchez alone, not by his employer's insurer.

No contractual duty to pay UIM benefits until liability and underinsured status established

Arnold v. Allstate Fire & Cas. Ins. Co., No. A-19-CV-00558-LY, 2019 WL 5102741(W.D. Tex. Oct. 10, 2019).

Plaintiff Jessica Arnold filed a lawsuit based on a claim for underinsured motorist benefits under her insurance policy with Allstate Fire & Casualty Insurance Company ("Allstate"). Arnold alleged that she was injured in an October 2017 automobile accident and that the accident was caused by the negligence of uninsured driver Amy Szemkus. Arnold originally filed her lawsuit in state court asserting negligence claims against Szmekus only. She later amended her original petition to join Allstate as a defendant, alleging that it refused to pay UIM benefits..

Thereafter, Arnold consented to Szmekus' voluntary dismissal from the lawsuit based on an agreement between the parties. Allstate then removed the lawsuit to federal court and sought the dismissal of Arnold's lawsuit under Fed. R. Civ. P. 12(b)(6). More specifically, Allstate argued in its motion to dismiss that Arnold's claims should be

dismissed because she had not pleaded that she obtained a judgment establishing her legal entitlement to recover damages from Szmekus.

Agreeing with Allstate, the District Court reaffirmed and cited to prior Texas Supreme Court case law stating that "neither a settlement with nor an admission of liability from the underinsured motorist establishes UIM coverage," but rather a judgment is required. The District Court held that such a judgment may be obtained against the tortfeasor, or, alternatively, in a declaratory judgment action against the insurer. Because Arnold failed to plead the existence of any judgment establishing Szmekus' liability or her own damages, the District Court granted Allstate's motion and dismissed Arnold's lawsuit.

Texas Insurance Code claims arising from UIM claim not ripe absent a judgment establishing tortfeasor's liability

Wilson v. State Farm Mut. Auto. Ins. Co., No. 3:19-CV-01875-X, 2020 WL 230853 (N.D. Tex. Jan. 15, 2020).

Detavia Wilson was injured in a motor vehicle accident in 2016. Wilson settled with the alleged tortfeasor's insurance company for its policy limits of $30,000, which was approved by Wilson's insurer, State Farm. Wilson then submitted a claim for UIM benefits with State Farm. Wilson communicated with insurance adjuster Robert Nash, whose supervisor was insurance adjuster Yulonda Jones. Nash requested five years of medical records from Wilson, which she purportedly failed to provide. Instead, Wilson sued State Farm, Nash and Jones in Texas state court alleging violations of the Texas Insurance Code. State Farm subsequently removed the suit to federal court and filed a motion to dismiss Wilson's lawsuit arguing that no viable claims exist against it because there was no judgment regarding the tortfeasor's liability to Wilson.

In granting State Farm's motion to dismiss, the District Court found that Wilson's claims for violations of the Texas Insurance Code were not yet ripe. In reaching this conclusion, the District Court reasoned as follows:

> [A] declaratory judgment is the proper path. [Wilson's] claims are not yet ripe because Wilson has not yet obtained the predicate adjudication of the tortfeasor's liability to her. Only then can she present a ripe underinsured-motorist claim to State Farm, who could then potentially be liable for breaching the relevant Insurance Code provisions.

As a result, the District Court dismissed without prejudice Wilson's claims for violations of the Texas Insurance Code due to a lack of subject matter jurisdiction.

Potential for coverage pursuant to eight corners' rule prevented application of exclusion to duty to defend

Mesa Underwriters Spec. Ins. Co. v. Gonzalez Plumbing Co., No. 1:19-cv-0001-RP, 2020 WL 1866879 (W.D. Tex. Apr. 13, 2020).

A magistrate of the Western District of Texas recommended denial of summary judgment to insurer, holding that it must defend a pipe installer for construction defect claims because the policy's exclusion to developments that exceeded ten homes did not apply under the broad allegations asserted against the insured.

Plaintiff Mesa Underwriters Specialty Insurance Company (“MUSIC”) asserted, through a declaratory action lawsuit, that it does not have a duty to defend or indemnify insured Gonzales Plumbing, Inc. ("Gonzales") against third-party construction defect claims asserted by NIBCO, Inc. ("NIBCO"). MUSIC issued a commercial liability policy to Gonzales for each year between 2012 to 2016. The first of the three policies at issue contained a New Residential Construction Exclusion that states:

> The insurance under this policy does not apply to “bodily injury”, “property damage”, “personal injury”, “advertising injury”, or any injury, loss or damage arising out of inadequate, improper, faulty or defective construction, and no duty to defend is provided by us for claims, “suits”, actions, accusations or charges, nor for any loss, cost or expense arising out of, relating to or in any way connected with “your work,” or “your product” involving:
>
> 1. Development or
>
> 2. “New construction” of the following:
>
> a. apartments;
> b. condominiums;
> c. town homes; or
> d. any single-family or tract homes where the total project or development exceeds 10 homes, whether by an insured, an entity to which an insured owes an indemnity obligation, or any other entity.

(emphasis added).

The policies for the next two years contained a similar endorsement exclusion. Christianson Air Conditioning and Plumbing, LLC ("Christianson") sued NIBCO seeking damages due to the alleged failure of PLEX plumbing pipes manufactured by NIMBCO. NIMBCO in turn filed a third-party complaint against numerous subcontractors, including Gonzales, who then sought coverage under its commercial liability policy with MUSIC.

In denying duty to defend or indemnify , MUSIC argued that the New Residential Construction Exclusions preclude coverage for property damage "arising out of" or connected in any way to new residential construction. Gonzales responded that the exclusion only precluded coverage to new residential construction where the total project or development exceeded 10 homes and that NIBCO's lawsuit made no mention of the size of the development. NIBCO’s petition alleged that:

> During the period from late 2007 to late 2012, Christianson employed and/or entered into subcontract agreements with Third-Party Defendants, as well as others, as subcontractors to assemble and install plumbing systems and NIBCO's PEX as a component of those systems *in houses, including those being built by Continental, in the greater San Antonio area.*

(emphasis in original).

Under Texas law, if a complaint potentially contains a covered claim, the insured must defend the entire suit. Thus, the court found that to meet its burden of proof on the exclusion, MUSIC must prove that all allegations must concern developments or new construction "where the total project or development exceeds 10 homes." Applying the eight-corners rule, the court held that the relevant language of NIBCO's allegations did not definitively indicate that all of the homes were in developments or subdivisions with

more than 10 homes. Thus, the exclusion did not apply to a duty to defend.

Insured's failure to provide pre-suit demand precluded recovery of attorney's fees

PMG International, LTD. v. Travelers Indemnity Co. of America; SA-20-CV-00142-FB, 2020 WL 1164118(W.D. Tex. March 11, 2020).

A magistrate judge in the Western District of Texas held that an insured was precluded from obtaining attorney's fees under Section 542A.007 of the Texas Insurance Code because the insured failed to provide statutory pre-suit notice of the claim under Texas Insurance Code Section 542A.003.

In a suit arising out of damage to a commercial property, PMG International, Ltd. ("PMG") filed suit against Travelers Indemnity Company of American ("Travelers") after which Travelers removed the case to federal court and filed a motion for an order precluding PMG's recovery of attorney's fees pursuant to Section 542A.007 of the Texas Insurance Code. In the motion, Travelers argued that PMG's failure to serve Travelers with a pre-suit demand before initiating the litigation precluded PMG's recovery of attorney's fees.

Section 542A.007 governs the award of attorney's fees to a claimant in an action under the Texas Insurance Code concerning certain property damage claims arising from forces of nature and provides a limit on the recovery of fees where a defendant was entitled to but not given pre-suit notice at least 61 days before the action was filed.

The notice must provide (1) a statement of the acts or omissions giving rise to the claim; (2) the specific amount alleged to be owed by the insurer on the claim for damage to or loss of covered property; and (3) the amount of reasonable and necessary attorney's fees incurred by the claimant. However, pre-suit notice is not required if giving notice is impracticable because (1) the claimant has a reasonable basis for believing there is insufficient time to give the pre-suit notice before limitations will expire; or (2) the action is asserted as a counterclaim. The 60-day notice requirement is to "discourage litigation and encourage settlements of consumer complaints."

Because Travelers pleaded and proved its entitlement to pre-suit notice and PMG failed to respond as to its failure to provide such notice, the court held that PMG was precluded from recovering attorney's fees incurred after the time that Travelers filed its motion.

Document created after the date a lawsuit is filed is not automatically covered by the work product privilege and reserve data may be relevant in a lawsuit based on Texas Insurance Code claims

Environmental Packaging Technologies, Ltd. et al v. Arch Insurance Company et al, No. 4:18-CV-00240, 2020 WL 1046822 (S.D. Texas Jan. 21, 2020).

Environmental Packaging Technologies, Ltd. ("EPT"), sued its insurers, Arch Insurance Company (Arch) and National Union Fire Insurance Company of Pittsburgh ("National Union"), for allegedly failing to honor the legal duties arising out of their respective insurance policies. At issue was a discovery dispute over a three-page Digest Report which was produced in redacted form. The Digest Report provided various claim history, policy information, and reserve data.

Arch argued the redacted document was accidently produced and argued it should have been entirely withheld as it is protected by the work product privilege.

This lawsuit was filed on January 25, 2018. The Digest Report was generated on February 26, 2018. Because the Digest Report was created after the lawsuit had commenced, Arch argued that the document was automatically protected from disclosure by the work-product privilege. However, the Court noted Arch failed to show the document "was created in anticipation of litigation as opposed to assembled in the ordinary course of business." Thus, according to the court, a party must do more than simply establish that the document was created after a certain date to establish the work product privilege is applicable.

As to the reserve data included in the report, Arch argued that such information is not relevant to the Texas Insurance Code claims. The court noted Federal Rule of Civil Procedure 26(b)(1) governs the scope of discovery and allows a party to discover any non-privileged matter that is relevant to any party's claim or defense and proportional to the needs of the case. According to the court, in cases alleging violations of the Texas Insurance Code for unfair and deceptive practices, establishment of loss reserves is highly relevant because it "could well belie a later claim that the insurer thought in good faith that there was no possibility of the claim falling within coverage."

Accordingly, the Southern District of Texas ordered Arch to produce the unredacted version of Digest Report.

Court grants insured's motion to compel appraisal, finding right to appraisal was not waived

Gonzalez v. Allstate Tex. Lloyds, 7:19-CV-137, 2020 WL 520769(S.D. Tex. Jan. 31, 2020).

Plaintiff Gonzalez made a claim with his insured, Allstate Tex. Lloyds ("Allstate"), for purported storm damaged sustained to his property in 2017. During the initial pretrial and scheduling conference, the court instructed the parties to consider the process of requesting appraisal as soon as possible, before the case progressed substantially, if appraisal was to be sought. The parties indicated that appraisal would "certainly not" be necessary in this case. However, on September 9, 2019, four days after unsuccessfully mediating the case, Gonzalez requested appraisal and Allstate rejected his request. Thereafter, Gonzalez filed a Motion to Compel Appraisal.

The Court noted that absent illegality or waiver, the Texas Supreme Court has generally held in favor of enforcing appraisal clauses. Further, it noted that a party seeking appraisal waives its right to appraisal where (1) the parties reached an impasse; (2) there was unreasonable delay between the "point of impasse" and the party's demand for appraisal; and (3) the opposing party shows it has been prejudiced by such delay. "[W]aiver requires intent, either the intentional relinquishment of a known right or intentional conduct inconsistent with claiming that right."

Gonzalez argued he did not waive his right to appraisal because he had not unreasonably delayed his appraisal invocation and Allstate had not been prejudiced. In response, Allstate argued that (1) because the property at issue was vacant for two years when the storm

damage occurred, the damage was not covered under the policy and appraisal was improper; and (2) if the damage was covered, Gonzalez waived his right to invoke appraisal based on the passage of time.

Allstate alleged Gonzalez's home was vacant for two years at the time the damage occurred to the property at issue, and that pursuant to the vacancy provision in Gonzalez's policy, coverage was suspended after the property was vacant for sixty days. Thus, according to Allstate, because "[t]his is a coverage dispute" in which the main issue is "whether there is even coverage on the date [of] loss," an assessment of the amount of loss is irrelevant. The court disagreed, noting Allstate cites to no case law suggesting that a coverage dispute acts as a waiver of an insured's right to invoke appraisal and further observed the issue of the vacancy of the property or coverage under the policy is one "fit for a motion to dismiss or motion for summary judgment and is irrelevant to the issue of appraisal."

As to the issue of waiver due to unreasonable delay, Gonzalez asserted he invoked appraisal without unreasonable delay, as he did so four days after mediation, where the parties reached an impasse. Allstate argued Gonzalez unreasonably delayed invocation of appraisal because Allstate denied Gonzalez's claim over two years ago in April 2017. The court noted that waiver of appraisal is measured from the time that the right to invoke appraisal arose—the time of disagreement or impasse—not the time notice of suit or a Texas Insurance Code claim is received. Therefore, the court held the parties reached an impasse on September 5, 2019.

Allstate further argued "[t]he passage of time and potential deterioration of the property prejudices Allstate's ability and the appraiser's ability to determine to what extent ... damage to the property might be attributable to the May 31, 2016 storm, what changes have occurred in the interim and arguably, exacerbated by the costs of repairs, if any." However, the Court noted Texas jurisprudence holding it is difficult to see how prejudice could ever be shown when the policy gives both sides the same opportunity to demand appraisal.

Accordingly, the Southern District of Texas granted Gonzalez's Motion to Compel Appraisal.

The policy controls the payment deadline of an appraisal award, attorney's fees cannot be the basis of a bad faith extracontractual claim, and payment of an appraisal award is neither an admission of liability nor a shield from PPCA damages

Lopez v. Allstate Texas Lloyds, No. 7:18-CV-260, 2020 WL 292342 (S.D. Texas Jan. 21, 2020).

The lawsuit arose from Lopez's denied claim for storm damage under his policy with Allstate. After two inspections (and coverage decisions) by Allstate and disagreement over the damages and value of the claim, Lopez filed suit. The parties entered into the appraisal process, the appraisers agreed on an amount and Allstate issued payment. However, the parties disputed whether the policy or the Texas Prompt Payment of Claims Act ("PPCA") controlled the payment deadline, which impacted the timeliness of Allstate's payment of the appraisal award and Lopez's available damages. Aside from Lopez's breach of contract claim, he also asserted bad faith and PPCA damages.

Specifically, Lopez argued that Section 542.058 of the Texas Insurance Code

controls the timeliness of the parties' appraisal payment instead of the Policy's Loss Payment Provision. The Court disagreed, citing precedence from *Barbara Technologies* holding "[b]ecause the [PPCA] does not address appraisals at all, the timeliness of any appraisal payment must be based on deadlines provided in the policy's appraisal provision, if any, and not on anything within the [PPCA]. But a payment that is timely under a policy appraisal provision may not be timely under the [PPCA]." Given Allstate's payment under the policy was timely, there was no breach of contract.

As to Lopez's bad faith claim, Lopez argued he need not show an independent injury to recover extra contractual damages but also argued exemplary damages and attorney's fees are independent actual damages. The Court disagreed, holding attorney's fees cannot be the basis of a bad faith extracontractual claim and noted Lopez provided no evidence that his requested exemplary damages are not actual damages or separate from the policy benefits.

Finally, Allstate argued Lopez's PPCA claim is precluded as the appraisal award has been timely paid. Lopez, on the other hand, argued *Barbara Technologies* allows his PPCA claim to survive because "there is no issue of material fact regarding liability after [Allstate] unconditionally admitted that its post-appraisal payment was for benefits due and owed to [Lopez] under the policy." The Court held *Barbara Technologies* clearly lays out that "payment in accordance with an appraisal is neither an acknowledgment of liability nor a determination of liability under the policy for purposed of [PPCA] damages." Thus, according to the court, Lopez erroneously equated payment of an appraisal award as an admission of liability and Allstate erroneously equated payment of an appraisal award as foreclosing [PPCA] damages.

Accordingly, the court granted Allstate's motion for summary judgment as to Lopez's breach of contract and bad faith claims but denied Allstate's and Lopez's motion for summary judgment as to Lopez's PPCA claim.

Mortgagor not an insured or third-party beneficiary under policy and could not invoke appraisal.

In Re American National Property and Casualty Company, No. 01-19-00727-CV 2020 WL 573250 (Tex. App.—Houston Feb. 6, 2020, no pet.).

The First Court of Appeals held that a homeowner-borrower qualifies as a third-party beneficiary under a force-placed insurance policy entered into between the insurance company and the mortgage company only if the contracting parties intended for the third party to benefit and only if the parties entered into the contract for the third parties' benefit.

Vanderbilt Mortgage Finance Inc. ("Vanderbilt") is the mortgagee of the property at issue. Mark Rennison is the homeowner-mortgagor of the property. Vanderbilt purchased a certificate of lender-placed insurance from American National Property and Casualty Company ("ANPAC"), that insured the lender's collateral in the event the borrower failed to maintain a specific type of insurance. Rennison is not a named insured on the policy—the policy expressly excludes Rennison as a named insured.

Vanderbilt made an insurance claim for damages to the property resulting from

Hurricane Harvey and ANPAC issued a payment to Vanderbilt. Rennison delivered a letter to ANPAC contesting the damages and demanding appraisal under the policy. ANPAC informed Rennison that because he was not an insured under the policy, he could not invoke appraisal. Rennison sued thereafter. ANPAC filed a plea to the jurisdiction, arguing Rennison was not a party or third-party beneficiary to the policy and therefore had no standing to sue. The court originally granted the plea, but thereafter issued an order granting Rennison's motion for new trial. Then, the court issued an order compelling appraisal and ANPAC sought mandamus review of the order.

To determine whether a third party may recover on a contract between other parties, we look to the intent of the contracting parties. A third party may recover only if the contracting parties intended for the third party to benefit and only if the parties entered into the contract for the third parties' benefit. The intent to confer third party beneficiary rights must be clearly spelled out in the contract.

Factors a court considers in ascertaining the parties' intent include: (a) the coverages contained in the policy (and whether they clearly indicated that the parties intended to confer a benefit on the homeowner), for example coverage for personal property and loss of use, including additional living expenses indicates intent to confer the homeowner a benefit; (b) whether the homeowner is named on the policy; (c) what the policy protects (the insurable interest); and (d) whether the policy includes endorsements with definitions and coverages that clearly covered the homeowner. The court of appeals found Rennison did not establish that he had a right to enforce the policy as a third-party beneficiary, and therefore had no standing to seek appraisal.

Accordingly, the First Court of Appeals conditionally granted the writ of mandamus and directed the trial court to vacate its order for appraisal.

Appraisal: Payment of ACV sufficient if insured has not made repairs; Prompt Payment of Claims

Lakeside FBBC, LP v. Everest Indemnity Insurance Co. et al., 5:17-cv-00491 2020 WL _____(W.D. Tex. April 8, 2020).

The Western District of Texas granted Everest Indemnity Insurance Co. ("Everest"), Engle Martin & Associates, and Christopher McCoys' (collectively, "Defendants") motion for summary judgment, holding:

I. An insurer has no duty to pay the replacement cost value amount of an appraisal award where Plaintiff has not completed a replacement or repair of the damaged property. As such, payment of actual cash value constitutes full payment of the appraisal award, thereby barring Plaintiff's breach of contract claim.

II. In order for an insurer to avoid a Prompt Payment Act claim the insurer must have made a reasonable pre-appraisal payment within the statutorily-provided period. The court formulated the following two-step process:

    1. Did Defendants [the insurer] act in accordance with the TPPCA in their requests for information,

investigation, and pre-appraisal payments?

2. If the pre-appraisal payments were indeed timely, were they also reasonable relative to the final appraisal award?

The lawsuit arose from two weather events—a hailstorm in 2016 and tornado in 2017—that damaged Lakeside FBBC, LP's ("Plaintiff") property and the amount and timing of insurance payments.

On April 12, 2016 a hailstorm caused damage to Plaintiff's property and Plaintiff made a claim for the loss under its 2016 Everest policy on April 20, 2020. Everest hired Engle Martin & Associates ("Engle Martin") as the adjuster and Engle Martin assigned Christopher McCoys ("McCoys") to the claim. McCoys established communication with Cary Krier ("Krier"), Plaintiff's property insurance claim representative, and requested information and documents related to the claim. Krier directed McCoys to contact Carolyn Coleman ("Coleman") who worked for Plaintiff's primary contractor.

McCoys made a preliminary inspection on April 26, 2020. Coleman advised McCoys on May 13, 2016, that she was "a week away from finalizing the details and estimate," but by June 17, McCoys had not received the estimate and renewed his request. McCoys emailed Krier on June 24 and informed her he was awaiting Coleman's estimate. McCoys attached a preliminary Statement of Loss for items McCoys had received and noted Everest agreed to issue an advance payment of $250,000. Krier responded by noting Plaintiff had several costs that were not included in the preliminary Statement of Loss and inquired on the process for updating the list. McCoys explained the process and Krier signed and returned the preliminary Statement of Loss. On July 22, 2016, McCoys informed Krier Everest agreed to a second Proof of Loss for $1,672,031.67. During this time period, McCoys urged Krier on multiple occasions to submit supporting documentation regarding other expenses associated with the hailstorm. Plaintiff initially refused to sign the second Proof of Loss and hired a new estimator, who estimated the total cost of repair amounted to $6,175,536.72.

On February 19, 2017, an EF-1 tornado struck the property, and Plaintiff made a claim under its 2017 Everest policy. Engle Martin assigned Thomas Koralewski ("Koralewski") to this claim. Koralewski and Coleman conducted the first inspection on March 1, 2017. On March 30, Koralewski requested from Coleman information and documents related to the loss. Coleman delivered Plaintiff's estimate on April 28, 2017, which amounted to over $700,000, while Koralewski's estimate was for $22,000. Everest issued a check for $8,029.86 on February 22, 2018.

Litigation ensued and the parties participated in the appraisal process. The property appraisal was issued on November 7, 2018 and awarded $4,247,147.74 as replacement cost value of the 2016 hailstorm claim, and a replacement cost value $255,861.82 for the 2017 tornado claim. A week later, Everest issued payment for each claim. For each claim, Everest issued the actual cash value (as opposed to the replacement cost value) because repairs were not completed and the polices both require the insured to repair and replace the damaged property to receive replacement cost value.

As to Plaintiff's breach of contract claim, Everest argued that where appraisal is the contractually mandated means of

determining the amount of loss attributable to a given claim, and where the insured pays the amount determined by the appraisal, Everest fully complied with its contractual obligations. Plaintiff argued Everest did not fully pay the appraisal value because Everest did not pay the replacement cost value. The court held Defendants' payment of actual cash value constituted full payment of the appraisal award where Plaintiff made no repairs, thereby barring Plaintiff's breach of contract claim.

Regarding Plaintiff's Texas Prompt Payment of Claims Act ("TPPCA"), Plaintiff argued Defendants violated various deadlines set by the TPPCA with respect to handling of the hailstorm and tornado claim. Everest argued that because it made a claim determination and payments before appraisal, the fact that appraisal was later demanded does not change the fact that it complied with the TPPCA with its pre-appraisal payments. Defendants stressed that to the extent they unsuccessfully sought information from Plaintiff, Plaintiff's delay in signing the proof of loss and its contractor's delay in providing estimates were the actual causes of any delay. The court held that when an insurer complies with the TPPCA in responding to the claim, requesting necessary information, investigating, evaluating, and reaching a decision on the claim, use of the contract's appraisal process does not vitiate the insurer's earlier determination on the claim. However, any such pre-appraisal payment(s) must be reasonable and within the statutory guidelines.

Accordingly, the Western District of Texas granted Defendants' motion for summary judgment, dismissing Plaintiff's breach of contract and TPPCA violations claims.

Auto exclusion did not preclude duty to defend wrongful death case resulting from vehicle being swept away in a flood.

Covington Specialty Ins. Co. v. USAI LP, 3:18-CV-3271-N, 2020 WL 2132598 (N.D. Tex. May 4, 2020).

The district court denied Covington's motion for summary judgement, holding Covington failed to meet its burden to establish that the incident fell within the commercial general liability policy's auto exclusion for purposes of a duty to defend. Further, the court found Covington's duty to indemnify was not ripe for adjudication.

The lawsuit involved a dispute regarding Covington Specialty Insurance Company's ("Covington") duty to defend and indemnify its insured USAI LP ("USAI"). Covington argued the auto exclusion applied to negate its duties because the decedent's death arose out of the use of a vehicle.

The underlying suit, filed against, in relevant part USAI, involved the death of decedent who passed away while working security at USAI's property. On the day of the incident, while patrolling the property, the decedent kept watch from inside his vehicle. Then, a thunderstorm passed through the area and caused a nearby stream to rise. The petition alleged that the floodwaters engulfed the decedent and his vehicle, and as the decedent escaped the vehicle, the floodwaters swept the decedent and his vehicle into the creek. The policy at issue covered bodily injuries and property damages, but it excluded damages "arising out of or resulting from the ownership, maintenance, use or entrustment to others of any aircraft, 'auto' or watercraft." Covington argued that because the decedent's death arose out of the use of a vehicle, the auto exclusion applied to negate

its duties to defend and indemnify USAI in connection with the underlying suit.

In finding Covington failed to establish that the auto exclusion applied, the court of appeals utilized the three-step *Lindsey* framework in order to determine whether the damages arose out of the "use" of a vehicle. The court found Covington failed to establish the second and third *Lindsey* factors:

A. The court held Covington failed to show the incident occurred within the territorial limits of the vehicle. Specifically, the court concluded that based on the factual allegations, it is unclear on this record whether decedent died in the vehicle and then was swept away or whether he exited the vehicle, was swept away, and then died outside the territorial limits of the vehicle.
    - Covington argued that decedent was trapped inside the vehicle and was swept away as he attempted to escape, which, according to Covington is sufficient to establish that the injury occurred within the territorial limits of the vehicle.
    - The court pointed out the petition's allegation stating the "floodwaters engulfed decedent's vehicle. As the Decedent escaped the vehicle, floodwaters swept the vehicle and Decedent over the embarkment and into Turtle Creek," to conclude plaintiffs asserted that the decedent *exited* the vehicle while the flood waters swept him away.

B. The court held Covington failed to establish that the vehicle was the producing cause of the decedent's death. According to the court, the fact that the decedent was in the vehicle when the water began to rise was insufficient to establish that the vehicle was the producing cause of decedent's death.
    - The court pointed out the petition's allegation asserting that the decedent passed *due to* the flash flood waters that rose and swept him away. Thus, according to the court, while the decedent may have been inside the vehicle as the flood waters rose, the allegations stated that *the flood waters, rather than the vehicle*, swept the decedent away.

Thus, the court held that Covington did not establish as a matter of law that the decedent's death arose out of the use of his vehicle, and thus rejected the auto exclusion as the basis to deny Covington's duty to defend. Further, the court held Covington's duty to indemnify was not ripe for adjudication.

Accordingly, the Court denied Covington's motion for summary judgment.

Chapter 541 violations must be pled with particularity

Blue v. Allstate Vehicle & Prop. Ins. Co., 2:19-CV-291, 2019 WL 6701419 (S.D. Tex. Dec. 9, 2019).

The district court held:

- The heightened pleading standard of Federal Rule of Civil Procedure 9(b) applies to the substance of the

allegations of misrepresentation under Texas Insurance Code § 541.060(a)(1).

- Appraisal is appropriate so long as damages remain an issue—even if a secondary issue. Further, there cannot be a finding of waiver of an appraisal clause without prejudice and an insurer's argument that an insured's delay in invoking appraisal deprived the insurer of its ability to promptly investigate the damage where the evidence would be untainted by time and deterioration is not sufficient to establish prejudice where the insurer conducted inspections and also had the right to invoke appraisal.

This is a residential property dispute between an insured and her insurer. Allstate Vehicle & Property Insurance Company ("Allstate") argued Plaintiff's assertions regarding Allstate's alleged misrepresentations in violation of Texas Insurance Code § 541.060(a)(1) were devoid of factual assertions in violation of the heightened pleading standards of Rule 9(b). The court held the heightened pleading standard of Federal Rule of Civil Procedure 9(b) applies to the substance of the allegations of misrepresentation. The court reasoned that because the pleading offered no factual details regarding exactly how the inspection was substandard, what damages were not included in the report, what damages were undervalued, and what the adjuster or insurance company stood to gain by such improprieties, the pleading was deficient under Rule 9(b).

Further, Allstate argued appraisal was not appropriate in this case because the principal issue was liability, not damages. Further, Allstate argued Plaintiff waived appraisal due to her untimely invocation of appraisal. The court held that appraisal is appropriate so long as damages remain an issue—even if only a secondary issue. As to prejudice, Allstate argued it was prejudiced while the claim remained unresolved because Plaintiff had not made repairs and the property had surely continued to deteriorate and it was deprived of its ability to promptly investigate the damage when the evidence would be untainted by time and deterioration. The court was unpersuaded by Allstate's arguments because Allstate sent its inspectors to the property to conduct inspections on three occasions, including the first within a month after the loss. The court further noted Allstate also had the right to demand an appraisal at an earlier time if it were concerned about delay. As such, the court found Allstate failed to establish prejudice, a prerequisite to finding waiver.

Accordingly, the district court granted Allstate's motion for partial dismissal, but granted Plaintiff's request for leave to amend the pleading. Further, the court denied Allstate's motion for protection from Plaintiff's Demand for Appraisal.

Failure to provide 542A notice precluded recovery of attorneys' fees

Gateway Plaza Condo v. Travelers Indem. Co. of Am., 3:19-CV-01645-S, 2019 WL 7187249 (N.D. Tex. Dec. 23, 2019)

The court held Plaintiff did not have a reasonable basis for believing there was insufficient time to give presuit notice under Section 542A.003(d)(1), therefore Plaintiff was precluded from recovering attorney's fees.

This case stems from property damage caused by a storm. The underlying factual allegations of the case were hotly contested by the parties. Plaintiff alleged its property

was damaged by a severe storm on or about June 2, 2017, but did not remember the date it notified Travelers Indemnity Company of America ("Travelers") of the claim. However, Plaintiff claimed Travelers retained JNT Developers to survey the property on August 16, 2017. Further, Plaintiff claimed that while it did not remember when Travelers denied the claim, it must have been before October 6, 2017 because Travelers delivered a denial letter on that date, referencing the parties' "recent conversations about the claim." On the other hand, Travelers submitted an affidavit to the court, stating Gateway filed its claim on October 2, 2017, and reported the damage to the property occurred on or about September 25, 2017. Travelers further stated it first came across JNT's report when Gateway showed it to Travelers during an inspection of the property on October 6, 2017.

Gateway retained a public adjuster in January 2018, a second adjuster by March 2019, and an attorney on April 26, 2019. On June 3, 2019, Gateway's attorney informed Travelers of its intent to file suit—Gateway filed suit on that same day. Given Gateway's failure to provide presuit notice under Section 542A.003(d)(1), Travelers filed its motion to preclude Gateway from recovering attorney's fees under Section 542A.007. Plaintiff conceded it did not provide the required presuit notice but argued that notice was not required because Gateway "had a reasonable basis for believing that there was not enough time for a 60-day presuit notice."

The court found the evidence established Gateway reported the claim on October 2, 2017, and since the statute of limitations would expire in October 2019, Gateway did not have a reasonable basis for believing that there was insufficient time to give presuit notice when Gateway filed the lawsuit on June 3, 2019. Further, the court noted Plaintiff failed to explain why it waited almost two years after the loss to hire an attorney.

Accordingly, the court granted Defendant's motion and precluded Plaintiff from recovering attorney's fees incurred after July 26, 2019.

Extra-Contractual claims precluded when appraisal award was less than prior payments

Becerra v. United Prop. & Cas. Ins. Co., 1:18-CV-00511-MAC, 2020 WL 85409 (E.D. Tex. Jan. 6, 2020).

The court held that when an insurer pays the insured more than the appraisal award through pre-appraisal payments, the insurer cannot be found to have breached the insuring contract. Further, because the insured's extracontractual claims stemmed from the purported breach of contract, he could not maintain his extracontractual claims.

On August 13, 2017, Becerra reported damage to his home allegedly caused by Hurricane Harvey. Becerra's insurer, United Property & Casualty Insurance Company ("UPC"), inspected the property on September 21, 2017, estimated $3,836.80 in covered damages, and issued Becerra payment in the amount of $1,619.75 (after applying the policy's deductible). Then, on March 27, 2018, UPC performed a re-inspection at Becerra's request and subsequently issued an additional payment of $699.72. Thereafter, Becerra retained counsel, delivered presuit notice to UPC on July 6, 2018, and filed suit on September 5, 2018.

The parties entered into the appraisal process and the appraisers issued an award of $3,990.30. As a result, UPC filed an amended motion for summary judgment stating that after application of the $2,150 deductible and $2,319.47 in prior payments, the amount owed to Becerra fell below zero. Therefore, according to UPC, it did not breach the insurance contract and payment of the appraisal award entitled it to summary judgment on Becerra's contractual and extra contractual claims.

The court reasoned that because the amount owed to Becerra fell below zero, UPC paid more than the appraisal amount. Therefore, UPC did not breach the insurance contract. Further, because Becerra's extracontractual causes of action were derivative of the breach of contract claim, and because UPC did not breach the contract, Becerra could not maintain his extracontractual claims.

Accordingly, the court granted UPC's motion for summary judgment on Becerra's contractual and extra contractual claims.

Court can stay case pending appraisal

Linnus v. Metro. Lloyds Ins. Co. of Tex., CV H-19-3163, 2020 WL 359905 (S.D. Tex. Jan. 22, 2020).

The court held:

- Where a part of an insurance dispute is about the amount of covered damages, an insurer's denial of a claim due to its adjuster finding the damage fell below the policy's deductible does not in itself waive a contractual appraisal right.
- It is appropriate to stay the entire case pending appraisal even in cases where a plaintiff brings extra-contractual claims.

The Linnuses made a claim for damage to their home allegedly caused by a storm. Metropolitan Lloyds Insurance Company of Texas ("Metropolitan Lloyds") had the property inspected in January 2019 and concluded there were no covered damages. The Linnuses hired a public adjuster, who arranged another inspection in March 2019 with a Metropolitan Lloyds representative. The public adjuster found $25,544.02 in hail and wind damage, while the Metropolitan Lloyds representative concluded that there was $823.08 in covered hail damage—an amount below the policy's deductible. On April 8, 2019, a Metropolitan Lloyds supervisor allegedly told another employee that no additional action was required in connection with the claim. Further, the next day, the supervisor allegedly asked the same employee to inform the Linnuses that their claim was denied.

As a result, the Linnuses hired counsel, who sent a demand letter to Metropolitan Lloyds on June 5, 2019 and attached the public adjuster's estimate. Metropolitan Lloyds invoked the appraisal process on June 13, 2019; however the parties could not agree on an appraiser and litigation ensued as a result. The Linnuses argued Metropolitan Lloyds waived its right to an appraisal and Metropolitan Lloyds requested the litigation be stayed pending appraisal.

According to the Linnuses, the parties reached an impasse on April 8, 2019, when the Metropolitan Lloyds supervisor reviewed the public adjuster's estimate and decided that no additional action was required. Specifically, the Linnuses argued that because the insurance company was aware of the impasse on April 8, but did not invoke

appraisal until June 13, it waived its right to appraisal.

The court was unpersuaded by the Linnuses argument, noting that when an insurance company denies a claim because its adjuster's damage determination falls below a policy deductible, and part of the dispute is about the amount of covered damages, the denial of payment in itself does not waive a contractual appraisal right. Further, the court held that most Texas courts stay the entire case pending appraisal even when a plaintiff asserts extra-contractual claims in addition to a claim for breach of contract.

Accordingly, the court granted the motion to stay and administratively closed the case pending appraisal.

Prompt Payment of Claims Act does not require payment of appraisal award within 60 days of initial making of claim.

Braulio Reyna v. State Farm Lloyds, No. H-19-3726 2020 WL 1187062 (S.D. Tex. Mar. 12, 2020).

The court held:

- An appraisal award in it of itself does not demonstrate that an insurer breached the contract by failing to pay the covered loss.
- In cases involving appraisal, the TPPCA does not require payment of the appraisal award within 60 days of the original insurance claim.
- Bad faith requires an independent injury if the insured does not claim any damages independent of the breach of contract claim.

This claim involves a post-Harvey first-party property damage insurance dispute. State Farm Lloyds ("State Farm") inspected Reyna's property on three occasions and issued timely payments on each occasion. Dissatisfied with the amounts, Reyna invoked appraisal, which resulted in an award of replacement cost in the amount of $31,545.79 (or $25,884.48 for the actual cash value). Thereafter, State Farm filed a motion for summary judgment, arguing that its timely payment of the appraisal award entitled it to summary judgment on Reyna's breach of contract and extra-contractual claims. Reyna responded that the appraisal award does not preclude him from recovery.

The court noted Texas Supreme Court precedence holding that an appraisal award in it of itself does not demonstrate that an insurer breached the contract by failing to pay the covered loss. Therefore, because Reyna's breach of contract claim was based on the fact that State Farm's initial estimate and payment was less than the appraisal award that State Farm ultimately paid, the court held State Farm was entitled to summary judgment on Reyna's breach of contract claim.

Further, the court noted Reyna's Prompt Payment of Claims Act claim was based on not receiving the amount established by appraisal within 60 days of the original insurance claim, but held that is not required by the Prompt Payment of Claims Act. As to Reyna's bad faith claim, the court noted no independent injury was alleged because Reyna's claim was based on the difference between the appraisal award and State Farm's preappraisal estimates and payments. Therefore, the court held State Farm was entitled to summary judgment on Reyna's TPPCA and bad faith claims.

Accordingly, the court granted State Farm's motion for summary judgment.

Appraisal

Ripley v. State Farm Lloyds, 4:19-CV-1066-A, 2020 WL 1643400 (N.D. Tex. Apr. 1, 2020).

The court held an insurer does not have a contractual obligation to pay appraisal awards unless the appraised damage is covered by the **policy.** Specifically, merely being subject to appraisal does not bring the damage under the policy's coverage.
This action arises from a homeowners' insurance policy and a disagreement between the parties regarding the assessment of the Ripleys' damages after their home was damaged by a hailstorm. After being dissatisfied with the results of State Farm Lloyds' ("State Farm") estimate of the damage, the Ripleys had their home independently appraised, resulting in an appraisal award. State Farm declined to pay the full appraisal award on the basis that it included damages not covered by the insurance policy. The Ripleys filed an amended complaint alleging breach of contract, TPPCA violations, and bad faith. Thereafter, State Farm moved to dismiss the Ripleys' lawsuit for failure to state a claim upon which relief can be granted.

State Farm argued that the Ripleys' claims for breach of contract and bad faith should be dismissed because the first amended complaint does not satisfy the pleading requirements of Rules 8(a) and 9(b).

The Ripleys allege breach of contract and premise the cause of action on State Farm's failure to pay the full amount of the appraisal award. In rejecting their claim, the court reasoned that because appraisers' authority is limited to assessing the amount of loss, not to construe the policy or decide whether the insurer should pay, an insurer does not have a contractual obligation to pay appraisal awards unless the appraised damage is covered by the policy. Relatedly, the court noted the Ripleys failed to allege any facts regarding the damages assessed by the appraisal, such as whether all the damage was caused by the storm or how such damage is otherwise covered by the insurance policy.

Further, because the Ripleys stated legal conclusions in connection with their bad faith claim—instead of alleging facts regarding the purported bad faith—the court found such pleading did not satisfy the Rule 8(a) standards.

As to the Ripleys' TPPCA claim, the court held they failed to articulate a breach of contract claim upon which prompt payment would depend. The court further noted they did not allege any facts to support a prompt payment claim even had they properly asserted breach of contract.

Accordingly, the court granted State Farm's motion to dismiss the Ripleys' lawsuit for failure to state a claim upon which relief can be granted.

"Pre Suit" Acceptance of Liability and Diversity Jurisdiction

Faith v. Philadelphia Indemnity Insurance Co.; Civil Action No. 1:19-cv-133; in the United States District Court in the Southern District of Texas, Brownsville Division.

The court dismissed claims against an insurance adjuster due to the insurer's pre-suit acceptance of responsibility for the adjuster.

Following a storm that allegedly damaged Faith Pleases God Church Corporation's ("Faith's") property, Philadelphia Indemnity Insurance Company ("Philadelphia"),

assigned VeriClaim, Inc. ("VeriClaim") and an adjuster to investigate the claim. Following the adjuster's inspection and appraisal of the property damage, Faith notified Philadelphia of its intent to sue them.

Philadelphia then elected to assume liability for its agents which included VeriClaim and the insurance adjuster. Four months later, Faith filed suit against Philadelphia, VeriClaim, and the additional adjuster. VeriClaim filed a Motion to Dismiss.

The court converted VeriClaim's Motion to Dismiss into a Motion for Summary Judgment but agreed that because Philadelphia elected to accept any liability for its agents before Faith filed suit, and VeriClaim was an agent of Philadelphia, the Texas Insurance Code prohibited Faith from asserting its claims against VeriClaim. As such, the court held that the Texas Insurance Code, and specifically Section 542A, precluded all causes of action against VeriClaim for any alleged violations of Chapter 541 of the Texas Insurance Code as a matter of law.

Limited Exception to the Voluntary-Involuntary Rule

Barnes Burk Self Storage, LLC v. United Fire & Casualty Co., Civil Action No. 7:19-cv-00099-M; in the United States District Court for the Northern District of Texas, Wichita Falls Division.

The court denied remand of a case in which the non-diverse adjuster was dismissed from the suit, holding that the plaintiff committed a voluntary "act" by not opposing the motion to dismiss.

Plaintiff, Barnes Burk Self Storage, LLC ("Barnes"), filed suit against United Fire & Casualty Company ("United Fire") and a United Fire adjuster for violations of Texas law relating to its insurance claim. Following the filing of suit, United Fire informed Barnes that it assumed liability for the adjuster, if any. United Fire then removed the case to federal court. The presiding federal judge remanded on the basis of the adjuster's citizenship and the lack of diversity.

Later, the state court dismissed the adjuster from the case and United Fire removed the case to federal court for a second time. The court denied remand, citing an exception to the voluntary-involuntary rule as stated in a Fifth Circuit case.

In *Hoyt*, the Fifth Circuit upheld the removal of a case in which diversity was created when a state court granted the non-diverse defendant's summary judgment motion and dismissed that party. The summary judgment could not be reversed on appeal because the Fifth Circuit considered that the plaintiff "abandoned" the right to appeal.

As such, the court in *Barnes* considered that the effect of the state court's order dismissing the adjuster was to leave only diverse parties and could not be reversed on appeal because Barnes waived its right to appeal by not opposing the dismissal. The court held that while the voluntary-involuntary rule requires an action of the plaintiff or a case to be removable. As such, the court held that the case was now properly before the federal court because there was complete diversity.

Insured Defeats Insurer's Allegations of Improper Joinder

(1) *Hill County Villas Townhouse Owners' Association, Inc. v. Everest Indemnity Insurance Co.*, Case No. SA-19-CV-0936-JKP; in the United States District Court, Western District of Texas, San Antonio Division.

The court remanded a case based on diversity based on diversity, holding that sufficient facts were alleged to support a finding that the non-diverse adjuster independently violated the Texas Insurance Code.

Plaintiff, Hill County Villas Townhouse Owners' Association, Inc., filed suit against Everest Indemnity Insurance Company ("Everest") and two insurance adjusters. Everest removed this action on the basis of diversity jurisdiction alleging improper joinder of the adjusters. However, the court held that Plaintiff alleged a cause of action that created a reasonable possibility for recovery against a nondiverse insurance adjuster. Thus, the court further held that Plaintiff properly joined the adjusters and diversity was absent. Therefore, the court granted the motion to remand the case.

The court reiterated that federalism concerns favor remand and that improper joinder is a heavy burden.

(2) *WF/TX Investments, LLC v. Seneca Insurance Co.,* Civil Action No. 4:19-cv-00751; in the Eastern District of Texas, Sherman Division.

In this case, the court found that the insurer incorrectly invoked the improper joinder doctrine based on a misunderstanding of the insured's citizenship. Therefore, the court held that no joinder to defeat jurisdiction could have occurred. Additionally, the insurer failed to secure consent for removal from its co-defendant adjuster.

This case arose out of Plaintiff, WF/TX Investments, LLC's allegations of wind and hail damage to its commercial property. Seneca Insurance Company, Inc. ("Seneca") removed the case to federal court, asserting that the adjuster was a Texas citizen and joined solely to defeat diversity jurisdiction. However, the court determined that Seneca was mistaken in assessing the citizenship of Plaintiff which was actually a citizen of California. Accordingly, the court considered that the parties briefed the court on a non-existent issue. However, the mistake was not only attributable to Seneca's misunderstanding of the law surrounding citizenship but because Plaintiff, who should have understood its own citizenship, failed to properly notify Seneca and other defendants that it was a citizen of California rather than Texas. In fact, a proper statement of citizenship was only provided after the Court ordered Seneca to file an Amended Notice of Removal with a correct statement of citizenship.

The court then asked the parties to provide supplemental briefing on whether the adjuster was required to consent to removal of the case given the new accurate facts. Seneca argued that it did not have to obtain consent from the adjuster to remove because the adjuster was improperly joinder. The court, however, considered that the improper joinder doctrine does not extend to forum defendants.

The court also considered that the adjuster's failure to consent to removal resulted in a procedural deficiency requiring remand. The court agreed with Plaintiff that the nominal defendant doctrine is the proper doctrine that should have been raised.

Generally, when a case is removed on the basis of diversity jurisdiction, the rule of unanimity applies. Under this rule, the removing defendant bears the burden of establishing compliance with the rule of unanimity, either by showing that all properly joined and served defendants consent to removal or by establishing that a named defendant's consent to removal is not required. If a removing party fails to obtain the consent to remove any of the co-

defendants, the notice of removal must affirmatively explain why consent of those defendants was unnecessary.

The nominal defendant doctrine involves a test substantially similar to the test for improper joinder. However, the court found that Seneca failed to *affirmatively explain* why Seneca's consent was unnecessary under this doctrine and thus, there was no argument supporting a deviation from the rule of unanimity. Accordingly, the court remanded the action to state court.

(3) *Hazari, LLC v. Everest Indemnity Insurance Co.*; Civil Action No. H-19-4071; in the Southern District of Texas, Houston Division.

A court in the Southern District of Houston denied remand and determined that a building consultant was a properly joined defendant that could be subject to liability under the Texas Insurance Code.

Hazari LLC ("Hazari") sued Everest Indemnity Insurance Company ("Everest") and its adjuster for claims under the Texas Insurance Code arising from a Hurricane Harvey insurance dispute. The defendants removed to federal court and Hazari filed a motion to remand based on the adjuster's citizenship which Hazari alleged defeated complete diversity.

The key issue was whether the adjuster was exempt from liability under Chapter 541 of the Texas Insurance Code because he was "estimator" who was "retained only to furnish technical assistance to a licensed adjuster to provide scope of damages for a building repair estimate."

The court reasoned that the adjuster in this case maintained an active adjuster license and performed some of the functions as an adjuster. The court further held that it could not conclude that Texas law categorically exempts estimators from the definition of a "person" who is engaged in the business of insurance."

While the defendant did not sell or service the insurance policy, make representations about policy coverage, or make the eventual adjustment decision, he did perform some of the same functions as an adjuster and was, in fact, a licensed adjuster with expertise in the field of insurance, although it is unclear that his current job as a "building consultant" required it. Additionally, the court considered that the record did not provide any basis to conclude that the defendant's job was clerical or janitorial in nature.

Resolving uncertainties in state law in favor of the non-moving party, the court concluded that it could not conclude as a matter of law that the defendant adjuster was exempt from liability under the Insurance Code.

Additionally, construing ambiguities against removal, the court held that Hazari alleged a plausible claim against the defendant adjuster for failing to "effectuate a prompt, fair, and equitable settlement" of the insurance claim.

As such, because the court held that the insurance adjuster was properly joined, there was no complete diversity and the court lacked jurisdiction. The court granted remand to the state court.

Remand Based on the Amount in Controversy

(1) *Boardman v. Allstate Fire and Casualty Insurance Co.*, No. 5:19-CV-013999-JKP; in the United States District Court, Western District of Texas, San Antonio Division.

The court remanded a case, holding that although an insured asserted damages between $200,000 and $1,000,000, the UIM policy limit was $30,000, and thus, even with an award of prompt payment penalties, the insured's damages would not exceed the $75,000 threshold. The court reasoned that the insured's damages allegation was not in "good faith" and therefore did not control the amount in controversy.

Plaintiff, Darlene Boardman, filed suit against Allstate Fire and Casualty Insurance Company ("Allstate"). Allstate removed the case to federal court and Plaintiff filed a motion to remand, alleging that she clarified the measure of damages. However, because Plaintiff initially claimed monetary relief in the amount of $200,000 to $1,000,000, and the policy limit was $30,000, the court held that Plaintiff's original damages claim was not in "good faith," as required to be controlling.

In addition, the court considered that it was not "facially apparent" from Plaintiff's petition that her claims would exceed the $30,000 limit of the policy. As such, the court held that Allstate failed to meet its burden to show that the amount of controversy exceeded the threshold. Accordingly, the court considered that the case was improperly removed and granted Plaintiff's motion to remand.

(2) *Walther v. Allstate Fire and Casualty Insurance Co.*; Civil No. SA-19-CV-01326-XR; in the United States District Court For the Western District of Texas, San Antonio Division.

A federal district court in the Western District of Texas held that an insured's UIM claim was not capped at the policy's $30,000 limit as a legal certainty because the insured also sought recovery for property and extra-contractual damages, the latter of which was only dropped after removal to federal court, which cannot strip the court of jurisdiction after removal on diversity grounds.

Plaintiff, Rosana Walther, filed suit against Allstate Fire and Casualty Insurance Company ("Allstate") and Allstate removed the case to federal court, arguing that Plaintiff was claiming monetary relief over $100,000 but not more than $200,000. In the suit, Plaintiff alleged serious and painful bodily injuries as a result of an accident with a negligent, uninsured motorist. Plaintiff also filed breach of contract and DTPA claims against Allstate, seeking additional damages, including punitive damages. Based on these alleged damages, the court agreed with Allstate that it was facially apparent from the allegations in the petition that the amount in controversy exceeded $75,000 at the time of removal. In addition to the $30,000 bodily injury limits, the court noted that plaintiff could recover up to $50,000 in property damage.

Plaintiff, however, argued that the court should remand because the amount in controversy was less than $75,000 based on the $30,000 policy limit. Plaintiff also sought leave to amend her petition to drop the extra-contractual claims and assert a declaratory judgment claim. The court, however, held that the amended complaint could not strip the federal court of jurisdiction, provided that the original claim was made in good faith. An amended petition filed after removal that alters the claims asserted cannot strip the court of jurisdiction once established. As such, the court denied Plaintiff's motion to remand.

(3) *Rodriguez v. Ocean Harbor Casualty Insurance Co.*, Civil Action H-19-4034; in the United States District Court of the Southern District of Texas.

A court in the Southern District of Texas denied a motion to remand for failure to stipulate with legal certainty damages below the jurisdictional amount. In so holding, the court found it insufficient that the insured stated that he would "never ask, receive, or take a judgment for any amount exceeding $75,000." The court held that a binding stipulation or affidavit establishing with legal certainty that the amount in controversy was less than $75,000 was required.

The court explained that to show that it is "legally certain" that a plaintiff will not exceed the amount stated, plaintiffs must file a binding stipulation or affidavit with the original state petition." A stipulation filed after removal, however, is irrelevant to the court's analysis.

In the present case, Ocean Harbor Casualty Insurance Company ("Ocean Harbor") was able to show with a pre-suit demand letter that the amount in controversy at the time of the filing of the action exceeded $75,000. Accordingly, the court held that Ocean Harbor found, by a preponderance of the evidence, that the amount in controversy exceeded $75,000 at the time that plaintiff filed the action. As such, the court denied plaintiff's motion to remand.

Allowing Leave to File Amended Petition that Destroys Diversity

Jones v. State Farm Mutual Automobile Insurance Co., Civil Action No. 4:19-cv-04282; in the United States District Court, Southern District of Texas, Houston Division.

The court granted an insured's motion to amend and remanded the insured's uninsured motorist case to state court.

To be entitled to amendment, courts review the *Hensgens* factors to determine if a balance of equities favors allowing amendment of the insured's complaint.

Plaintiff, Robert Jones, filed suit against State Farm Mutual Automobile Insurance Company ("State Farm") to recover under his uninsured motorist coverage. State Farm answered and removed the case to federal court. Plaintiff then sought leave to file an amended complaint, seeking to add the uninsured motorist that was mistakenly not sued in state court. Because the motorist was a resident of Texas, his addition to the case would destroy diversity jurisdiction.

While a party may generally amend its original pleading as a matter of course within twenty-one (21) days of service, after that time, the court must consider the factors listed by the Fifth Circuit in *Hensgens v. Deere & Co.*, 833 F.2d 1179, 1182 (5th Cir. 1987). The factors are (1) the extent to which the purpose of the amendment is to defeat jurisdiction (2) whether plaintiff has been dilatory in asking for amendment, (3) whether plaintiff will be significantly injured if amendment is not allowed, and (4) any other factors bearing on the equities.

Plaintiff argued that the purpose of amending his complaint was to obtain a more complete recovery, while avoiding litigation of claims against the uninsured motorist in state court, separately from the federal court action. Plaintiff argued that leaving the uninsured motorist off the original complaint was simply a mistake.

In turn, State Farm argued that the uninsured motorist was not a "necessary party" to an uninsured motorist claim and that it was "suspicious" that Plaintiff left the uninsured motorist off in the first instance—but without

indication of what advantage Plaintiff pursued by doing so. As such, while the court considered that Plaintiff's mistake provided no excuse, the court also considered that nothing indicated that the uninsured motorist was left off the petition as a *strategic* matter. Accordingly, the court held that the first factor weighed in favor of Plaintiff.
Secondly, because Plaintiff sought to amend approximately a week after removal, the court considered that a delay of seven days after removal was not dilatory.

Further, to determine whether Plaintiff would be significantly injured if amendment was not allowed, the court considered two more things: (1) whether the already-named diverse defendant would be unable to satisfy a future judgment; and (2) whether a separate state court proceeding would lead to inefficient parallel proceedings or place a financial burden on the plaintiff. The court decided that these factors weighed in favor of amendment because of the gap between the policy limits and entire amount of monetary relief at issue.

Lastly, the court considered that denying leave would result in the Plaintiff litigating this case simultaneously in two different courts. As such, the court held that the balance of equities under the *Hensgens* factors weighed in favor of allowing amendment. Therefore, the court ultimately remanded the case to state court for lack of diversity.

Section 542 Continues to Apply Post-Appraisal

Kee v. Safeco Insurance Co. of Indiana; Civil Action No. 3:18-CV-2776-N; in the United States District Court, Northern District of Texas, Dallas Division.

The court held that an insurer was entitled to summary judgment on a plaintiff's extracontractual claims after the insurer paid the appraisal award.

Plaintiff, Carolyn Kee, filed suit alleging that Safeco Insurance Company of Indiana ("Safeco") conducted an inspection of her property and reported minimal damage falling below her policy's deductible. Kee then filed suit for breach of contract, under the Texas Prompt Payment Claims Act, and for extracontractual claims under the Texas Insurance Code. Safeco invoked a binding appraisal process, resulting in an appraisal award that was significantly higher than Safeco's initial damages assessment. Upon payment of the appraisal, Safeco sought summary judgment on all of Kee's claims.

With regard to Kee's extracontractual claims, the court noted that the Texas Supreme Court in *Menchaca* clarified the prerequisites to recovering policy benefits for extracontractual claims. The Texas Supreme Court in *Menchaca* held that a party claiming policy benefits as actual damages for contractual claims need not show either breach of contract or independent injury to recover.

The court in *Kee* explained that independent inquiry is an alternative ground that may be used to recover policy benefits for extracontractual claims when a claimant is otherwise not entitled to policy benefits, but it is not a threshold requirement to recovery. A party must establish both that (1) it is entitled to policy benefits, and (2) the alleged statutory violation proximately caused the loss of some policy benefits.

The court in *Kee* held that because Kee was seeking policy benefits as the sole measure of actual damages for her extracontractual claims, but suffered no loss of those policy

benefits proximately caused by the alleged statutory violations, Safeco was entitled to summary judgment after establishing that the policy benefits were paid via the appraisal award. However, the court also clarified that a plaintiff can still potentially prevail on an action for failure to promptly pay, even when contractual claims fail. In turn, a plaintiff must establish the prerequisites necessary to recover actual damages on extracontractual claims.