Martin, Disiere, Jefferson & Wisdom

The Weekly Update of Texas Insurance News

TEXAS INSURANCE LAW NEWSBRIEF

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COURT DENIES UIM INSURER'S MOTION TO DISMISS AND WARNS OF SANCTIONS

Last week, the United States District Court for the Western District of Texas denied Allstate's motion to dismiss an insured's declaratory judgment action for underinsured motorist benefits, and warned Allstate that further motions to dismiss based on the same losing position may be met with sanctions. In *Valdez v Allstate Fire and Casualty Ins. Co.,* No. SA-21-CV-00494-XR, 2021 WL 4340973 (W.D. Texas, Sept. 22, 2021, mem. op.), Alicia Valdez brought a declaratory judgment action against Allstate for underinsured motorist ("UIM") benefits, and extra-contractual bad-faith claims, without having first obtained a prior judgment against the underinsured motorist.

Allstate filed a motion to dismiss, contending that its insureds may not pursue any court claim against it, including a declaratory judgment claim, unless they have first separately obtained a judgment against the underinsured tortfeasor.

Addressing the declaratory judgment action, the Western District denied Allstate's motion. The court began its analysis by noting that it had repeatedly rejected Allstate's position that a UIM insured must obtain a judgment against the tortfeasor before the insured can file suit against Allstate for UIM benefits. Then, the court referenced the recent Texas Supreme Court decision in *Allstate Insurance Co. v. Irwin*, 627 S.W.3d 263 (Tex. 2021), which ruled that an insured may file a declaratory judgment action to simultaneously obtain a judgment against the tortfeasor and litigate UIM coverage. Because the ruling in *Irwin* was issued four days before Allstate filed its motion, and more than two months before Allstate filed its reply brief, and Allstate nonetheless continued to argue that a judgment must be obtained prior to filing a declaratory judgment action, the court stated that further motions to dismiss by Allstate based on its losing position may be met with sanctions. Further, "Allstate cannot claim ignorance of [*Irwin*], given that Allstate was the losing appellant in [*Irwin*]."

Addressing the extra-contractual bad-faith claims, the Western District rejected Allstate's argument that liability cannot be reasonably clear until the plaintiff obtains a judgment against the uninsured/underinsured motorist. "When a reasonable investigation reveals overwhelming evidence of the UM/UIM's fault, the judicial determination that triggers the insurer's obligation to pay is no more than a formality. In such cases, an insurer may act in bad faith by delaying payment and insisting that the insured litigate liability and damages before paying benefits on a claim."

COURT DISMISSES INSURED'S CLAIMS AFTER PAYMENT OF APPRAISAL AWARD

Last week, the United States District Court for the Southern District of Texas granted Allstate's motion for summary judgment, based on Allstate's payment to the insured of the appraisal award. In *White v Allstate Vehicle and Property Ins. Co.,* No. 6:19-CV-00066, 2021 WL 4311114 (S.D. Texas, Sept. 21, 2021, mem. op.), Chris White's dwelling was damaged during Hurricane Harvey in August 2017. White filed a claim under his homeowner's insurance policy with Allstate. Subsequently, Allstate's adjusters inspected the damage, issued repair estimates, and paid White in November of 2018. Unsatisfied, White sued Allstate asserting claims of breach of contract and bad faith.

In September of 2019, White invoked the appraisal process under the policy. Allstate declined White's request for appraisal, asserting that White waived his right to the appraisal process due to his delay in invoking it. White subsequently filed a motion to compel appraisal, which the court granted. The appraisal process was conducted and concluded that the covered damages were greater than the amount Allstate initially estimated. Allstate paid White this greater amount less the deductible and the amount it had already paid based on the initial estimate. Then, Allstate filed a motion for summary judgment, which the court granted.

The Southern District quickly dismissed White's claim of breach of contract, as Allstate paid White the amount agreed upon by both appraisers shortly after the appraisal process concluded. "[W]hen an appraisal clause states that an appraisal shall determine the amount of loss under an insurance policy, the insurer's payment of the appraisal award bars the insured's breach of contract claim premised on failure to pay the amount of the covered loss."

Allstate also contended that payment to White also barred recovery of the extra-contractual claims. White contended that payment of the appraisal amount did not mean that Allstate fairly and properly handled his insurance claim. The court concluded that White could not recover on his bad-faith claim because he did not sustain actual damages or an injury independent of his right to recover policy benefits. That is, the harms White claimed he suffered because of Allstate's alleged bad faith all stemmed from the dispute over his proceeds under the policy. The court determined that "Such benefits are not independent injuries as a matter of law."

COURT CONCLUDES THAT FLOOR MAT WAS NOT AN UNREASONABLY DANGEROUS CONDITION; DISMISSES PREMISES-LIABILITY CLAIM

Last week, the United States District Court for the Western District of Texas concluded that a floor mat at the entrance of a Skechers store was not an unreasonably dangerous condition, and dismissed customer's premises-liability claim. In *Sepulveda v. Skechers USA Retail, LLC*, No. 5:20-CV-00915-JKP-ESC, 2021 WL 4267714 (W.D. Texas, Sept. 20, 2021, mem. op.), Alicia Sepulveda's foot got caught in a floor mat at the entrance of a Skechers store, and she fell face first onto the floor. Consequently, she lacerated her head, which resulted in having a metal plate surgically implanted into her head and face. Sepulveda sued Skechers for premises liability. In response, Skechers filed a motion for summary judgment, which the court granted.

In granting summary judgment, the court began by noting that Skechers owed Sepulveda a duty "to make safe or warn against any concealed, unreasonably dangerous conditions" of which Skechers was or reasonably should have been aware, but Mrs. Sepulveda was not." However, the court concluded that the mat was not an unreasonably dangerous condition. "Texas courts have rejected the argument that the existence of a mat alone creates a dangerous condition. Rather, it is a trip hazard—such as the buckle, ruffle, or bend—in a mat that can create a dangerous condition." The court reasoned that there were no previous trip-and-falls or complaints regarding the subject mat or the store entrance. Further, each of the witnesses, including Sepulveda, testified that they observed the mat as flat. Lastly, although Skechers had no policies, training, or specific responsibilities with respect to the mat, such alleged failures were not evidence that the mat itself was unreasonably dangerous.

COURT CONCLUDES THAT WATER ON FLOOR FOR TEN MINUTES IS LEGALLY INSUFFICIENT TO ESTABLISH CONSTRUCTIVE NOTICE OF THE CONDITION; DISMISSES PREMISES-LIABILITY CLAIM

Last week, the United States District Court for the Northern District of Texas concluded that the presence of water on the floor of a Kroger store for ten minutes was legally insufficient to establish that Kroger had constructive notice of the alleged dangerous condition. Consequently, the court dismissed the customer's premises-liability claim. In *Leeuw v. Kroger Texas, L.P.*, No. 3:19-CV-1771-L, 2021 WL 4295405 (N.D. Texas, Sept. 21, 2021, mem. op.), Sheri Leeuw slipped on water in a Kroger store, and fell. The water was a one-half to one-inch wide strip/stream of water, dribbled in a straight line across an area of no more than two feet in length. Leeuw contended that the water was on the floor for about ten minutes before she slipped. Kroger contended that the water could have been on the floor for as little as five minutes.

Leeuw sued Kroger for premises liability. In response, Kroger filed a motion for summary judgment, contending that there was no proof that the water was present long enough for Kroger to have discovered it in the exercise of reasonable care. In other words, Kroger contended that it did not have constructive notice of the alleged dangerous condition.

The court agreed with Kroger, granted summary judgment and dismissed Leeuw's claim. The court concluded that "[e]ven assuming that the water was on the floor ten minutes … such evidence is legally insufficient based on the facts of this case to raise a genuine dispute of material fact regarding Kroger's constructive knowledge." *Robbins v. Sam's East, Inc.*, 2021 WL 3713543, at *2 (5th Cir. Aug. 20, 2021) (explaining that "the ten minutes during which the inconspicuous fruit was on the floor did not afford...employees a reasonable time to discover and remove the hazard."); *Shirey v. Wal-Mart Stores Texas, LLC*, 699 F. App'x 427, 429 (5th Cir. 2017) ("[T]he seventeen minutes during which the inconspicuous grape was on the floor did not afford Wal-Mart a reasonable time to discover and remove the hazard."); *Brookshire Food Stores, LLC v. Allen*, 93 S.W.3d 897, 901 (Tex. App.—Texarkana 2002, no pet.) ("evidence indicating grapes were not on [the] floor for longer than fifteen minutes, and no one saw grapes on [the] floor before customer fell, was legally insufficient to show constructive knowledge).

FEDERAL COURT IN SAN ANTONIO ISSUES BACK-TO-BACK RULINGS IN FAVOR OF UIM INSURER

Recently, the District Court for the Western District of Texas – San Antonio Division issued two orders in favor of an insurer faced with a dispute over whether a insured is entitled to UIM coverage. *Blazejewski v. Allstate Fire and Cas. Ins. Co.*, Case No. SA-21-CV-00700-JKP, 2021 WL 417349 (W.D. of Tex. Sept. 14, 2021) and *Blazejewski v. Allstate Fire and Cas. Ins. Co.*, Case No. SA-21-CV-00700-JKP, 2021 WL 4204148 (W.D. of Tex. Sept. 15, 2021) arise from a motor vehicle accident and a insured's subsequent assertion of entitlement to underinsured motorist (UIM) benefits under her policy with the insurer.

After the insured filed her original state court petition, the insurer removed the case to federal court on the basis of diversity jurisdiction. The insured them filed a motion to remand, asserting that the insurer's notice of removal was procedurally and substantively deficient. First, the insured argued that the insurer failed to allege in the Notice of Removal ("Notice") the parties' citizenship at the time suit was filed and at removal, and that the insurer failed to attach evidence of its citizenship. The Court considered this argument "frivolous," as the Notice contained a clear statement of the parties' citizenship at the time of filing and at the time of removal. The Court further reiterated that the insurer was not required to attach evidence of its allegations regarding citizenship. Second, the insured argued that removal was improper because the amount in controversy was less than the required $75,000. As evidence, the insured pointed to the insurer's response the insured's pre-suit demand letter indicating the insurer's valuation of the claim was $0. At the outset, the Court reminded the insured that the proponent of removal has the burden of proving that it is facially apparent from the petition that damages are more likely than not to exceed $75,000. Once the proponent of removal does so, the burden switches to the other party to establish to a legal certainty that his recovery would not exceed the amount stated in the petition. Upon review of the insured's petition—which asserted claims that, if proven, would allow for a recovery of treble and

exemplary damages, and pled for recovery of damages less than $250,000---the Court held that the $75,000 threshold was met. The Court then turned to the insured, who could not point to anything other than the insurer's response to their demand letter in support of their argument. Accordingly, the Court concluded that the insured had not bet her burden and denied her motion to remand.

The Court's other decision in his matter addressed the insurer's motion for partial dismissal. In her petition, the insured sued the carrier for breach of contract, breach of the duty of good faith and fair deadline, and violations of the Texas Insurance Code, and sought a declaratory judgment regarding her claim for UIM coverage. Except for the claim for declaratory relief, the carrier sought dismissal of the insured's causes of action because it contended it had no contractual duty to pay UIM benefits until the insured obtained a judgment establishing the tortfeasor's liability, his underinsured status, and the amount of recoverable damages, none of which had occurred.

Without getting to the merits of the carrier's motion, the Court held that any of the insured's causes of action based on the carrier's failure to pay UIM benefits were premature because the insured had not obtained a judgment against the tortfeasor, so the Court did not have subject matter jurisdiction over them. Consequently, the Court dismissed the claims without prejudice but allowed the insured to pursue declaratory relief to determine her entitlement to UIM benefits.

FEDERAL COURT DISMISSES INSURED'S CAUSES OF ACTION AGAINST INSURER FOR NOT BEING PLED WITH SPECIFICITY BUT GIVES INSURED SECOND CRACK AT BAT

A federal court in San Antonio recently granted an insurer's partial motion to dismiss because the insured failed to plead certain causes of action with factual particularity. *Janssen v. Allstate*, 2021 WL 42000618, Case No. SA-21-CV-00750-JKP centered on a coverage dispute arising from a hailstorm that allegedly damaged the insured's home. The insured filed suit in state court, asserting causes of action for breach of contract, violations of the Texas Insurance Code (TIC), breach of the duty of good faith and fair dealing, violations of the Texas Deceptive Trade Practices Act (DTPA), and common law fraud against the insurer. Once the case was removed to federal court, where stricter pleading requirements apply to Causes of action based on fraud, the insurer moved for dismissal of the fraud-related claims in the insured's petition because he did not plead any specific facts to support his claim.

The Court noted it had the power to dismiss such claims if a review of the pleadings called for dismissal, but the Court was also required to allow the party a change to amend his pleading to cure his defects—unless the defects could not be cured, or the party failed to amend after being given an opportunity to do so. Here, the insured's petition did not allege specific facts to support the insured's causes of action for common law fraud, Texas Insurance Code and DTPA violations; however, the Court concluded that a more careful or detailed drafting might overcome the deficiencies, so it was appropriate to allow the insured the opportunity to address the defects. As such, the Court granted the insured leave to amend his petition within twenty days; if the insured failed to do so, the motion would be granted in full and the causes of action would be dismissed.

FEDERAL JUDGE IN MCALLEN ISSUES REBUKE ON 542A REMOVALS

As our regular readers know, federal courts of Texas have been grappling with the removal of weather-based insurance cases that name local adjusters under Texas Insurance Code § 542A.006 since it was passed in late 2017. A split among the four federal districts of Texas has been gradually developing during that time, with the Northern District strongly favoring remand of cases in which the insurer does not elect to accept its adjuster's responsibility until after suit is filed, while the other districts have been somewhat less cohesive in their approach.

In *Valverde v. Maxum Cas. Ins. Co.*, No. 7:21-CV-00240, 2021 WL 3885269 (S.D. Tex. Aug. 31, 2021), a McAllen judge took a hard look at several recent opinions on this topic issued out of the Northern District, and openly rejected their reasoning. In this case, Maxum made its election to accept its in-state adjuster's liability after being sued and removed the case to federal court, seeking dismissal of the adjuster under §542A.006. Under these circumstances, Northern District courts have been reliably rejecting the removals and remanding the cases to the originating state courts.

In a lengthy and detailed opinion which appears to be designed to both persuade other district judges and potentially set the case up for eventual review by the Fifth Circuit, the court carefully traced the history of the voluntary-involuntary rule, examined modern Fifth Circuit opinions, and looked to commentary from other federal circuit courts on the intended scope and application of the rule. The court then closely examined the improper joinder rule and the most comprehensive statements on its operation by the Fifth Circuit, concluding Fifth Circuit precedent requires federal courts to determine improper joinder based on the facts that exist at the time of removal, ***not*** the time the suit is originally filed.

Finally, the court formulated this rule synthesizing all of its analysis:

"One rule is consistent with the Supreme Court and Fifth Circuit jurisprudence on 28 U.S.C. § 1446(b)(3), the improper joinder rule, and the voluntary-involuntary rule and governs this case: A case may not be removed from state court to federal court on the basis of federal diversity jurisdiction unless (1) the plaintiff voluntarily dismisses all out-of-state defendants, or (2) the plaintiff improperly joined all out-of-state defendants such that no out-of-state defendant may be restored to the case by any court."

Applying that rule, the court dismissed the local adjuster under §542A.006 and held that diversity jurisdiction existed.

Editor's Note: This opinion appears to be a salvo in an ongoing jurisprudential duel between two federal judges who have each openly disagreed with and rejected the other's legal reasoning on this topic. This opinion included barbs such as, "… the Court does

not find that the Fifth Circuit has left the law in such disarray that the Court is entitled to breezily remand a case over which diversity jurisdiction evidently attaches." Chapter 542A is now five years old, and the split between the federal districts only appears to be widening.

FIFTH CIRCUIT OVERTURNS INSURER WIN IN WIRE FRAUD CASE

The Fifth Circuit recently overturned a summary judgment in favor of a liability insurer on a claim involving a fraudulently-induced wire transfer of money. In *HM Int'l, L.L.C. v. Twin City Fire Ins. Co.*, No. 20-20122, 2021, -- F.4th --, WL 3928970 (5th Cir. Sept. 2, 2021), HM was a provider of accounting and financial services, and its CFO received a fraudulent email purporting to be from one of its clients, directing HM to transfer $1 million to another bank account. HM wired the money without directly contacting the client to verify the request, and most of the money was lost to the fraudster. When the client demanded compensation for the loss, HM reported the claim to its D&O insurer, Twin City. After Twin City denied the claim, HM sued Twin City, and the client joined the suit, asserting independent coverage for the loss under the policy. Significantly, the client never actually sued HM for negligence, although it threatened to do so.

More than two years later, and while the coverage litigation was ongoing, HM settled with the client and demanded Twin City reimburse the settlement amount. Twin City sought and won summary judgment in the trial court on the ground that the settlement was not covered because the client's negligence claim was barred by the two-year limitations period at the time of the settlement and thus the insured was not "legally liable to pay" any negligence claim that could have been brought by the client.

On appeal, the Fifth Circuit disagreed, first finding that a "claim" could include a demand for money and not only a lawsuit, and that "legally liable to pay" could refer to contractual liability such as liability arising out of a settlement agreement, and not merely to judicially imposed liability resulting from a lawsuit. While it was true that HM probably could have defeated a negligence suit in court on its limitations defense, it nevertheless became legally liable to pay the settlement amount specified in the settlement agreement it entered into with the client. The court concluded nothing in the insuring agreement required the insured to actually win a judgment against the insured for a claim to be covered. Twin City's summary judgment was reversed and the case was remanded to the trial court.

Editor's Note: It is not clear from the court's opinion whether the policy included a voluntary payment clause, which is present in most CGL policies and which the settlement paid by HM probably would have violated if it were present in this policy.

FEDERAL JUDGE IN HOUSTON ENFORCES ANTI-ASSIGNMENT CLAUSE, RETAINS JURISDICTION

Recently, a federal judge in Houston demonstrated some federal courts will carefully examine the totality of the circumstances when considering their jurisdiction, and will not be swayed by manipulative corporate shell games sometimes intended to deprive them of jurisdiction. *LNY 5003, LLC v. Zurich Am. Ins. Co.*, No. 4:20-cv-02992, 2021 WL 4026292 (S.D. Tex. Sep. 3, 2021) involved a claim for COVID-19 shutdown-related losses by the Houston-based restaurant empire Fertitta Entertainment, Inc. Although Fertitta has global operations, including restaurants in Asia which were affected by COVID-19 well before most American business were, it is based in Texas. Its insurer, Zurich, is a New York corporation with its principal place of business in Illinois.

In February 2020, apparently anticipating the effect of COVID-19 on its restaurant business, Fertitta formed a new LLC titled LNY 5003, with members in both Texas and Illinois. Fertitta then assigned its rights in the Zurich insurance policy to LNY, and LNY promptly sued Zurich in Texas state court. When Zurich removed the case to federal court, LNY argued the federal courts did not have diversity jurisdiction because both it and Zurich were citizens of Illinois.

The court first rejected LNY's argument that the court did not even have power to consider whether the assignment was genuine, and then carefully examined the formation of LNY, Fertitta's assignment of rights to it, and the policy's anti-assignment clause. The court observed the assignment did not appear to be an arms-length transaction, but involved entities that were wholly owned by Fertitta and individuals who were officers, directors, or shareholders of those Fertitta-owned entities. And in addition to the apparently sham nature of the assignment, it directly violated the policy's anti-assignment clause.

LNY argued it had been assigned *claims,* and assignment of those *claims* was not barred by the contractual anti-assignment clause. Rejecting this argument, the court concluded LNY's contractual claims were in fact barred by the contractual anti-assignment clause, and its claims for common-law bad faith and Texas Insurance Code violations were non-assignable as a matter of Texas law.

The court ultimately concluded Fertitta, not LNY, was the real party in interest, diversity jurisdiction existed, LNY's motion to remand must be denied, and LNY could not proceed any further as plaintiff.

COURT CONCLUDES THAT LAMBORGHINI WAS BEING TEST-DRIVEN, NOT PLEASURE-DRIVEN, AT THE TIME OF LOSS; COURT GRANTS SUMMARY JUDGMENT BASED ON POLICY EXCLUSION FOR USE "OTHER THAN OCCASIONAL PLEASURE USE"

The United States District Court for the Southern District of Texas recently granted summary judgment in favor of insurer, after concluding that the insured's Lamborghini was being test-driven, not driven for occasional pleasure, at the time of the collision. In *Aqrawi v American Modern Property and Casualty Co.*, Civil Action No. 4:20-CV-3161 (S.D. Tex. [Houston Division] August 18,

2021), Aqrawi purchased a 2019 Lamborghini Urus Lamborghini for the purpose of reselling it through his combination garage and dealership ("shop"). Four months later, Aqrawi's shop allowed a potential buyer to test-drive the Lamborghini. During the test-drive, the Lamborghini ran out of gas on the highway and was rear-ended by another vehicle.

Aqrawi insured the Lamborghini through American Modern with a "Collector Vehicle Policy." The policy defined "your covered auto" as "any vehicle shown on the Declarations which is a Collector Vehicle and is used solely for occasional pleasure use." The policy excluded from coverage "loss or damage to your covered auto while it is being used for other than occasional pleasure use."

Aqrawi made a demand on American Modern for the repair costs ($134,225.70), but American Modern denied the claim. Aqrawi subsequently filed suit against American Modern, claiming breach of contract, extra-contractual claims, etc. In response, American Modern moved for summary judgment, making two main arguments: (1) Aqrawi's intent to sell the Lamborghini when he bought it removed the Lamborghini from the definition of "your covered auto" such that there was no coverage for the vehicle at all, and (2) even if the Lamborghini did fall within the definition of "your covered auto," the policy exclusion removed the loss from coverage.

The U.S. District Court granted summary judgment. The court began its analysis by casting doubt on American Modern's first argument, stating: "Even assuming that there is no doubt that Aqrawi's intent was to resell the [Lamborghini], it is unclear that mere intent would control over the terms of the policy itself and would have such sweeping consequences. American Modern's interpretation of the policy would mean that Aqrawi's intent when he purchased the [Lamborghini] vitiated any coverage for it, regardless of the actual circumstances leading to damage." The court found it unnecessary to determine whether American Modern's intent-based argument was a correct interpretation of the policy, because the court concluded summary judgment was proper based on American Modern's second argument.

The U.S. District Court concluded that the damage to the Lamborghini was sustained while it was "being used for other than occasional pleasure use," and the loss fell into the policy's exclusion. The court reasoned that "there can be no doubt that [the potential buyer's] 'drive' of the [Lamborghini] was a 'test drive' to determine whether he wanted to purchase it. This does not constitute a 'leisure/pleasure drive' under the definition of 'occasional pleasure use' under the policy."

U.S. DISTRICT COURT DISMISSES CLAIMS AGAINST INSURANCE AGENCY AS PLAINTIFF FAILED TO MEET THE PLEADING REQUIREMENTS

The United States District Court for the Western District of Texas recently dismissed claims against an insurance agency due to the plaintiff's failure to meet the pleading requirements. In *Molina v. American Access Casualty Co.*, Civil Action No. SA-21-CV-00363-XR (W.D. Tex. [San Antonio Division] August 17, 2021), Vargas was involved in a motor vehicle collision with Molina, who subsequently filed suit against Vargas and obtained a default judgment for $200,000, plus costs and interest. Vargas was insured with American Access Casualty Company ("AACC"). A-Max Automobile Insurance Company ("A-Max"), an insurance agency, facilitated the issuance of Vargas' policy with AACC.

As the judgment creditor of Vargas, and the assignee of his rights under the policy, Molina sued A-Max (and AACC) for breach of contract, bad faith, violations of the DTPA and Texas Insurance Code, and fraud.

The U.S. District Court dismissed Molina's claims against A-Max. To start, the court concluded that, "to the extent [Molina's] claims arise out of the terms of the Policy itself, [Molina] cannot plausibly recover from A-Max because A-Max is not a party to the Policy." Next, the court recognized that sales agents may be individually liable to insureds (when the agent misrepresents specific policy terms, and the insured's reliance upon that misrepresentation actually causes the insured to incur damages), but the court concluded that Molina's pleading did not provide any factual allegations to support the claims. Instead, the pleading merely recited the statutory language of the claims. "The petition does not identify any specific statements made by, or on behalf of A-Max, or explain how those statements amounted to misrepresentations …." "[Molina's] statutory claims fail to allege with sufficient specificity the "who, what, when, and where" of the alleged misrepresentations and must be dismissed."

FEDERAL COURT DENIES INSURER'S MOTION FOR SUMMARY JUDGMENT, AGREEING WITH INSURED THAT FACT ISSUES EXISTED AS TO WHETHER THE INSURER ACTED IN BAD FAITH AND DENYING THE INSURER'S REQUEST TO LIMIT DAMAGES IN THE INSURED'S SWORN PROOF OF LOSS

A federal court recently denied an insurer's motion for summary judgment, which sought to dismiss an insured's bad faith claims, and should coverage be proven, to limit the insured's damages to the amounts in his pre-suit demand letter and sworn proof of loss statements. *Cocanougher Asset No. 3, LLC v. Twin City Fire Ins. Co.*, No. 4:20-CV-00784-O (N.D. Tex. August 6, 2021) involved an insurance coverage dispute arising from an alleged hail damage to a commercial building owned by the insured.

The insured reported a claim for roof damage allegedly caused by hail. The insurer timely acknowledged the claim and began its investigation, including sending a claims professional to inspect the building. The claims professional determined hail had not damaged the roof, and the insurer issued a declination letter to the insured. In turn, the insured retained a public adjuster, who submitted an estimate in the amount of $514,497.33 over a year after the date of the declination letter. In the estimate, the public adjuster demanded payment for $172,980.94 and included a Sworn Proof of Loss in the amount of $171,980.94 (accounting for the $1,000 deductible).

The insurer responded by retaining an engineer to perform a second inspection, and the engineer concluded that the 1-inch hail that fell

at the building was insufficient to damage the roof. Upon review of the public adjuster's photos and correspondence, the engineer supplemented his opinion and stated that the photos showed blemishes on the roofs, but the locations were unknown, so no determination could be made about them.

Subsequently, the insured hired attorneys, who sent the insurer a statutory pre-suit demand latter claiming damages of $414,491.00 ($100,000 less than the public adjuster's estimate). The insurer then sought a third opinion and retained a forensic architect to inspect the property and obtain roof core samples to have laboratory tested for hail impact damage. The forensic architect found there had been long-term drainage/water intrusion issue at the roof prior to the hail event and concluded the origin of the coating distress on the roof was not the result of the hail event.

After receiving the insurer's updated response, the insured filed suit, and the insurer removed the action to federal court. During discovery, the insurer retained another engineer to conduct a fourth inspection, and the results were consistent with all prior reports from the insurer's engineers and architect. The insurer then moved for summary judgment, seeking to dismiss the insured's extra-contractual bad faith claims due to the existence of a bona-fide coverage dispute. The insured argued fact issues existed as to whether the insurer's investigation was done in good faith.

The Court first noted that whether the insurer knew or should have known the claim was covered when it denied the claim is a question of fact. In making this determination, the Court stressed the factfinder must consider only the facts that were before the insurer at the time it denied the claim. Here, the Court emphasized that, at the time the insurer denied the claim, it had not retained any experts and instead relied solely on its own adjuster's opinions about the damage. The Court agreed with the insured that fact issues existed as to his bad faith claims because the insurer only hired experts after its unequivocal denial and in anticipation of litigation and because the factfinder could conclude from the testimony, report, and photos of his expert that the insurer knew or should have known that its liability was reasonably clear when it denied the claim. Therefore, the Court denied the insurer's motion for summary judgment.

As to whether the insured's damages should be limited to the amount in his sworn proof of loss, the Court disagreed with the insured that the carrier could not use the sworn proof of loss against him at trial because the carrier did not rely on it in making its claim determination. Instead, the Court pointed out that, due to when the insured presented the sworn proof of loss (more than a year after the denial), the insurer could not have relied on it at the time it made its claim decision. As such, the factfinder could properly consider it as an "admission against interest," but it could not serve as a conclusive cap on damages, as requested by the insurer. Consequently, the Court denied the insurer's motion for summary judgment.

DALLAS FEDERAL COURT JOINS CHORUS OF COURTS NATIONWIDE IN DISMISSING COVID-19-RELATED BUSINESS LOSS CLAIMS DUE TO LACK OF "DIRECT PHYSICAL LOSS"

The Federal District Court for the Northern District of Texas in Dallas recently granted an insurer's motion to dismiss an insured's COVID-19-realted business loss claim, adding its voice to a growing list of courts dismissing such claims based on policy language requiring a "risk of direct physical loss." In *Graileys, Inc. d/b/a Graileys Fine Wines* v. *Sentinel Ins. Co., Ltd.*, No. 3:20-cv-01181, 2021 WL 3524032 (N.D. Tex. Aug. 9, 2021), the insured, a wine club, made a claim under its policy with the insurer for business losses resulting from coronavirus after Dallas County issued an Order closing all private clubs in the face of the coronavirus pandemic.

After the insurer denied the claim, the insured filed suit and asserted claims for breach of contract, violations of the Texas Insurance Code, and breach of the duty of good faith and fair dealing, amongst others. The insurer responded to the lawsuit by filing a motion to dismiss, claiming the claim was not covered under the Policy and was subject to an endorsement that also precluded coverage.

Striking down the insured's assertion that the policy term "physical loss" was ambiguous, the Court clarified that the term excluded alleged losses that were intangible or incorporeal and did not involve a physical alteration of the property. As such, and because the insured could not show any nexus between any property damage and the presence of coronavirus or the Dallas County Order, the policy did not cover the alleged loss.

Interestingly, the insurer in this case did not rely on the absence of physical loss in its motion to dismiss; instead, the insurer argued that the Virus Coverage Provision specifically excluded "loss or damage caused directly or indirectly by the presence, growth, proliferation, or any activity of virus." The insured responded by arguing that such exclusion did not apply because its losses were due to a civil order responding to a "civil commotion," a Specified Cause of Loss. The Court quickly disposed to insured's argument, interpreting a "civil commotion" to mean something like a riot and not the spread of a virus. In turn, the civil order causing an insured to close its business must have been in response to a riot or "analogous civil commotion." Similarly, the Court disagreed with the insured's contention that the Virus Coverage Provision covered business interruption in the presence of a virus—concluding that the opposite was true, that the provision covered business loss that *resulted* in the presence of a virus. The Court based its ruling on the lack of coverage and granted the insurer's motion to dismiss.

FIFTH CIRCUIT COURT OF APPEALS CLARIFIES THAT, WHILE AN INSURED'S ACCEPTANCE OF AN APPRAISAL AWARD PRECLUDES A BREACH OF CONTRACT CLAIM, AN INSURER MAY STILL BE LIABLE UNDER THE TEXAS PROMPT PAYMENT OF CLAIMS ACT IF THE APPRAISAL PAYMENT WAS NOT TIMELY

The Fifth Circuit Court of Appeals recently affirmed in part and reversed in part a district court's ruling on an insurer's motion for summary judgment, holding that the acceptance and payment of an appraisal award bars an insured from suing an insurer for breach of contract but not from making a claim under the Texas Prompt Payment of Claims Act. *Randel v. Travelers Lloyds of Tex.*, No. 20-20567 2021 WL 3560910 (5th Cir. Aug 12, 2021) involved a claim under a homeowners' insurance policy by insureds whose garage had caught fire during a Fourth of July celebration. The insureds notified their insurer, who responded by acknowledging receipt of the claim, issuing a $10,000 advance for personal property damage, and inspecting the property with the insureds and their restoration contractor. A few weeks after work began, the insureds fired their restoration contractor due to a disagreement.

The next month, the insurer provided the insureds with its estimate of the damage to the dwelling and paid the insureds an amount accounting for the deductible and depreciation costs. Two months later, the insurer completed its personal property estimate, and over the next few months, made three loss-of-use payments to the insureds.

The insureds public adjuster provided an estimate of the damage to the dwelling that was much higher than that of the insurer. When the insurer completed a reinspection to complete the personal property claim, it found that, after the insureds fired their restoration contractor, repairs ceased and so any additional damage was due to the insureds' failure to mitigate their damages. As a result, the insurer declined coverage for additional damage to the property.

After completing the appraisal process, an award was issued to the insureds, and the insurer paid the award within five business days. Several weeks later, the insureds sued the insurer in state court, alleging a breach of contract by the insurer for underpaying their claims, bad faith, and a violation of the Texas Prompt Payment of Claims Act. The insurer then removed the case to federal court and successfully moved for summary judgment on all claims. The insureds followed with the appeal.

On appeal, the Court held that, although the mere issuance of an appraisal award does not bar a breach of contract claim premised on a failure to pay the amount of a covered loss, payment by the insurer and acceptance by the insured of the award does. This, the Court stated, is exactly what happened here. Thus, the Court affirmed the trial court's ruling on the breach of contract claim.

That said, the Court was clear that, even if an insurer pays a insured in full, the insurer may still be found to have violated the Texas Prompt Payment of Claims Act if the payment was not made timely. Due to the precedent in place at the time the district court ruled on the prompt-payment claim, the district court held that the insurer did not violate the statue because the early payments the insurer made, although not in full, were in an amount the insurer deemed reasonable at the time. However, the Court relied on a Texas Supreme Court case that was decided subsequent to the district court's ruling, which changed the law. In that case, *Hinojos v. State Farm Lloyds*, 619 S.W.3d 651 (Tex. 2021),[1] the Texas Supreme Court held that, even a pre-appraisal payment that appeared reasonable at the time it was issued does not bar a prompt-payment claim if the payment does not "roughly correspond" to the amount ultimately owed. Without ruling on the issue of how close pre-appraisal payments need to be to "roughly correspond" with the final amount owed, due to the fact that the gap in this case between the pre-appraisal dwelling and personal property payments and the appraisal award was much greater than the underpayment in *Hinojos*, the insurer's pre-appraisal payment is not a defense to liability under the Texas Prompt Payment of Claims Act. The Court therefore remanded the prompt-payment issue to the district court.

[1] We addressed this ruling in the Newsbrief. https://www.mdjwlaw.com/newsroom-news-TIN-20210405-item2.html