Martin, Disiere, Jefferson & Wisdom

The Weekly Update of Texas Insurance News

TEXAS INSURANCE LAW NEWSBRIEF

FEB 9, 2021

U.S. DISTRICT COURT HOLDS THAT INSUREDS' BREACH-OF-CONTRACT CLAIMS FOR ALLEGED IMPROPER CALCULATION OF "ACTUAL CASH VALUE" FOR TOTAL-LOSS VEHICLES IS NOT A VIABLE CLAIM

Last week, the United States District Court for the Northern District of Texas concluded that there was no support under Texas law or in the relevant insurance policy mandating the insurer to use the "Cost Approach" or "Comparable Sales Approach" in calculating the "actual cash value" of total-loss vehicles. Accordingly, the court held that Plaintiffs' claims of breach of contract were not viable and dismissed the claims. In *Cody et.al. v. Allstate Fire and Casualty Ins. Co. and Allstate Cty. Mutual Ins. Co..*, No. 3:19-CV-665-1935-K, 2021 WL 389768 (N.D. Texas [Dallas Division], Feb. 3, 2021), Plaintiffs were insured under separate but materially identical automobile polices issued by Allstate Fire and Casualty Insurance Company and Allstate County Mutual Insurance Company. Coverage for losses under the Policy was limited to "the actual cash value of the property . . . at the time of the loss." The term "actual cash value" was not defined in the Policy.

The insureds were each involved in separate motor vehicle accidents, and they subsequently filed claims with Allstate for property damage. For each claim, Allstate concluded that the automobile was a total loss. In calculating the "actual cash value," Allstate did not include tax and/or full title, registration, or inspection fees. Unsatisfied with Allstate's valuation method, the insureds filed a class-action suit against Allstate alleging breach of contract. The insureds alleged that "actual cash value" should be measured by either (1) the "Cost Approach": replacement cost, including all fees and taxes related to replacing a vehicle (e.g., sales tax and registration fees), less depreciation, or (2) the "Comparable Sales Approach" which uses comparable sales data showing the amount for which comparable vehicles were sold in the counties of residence during the month the loss occurred.

Allstate filed a motion to dismiss, which the United States District Court granted. The court held as a matter of law that the requested compensation was not required, and that the insureds' claims were not viable under Texas law. The court reasoned that there was no support under Texas law or in the Policy mandating the Cost Approach or Comparable Sales Approach in the car-insurance context. "[N]o Texas law set[s] forth how insurers must calculate ACV or market value in this context outside the definition of market value (i.e., "the price property will bring when offered for sale by one who desires to sell, but is not obliged to sell, and is bought by one who desires to buy, but is under no necessity of buying."). The court further reasoned that although the Policy was silent on how "actual cash value" was to be calculated, the Policy was not ambiguous because "ACV can be given a definite legal meaning under well-established Texas law" defining the term. Lastly, the court reasoned that if it were to conclude that either valuation approach was required in calculating "actual cash value," the court would improperly be inserting an additional requirement into the Policy.

U.S. DISTRICT COURT GRANTS SUMMARY JUDGMENT BASED ON "COSMETIC LOSS" EXCLUSION

Last week, a federal District Court in the Southern District of Texas concluded there was no evidence that hail damage to the insured's metal roof was not merely "cosmetic" as defined by the policy and granted summary judgment in favor of the insurer based on the "cosmetic loss" exclusion. In *Farris v. State Farm Lloyds*, No. H-19-3872, 2021 WL 398489 (S.D. Texas [Houston Division], Feb. 4, 2021), the metal roof of Plaintiff's home was allegedly damaged in a hailstorm. Eleven months later, when Plaintiff's parents and other family members were getting roof replacements paid for by their respective insurance companies, so the insured made a claim with his insurer, State Farm. The policy with State Farm contained a Cosmetic Damage Endorsement which excluded "cosmetic loss," which was defined as a "loss that alters the physical appearance of the metal roof covering but does not result in the penetration of water through the metal roof covering …." State Farm, finding no non-cosmetic hail damage to the roof (and the cost to repair other damage was below the policy deductible), denied the claim. The insured then filed suit, asserting breach-of-contract and extra-contractual claims. In response, State Farm filed a motion for summary judgment, which the court granted.

In granting summary judgment, the United States District Court concluded that "there [was] no evidence that any hail damage to the metal roof was not merely "cosmetic" as defined by the policy and within the Cosmetic Damage Endorsement exclusion." Interestingly, the court relied on the insured and his own causation expert's deposition testimony. The insured admitted that there were no areas of the roof found to be punctured by hail. The insured's causation expert also testified that although hail hit the ridge cap of the metal roof, it did not create any penetrations or water intrusion.

Because the insured did not establish a right to receive benefits under the policy or an injury independent of a right to benefits, which is required to recover damages based on an insurer's statutory violations, the court held that they could not recover on their bad-faith claims. With respect to an "independent injury," the court quickly rejected the insured's assertion that he sustained such an injury as he was "forced to appear for deposition, respond to discovery requests, allow multiple adjusters and experts access to inspect his

property, and engage legal representatives to endeavor to obtain policy benefits." To that end, the court recognized the rule that "[a]n injury is not 'independent' from the insured's right to receive policy benefits if the injury 'flows' or 'stems' from the denial of that right."

FEDERAL DISTRICT COURT UPHOLDS PRIOR ORDER DISMISSING INSURED'S HURRICANE HARVEY-RELATED PROMPT PAYMENT CLAIM

Recently, a federal District Court in Houston denied an insured's motion for reconsideration in which the insured sought to have the court change its prior decision granting the insurer's motion for summary judgment as to the insured's prompt payment claim under Ch. 542 of the Texas Insurance Code. *Caramba, Inc. v. Nationwide Mut. Fire Ins. Co.*, No. H-19-1973, 2021 WL 259388 (S.D. Tex. Jan. 26, 2021) involved claims made by insured Caramba, Inc., d/b/a Pueblo Viejo alleging its commercial property suffered wind and water damage due to Hurricane Harvey.

After Caramba made its claims, which included breach of contract and claims arising under Ch. 542 of the Texas Insurance Code, amongst others, the insurer assigned an adjuster to investigate and inspect the claim. The adjuster engaged an expert to inspect the property, and the expert reported that the property did not suffer wind damage from Hurricane Harvey. Consequently, the insurer denied the claim.

In turn, Caramba retained counsel, submitted additional information to the insurer, and filed suit against the insurer in state court alleging breach of contract and extra-contractual claims, which the insurer timely removed to federal court. Once removal was complete, the insurer moved for summary judgment on all Caramba's claims. The court granted summary judgment on all the extra-contractual claims but denied it as to the Caramba's breach of contract claim. Caramba responded by seeking to have the court reconsider its ruling as to its prompt payment claim under Ch. 542 of the Texas Insurance Code.

The court noted that Caramba entirely failed to address the insurer's argument that Caramba could not show that it wrongfully denied the claim or otherwise delayed payment, let alone meet its burden to provide evidence sufficient to raise a genuine issue of material fact on each element of its Ch. 542 claim, including evidence that the insurer received "all items, statements, and forms reasonably requested and required" under the Texas Insurance Code. As a result, the court denied Caramba's motion for reconsideration and thereby upheld its previous decision to dismiss Caramba's prompt payment claim.

INSURER'S MOTION FOR SUMMARY JUDGMENT BASED ON STATUTE OF LIMITATIONS DENIED, INSURED ABLE TO SHOW DUE DILIGENCE

A federal District Court in Austin recently denied an insurer's motion for summary judgment, which sought to dismiss an insured's cause of action because the insured did not serve the insurer until after the expiration of the statute of limitations. In *Dadfar v. Liberty Mut. Ins. Co.*, No. A-20-CV-071-AWA, 2021 WL 272216 (W.D. Tex. Jan. 27, 2021), the insured made a claim under a homeowners' insurance policy due to damage to their home allegedly caused by a tornado in April 2017. The insurer hired an engineer to address the necessity of the various estimated repairs and issued a final payment and coverage decision on September 27, 2017. The insured thereafter filed an Original Petition in state district court on April 1, 2019, suing the insurer for breach of contract, breach of the duty of good faith and fair dealing, and alleged violations of the Texas Insurance Code and Deceptive Trade Practices Act.

The insurer denied having been served with the Original Petition and was not served with Plaintiff's First Amended Petition until December 23, 2019—well after the two-year statute of limitations ran on September 27, 2019, the date both parties agreed was the date the statute of limitations began to run. As a result, the insurer filed a motion for summary judgment on the statute of limitations issue.

Applying Texas law, the court denied the insurer's motion because the insured was able to show that they filed their Original Petition within the applicable statute of limitations and, when they discovered they named and served the wrong party in their petition, "worked diligently" to effect service upon the correct party as soon as possible afterward. That is, the insured e-mailed a courtesy copy of the petition to the insurer's attorneys—who had participated in a failed pre-suit mediation with the insured—on the day of filing. Afterward, the insured served the insurer via direct service to its president.

After the statute of limitations ran, the insurer's attorney e-mailed the insured's attorney and informed him that the insured misnamed the insurer in the petition and did not effectuate service because the president was not the insurer's registered agent. The insured's attorney responded and asked if the insurer's attorney was able to accept service on behalf of the insurer, which the insurer's attorney denied.

In response, the insured's attorney asked the insurer's attorney to confirm the insurer's registered agent, and the insured's attorney merely directed him to the Texas Secretary of State web site, informing him that he could find out on his own. The insured's attorney then amended the insured's petition to correct the misnomer, sent a courtesy copy to the insurer's attorney, and asked her to confirm that the agent the insured was intending to serve was correct. There was no evidence the insurer's attorney ever responded.

The Court reviewed the summary judgment evidence, which included a sworn statement by the insured's attorney detailing the efforts described above and concluded that such efforts constituted "due diligence." As such, they denied the insurer's motion for summary judgment. Because the briefing the parties submitted was only related to the motion for summary judgment, the court also denied the insured's motion to correct misnomer, which was also before the court, because the court did not have sufficient information to decide whether the insured sued the wrong entity or misnamed the correct entity.