Martin, Disiere, Jefferson & Wisdom

The Weekly Update of Texas Insurance News

TEXAS INSURANCE LAW NEWSBRIEF

MAY 2, 2016

SHOW CAUSE HEARING ORDERED AFTER INSURED'S COUNSEL ARGUES PROPOSED POST-REMOVAL STIPULATION DEFEATS REMOVAL

Last Thursday, Judge Micaela Alvarez denied an insured's motion to remand, emphasizing that post-removal stipulations are irrelevant in determining whether removal is proper and ordering insured's counsel to appear at a show cause hearing. In *Cantu v. Allstate Vehicle & Property Ins. Co.*, 2016 WL 1695284 (S.D. Tex., McAllen Division, April 28, 2016), the insured brought various insurance-related claims in state court based on alleged wind and hail damage. Allstate timely removed the action to federal court based on diversity jurisdiction because the amount-in-controversy exceeded $75,000. The insured then filed a motion to remand to state court based on an alleged stipulation between the parties that the claimed damages were limited to $23,945.43. The court focused its analysis on the insured's pleadings and well-established Fifth Circuit law on post-removal stipulations in denying insured's motion. Because the insured's pleadings sought more than $200,000, the insured bore the burden to show with legal certainty that the claimed damages were actually less than $75,000. In a failed attempt to meet this burden, the insured argued that the parties had agreed to a binding stipulation prior to removal limiting the claim to $23,945.63. In fact, the parties had not actually signed the stipulation. Even if the stipulation had been signed, the court noted it would have been irrelevant to the court's removal analysis as a post-removal stipulation. Accordingly, the court denied insured's motion to remand.

The court then admonished insured's counsel for representing that the insured had filed a stipulation with her original petition prior to removal. Instead, the insured had merely attached a proposed stipulation with its motion to remand filed *after removal.* The court reminded the insured's counsel of his obligations under Rule 11 of the Federal Rules of Civil Procedure that by filing a motion, he certified that his claims regarding the amount-in-controversy had evidentiary support. Due to the utter lack of support for insured's claim that a pre-removal agreed stipulation existed, the Court ordered insured's counsel to appear at a show cause hearing to explain why the court should not issue sanctions against him.

Editor's Note: The order marks the second time this spring that Judge Alvarez has ordered an insured's counsel to appear at a show cause hearing after determining that their claims lacked factual support.

CHICKEN AND WAFFLES A MORE SEAMLESS COMBO THAN CONFLICTING LETTERS FROM INSURER – SOUTHERN DISTRICT ORDERS NEW TRIAL TO DETERMINE WHETHER INSURED FAILED TO PROVIDE ALL MATERIAL FINANCIAL INFORMATION

Last week, the Southern District's Houston Division granted an insured's motion for new trial, invalidating the jury's finding that the insured failed to provide all financial information material to the insurer's investigation. In *Resie's Chicken & Waffles Restaurant v. Acceptance Indemnity Company*, 2016 WL 1643053 (S.D. Tex., Houston Division, April 26, 2016), the insured, Resie's Chicken & Waffles Restaurant, opened in August 2011. In January, a fire caused damage in excess of $100,000 to the restaurant. The insured then made a claim under its property loss policy with Acceptance Indemnity Company. The insurer dispatched its arson investigator to the scene within three days of the fire. The investigator concluded that the fire had been intentionally set in part because the insured refused to turn over footage from their security cameras. In addition, the arson investigator identified multiple points of origin and an ignition source for the fire. He concluded that pure ethanol—the high proof alcohol found in whiskey—was an accelerant of the fire. Other evidence revealed that insured stored beer, wine, and cleaning supplies on its premises. In contrast to the insurer's arson investigator, the fire department and insured's electrical expert concluded that a lighting strike had caused the fire. The insurer's attorneys sent a letter acknowledging receipt of insured's financial documents and authorizations to obtain additional financial documents from the insured in October 2012. However, the insurer's December 2012 denial letter explained that it was denying coverage due to insured's failure to have an operational fire alarm, failure to provide requested financial information, and its conclusion that the fire had been set intentionally.

The insured then filed suit against the insurer alleging breach of contract and failure to comply with various provisions of the Texas Insurance Code. The breach of contract claim was tried to a jury. The jury found that the insured did not fail to keep an operational fire alarm and that employees had not intentionally set the fire. However, the jury also found that insured failed to provided all material financial information to the insurer and that this failure was prejudicial to insurer. The insured moved for judgment as a

matter of law, or in the alternative, for a motion for new trial with respect to the jury's findings regarding financial documents. The insurer moved for judgment that insured take nothing in light of the jury's finding that insurer was prejudiced by insured's failure to provide all financial information requested.

In evaluating the competing motions, the court focused on the conflict between the October 2012 letter from the insurer's attorneys acknowledging receipt of insured's pertinent financial information, and the December denial letter from insured's claims department stating that material financial documents had been withheld. In addition, the court noted that the insured owner had testified that all financial documents had been provided. In contrast, the court found no corroborating evidence to support insurer's assertion in its denial letter that insured had failed to comply with "numerous requests" for financial documents. Due to the lack of documentation of the timing of these "numerous requests," the court held that no competent evidence supported the jury's finding that insured had failed to provide sufficient financial information. Consequently, the court ordered a new trial on the issue of whether insurer had failed to provide all requested financial information.

LATE NOTICE DEFENSE FAILS TO BAR BREACH OF CONTRACT CLAIM AND ABATEMENT FOR APPRAISAL

In *Herrera v. State Farm Lloyds*, Civ. Act. No. 5:15-cv-148 (S.D.Tex. – Laredo Div., March 18, 2016), Herrera insured her rental home with State Farm Lloyds. Herrera claimed her property suffered "incredible" hail damage on March 30, 2013. She notified State Farm of her claim on March 1, 2015, about 700 days later. State Farm's adjuster inspected the property on March 10, 2015, and found signs of light hail damage to sections of the roof. He did not inspect the interior. He estimated the loss at $499.58, which was below the deductible. The insured's attorney sent a $29,962.12 demand letter to State Farm under the DTPA on May 27, 2015. State Farm offered to re-inspect under a reservation of rights, but the insured filed suit for breach of contract, violations of the DTPA and the Texas Insurance Code, breach of the common law duty of good faith and fair dealing, breach of fiduciary duty, unfair insurance practices, misrepresentations, and common law fraud by negligent misrepresentations. The case was removed to federal court. State Farm moved for summary judgment on all claims. The insured did not file a response to the motion for summary judgment, but moved to compel appraisal.

State Farm moved for summary judgment on the late notice defense as a bar to the breach of contract claim. A late notice defense requires two elements: 1) breach of the notice clause by an unreasonable delay in tendering notice and 2) the breach is material because, among other things, State Farm is prejudiced by the delay. The Court agreed that waiting approximately 700 days to provide notice of the claim constituted an unreasonable delay as a matter of law. However, State Farm failed to provide specific evidence of prejudice, and the Court rejected the argument that a nearly two year delay constituted prejudice as a matter of law. The Court further noted "there is at least some evidence that State Farm was not prejudiced," because the adjuster could still: 1) investigate the property, 2) differentiate between hail damage and wear and tear, and 3) determine the amount of the loss. Accordingly, summary judgment was denied on the breach of contract claim.

Addressing the negligent investigation claims, however, the court held that since the insurer's duty to adjust arises under the insurance policy, then Plaintiff cannot also sue under tort. And, summary judgment was granted on the negligence allegation. Further, the court held there was no evidence of any damage producing "false, misleading or deceptive act," nor did Plaintiff allege any specific wrongful acts to support the DTPA allegations and granted summary judgment in favor of the insurer on these claims. Additionally, in addressing the allegations under the Texas Insurance Code, the court recognized that the "mere denial of a claim does not violate the insurance code if there is a reasonable basis for the denial. The summary judgment evidence shows State Farm promptly investigated the claim and denied it because the calculated loss was below the deductible." Although Plaintiff disagreed with the valuation, it was no shown to be "inherently unreasonable." Summary judgment was granted on these claims as well. Lastly, addressing the common-law claims, the court held that Plaintiff's remaining claims of common-law duty of good faith and fair dealing, breach of fiduciary, unfair insurance practices, misrepresentation and fraud were merely restating the DTPA and Texas Insurance Code claims. Thus, they fail for the same reasons, and summary judgment was granted.

The court then turned its attention to the insured's motion to compel appraisal. The court acknowledged that the Texas Supreme Court strongly favors enforcing appraisal clauses, granted the insured's motion and ordered the case abated pending completion of the appraisal process.

FIFTH CIRCUIT AGREES WITH INSURER'S CALCULATION COMMERCIAL PROPERTY WINDSTORM DEDUCTIBLE

In *Saratoga Resources, Inc. v. Lexington Insurance Company*, 2016 WL 1127399 (5th Cir. March 22, 2016), Lexington issued an insurance policy to Saratoga covering several oil and gas properties. Each property had a different insured value. When Hurricane Isaac made landfall in Louisiana and damaged several properties, Saratoga submitted a claim for $3,085,047.39. Lexington's adjuster inspected the properties, and Lexington paid $2,001,191.28, based on a calculation of the deductible being $912,500. Saratoga disagreed, contending the deductible should be $400,000. Lexington filed suit in the Southern District of Texas. Both parties filed cross motions for summary judgment. The district court granted Lexington's motion. Saratoga appealed.

The issue on appeal is how to correctly calculate the deductible. The relevant policy provisions provide:

Deductible: Each claim for loss or damage under this policy shall be subject to a per occurrence retention amount of $125,000 unless a specific deductible shown below applies:

Earth Movement/Flood/Named Windstorm: 5% of Total Insurable Values at the time and place of the loss, subject to a minimum of $250,000 any one occurrence.

If two or more deductible amounts apply to a single occurrence, the total to be deducted shall not exceed the largest deductible unless otherwise stated in the policy.

The parties agreed Hurricane Isaac was a "Named Windstorm." They agreed on the identity and insured values of the properties that were damaged. But they disagreed on how the deductible is calculated when more than one property was damaged.

Lexington argued the "plain language" of "5% of Total Insurable Values" sets the deductible at 5% of the aggregate sum of the insured values. This equaled $912,500. Saratoga argued the policy required the calculation of "mini-deductibles" that represent 5% of the insured value of each property. Then when the $250,000 minimum is reached, the "two or more deductible" clause prevents the total deductible from exceeding the highest "mini-deductible," which is $400,000.

The Fifth Circuit agreed with Lexington's interpretation. Texas law requires that terms be given their ordinary meaning unless the policy shows a technical or different sense was meant. The Court of Appeals held that Lexington's interpretation was reasonable and nothing in the policy indicated a more technical interpretation was meant. "The 'ordinary meaning' of '5% of Total Insurable Values' is 5% of the 'Total' of the 'Insurable Values' of the damaged properties – that is, 5% of the aggregate sum of the insured value of each damaged property."

REMINDER: DUTY TO DEFEND IS BASED ON FACTS, NOT LEGALESE

In a case involving the CGL policy's Coverage B for personal and advertising injury, a federal judge in the Western District of Texas meticulously applied the eight-corners rule to determine whether a complaint alleged a potentially covered cause of action against the insured. In *Great American Insurance Co. v. American College of Allergy, Asthma & Immunology*, CA. No. SA-15-CV457-XA, 2016 WL 1532261 (W.D. Tex. Apr. 15, 2016) (slip copy), one allergy clinic had sued another, alleging a variety of anti-competitive practices. The critical question for determining Great American's duty to defend the suit was whether the alleged facts, construed liberally, presented a matter that could be potentially covered under the CGL policy. The core of Coverage B is the definition of "personal and advertising injury," which consists of a list of specifically enumerated offenses that includes "publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services."

Most of the allegations against the insured were plainly not covered. But the complaint alleged, among other things, that the defendant sent correspondence to insurance companies and medical professionals critical of the claimant's practices and stating or suggesting they were of poor quality and fraudulent. The court read the complaint as a whole, and concluded the factual allegations in several paragraphs, read together, fell within the above definition. Although the legal causes of action alleged in the complaint did not expressly include libel, slander, or disparagement, the ***facts*** alleged allowed evidence of such a claim to be reasonably inferred. Therefore, the entire suit must be defended.

The court also rejected an attempt by Great American to convert its policy into a *de facto* eroding-limits policy based on a sublimit for antitrust claims. The court pointed out that any attempt to limit the amount of attorney fees to be expended in satisfying the duty to defend must be explicitly stated in the policy. This policy contained standard language stating that expenses the insurer incurred would be ***in addition to*** the limits of insurance.

Editor's Note: In this textbook application of the eight-corners rule, the court reminds us that no magic words are required to allege a cause of action or trigger the duty to defend – only enough facts to allow the cause of action to be inferred by a "reasonable reading" of the complaint. Here, the court carefully walked the line between construing the pleadings liberally, which the eight-corners rule requires, and "imagin[ing] factual scenarios which might trigger coverage," which it forbids.