ANNUAL SURVEY OF TEXAS INSURANCE LAW

2021

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I. INTRODUCTION

The Texas Supreme Court in *Hinojos v. State Farm Lloyds*, 619 S.W.3d 651 (Tex. 2021), further clarified the decisions in *Barbara Technologies Corp. v. State Farm Lloyds*, 589 S.W.3d 806 (Tex. 2019) and *Alvarez v. State Farm Lloyds*, 601 S.W.3d 781 (Tex. 2020), holding an insurer's acceptance and partial payment of a claim within the statutory deadline do not preclude liability for interest on amounts owed but unpaid when the statutory deadline expires. The Fifth Circuit along with several appellate courts applied the *Hinojos* ruling.[1]

The Fifth Circuit delved into the *Stowers* elements in holding that a primary carrier was required to pay back an excess carrier following a judgment outside of the primary carrier's limits.[2]

And the Texas Supreme Court held insureds must first try and win their underlying claim before proceeding to the extra-contractual damages under the Texas Insurance Code.[3] The insureds, relying on *USAA Texas Lloyds v. Menchaca*, 545 S.W.3d 479 (Tex. 2018), argued this step was unnecessary.

Finally, in *Allstate Ins. Co. v. Irwin*, 627 S.W.3d 263 (Tex. 2021), the Texas Supreme Court affirmed the appellate court's opinion, holding a declaratory judgment action was an appropriate vehicle for uninsured/underinsured motorist cases, and that the trial court had discretion to award attorney's fees.

II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile

An insured driver was sued for allegedly failing to close a gate after he delivered cows. The cows got through the gate and escaped onto the road where one was struck by a car. The injured motorist sued the insured delivery driver. The insurer of the delivery driver intervened in the lawsuit between the motorist and the insured, seeking a declaration that it owed no duty to defend or indemnify under its commercial automobile policy. The court looked at the policy language that covered "use of a covered vehicle" in deciding the case. The court noted the broad interpretation of "use" in the auto insurance context but limited it to those found in *Mid–Century Ins. Co. of Tex. v. Lindsey*, 997 S.W.2d 153, 157 (Tex. 1999), e.g. (1) the accident must have arisen out of the inherent nature of the automobile; (2) the accident must have arisen within the natural territorial limits of an automobile, and the actual use must not have terminated; and (3) the automobile must not merely contribute to causing the condition which produces the injury, but must itself produce the injury. Failing to close a gate during a cow delivery was not considered "use." The court reversed summary judgment for the insured and rendered judgment for the insurer. *State Farm Mut. Auto. Ins. Co. v. Lopez*, No. 13-19-00605-CV, 2020 WL 6878734 (Tex. App.—Corpus Christi-Edinburg 2020, no pet.).

B. Homeowners

An insured sued her homeowner's insurer for failure to pay claims for roof damage, overflow from her washing machine, and a water leak from her air conditioner. There was conflicting evidence on the timing and cause of her loss. The insured argued that a fact dispute precluded summary judgment and that the insurer was limited to the allegations stated in its denial letters. The court did not reach the issue of the denial letters, holding that they encompassed the summary judgment allegations. The court further held the insured had the burden to show the loss was within the policy and failed to do so based on the timing of the loss. The court applied the rule outlined in *Don's Building Supply, Inc. v. OneBeacon Ins. Co.*, 267 S.W.3d 20 (Tex. 2008) to the policy, noting the similar language. The loss must occur during the policy period, not its manifestation. The court stated, "… the only reasonable interpretation of the policy is that it covers a loss that actually "occurs during the policy period," not an earlier loss that manifests during the policy period." The appellate court affirmed summary judgment for the insurer. *Powell v. USAA Cas. Ins. Co.*, 2021 WL 1414217 (Tex. App.—Houston [1st Dist.] April 15, 2021, pet. denied).

C. Commercial Property

A business sued its insurer to recover under an "all-risk" commercial property insurance policy for losses to three of its restaurants allegedly caused by the COVID-19 pandemic. The policy provided business interruption coverage for certain losses to the restaurants. Following the county judge's order that prohibited access to any dine-in restaurants, the insured restaurant company closed its three restaurants until authorities decided the danger from COVID-19 had passed. The insured restaurant provided notice of claim to its insurer the same day. Its insurer submitted a reservation of rights letter stating the COVID-19 pandemic, without more, was not a direct physical loss or damage to property sufficient to trigger policy coverage. The insured's first two complaints were dismissed for failure to state a claim. It filed a third amended complaint alleging breach of contract, breach of the duty of good faith and fair dealing, and violations of the Texas Insurance Code. The insurer moved to dismiss the third amended complaint for failure to state a claim. The policy provides coverage for all losses except those specifically excluded. A covered cause of loss in the policy is defined as a "direct loss" and "loss" is defined as an "accidental physical loss or accidental physical damage." The court noted that, "every district court within the circuit to address the issue has determined that a building's exposure to the coronavirus does not meet this requirement." The insured argued at least one member of its staff contracted COVID-19 while working on the covered property. However, the court stated COVID-19 could be removed from the surfaces by routine cleaning. Therefore, "the mere presence of the virus on Vandelay's property does 'not constitute the direct physical loss or damage required to trigger coverage under the Policy because the virus can be eliminated….'" The court held the insured failed to allege anything about COVID-19 itself that threatened the physical structures of its restaurants, resulting in the dismissal of its case with prejudice. *Vandelay Hospitality Grp., LP v. Cincinnati Ins. Co.*, No. 3:20-CV-1348-D, 2020 WL 5946863 (N.D. Tex. July 13, 2021).

The Texas Supreme Court held insureds must first try and win their underlying claim before proceeding to the extra-contractual damages under the Texas Insurance Code.

III. FIRST PARTY THEORIES OF LIABILITY

A. Breach of Contract

An employer allowed its employees to share in the ownership of the company through an employee stock ownership plan (ESOP). The employer appointed a third-party professional trustee to manage the ESOP's investments. To manage risk, the employer purchased a claims-made executive protection portfolio policy. The employees filed a class action against the trustee alleging that the employer improperly loaned money to the ESOP, which then, at the employer's request, used the funds to buy stock from the employer and its insiders at an inflated price. The employer was not named in the litigation. The trustee requested a defense from the employer who tendered the demands to its insurer. Initially, the insurer paid the defense costs, but subsequently it declined coverage and stopped payment of the defense. The employer filed suit against the insurer for breach of contract and multiple other violations, and the insurer moved for a motion to dismiss which was granted. The employer appealed. The insurer argued that the employer failed to allege it had a duty to provide coverage to the employer under the policy. The court held the demands from the trustee were facially insufficient to trigger the insuring clause, which required the assertion of a "Fiduciary Claim … made against [employer] … for a Wrongful Act committed … by [Martin.]" The insurer argued because the employer was not named in the suit, coverage was not required. The employer is first required to establish that a fiduciary claim against it is covered under the insuring clause. It failed to meet that requirement as there was no claim against the employer directly. However, the employer attempted to invoke an exception to the exclusion, when it first failed to establish coverage under the policy. Coverage must be established first. Therefore, the appeals court affirmed the dismissal of the breach of contract claim. *Martin Res. Mgmt. Corp. v. Fed. Ins. Co.*, No. 20-40571, 2021 WL 42695652021 (5th Cir. Sept. 20, 2021).

B. Unfair Insurance Practices, Deceptive Trade Practices & Unconscionable Conduct

In an underinsured motorist (UIM) case, the insured secured a judgment against the UIM carrier in excess of the combined liability and UIM limits. The insured then sued the insurer for breach of contract, common law bad faith, and insurance code violations. The insurer sought mandamus to block discovery on this second action, arguing that since it paid its UIM limits following the verdict, it was not liable for the causes of action asserted by the insured against it. The opinion goes into detail analyzing the prior case law and noting the sometimes-contradictory opinions. The court ultimately denied mandamus and allowed discovery to go forward, holding that the precedent set by *Arnold v. National County Mutual Fire Insurance*, 725 S.W.2d 165 (Tex. 1987) (modified by *Murray v. San Jacinto Agency*, 800 S.W.2d 826 (Tex. 1990)) controlled this issue. This opinion contains a rich and thorough history of contractual and extra contractual remedies in UM/UIM cases. *In re State Farm Mut. Auto. Ins. Co.*, 614 SW.3d 316 (Tex. App.—Fort Worth 2020, orig. proceeding).

C. Prompt Payment of Claims – Article 21.55

An insured reported damage to his home after a hailstorm. An adjuster inspected the home finding the damage was less than the deductible. The insured requested a second inspection where the adjuster found additional damage, and the insurer paid the amount less the deductible and depreciation. The insured sued the insurer and its adjuster, alleging the insurer violated Texas Insurance Code, chapter 542 by delaying payment of the claim. Almost two years after the insured submitted his claim and fifteen months after he filed suit, the insurer invoked the policy's appraisal clause. The appraiser valued the loss over six times what the second adjuster had determined. The insurer paid the loss, and moved for summary judgment contending that "timely tendering of the appraisal award precludes prompt payment damages under Chapter 542 of the Texas Insurance Code." The insured argued the insurer was subject to statutory liability because it failed to issue payment within the deadlines set out in section 542.057 of the Texas Insurance Code. The trial court granted summary judgment in favor of the insurer, and the appellate court affirmed. Following its decisions in *Barbara Technologies Corp. v. State Farm Lloyds*, 589 S.W.3d 806 (Tex. 2019) and *Alvarez v. State Farm Lloyds*, 601 S.W.3d 781 (Tex. 2020), the Texas Supreme Court held the insured's payment of the appraisal award outside the statutory deadline did not relieve it of Chapter 542 liability. An insurer's acceptance and partial payment of the claim within the statutory deadline does not preclude liability for interest on amounts owed but unpaid when the statutory deadline expires. Therefore, the Texas Supreme Court reversed the judgment of the appellate court and remanded the case to the trial court. *Hinojos v. State Farm Lloyds*, 619 S.W.3d 651 (Tex. 2021) (*dissenting* Justice Blacklock and Justice Guzman) (arguing that in *Barbara Tech.*, the insurer had rejected the full amount of the claim and paid nothing before the sixty-day window closed, whereas in *Hinojos* a timely payment was made but later required an additional payment. Because a payment was made, the insurer should not be liable for delaying payment of a claim, when the appraisal award is later a higher amount.)

In *Hyewon Shin v. Allstate Tex. Lloyd's*, 848 Fed. Appx. 173 (5th Cir. 2021), the district court granted summary judg-

ment in favor of the insurer, concluding that the insurer's pre-appraisal payment to the insured was timely and reasonable, notwithstanding the final appraisal amount was 5.6 times greater than the pre-appraisal amount. The insured appealed, and following the ruling in *Hinojos v. State Farm Lloyds*, 619 S.W.3d 651 (Tex. 2021), the Fifth Circuit vacated the judgment in *Shin* and remanded for further proceedings consistent with *Hinojos*, which held that an insurer's acceptance and partial payment of the claim within the statutory deadline does not preclude liability for interest on amounts owed but unpaid when the statutory deadline expires.

An insured church's property was damaged during a storm. The insured notified its insurer who inspected the property and paid a small amount. The insured requested a second inspection, and additional money was paid. The insured sued the insurer as it argued the damage amount was higher than what the insurer paid. Fifteen months after suit was filed, the insurer moved to compel an appraisal. The appraiser awarded an additional $24,692.10, which the insurer paid. Both parties filed motions for summary judgment on the Texas Prompt Payment of Claims Act (TPPCA), and the trial court granted the insurer's motion in its entirety. Following *Hinojos*, the appellate court reversed the trial court's judgment regarding the TPPCA claim and remanded to the trial court, noting the later payment of an appraisal award did not bar Chapter 542 liability. 619 S.W.3d 651 (Tex. 2021). Additionally, the court stated that because the insurer did not promptly pay the claim, the insured was entitled to interest and attorney's fees as set out by the TPPCA. *First United Methodist Church v. Church Mut. Ins. Co.*, No. 13-18-00048-CV, 2021 WL 3776728 (Tex. App.—Corpus Christi Aug. 26, 2021, no pet. h.).

Homeowners filed a claim for property damage to their home caused by a fire. The insurer made some payments, but the damage amount was still in dispute. All parties agreed to an appraisal. The appraisal award came in closer to the insureds' amount, and the insurer paid the award. Before the appraisal award was issued, the insureds sued the insurer in state court for violation of the insurance policy, bad faith, and violations of the TPPCA. After removing the case to federal court, summary judgment was granted for the insurer on all claims. The insured appealed. The Fifth Circuit affirmed the breach of contract claim in favor of the insurer, as acceptance of the appraisal payment barred the insurers' breach claim seeking payment for the dwelling damage that the appraisal award covered. Additionally, the loss of use claim was not submitted to appraisal and was paid by the insurer. However, the Fifth Circuit reversed the district court's ruling on the TPPCA violation. The Texas Supreme Court in *Hinojos* held that even a pre-appraisal payment that seemed reasonable at the time does not bar a prompt-payment claim if it does not "roughly correspond" to the amount ultimately owed. 619 S.W.3d 651 (Tex. 2021). Therefore, to avoid prompt-payment liability, a pre-appraisal amount must "roughly correspond" to the amount ultimately owed. There is a substantial gap of $185,000 between the pre-appraisal dwelling and personal property payments and the appraisal award in this case. Following the recent clarification in the *Hinojos* case, the claim seeking interest for late-payment of dwelling coverage was remanded. *Randel v. Travelers Lloyds of Tex. Ins. Co.*, No. 20-20567, 2021 WL 3560910 (5th Cir. Aug. 12, 2021).

Insurer initially denied insured homeowner's claim but paid the appraisal award. Insured sued under the Texas Insurance Code, chapter 542 for failure to promptly pay the claim. The court held that it takes more than a simple disparity between the insured's initial evaluation of the claim and the appraisal award to trigger the penalties under chapter 542. Paying the appraisal award is not an "acceptance" of the claim. Otherwise, the prompt payment statute would force insurers to pay claims they had a basis for denying. The appellate court makes an exhaustive analysis of *Barbara Techs. Corp. v. State Farm Lloyds*, 589 S.W.3d 806 (Tex. 2019) in reaching its conclusions noting that the opinion, created "a host of questions." Then the court affirmed summary judgment for the insurer. *Crayton v. Homeowners of Am. Ins. Co.*, No. 02-20-00037-CV, 2020 WL 7639582 (Tex. App.—Fort Worth Dec. 23, 2020, no pet.). It appears the "host of questions" from *Barbara Techs. Corp.* was answered by the Texas Supreme Court in *Hinojos* after this decision was entered. Had *Hinojos* been decided prior to this case, the outcome in favor of the insurer most likely would have been reversed by the appellate court.

IV. DUTIES OF LIABILITY INSURERS

A. Duty to defend

A restaurant hired a payment processing company to handle its credit card payments made by customers. There was a data breach of customers' credit card information involving the unauthorized installation of a program on the restaurant's payment processing devices. The payment processing company owed millions to Visa and MasterCard associated with the breach. The restaurant had a contract with the payment processing company requiring it to indemnify the company for any assessments or fines stemming from the restaurant's failure to comply with the payment brand rules. The payment processing company alleged that the breach was caused by the restaurant's violation of the payment brand rules, and sued the restaurant for breaching their agreement. The restaurant turned to its insurer to provide a defense in the lawsuit and pay the damages. The insurer denied its duty to defend the restaurant arguing the payment processing litigation did not qualify for coverage, as it was not a "personal and advertising injury." The restaurant sued its insurer, and the parties filed cross-motions for summary judgment. The district court denied the restaurant's motion, granted the insurer's motion, and dismissed all the claims. The restaurant appealed. Under the policy, the insurer had a duty to defend if the complaint sought damages "arising out of … [the] [o]ral or written publication … of material that violates a person's right of privacy." Coverage is triggered from reading the eight corners of the policy by a "publication, *in any manner"* that is exposed to view. The complaint in this case alleges that the restaurant published its customers' credit-card information - that is, exposed it to view. Moreover, the policy does not simply extend to violations of privacy rights, the policy extends to all injuries that arise out of such violations. Therefore, the court held the plain text of the policy anticipated the insurer's duty to defend in this litigation. The court noted it does not matter that the payment processing company's legal theories sound in contract rather than tort, and it does not matter that the company rather than individual customers sued the restaurant. Under the eight-corners rule, the court held the insurer must defend the restaurant in the payment processing litigation, reversing the district court's judgment. *Landry's, Inc. v. Ins. Co. of the Pa.*, 4 F.4th 366 (5th Cir. 2021).

The Texas Supreme Court in *Hinojos* held that even a pre-appraisal payment that seemed reasonable at the time does not bar a prompt-payment claim.

A security guard was sitting post in his car when a thun-

derstorm passed through, causing a nearby stream to rise and flood. After his car became inundated, the security guard called for help but could not move to safety. As he escaped the car, floodwaters swept him and the car over an embankment, and his body was not found for two months. His estate sued his employer, who had an insurance policy that covered bodily injury and property damage, but not when such injuries arose out of or resulted from use of an automobile. The insurer bore the burden of establishing that the auto exclusion applied. The court held the insurer failed to show that the injuries resulted from use of the vehicle, and, therefore, affirmed the district court's granting of summary judgment to the employer on the duty to defend issue. Additionally, because the allegations stated that the floodwaters caused the death, not the vehicle, the insurer failed to establish that the vehicle was the producing cause of the injury. The court held the insurer must defend the employer in the underlying lawsuit. *Covington Specialty Ins. Co. v. USAI LP*, No. 21-10010, 2021 WL 4901485 (5th Cir. Oct. 20, 2021).

A lawsuit was brought against the insurer by the receiver for the insured for breach of contract, violations of the Tex. Deceptive Trade Practices Consumer Protection Act, violations of the Texas Insurance Code and breach of the common law duty of good faith and fair dealing. Insured was sued initially for dumping material on land where he mistakenly believed he had permission to dump. Insurer denied coverage asserting the act was intentional and not an "accident." After some discussion, the court agreed with the insurer holding there was no duty to defend or indemnify under these facts. *LaTray v. Colony Ins. Co.*, No. 07-19-00350-CV, 2021 WL 97204 (Tex. App.—Amarillo Jan. 11, 2021, no pet.).

An insured had four layers of liability coverage in a lawsuit with two plaintiffs. The first plaintiff settled and exhausted the first three layers of coverage. The second plaintiff went to trial and secured a judgment within the remaining fourth layer of coverage. The carrier insuring the fourth layer of coverage had a policy that gave the carrier the "right but not the duty" to defend. Insured argued that the fourth carrier assumed the defense so waived its right to decline a defense or alternatively modified the insuring agreement to require a defense. Insured also sued the first layer carrier for terminating its defense early. The Fifth Circuit looked strictly at the policy language, found no waiver or modification, and enforced the policy as written, affirming summary judgment in favor of the insurer. *Tex. Disposal Sys., Inc. v. FCCI Ins. Co*. 854 Fed. Appx. 576 (5th Cir. 2021).

A general contractor was sued for construction defects. The general contractor brought a third-party action against the insured, a subcontractor on the job. The issue in the case was the date of the "occurrence." And, based on that issue whether the insurer had a duty to defend. The insured's work began on December 21, 2015. A certificate of substantial completion was submitted on March 9, 2017. The policy in dispute was effective beginning on October 1, 2017. The "pre-existing injury of damage exclusion" was the issue. The court held that it was unclear from the petition that the loss was outside of the policy period and that the carrier had the burden to prove an exclusion. Therefore, summary judgment in favor of the insurance carrier was reversed. *Tejas Specialty Grp., Inc. v. United Specialty Ins. Co.*, No. 02-20-00085-CV, 2021 WL 2252742 (Tex. App.—Fort Worth, June 3, 2021, no pet. h.).

V. THIRD PARTY THEORIES OF LIABILITY

A. *Stowers* duty & negligent failure to settle

A man was killed after his road bike collided with a stopped truck. His survivors sued the truck's owner, an entity insured by two insurers. The underlying insurer rejected three settlement offers before and during the trial, and the jury awarded the survivors nearly $28 million. The parties eventually settled for nearly $10 million, of which the excess carrier paid nearly $8 million.

The insured had coverage with its primary insurer for $2 million and with its excess carrier for $8 million. Prior to trial, the survivors asked for $2 million, and the primary insurer countered for $500,000. This offer was rejected and the case went to trial. Before the jury reached a verdict, the survivors' counsel first orally offered a high/low of $1.9 million to $2 million with costs. The primary insurer believed this offer was outside of its settlement valuation, as the inclusion of "costs" would push the final settlement beyond $2 million, so it rejected the offer. Then the survivors' counsel sent an email offering to settle for the policy limits of $2 million. The evidence admitted during trial was in favor of the survivors, as evidence that the truck was legally parked was disallowed and testimony from the deceased's daughter about her psychological trauma was allowed. However, the primary insurer declined the offer, resulting in a verdict well outside policy limits.

The excess insurer sued the primary insurer for equitable subrogation, urging that the primary insurer violated its *Stowers* duty by rejecting the settlement offers. The district court held on dueling summary judgment motions that all three demands invoked the *Stowers* duty. Then, after a bench trial, the court held the first rejection was reasonable under *Stowers* but the last two were not, and therefore, the primary insurer was required to pay the excess carrier for its excess payment. The primary insurer appealed regarding whether the second two rejections were reasonable under *Stowers*, as the excess insurer did not cross-appeal the lower court's holding that the primary insurer fulfilled its *Stowers* duty for the first offer.

The Fifth Circuit held the second offer did not invoke *Stowers* as the record revealed confusion regarding the offer's terms, specifically the meaning of "costs." The primary insurer argued that the third offer did not invoke the *Stowers* duty because the spouse's claims were asserted along with her minor children, whom she represented as next of friend. The Fifth Circuit noted no Texas court had ruled on this issue in the *Stowers* context, stating "Texas courts have not explicitly determined whether any uncertainty about judicial and third-party approval necessarily creates an unacceptable "risk of further liability" that precludes a *Stowers* duty." The Fifth Circuit held there is no conflict and thus no "conditionality" precluding the *Stowers* duty, where a lump sum settlement offer is accepted on behalf of parents and children. The issue of fairly dividing the proceeds arises only after the settlement is agreed upon, and Texas courts have the duty to scrutinize apportionments. Therefore, the third offer did invoke the *Stowers* duty because it "proposed to release the insured fully" and it was not conditional. Given the facts turned in favor of the survivors during the trial, the Fifth Circuit held that when presented with the third offer, an ordinary, prudent insurer would have accepted it. The primary insurer violated its *Stowers* duty by failing to reevaluate the settlement value of the case and accept the reasonable offer. The district court's judgment in favor of the excess insurance carrier was affirmed. *Am. Guar. &*

The third offer did invoke the *Stowers* duty because it "proposed to release the insured fully" and it was not conditional.

Liab. Ins. Co. v. ACE Am. Ins. Co., 990 F.3d 842 (5th Cir. 2021).

B. Unfair insurance practices

Insureds' home was damaged in a hailstorm, and they contacted the insurer to review the damage. The adjuster told the insureds the storm only caused cosmetic damage to their metal roof that was not covered under the policy. The insureds later testified this was the first time they were told about the cosmetic damage exclusion. When the insureds purchased the policy, they asked the agent if hail damage to the roof would be covered like it was in their previous policy. The agent told them it would be covered. Shortly after the inspection, the insureds noticed interior leaks in the home. They contacted the insurer for another inspection. Without first inspecting the property, the second adjuster told them that he did not think he would find anything worse than the first adjuster found. The insureds asked to reschedule the second inspection, and two days later the insurer closed the file. The insureds sued the insurer and adjuster for breach of contract, fraud, and violations of the Tex. Ins. Code, and the jury found the insured knowingly engaged in deceptive acts or practices. The evidence showed that if an insured disagreed with an adjuster's finding of cosmetic damage, the insurer required the adjuster to request a report from a structural engineer, which the adjuster did not do. Additionally, the adjuster did not look inside the house for damage, which the insured's claims adjusting expert testified is unreasonable for an adjuster investigating hail damage to a roof. Therefore, the appellate court affirmed the trial court's ruling in favor of the insureds holding the evidence was legally sufficient to support the jury's finding that the insurer knowingly engaged in unfair or deceptive acts or practices. *Allstate Vehicle & Prop. Ins. Co. v. Reininger*, No. 04-19-00443-CV, 2021 WL 2445622 (Tex. App.—San Antonio June 16, 2021, pet. filed).

VI. DAMAGES & OTHER ELEMENTS OF RECOVERY

A. Attorney's fees

In an underinsured motorist claim, the insured filed suit against his insurer under the Uniform Declaratory Judgment Act (Tex. Civ. Prac. & Rem. Code, chapter 37) and the trial court awarded discretionary attorney's fees under the act. The insurer appealed citing *Brainard v. Trinity Universal Ins. Co.*, 216 S.W.3d 809 (Tex. 2006) and arguing that attorney's fees which were denied in *Brainard* under Tex. Civ. Prac. & Rem. Code, chapter 38 were not allowed through any other cause of action. In a 5 – 4 opinion, the Texas Supreme Court held for the insured, affirming the trial court's discretion to award attorney's fees in a declaratory judgment action against an uninsured/underinsured motorist carrier. Several amicus briefs were filed and a motion for rehearing was denied. *Allstate Ins. Co v. Irwin*, No., 627 S.W.3d 263 (Tex. 2021, rehearing denied).

VII. DEFENSES & COUNTERCLAIMS

A. Limitations

An insured homeowner filed a claim with its insurer for damage to his property after a hurricane. On October 13, 2017, the insurer sent a letter accepting the loss, detailing the amount owed under the policy, and enclosing a check for payment of the loss. The insured believed the insurer undervalued his loss. However, no other activity occurred on the claim until January 28, 2019, when the insurer received a letter of representation from the insured's attorney filing a notice of claim. The insurer responded on March 14, 2019, stating it paid the loss in 2017. The insurer invoked the policy's appraisal process, but reserved its rights under the policy. On the same day, the insured's counsel also invoked the appraisal process and sent a demand letter. On December 3, 2019, the insured's counsel filed a declaration for umpire, as the parties' appraisers were at an impasse, and an umpire was appointed on December 9, 2019. On December 30, 2019, after the umpire attempted to talk with both parties to resolve the dispute, the insurer informed the umpire it would no longer participate in the appraisal because limitations passed on October 14, 2019, which was two years and one day from the date it accepted and paid the claim in accordance with the contractual limitations provision in the policy. The insured filed suit for the first time on December 30, 2019. The insured filed a motion for summary judgment alleging the contractual limitations had run, and the trial court granted the motion. Although the general statute of limitations for a breach of contract case is four years, the appellate court held the contractual limitations provision shortening the statute of limitations in the insurance policy did not violate Tex. Civ. Prac. & Rem. Code section 16.070. Additionally, on October 13, 2017, the insured knew that facts came into existence authorizing him to seek judicial remedy because he suffered an injury when the insurer allegedly failed to pay the full value of the claim under the policy. The parties' decision to participate in the appraisal process did not toll or restate limitations under these facts. Therefore, the appellate court affirmed the trial court's summary judgment ruling in favor of the insurer as the statute of limitations ran on October 14, 2019. *Abedinia v. Lighthouse Prop. Ins. Co.*, No. 12-20-00183-CV, 2021 WL 4898456 (Tex. App.—Tyler Oct. 20, 2021, no pet. h.).

B. Res judicata & collateral estoppel

The insured sued both the tortfeasor (with a minimum limits policy) and his underinsured motorist carrier. The UIM claim was severed from the underlying case by the tortfeasor to keep insurance out of his case. Although the verdict in the underlying case exceeded the minimum limits, the liability carrier paid it. After the verdict, but before judgment, the insurer agreed to be bound by the underlying case and moved for judgment based on its agreement to be bound and collateral estoppel from the underlying verdict. The Texas Supreme Court held that since the case settled before judgment was entered, collateral estoppel did not apply. In denying the insurer's motion for judgment based on its agreement to be bound, the court did not reach the timeliness of the agreement, but held that absent a final judgment there was nothing to bind the insurer. The court noted the damages to which the insured is legally entitled remain to be determined in the UIM lawsuit. *In re USAA Gen. Indem. Co.*, No. 20-0075, 2021 WL 1822944 (Tex. May 7, 2021).

VIII. PRACTICE & PROCEDURE

A. Discovery

An insured movie theater sued its insurer after it failed to provide coverage for business interruption losses during the COVID-19 pandemic. The insured in initial disclosures asked to receive categories of documents including: "(1) The drafting of the disputed policy wording and underwriting of the Policy; (2) Factory Mutual's investigation and handling of the claim; (3) Governing procedure manuals (claims and underwriting); (4) Representations to state regulators that inform the meaning of the policy wording; (5) Factory Mutual's knowledge of COVID-19 and Cinemark's loss; (6) Information about other similar COVID-19 claims." The insurer argued the requests were irrelevant and unduly burdensome. The court found the requested information was relevant because it related to the central insurance coverage dispute. If a party fails to make initial disclosures, the evidence cannot be used in their case unless the failure is found

to be harmless. The court held that although the insurer did not produce all relevant information, the insured was not harmed by the delay and ordered the insurer to supplement its initial disclosures within thirty days. *Cinemark Holdings, Inc. v. Factory Mut. Ins. Co.*, No. 4:21-CV-00011, 500 F.Supp.3d 565 (E.D. Tex. 2021, no pet. h.).

The insured sued for uninsured motorist benefits and sought to take the insurer's corporate representative's deposition. The insurer sought mandamus after the trial court ordered the deposition. The Texas Supreme Court allowed the deposition but limited the topics. The Texas Supreme Court noted that the insurer took the "unusual" position that the insured "is not entitled to depose the only party defendant in this suit." In holding that the deposition is allowed, the Court restricted the topics, based on the insurer's stipulations, to 1) any facts supporting the insurer's legal theories and defenses; 2) whether the tortfeasor was an uninsured/underinsured motorist at the time of the collision; and 3) insurer's claims and defenses regarding insured's assertions in this lawsuit. The Texas Supreme Court disallowed any discovery of the underlying claim's handling by the insurer as that part of the case was severed. Finally, the court did not close the door on ever disallowing a corporate representative's deposition. *In re USAA Gen. Indem. Co.*, 624 S.W.3d 782 (Tex. 2021).

The Texas Supreme Court disallowed any discovery of the underlying claim's handling by the insurer as that part of the case was severed.

After a car accident, the injured party collected insurance from the party at fault in a settlement and then filed a lawsuit against his underinsured motorist carrier for the remainder of the damage. His insurer answered with a general denial. The insured noticed the deposition of the insurer's corporate representative on twelve topics: (1) facts surrounding the plaintiff's claims; (2) validity and specifics of the insurance policy sold to plaintiff; (3) plaintiff's rights under the insurance policy at issue; (4) requirements for coverage and payment under the policy; (5) investigation of plaintiff's claims; (6) reasons for denying or limiting plaintiff's claims; (7) defendant's investigation of the tortfeasor; (8) defenses raised in any of the defendant's pleadings; (9) possible defenses not yet raised in defendant's live pleadings; (10) damage model proposed by defendant; (11) process of determining liability and amount of damages in this claim; and (12) settlement negotiations in this case. The insured filed a motion to quash, which the trial court denied. The insurer filed a petition for writ of mandamus, which was granted. The appellate court noted that the relevant issues in the case were the alleged underinsured driver's liability for the underlying accident, the existence and amount of the plaintiff's damages, and whether the other driver was underinsured. The appellate court held the insured is entitled to discover the insurer's defensive contentions raised by its pleadings and the evidence to support them, such as requested by topics 1, 8, & 10. However, the insured did not plead any extra-contractual claims, so topics 5, 6, 7, 11, and 12 addressing the handling of the claim were outside the scope of permissible discovery related to pending claim defenses. Additionally, topics 2, 3, and 4 address the specifics of the policy sold to the insured and his rights under the policy. The court held that because the insurer conceded the policy's validity, compelling corporate representative testimony on these topics was an abuse of discretion. Topic 9 requested possible defenses not yet raised in the insurer's pleadings, and the court found this to be protected work product. Therefore, the court concluded the trial court did not abuse its discretion in compelling a corporate representative's deposition on topics 1, 8, and 10. However, the trial court did abuse its discretion in refusing to narrowly focus the deposition's scope to the facts the insured must prove and the insurer's contentions in defense to those facts. The appellate court ordered the trial court to issue a new order granting part of the insured's motion to compel and part of the insurer's motion to quash in accordance with its opinion. *In re Allstate Fire & Cas. Ins. Co.*, 617 S.W.3d 635 (Tex. App.—Houston [14th Dist.] 2021, no pet.).

B. Appraisal

Several cases involved appraisals and their relation to violations of the Texas Prompt Payment of Claims Act. *See* Section III. C. of this article.

C. Motions for summary judgment

A condo association suffered property damage during a hurricane. The association insured its boat dock, which was destroyed during the hurricane when the governing authority released water from the dam to prevent it from failing. The insured condo association submitted a demand to its insurer who denied coverage. The association sued the insurer, and was granted summary judgment on the coverage issue. The parties submitted a jointly agreed stipulation that the association incurred $190,827.50 in damages and $50,000 in attorney's fees, which was approved and entered by the court. The insured moved for entry of final judgment, which was entered. However, the insurer then claimed that by agreeing to the stipulation, the insured admitted the loss fell within the policy's exclusion for "acts or decisions, including the failure to act or decide, of any person, organization or governmental body." The district court denied the motion, and the insurer appealed. The Fifth Circuit held the floodwater exclusion did not apply because testimony from the association's president confirmed the boat dock was not destroyed by flood waters but rather by a powerful suction effect that pulled debris from the lake and violently whipped it around. The Fifth Circuit also held that if the insurer wanted to rely on the governmental-body exclusion, it was obligated to raise it at the latest at summary judgment which it did not do. Therefore, judgment in favor of the insured by the district court was affirmed. *Playa Vista Conroe v. Ins. Co. of the W.*, 989 F.3d 411 (5th Cir. 2021).

D. Severance & separate trials

The Texas Supreme Court consolidated two appeals where the insureds sought insurance code remedies in uninsured motorist claims. The insurer complained that before the insureds could seek remedies under the insurance code, they must first prove their entitlement to damages by proving liability and damages against the tortfeasor and asked the trial court to bifurcate the case. The insureds, relying on *USAA Texas Lloyds v. Menchaca*, 545 S.W.3d 479 (Tex. 2018), argued this step was unnecessary. The Texas Supreme Court agreed with the insurer, holding that the insureds must first try and win the underlying claim before proceeding to the extra-contractual damages under the insurance code. *In re State Farm*, 629 S.W.3d 866 (Tex. 2021).

IX. OTHER ISSUES

A. Multiple insurers

An insured employee sued two insurers who provided long-term disability (LTD) coverage at his company. One insurer, Standard Ins. Co., provided coverage for the 2016 calen-

dar year, while another insurer, MetLife Ins. Co., provided coverage for the 2017 calendar year. The insured became disabled on November 9, 2016, and received short-term disability benefits. On December 22, 2016, the insured went back to work full-time. Standard's policy terminated on December 31, 2016, and MetLife's policy became effective on January 1, 2017. On January 12, 2017, the insured employee stopped working and became disabled. Standard denied the insured's LTD claim on the basis that it was not covered, and MetLife did not respond to the claim. The insured filed suit against Standard and MetLife. The district court granted summary judgment in favor of MetLife, concluding that a reading of the two policies showed that MetLife owed no benefits to the insured. The Fifth Circuit reviewed the granting of summary judgment de novo. The court noted the Standard policy excluded LTD benefits once benefits become payable to an insured under any other disability insurance plan under which you became insured during a period of temporary recovery. Because the insured in this case became insured under MetLife's policy during his temporary recovery, the Standard exclusion applied, and MetLife must provide LTD benefits coverage. Therefore, the Fifth Circuit reversed and remanded the lower court's ruling. *Talamantes v. Metro. Life Ins. Co.*, 3 F.4th 166 (5th Cir. 2021).

B. Excess & primary coverage

An employee ran a truck into a bridge causing it to collapse, injuring a mother and killing her daughter. The siblings witnessed the accident but were not injured. A lawsuit was brought by the mother, the surviving children, the deceased child's estate and her father. The employer had four insurance policies. All of the claimants, except the father, agreed to settle for an amount that would exhaust all of the first three insurance policies. After payment of the policies, the first insurer notified the other insurers and the insured that it would cease its defense after paying the coverage limits. The last insurer, the only one that had not exhausted its coverage, had a policy that said it had the "right but not the duty," to defend covered claims after the exhaustion of the other three policies. It declined its right to assume the employer's defense, so the employer paid its own defense in the case with the father, which yielded a $1.1 million judgment, which was less than the total policy limits of the four policies. The employer sued the first insurer for withdrawing its defense after payment of the claim. The Fifth Circuit affirmed the lower court's ruling that the first insurer tendered payment after the settlement with the minor children was finalized by the court. The fact that the deceased child's estate settlement was not approved until later, did not prohibit the first insurer from withdrawing its defense after the minor children's settlement was approved, as the minor children's settlement was in excess of the first insurer's policy limits. Therefore, summary judgment was appropriate for the first insurer. Additionally, the Fifth Circuit held the fourth insurer did not waive its condition on its right to defend, and following *USAA Texas Lloyds Co. v. Menchaca*, 545 S.W.3d 479 (Tex. 2018), the employer did not identify any harms stemming from the fourth insurer's alleged extra-contractual violations beyond the loss of policy benefits, meaning that the employer's extra-contractual claims were barred under *Menchaca*. *Tex. Disposal Sys., Inc. v. FCCI Ins. Co.*, 854 Fed. Appx. 576 (5th Cir. 2021).

> An excess carrier sued the primary carrier for negligently failing to settle the underlying case within its policy limits in a quasi-*Stowers* action. The primary carrier argued that since a minor's claim was involved in the underlying case, the offer of settlement was of necessity conditional. Until a guardian ad litem was appointed and the settlement approved, the offer of settlement remained conditional. The Fifth Circuit rejected that argument and held that the *Stowers* elements were still applicable, affirming the trial court's judgment against the primary carrier. *Am. Guarantee and Liab. Ins. Co. v. ACE Am. Ins. Co.*, 990 F.3d 842 (5th Cir. 2021).

C. Worker's Compensation

An administrative appeal arose out of a medical fee dispute between a medical center and a worker's compensation insurer over the proper amount of reimbursement for services given to a patient. The issue was whether the Administrative Law Judge (ALJ) who heard the case at the State Office of Administrative Hearings (SOAH) erred in placing the burden of proof on the insurance carrier at the hearing. The medical center requested preauthorization from a worker's compensation insurer to perform surgery on a covered patient. The insurer issued a preauthorization letter, and the surgery was performed. After the bill was received, the insurer determined it was responsible for only a very small portion, arguing that most of the bill exceeded the scope of the preauthorization. The medical center submitted a request for medical fee dispute resolution to the Division of Workers' Compensation. The officer found the services rendered were not subject to a contractual fee agreement and found the insurer owed additional money to the medical center. The insurer appealed to SOAH, who concluded that the insurer failed to carry its burden of proving that the medical center was not entitled to additional reimbursement. The insurer filed a petition for judicial review of SOAH's decision. The trial court affirmed, holding the ALJ's order was supported by substantial evidence. The court of appeals addressed one issue that the ALJ erred in placing the burden of proof on the insurer at the SOAH hearing and that this error prejudiced the insurer's substantial rights, thus, reversing the trial

court's judgment and remanding the case to the Division for further proceedings.

The Texas Supreme Court granted the medical center's petition for review, and held that the ALJ's determination regarding the burden of proof was correct. The Division's administrative rules place the burden of proof in a SOAH hearing on the party seeking relief. The party that requested the hearing to challenge the Division's medical fee dispute resolution (MFDR) decision bore the burden of proof at the hearing. The Division decided the proper reimbursement amount in this medical fee dispute, and the medical center was satisfied with the outcome, but the insurer was not and sought review of the decision by requesting a contested case hearing. However, the insurer was the party seeking relief. The ALJ ultimately determined that the insurer failed to meet its burden showing that the medical center was not entitled to the additional reimbursement amount ordered by the Division. The Texas Supreme Court held in a worker's compensation medical fee dispute resolution proceeding, the burden of proof in a contested case hearing before SOAH is on the party seeking review of the Division's initial MFDR decision. Thus, the appellate court erred in holding that the burden always and necessarily remains on the provider. The Texas Supreme Court reversed the court of appeals' judgment and remanded the case. *Patients Med. Ctr. v. Facility Ins. Corp.*, 623 S.W.3d 336 (Tex. 2021).

The burden of proof in a contested case hearing before SOAH is on the party seeking review of the Division's initial MFDR decision.

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1 *Randel v. Travelers Lloyds of Tex. Ins. Co.*, No. 20-20567, 2021 WL 3560910 (5th Cir. Aug. 12, 2021); *Hyewon Shin v. Allstate Tex. Lloyd's*, 848 Fed. Appx. 173 (5th Cir. 2021); *First United Methodist Church v. Church Mut. Ins. Co.*, No. 13-18-00048-CV, 2021 WL 3776728 (Tex. App.—Corpus Christi Aug. 26, 2021, no pet. h.).

2 *Am. Guar. & Liab. Ins. Co. v. ACE Am. Ins. Co.*, 990 F.3d 842 (5th Cir. 2021).

3 *In re State Farm*, 629 S.W.3d 866 (Tex. 2021).