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TEXAS INSURANCE LAW NEWSBRIEF

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INSURER'S LATE PAYMENT OF PIP BENEFITS TRIGGERS STATUTORY PENALTY PROVISION – NO LAWSUIT REQUIRED

The Texarkana Court of Appeals recently addressed whether an insured must file a lawsuit to be entitled to statutory penalties arising from an untimely payment of Personal Injury Protection (PIP) benefits and concluded that a lawsuit is not a prerequisite to recover the 12% penalty interest provision under the statute. In *State Farm Mutual Ins. Co. v. Rumbaugh,* 2022 WL 452280, (Tex. App. – Texarkana February 15, 2022), the parties submitted cross motions for summary judgment and stipulated that the insured was owed $2,500 in PIP benefits and that payment was "due not later than the 30th day after the insurer received satisfactory proof of claim" as required by Texas Insurance Code Section 1952.156. They also stipulated that the amounts were due on April 2, 2018, State Farm issued payment on April 5, 2018, but mailed the check to an incorrect address. On April 25, 2018, State Farm reissued the check and mailed it to the correct address and paid all benefits owed the insured before suit was filed but did not pay attorney fees and interest. State Farm argued that the 12% statutory penalty could only be awarded in a lawsuit and because all benefits were paid *before* suit was filed, no penalties were owed. The trial court disagreed, awarded the penalty interest and this appeal followed.

On appeal, the court examined the statutory provisions as a matter of law which stipulate in relevant part:

Sec. 1952.157. ACTION FOR FAILURE TO PAY BENEFITS. (a) If the insurer fails to pay benefits under the coverage required by this subchapter when due, the person entitled to those benefits may bring an action in contract to recover the benefits.

(b) If the insurer is required to pay benefits described by Subsection (a), the person entitled to the benefits is entitled to recover reasonable attorney's fees, a penalty of 12 percent, and interest at the legal rate from the date those amounts became overdue.

Addressing State Farm's two part argument that 1) because all PIP benefits had been paid before suit was filed, they were not recovered in "an action in contract to recover the benefits" and 2) that a court order awarding those benefits was a "precondition to the imposition of the statutory penalty" the court summarized its analysis: "Simply put, an insurer's obligation to pay benefits is not triggered by a lawsuit, it is triggered by the statutory deadline." And when it comes to PIP benefits, that statutory deadline is "not later than the 30th day after the insurer received satisfactory proof of claim" as required by Texas Insurance Code Section 1952.156. The court concluded that the insured was "entitled to statutory penalties as soon as State Farm failed to pay PIP benefits when due." Accordingly, the trial court's judgment was affirmed.

SAN ANTONIO JUDGE TEACHES "STATUTE OF LIMITATIONS 101" FOR INSURANCE CLAIMS

Last week, a federal judge in San Antonio dismissed what could well be one of the last straggler lawsuits arising from a series of 2016 storms that deluged the state of Texas with wind/hail claims. *Tobin Endowment v. Great American Assurance Co.,* No. 5:20-CV-1146-JKP, 2022 WL 817895 (W.D. Tex. Mar. 17, 2022), involved a hail claim arising from an April 2016 storm. Great American determined the roof could be repaired, did not need to be replaced and paid the actual cash value for the repair in August 2016. In June 2017, never having received any further communication from Tobin and no indication he had completed the repairs, Great American issued a closing letter. Tobin took no further action until 2019, when he hired counsel to dispute the claim decision, and filed suit in August 2020.

In granting Great American's motion for summary judgment on statute of limitation grounds, the court laid out a useful guidebook on statute of limitations rules and practices for first-party claims. Key principles the court reviewed include:

- Although the standard limitations period for a breach of contract claim is four years from the date the cause of action accrues, parties may contractually modify the limitations period so long as it is not less than two years.
- Texas law does not require an insurer's decision letter to expressly state that the claim is being closed, although a clear statement definitively closing the file is the best practice.
- Where the insurer has paid the claim and closed the file, the cause of action begins to accrue, at the latest, upon the issuance of a final letter and closing of the claims file.
- Unilateral requests by the policyholder to reconsider or reopen the claim do not toll or extend the limitations period following the claims decision.

- Even if the insurance company is willing to review additional materials, the limitations period continues to run if the insurer does not change its position.
- However, the statute of limitations can be tolled if the carrier attempts to string the insured along without either denying or paying a claim.

FEDERAL COURT DENIES INSUREDS' CLAIMS FOR ATTORNEYS' FEES IN TWO INSURANCE COVERAGE LAWSUITS

1. *Rahe v. Meridian/State Farm*

Recently, the United States District Court for the Northern District of Texas—Dallas Division granted an insurer's motion to deny an insured's claim for attorneys' fees in a case arising from an insurance coverage dispute. *Rahe v. Meridian Security Ins. Co. d/b/a State Auto. Mut. Ins. Co.*, No. 3:21-CV-545-E, 2022 WL 614995 (N.D. Tex.—Dallas Feb. 28, 2022), involved a claim for wind and hail damage by the insured, who argued that a July 9, 2019 storm caused covered losses from wind and hail to her home. After the insured received a partial payment for her losses and a partial denial letter for the rest of her claims from her insurer, Meridian Security Insurance Company ("Meridian"), the insured hired attorneys to pursue the claim and possibly initiate litigation against Meridian.

On January 8, 2021, the insured's attorneys sent a pre-suit notice letter to Meridian pursuant to the Texas Insurance Code. Three days later, the insured's attorneys sent an amended pre-suit notice letter adding the alleged actual damages and interest under the Prompt Payment Statute. A week later, the insured's attorneys received a letter from Meridian indicating that the insured's claim had not been resolved due to a delay that was caused litigation was pending. The insured then filed suit on February 9, 2021.

In response, Meridian responded and argued that the insured could not recover attorneys' fees incurred after the date Meridian asserted the defense—March 9, 2021—because the insured failed to comply with the provisions of the Texas Insurance Code requiring a pre-suit notice to contain the specific amount alleged to be owned by the insurer and to be provided at least sixty days prior to filing suit. Here, the insured filed suit a little less than one month from the date she sent her pre-suit notice containing her specific claim of damages.

The Court first noted the requirements of the provisions at issue and an exception applicable when providing the pre-suit notice would be impracticable because the insured has a "reasonable basis" for believing there is not enough time to give the notice before the statute of limitations expire or if the legal action is asserted as a counterclaim. Meridian argued that it was entitled to the sixty-day notice and did not receive it, while the insured argued waiting the full sixty days was unnecessary based on the purpose of the pre-suit notice and her interpretation of the insured's letter detailing the reasons for the delay in resolving the insured's claim. In the alternative, the insured argued that the appropriate remedy was to abate the lawsuit.

After confirming that Meridian had complied with the statutory requirements entitling it to contest the insured's claim for attorneys' fees, pointing out that the insured was not relying on the exceptions to the requirement, and rejecting the insured's arguments as an improper attempt to create additional exceptions not contemplated by the statute or the legislature, the Court concluded that the insured failed to comply with the statute. Additionally, the Court held that abatement was not available in this case because the statute, as written, provided the insurer with the choice of whether to abate the case or choose to limit attorneys' fees, not the insured.

Given the above, the Court granted Meridian's motion to limit attorneys' fees and barred the insured from recovering attorneys' fees incurred after March 9, 2021.

2. *Paradise Fruits and Vegetables, L.P. v. State Auto*

In another case being litigated in the United States District Court for the Northern District of Texas—Dallas Division, the Court granted the insurer's motion to deny an insured's claim for attorney's fees due to the insured's failure to comply with the statutory pre-suit notice requirement in an insurance coverage dispute. *Paradise Fruits and Vegetables, L.P. v. Nat'l Fire & Marine Mut. Ins., et al.*, No. 3:21-CV-0962-N (N.D. Tex.—Dallas March 1, 2022). This case involves a dispute between the insured and two of its previous insurers, including State Automobile Mutual Insurance Company ("State Auto") and National Fire & Marine Mutual Insurance ("National"), over alleged damages to the insureds' property arising from several storms that occurred on the property in the spring of 2019 and summer of 2020. Both State Auto and National denied the insured's claims, and the insured retained counsel to sue the insurers to obtain payment on its claims and other damages. The insured did not dispute that it failed to provide the required pre-suit notice or that State Auto did not timely plead and prove the deficiency in the pre-suit notice letter.

However, the insured argued that the exception regarding the impracticability of serving the pre-suit notice due to concerns about the statute of limitations applied because its claims against National Fire were about to be time barred, and it therefore sought to have State Auto's motion stricken. According to the insured, the necessity of filing suit against National Fire should be "bootstrapped" to State Auto because State Auto was a "necessary and indispensable party" given that National Fire and State insured the same property at issue, and both denied its claims for damages.

The Court disagreed State Auto was a "necessary and indispensable party" because the insured's claim against National Fire arose

out of storms that allegedly occurred in March and May 2019, while the insured's claim against State Auto arose out of a storm that allegedly occurred in August 2020—more than a year later. The Court therefore concluded that the insured could have sued National before August 2020, and the August 2020 storm and subsequent denial of the claim by State Auto had "no direct connection" to the insured's claims against National Fire. That is, the Court emphasized that the claims by the insured were separate and related to independent occurrences, and the insured could have sued National Fire in March 2021 (before the statute of limitations would have run) while providing Tate Auto with the required pre-suit notice before commencing a section lawsuit against State Auto after the sixty-day period elapsed. Therefore, the Court granted State Auto's motion to deny the insured's claim for attorney's fees and barred the insured from obtaining attorneys' fees incurred after June 22, 2021.

FIFTH CIRCUIT UPHOLDS LOWER COURT DECISION DISMISSING HURRICANE HARVEY CLAIM

The Fifth Circuit Court of Appeals (the "Fifth Circuit") recently affirmed a trial court's judgment dismissing a lawsuit filed by insureds after a dispute with their insurer, American Bankers Insurance Company of Florida ("American"), over a claim for insurance coverage following Hurricane Harvey. *Shaw v. American Bankers Ins. Co. of Fl.*, No. 21-20455, 2022 WL 621694 (5th Cir. March 3, 2022). The insureds filed a claim with American after allegedly sustaining flood damage to their home from Hurricane Harvey. An adjuster with American inspected the insureds' home and reported no visible signs of covered flood damage, so American denied the claim. The insureds then filed suit against American for breach of contract.

American filed a motion for summary judgment, arguing that the insureds did not provide evidence of a "flood" as defined by the policy, or that the damage sustained to their property resulted from a "flood" and not from another event not covered by the policy. The insureds did not respond to the motion, and the trial court granted it. Subsequently, the insureds filed a motion for relief from judgment to add new evidence to the record, including responses to American's interrogatories, the notice of deposition for one of the insureds, an affidavit of their attorney, an affidavit of their attorney's legal assistant, and a water damage assessment report from one of its experts, and argued that such evidence supported a denial of American's motion for summary judgment. After the trial court denied the insureds' motion and declined to consider the newly presented evidence, the insureds' appealed.

The Fifth Circuit reviewed the new evidence but did not find it persuasive and concluded that the trial court properly denied the insureds' motion for relief from judgment. Pointing to the language of the policy that specifically defined "flood," the Fifth Circuit held that the evidence failed to create a genuine fact issue regarding whether there was a "flood," as defined by the policy, and whether a "flood" caused the damage to the insureds' home. Thus, the Fifth Circuit affirmed the trial court's ruling, and the case was dismissed.

COURT OF APPEALS DECLINES TO EXTEND HOLDING IN K & L AUTO CRUSHERS TO HEALTHCARE INSURANCE COMPANIES

The San Antonio Court of Appeals recently declined to extend the holding in *K & L Auto Crushers* (i.e., that the negotiated rates providers charge to healthcare insurance companies for medical services provided to a plaintiff are relevant to whether the charges billed to the plaintiff are reasonable) to healthcare insurance companies that have not been presented claims for payment. In *In re United Healthcare Ins. Co.*, No. 04-21-00532-CV, 2022 WL 527659 (Tex. App. –San Antonio, Feb. 23, 2022, mem. op.), Garza sued Defendants for personal injuries she sustained in a motor vehicle accident. Although Garza had health insurance with United Healthcare, her healthcare services rendered in connection with the accident were performed under letters of protection.

Defendants served United Healthcare with a notice of deposition, seeking, in part, testimony regarding "the maximum allowed contractual reimbursement rate [certain named medical providers] would receive from United Healthcare for the specific services (as identified by CPT/procedure codes) provided by [the medical providers] to Garza", and production of the contracts between United Healthcare and the medical providers who treated Garza. In response, United Healthcare filed a motion to quash, and submitted an affidavit of its employee, Amanda Edmondson, who affirmed that negotiated contractual reimbursement rates were "highly confidential, proprietary, and trade secret data." In turn, Garza served Edmondson with a notice of deposition, which was followed by another motion to quash by United Healthcare. The trial court granted the motion to quash United Healthcare's deposition but denied the motion to quash Edmondson's deposition.

On appeal, the court concluded that the trial court abused its discretion in permitting the deposition of Edmondson. The court declined to extend the holding in *K & L Auto Crushers* to healthcare insurance companies that have not been presented claims for payment. The court emphasized that "the defendants in the underlying case have not sought information from Garza's medical providers about the negotiated rates these providers charge to private insurers and public payors [as was the case in *K & L Auto Crushers*]; instead, the defendants ultimately seek information from Garza's health insurance provider about claims that were never submitted and thus simply do not exist." The court further reasoned that the information sought in *K & L Auto Crushers* was relevant because the services were provided to the plaintiff by the healthcare providers, but the information sought by Defendants was not relevant because Garza did not submit claims to United Healthcare.

U.S. DISTRICT COURT JOINS LINE OF CASES HOLDING THAT AN INSURER'S SECTION 542A.006 ELECTION AFTER COMMENCEMENT OF LAWSUIT DOES NOT ESTABLISH IMPROPER JOINDER

The United States District Court for the Southern District of Texas recently concluded that an insurer's Section 542.006 election to accept claims adjusters' liability after a lawsuit has commenced against the adjuster does not by itself establish improper joinder. In *Macey Property Management, LLC v Starr Surplus Lines Ins. Co.,* No. H-21-3943, 2022 WL 540948 (S.D. Texas, [Houston Division] Feb. 23, 2022, mem. op.), Macey sued its insurer, Starr Surplus, and two adjusters assigned to Macey's property damage claim, in state court, asserting causes of action arising from the alleged failure to pay claims. Subsequently, Starr Surplus elected to accept whatever liability the adjusters may have had pursuant to Section 542A.006 of the Texas Insurance Code.

Next, Macey amended its petition and added new defendants, including Underwriters, who removed the lawsuit to federal court, contending that the Starr Surplus adjusters were improperly joined and, consequently, complete diversity existed to establish federal jurisdiction. In response, Macey filed a motion to remand, which the U.S. District Court granted.

The U.S. District Court noted the split in the decisions of Texas district courts:

One line of cases holds that a § 542.006 election made after a lawsuit commences but before removal renders the in state adjuster improperly joined because the election, which requires that the adjuster be dismissed with prejudice, precludes any recovery against the adjuster. Another line of cases focuses on whether the parties were improperly joined at the time of joinder, and holds that an insurer's § 542A.006 election after a lawsuit has commenced does not by itself establish improper joinder.

The U.S. District Court adopted the latter approach and ultimately concluded that Underwriters did not allege facts establishing complete diversity and accordingly, remanded the case to state court.