ZELLE LLP

LONESTAR LOWDOWN

Dedicated to Texas First-Party Property Claims

The Zelle Lonestar Lowdown | Wednesday, October 9, 2024 | ISSUE 18

Welcome to The Zelle Lonestar Lowdown, our monthly newsletter bringing you relevant and up-to-date news concerning Texas first-party property insurance law.

If you are interested in more information on any of the topics below, please reach out to the author directly. As you all know, Zelle attorneys are always interested in talking about the issues arising in our industry. If there are any topics or issues you would like to see in the Lonestar Lowdown moving forward, please reach out to our editors: Shannon O'Malley, Todd Tippett, and Steve Badger.

INSIDE THIS ISSUE

Upcoming Events

You don't want to miss this!

October 16 – Steven Badger will present at the Property Loss Appraisal Network (P.L.A.N.) Appraiser & Umpire Certification Conference.

October 17 – Zelle LLP is proud to sponsor the Dallas Claims Association Bowling tournament in Dallas, TX from 5:30 pm - 8:30 pm.

October 21, 2024 – Steven Badger will present "Texas Hail Damage Claims – Update from the Trenches" at the Texas Association of Mutual Insurance Companies TAMIC 88th Convention & Seminar in Round Rock, TX from 3:45 pm – 4:45 pm.

October 24, 2024 – Steven Badger will present "Fraud and Other Abuses In CAT Claims, What The Hail Is Going On?" as the Keynote Speaker at the 2024 PLRB Large Loss Conference in Tampa, FL.

October 24 & 25, 2024 – Brandt Johnson will co-present "Back to the Future: How Adjusters Can Use Forensic Meteorology in Hail and Wind Claims" at the 2024 PLRB Large Loss Conference in Tampa, FL with co-presenters Howard Altschule (Forensic Weather Consultants) and Annette Tarquinio (Engle Martin).

October 28 - Steven Badger will present "Hot Topics In Roofing-Related Insurance Claims" at the IIBEC Conference in Grapevine, TX.

November 4 – Steven Badger will present "What The Hail Is Going On? - Update From the Trenches" at the Joint Claim Executive Association (JCEA) Fall Meeting in New Orleans, LA.

November 5 – Steven Badger will present “Insurance & Public Policy Issues Rising from the 9/11 Terrorist Attack” at the Wisconsin Fire Loss Association in Fond du Lac, WI.

November 7 – Jennifer Gibbs will present "Avoiding Bad Faith Allegations When Dealing with Narcissists" and Steven Badger will moderate the Property Insurance Panel Discussion at the Dallas Claims Association 6-CE Property Seminar in Grapevine, TX.

Simply Providing a Contractor’s Estimate Fails to Satisfy the “Specific Amount Alleged to be Owed by an Insurer” Requirement Under Section 542A.003(b)(2) of the Texas Insurance Code

by Alexander Masotto and Todd M. Tippett

Since the enactment of Chapter 542A of the Texas Insurance Code in 2017 (also known as the “Hail Bill”), insurers and policyholders have incessantly litigated over the interpretation of the presuit notice requirements under Section 542A.003. During a typical claims adjustment, and after a coverage decision has been made, policyholders often provide an estimate to support their claimed and/or disputed damages. Recently, a Federal Court in the Southern District of Texas found that a contractor’s estimate submitted to an insurer does not qualify as satisfying the “specific amount alleged to be owed by an insurer” requirement under Section 542A.003(b)(2).

The very purpose of Section 542A.003’s notice requirements “serves to ‘discourage litigation and encourage settlements of consumer complaints’ by assuring defendant-insurers have time to assess the situation and make a settlement offer.”[i]

Texas Insurance Code § 542A.003 provides that:

> a) In addition to any other notice required by law or the applicable insurance policy, not later than the 61st day before the date a claimant files an action to which this chapter applies in which the claimant seeks damages from any person, the claimant must give written notice to the person in accordance with this section as a prerequisite to filing the action.
>
> (b) The notice required under this section must provide:
>
> (1) a statement of the acts or omissions giving rise to the claim;
>
> (2) ***the specific amount alleged to be owed by the insurer on the claim for damage to or loss of covered property;*** and
>
> (3) the amount of reasonable and necessary attorney's fees incurred by the claimant, calculated by multiplying the number of hours actually worked by the claimant's attorney, as of the date the notice is given and as reflected in contemporaneously kept time records, by an hourly rate that is customary for similar legal services.

If an insured’s presuit notice fails to state the “specific amount alleged to be owed by the insurer under Section 542A.003(b)(2), an insurer may move to preclude an insured’s claim for attorneys’ fees pursuant to **§ 542A.007(d):**

> (d) If a defendant in an action to which this chapter applies pleads and proves that the defendant was entitled to but was not given a presuit notice stating the specific amount alleged to be owed by the insurer under Section 542A.003(b)(2) at least 61 days before the date the action was filed by the claimant, the court may not award to the claimant any attorney's fees incurred after the date the defendant files the pleading with the court. A pleading under this subsection must be filed not later than the 30th day after the date the defendant files an original answer in the court in which the action is pending.

On June 20, 2024, Judge Lee Rosenthal in the Southern District of Texas, Houston Division, issued an opinion granting the Insurer’s Motion to Preclude the Insured’s Claim for Attorneys’ fees, and held that a contractor’s estimate failed to give notice of the “specific amount alleged to be owed” under Section 542A.003(b)(2). In *Baker v. Am. Econ. Ins. Co.*,[ii] the Insured sustained storm-related damage to her home. After inspecting the Insured’s property, the Insurer transmitted payment for the covered damage. Following payment, the Insured emailed the Insurer several mitigation and repair estimates from her contractor over a three-month period, and requested for the Insurer to reopen her claim for roof damage that had been denied. Once reviewed, the Insurer subsequently made additional payments based on some of the estimates.

Eventually, the Insured filed suit, and the Insurer subsequently moved to preclude the Insured from recovering attorneys’ fees for failing to provide proper presuit notice and providing a “specific amount alleged to be owed” pursuant to Section 542A.007(d). The Insurer argued that emails containing repair estimates do not qualify as the “specific amount alleged to be owed,” and that the emails only referenced the alleged work to be completed at the Insured’s residence. In contrast, the Insured asserted that the total cost of the estimates provided “the specific amount alleged to be owed.” The court disagreed, and held that the emails “did not specifically state the amount” alleged that the Insurer owed. The Court noted, however, that the Insurer could calculate the difference between the Insured’s various estimates and the amounts previously paid, but that mere “information sufficient to calculate a specific amount” does not comply with Section 542A.003(b)(2).

The Court further reasoned that Section 542A.003(b)(2) “is not satisfied by the trading of estimates that often occurs during the adjustment process.” Accordingly, the Court held that the estimates “were too premature to constitute valid presuit notice” even though the estimates came *after* payments made. In support of its holding, the Court relied on *Henry v. Nationwide Prop.*,[iii] which held that “adequate presuit notice cannot be given until the insurer has made a ‘final coverage decision’ on the insurance claim.” Lastly, the Court notes that it found the reasoning in the contrary decision of *Nisha Hospitality LLC v. Scottsdale Insurance Company*[iv] unpersuasive.

In *Nisha Hospitality*, Judge Starr in the Northern District of Texas, Dallas Division, held that a public adjuster’s estimate provided during the adjustment process satisfied the “specific amount alleged to be owed” under Section 542A.003(b)(2) requirement. In that matter the Insured had retained a public adjuster after: 1) the Insurer inspected the property, 2) scoped for covered damages under the policy, and 3) transmitted payment on the claim. The Insured proceeded to retain a public adjuster who disagreed with the scope and amount of loss. The public adjuster provided an estimate and a photo report to the Insurer. In response, the Insurer proceeded to reinspect the property with an engineer; however, the Insured continued to dispute the findings from the public adjuster. Ultimately, the Court declined to preclude the Insured’s claim for attorneys’ fees because the estimate “indicated the replacement cost” for the alleged damage to the Insured’s property, that was “the only requirement Chapter 542A states will result in no further attorneys’ fees if violated.”

Similarly, in *Selinger v. Meridian Sec. Ins. Co.*,[v] the Court also declined to grant the Insurer’s Motion to Preclude Attorneys’ fees where the Insured’s public adjuster submitted an estimate *before* the Insurer ultimately denied the claim. In that matter, however, the Court failed to analyze whether sufficient presuit notice could be provided before or after a final claim determination.

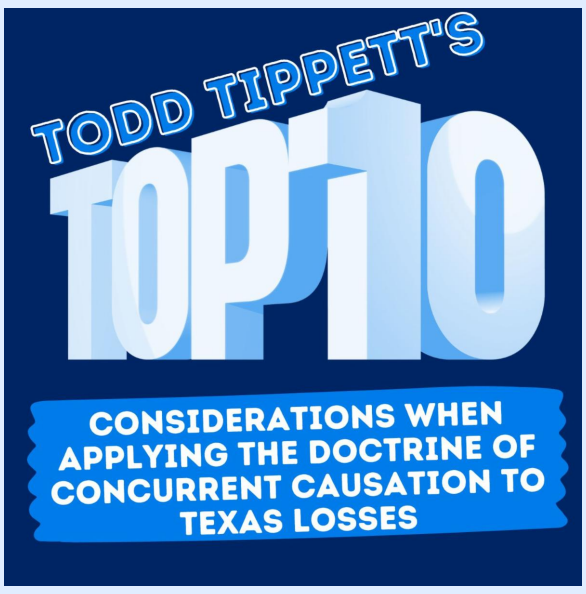
Another case that held a public adjuster’s estimate satisfied the “specific amount alleged to be owed” requirement is *Compound South, LLC v. State Auto Mut. Ins. Co.*.[vi] However, *Compound South* is distinguishable because the Insured’s public adjuster provided an estimate *as well as* a sworn statement in proof of loss after the Insurer denied the claim. The Court ultimately found that presuit notice and the Section 542A.003(b)(2) requirement were satisfied since the documents were issued after the Insurer denied the claim.

Based on the above caselaw above, there appears to be a split in authority as to whether an estimate prepared by a contractor or public adjuster on behalf of an insured during the adjustment process satisfies the "specific amount alleged to be owed" requirement under Section 542A.003(b)(2). We believe that the *Baker* decision provides the best guidance on the issue in holding as follows:

> [T]he trading of estimates. . .[that] often occurs during the adjustment process. . .is an ordinary part of the claims process. . .and does not fulfill the purpose of presuit notice of 'discourag[ing] litigation and encourage[ing] settlements.

Consistent with this holding, we believe Insurers should continue to file Motions to Preclude Attorneys' Fees under Section 542A when only an estimate is provided during the adjustment process and no specific amount is alleged to be owed in the presuit notice letter.

[i] *Jordan Indus., LLC v. Travelers Indem. Co. of Am.*, No. 7:21-cv-00114-O, 2022 WL 2719630, at *2 (N.D. Tex. Apr. 12, 2022).
[ii] *Baker v. Am. Econ. Ins. Co*., No. CV H-24-1145, 2024 WL 3070193 (S.D. Tex. June 20, 2024).
[iii] *Henry v. Nationwide Prop.*, No. CVH-23-2488, 2023 WL 6049519, at *2 (S.D. Tex. Sept. 15, 2023).
[iv] *Nisha Hospitality LLC v. Scottsdale Insurance Company*, No. 3:22-cv-1811-X, 2022 WL 17417995 (N.D. Tex. Dec. 2, 2022).
[v] *Selinger v. Meridian Sec. Ins. Co.*, No. 4:23-cv-747-Y (N.D. Tex. Oct. 31, 2023) (unpublished).
[vi] *Compound S. LLC v. State Auto Mut. Ins. Co.*, No. 5:23-CV-070-H-BQ, 2024 WL 858011 (N.D. Tex. Jan. 31, 2024).



1. Texas is a Concurrent Causation state, not an Efficient Proximate Cause state.

2. Concurrent Causation exists when non-covered and covered events combine to cause a loss and the two losses cannot be separated. Under this circumstance, the insurer has no obligation to provide coverage for any of the loss.

3. When covered and excluded events each independently cause the loss, then separate and independent causation exists and the loss is covered.

4. Texas courts applying Concurrent Causation recognize that if an insured can show that the damage is capable of being apportioned between covered and non-covered losses, then the insured remains eligible for coverage for the covered portion of the loss. The Doctrine stands for the strong proposition that the insured is only entitled to recover that which is covered under the policy.

5. Despite what some policyholders argue, courts have held that the Doctrine of Concurrent Causation does not unduly burden the insured to prove its claim or refute a policy exclusion.

6. The Doctrine applies to more than just exclusions. For example, it is undisputedly the insured's burden to prove when a loss occurs. Therefore, if a claimed loss occurs on two different dates, one covered by the policy and one not covered by the policy, it is the insured's burden to prove what portion of the loss occurred during the relevant policy.

7. Concurrent Causation should be considered when the insured argues the covered damage is not repairable or the damage involves non-covered issues such as wear & tear or rot.

8. The Doctrine applies to both sequential causes of loss as well as simultaneous causes of loss.

9. Always look for an Anti-Concurrent Causation provision in the policy to determine if it impacts the claim analysis. The Concurrent Causation Doctrine applies regardless of whether the policy has such a provision.

10. At trial, the insured and its experts must present some evidence upon which a jury can

News From the Trenches

by Steven Badger

The talk of the industry the past couple weeks has been the 60 Minutes segment about a Florida insurance company that altered a number of their field adjuster estimates downward (in one case from over $200,000 to $15,000), without talking to the field adjuster and then leaving the field adjuster name on the estimate. Various policyholder-side advocates (lawyers, PAs, contractors, etc.) have used the segment to ramp up their anti-insurance company rhetoric, referring to the practice as "systemic" in the industry and calling for criminal fraud prosecutions.

I've looked at 1000's of claim files. I've only ever seen this happen one time. And that was after the field adjuster failed to return the insurance company's calls seeking clarification. So calling the practice a "systemic" practice is a bit of a stretch. It certainly isn't in Texas.

But with that said, I do agree that reducing a field adjuster estimate from over $200,000 down to $15,000 without ever talking to the field adjuster and then leaving the field adjuster's name on the estimate is not a good practice. If that is what went on in these Florida matters, it shouldn't have. And as insurance industry professionals, we should all acknowledge that.

With that said, let's also be very clear: There are situations where it is absolutely proper for an insurance company to make changes to a field adjuster estimate. The most obvious situation is applying coverage. For example, if the field adjuster included the cost to replace a metal roof and the policy contains a cosmetic damage endorsement, then the metal roof is rightly removed from the estimate. If underwriting photos show the siding was damaged on the date of policy inception, the siding should not be included in the estimate. Additionally, there is no disputing that collaboration between the field adjuster and company adjuster on proper line items and pricing is always proper, and Xactimate is set up to allow it. All of these are absolutely acceptable reasons to change an estimate after it is received by the insurance company.

Unfortunately, I expect that given the attention the 60 Minutes piece has received, we will now all be dealing with a wave of "but you altered the estimate" allegations. Aggressive policyholder advocates will cry "fraud" whenever an estimate is changed and try to use the issue to their advantage.

In the spirit of "Todd Tippett's Top Ten" list in the Lowdown each month, here are Badger's Top Five Tips in making changes to claim estimates….

> 5. Always include the field adjuster in any discussions about changes to an estimate (even if just to explain how coverage is being applied).
>
> 4. Add the company adjuster's name to any revised estimate (or have just the company name on the estimate).
>
> 3. Clearly document in the claim file the reasons for any changes to the estimate.
>
> 2. Explain to the insured in writing the reasons for any changes to the original field adjuster estimate.
>
> 1. Ensure all changes are consistent with the facts, the policy, and the law.

By following these simple steps, there can be no objection to an insurance company making changes to a field adjuster's estimate. The company will have a solid response to the aggressive policyholder advocate looking for an angle to create pressure.

Finally, as stated above, the "fraud" word has been used a lot these past couple weeks. That is a slippery slope for the policyholder side. Grossly inflated estimates submitted by policyholder advocates cross my desk every day -- $50 per square foot for TPO roof replacement, $1200 a square for comp shingle replacement, 30+30 for GCOP, etc. Then there are also the estimates that include damage from prior storm events or that include damage that is clearly excluded.

Do these estimates, which are equally as "systemic" from the policyholder side, always warrant a "fraud" allegation?

Of course not. There is a big difference between honest disagreements as to opinion and actionable fraud. While it does exist, the latter is not common, on either side, and allegations of fraud should be used judiciously and only when absolutely warranted.

Fraud on either side is wrong. But let's avoid the unnecessary rhetoric in attacking one another.

allocate the damage attributable to the covered peril. Without a showing of such evidence, the insured's claim fails.

If you have questions about this Doctrine, consult a well-versed coverage attorney to discuss the issues involved in the adjustment of the claim you are handling.

Feel free to contact **Todd M. Tippett** at 214-749-4261 or ttippett@zellelaw.com if you would like to discuss these Tips in more detail.

Despite the Deepest Desires of Policyholder Attorneys, Concurrent Causation Continues

by Kristin C. Cummings

A few months ago (in the August 2024 *Lowdown*), I wrote about a recent case that again reiterated the rule that payment of statutory interest with an appraisal award precludes attorneys' fees. I was proud of my snarky title: "Once More for Those in the Back: Payment of Any Potential Statutory Interest Along with Payment of an Appraisal Award Precludes Claim for Attorneys' Fees." Well, now I wish I had saved that particular snark for this article, which could absolutely be called "Once More for Those in the Back: Texas Follows the Concurrent Causation Doctrine." But having already used that particular title, I instead was forced to resort to alliteration for this one. (If you are a regular reader, you know we Zelle lawyers like our alliteration – Lonestar Lowdown, Todd Tippett's Top Ten Tips, Lassoing Liability, and our newest addition, Beyond the Bluebonnets.)

Texas is unique for lots of reasons - one is that we are the only state that has its own power grid – another is that we are in the minority of states that apply the doctrine of concurrent causation to insurance disputes. Concurrent causation occurs when an insured's loss is caused by a combination of events that cannot be separated, but together resulted in the loss. As the Texas Supreme Court has explained, "[i]n cases involving concurrent causation, the excluded and covered events combine to cause the plaintiff's injuries[] [and] [b]ecause the two causes cannot be separated, the exclusion is triggered"[1] and there is no coverage. Again and again, Texas courts have reiterated this doctrine and held policyholders to their burden to segregate covered damage from non-covered damage. When policyholders can't meet that burden – they don't get coverage.

Although the law is clear, policyholder lawyers persist in trying to convince judges in the Lonestar State that as long as they can prove that some of the damage was caused by a covered peril – they get coverage for all of the damage. Thankfully, Texas courts (and federal courts sitting in Texas) are not falling for it and continue to hold insureds to their burden.

The latest example of this is out of the Western District of Texas, Amarillo Division. On September 16, 2024, the court issued its Order Granting State Farm Lloyds' Motion for Summary Judgment in *Espinoza v. State Farm Lloyds*.[2] In *Espinoza*, the insured made a claim for wind and hail damage to his home. State Farm Lloyds inspected the property and found that the only damage from wind or hail that had occurred during the policy period was wind damage to a single shingle, which fell under the deductible. However, there was evidence of hail impacts occurring prior to the policy period and normal wear and tear and deterioration of shingles. Based on the fact that the only covered damage fell under the deductible, State Farm Lloyds issued a letter stating no payments were owed.

As is so often the next step when an insurer's adjustment reveals there is no covered damage (or the covered damage is under the deductible), the policyholder retained an attorney and sued for, among other things, breach of contract and violations of the Texas Insurance Code.

In its Motion for Summary Judgment, State Farm Lloyds argued that the insured could not prove the insured's claim fell within the insuring agreement of the Policy. Specifically, State Farm Lloyds argued that the insured had no evidence segregating the alleged covered damage from other damage and therefore could not meet his burden to provide evidence upon which the factfinder could allocate damages between covered and noncovered damages.

Acknowledging that the insured had the burden to segregate, the court turned to the evidence submitted by both parties. The court noted that State Farm Lloyds' evidence demonstrated the storm on the alleged date of loss could not have caused all the claimed damage, pointing to observations by the investigating adjuster and expert witnesses. Based on this evidence the Court held that State Farm Lloyds "has made an initial showing that there is no evidence to support Plaintiff's breach of contract claim," and that therefore, "the burden is now on Plaintiff to come forward with competent summary judgment evidence of the existence of a genuine fact issue."

The court then turned to the insured's evidence and provided a catalogue: 1) expert witness testimony that a "significant hailstorm" passed through the Property's immediate area on the alleged date of loss; 2) expert witness testimony that confirmed there was storm activity with wind gusts over 30mph on the date of loss; and 3) expert witness testimony that a severe hailstorm caused damage to the roof at the property. The court found this evidence did not meet the insured's burden.

The court held the insured's summary judgment evidence would not allow a jury to segregate pre-existing damage from damage occurring on the alleged date of loss. The court explained that while the insured's evidence "may raise a fact issue as to whether there is hail damage to the Property, it does not raise any fact issue as to whether the damage occurred during the coverage period of the Policy, let alone the alleged date of loss." The court went on to explain that the insured's expert report suggested "that hail could have damaged the Property on May 30, 2021, but it does not provide any evidence that it actually did."

The court's holding in *Espinoza* shouldn't warrant a write-up in the *Lowdown*; he simply applied the concurrent causation doctrine to the evidence submitted by the parties in order to reach a legal conclusion supported by the Texas Supreme Court and other courts throughout the state. But because policyholder attorneys continually fail to produce evidence sufficient to meet the insured's burden, this issue remains an important one. Therefore, insurers should consider this case's following take-aways:

1. Once an insurer provides evidence that at least some of the insured's claimed damage was not caused by a covered peril, the burden is on the insured to produce evidence allowing the fact finder to segregate covered and noncovered damage;

2. An insured does not meet its burden by providing evidence that a covered peril *could* have damaged its property; it must provide evidence showing that a covered peril *did* damage its property;

3. If an insured fails to provide competent summary judgment evidence that would allow the trier of fact to segregate covered loss from non-covered losses, an insurer is entitled to summary judgment.

So, once more for those in the back: Texas Follows the Concurrent Causation Doctrine.

[1] *Utica Nat'l Ins. Co. of Texas v. Am. Indem. Co.* , 141 S.W.3d 198, 204 (Tex. 2004)
[2] 1:23-CV-751-DH (W.D. Tex. Sept. 16, 2024).

AI Update

California Governor Vetoes AI Safety Bill

by Jennifer Gibbs

California Gov. Gavin Newsom recently vetoed a landmark bill aimed at establishing safety measures for large AI models after the tech industry raised objections, cautioning it could drive AI companies from the state and hinder innovation.

The decision to veto the bill delivered a significant blow to attempts to rein in the rapidly evolving industry with little oversight. The bill would have mandated safety testing for many of the most advanced AI models. Developers of AI software operating in the state would have also needed to outline methods for turning off the AI models, effectively a kill switch. The bill would have established a state entity to oversee the development of so-called "Frontier Models" that exceed the capabilities present in the most advanced existing models.

Earlier this month, Newsom told an audience at Dreamforce, an annual conference hosted by software giant Salesforce, that California must lead in regulating AI in the face of federal inaction but that the proposal "can have a chilling effect on the industry."

The proposal, which drew fierce opposition from startups, tech giants and several Democratic House members, could have hurt the homegrown industry by establishing rigid requirements, Newsom said.
"While well-intentioned, SB 1047 does not take into account whether an AI system is deployed in high-risk environments, involves critical decision-making or the use of sensitive data," Newsom said in a statement. "Instead, the bill applies stringent standards to even the most basic functions — so long as a large system deploys it. I do not believe this is the best approach to protecting the public from real threats posed by the technology."

The United States is already behind Europe in regulating AI to limit risks. The California proposal wasn't as comprehensive as regulations in Europe, but it would have been a good first step to set guardrails around the rapidly growing technology that is raising concerns about job loss, misinformation, invasions of privacy and automation bias, supporters said.

But even with Newsom's veto, the California safety proposal is inspiring lawmakers in other states to take up similar measures, said Tatiana Rice, deputy director of the Future of Privacy Forum, a nonprofit that works with lawmakers on technology and privacy proposals. "They are going to potentially either copy it or do something similar next legislative session," Rice said. "So it's not going away."

In late August, the Texas Senate Business and Commerce Committee heard over 4 hours of testimony on the use of AI, in both the public and private sectors. Several state agencies, such as the Office of the Attorney General, the Department of Insurance, and the Workforce Commission, have already begun implementing AI and similar programs internally.

As Texas lawmakers prepare for the 89th Legislative Session, set to begin in January 2025, their recommendations regarding the proper regulation of AI will likely play an important role in shaping the future of AI governance in the state and throughout the country.

Lassoing Liability

with Megan Zeller

The Fifth Circuit Continues to Uphold Texas' General "Physical Injury" Definition

In *TIG Insurance Company v. Woodsboro Farmers Cooperative*, the Fifth Circuit once again relied on Texas' well-established "physical injury" definition in its latest "property damage" analysis under a Commercial General Liability ("CGL") policy. *See* 2024 WL 4247287 (5th Cir. September 20, 2024).

Here, Woodsboro Farmers Cooperative hired a general contractor to construct two grain silos. The general contractor subsequently retained a subcontractor to assist with the construction. Although the general contractor observed some cosmetic issues to the silos during its inspections of the subcontractor's work, the general contractor nonetheless determined that the silos were structurally sound. After the subcontractor completed the assembly, the general contractor then completed the rest of the project. By the end of the project, however, it became clear that the work was highly defective, causing the silos to significantly deteriorate.

As a result, Woodsboro Farmers Cooperative sued the general contractor in state court, which was later removed to arbitration. Woodsboro Farmers Cooperative won the arbitration award, with the arbitration panel finding that there was a breach of contract claim against the general contractor as a result of the subcontractor's defective assembly of the silos. Based on the arbitration award, the general contractor's insurer brought an action against Woodsboro Farmers Cooperative and the subcontractor for a declaratory judgment that it did not owe a duty to defend or duty to indemnify based on the breach of contract claim and the subcontractor's defective workmanship. The United States District Court for the Southern District of Texas granted the insurer's summary judgment motion in part and denied it in part, and later, entered a summary judgment in favor of the insurer. The owner appealed, and the Fifth Circuit reversed and remanded the Southern District's ruling.

Specifically, the Fifth Circuit reviewed what constituted as "property damage" under the applicable CGL policy when providing **only** a duty to indemnify analysis. While the parties generally agreed on the meaning of "property damage" and "physical injury," the parties disputed, whether the problems were defective assembly, or whether the general contractor caused tangible, manifest harm to the silos. As a result, the Fifth Circuit had to review both the policy's terms as well as the facts established in the underlying arbitration.
The general contractor's CGL policy defined "property damage" in two ways:

> a. Physical injury to tangible property, including all resulting loss of use of that property. All such loss of use shall be deemed to occur at the time of the physical injury that caused it; or
> b. Loss of use of tangible property that is not physically injured. All such loss of use shall be deemed to occur at the time of the "occurrence" that caused it.

Like most CGL policies, this policy failed to define "physical injury," and as a result, the Fifth Circuit relied on the accepted definition that is well-established in Texas courts, where "physical injury" "requires tangible, manifest harm and does not result merely upon

the installation of a defective component in a product or system." *Court. U.S. Metals, Inc. v. Liberty Mut. Grp., Inc.*, 490 S.W.3d 20, 27 (Tex. 2015). According to Texas' definition, "faulty workmanship that merely diminishes the value of the [property] without causing physical injury or loss of use does not involve 'property damage.'" *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1, 10 (Tex. 2007).

The Fifth Circuit also reviewed facts established during the arbitration award, which included the fact that the general contractor had "sole control of the means and methods of construction," and the "erection work performed by [the subcontractor] was negligently performed." The arbitration panel also found that the silos "required deconstruction, repair, and proper reerection." Based on the policy language, Texas' definition of "physical injury" and this evidence, the Fifth Circuit first found that "property damage" did occur in this matter. While the Fifth Circuit also reviewed the policy for any general exclusions, the important issue to note here is that despite its relatively long analysis, The Fifth Circuit did little to expound upon or disagree with Texas' overall "physical injury" definition. Ultimately, the Fifth Circuit reversed and remanded the case back to the lower court to provide a more thorough indemnity analysis. By doing so, the Fifth Circuit continues to allow insurers to confidently rely on well-established caselaw in Texas when addressing construction defect issues in liability matters.

Hamlet Analyzes a Construction Exclusion

by Michael O'Brien

"Coverage or no coverage—that is the question in this insurance dispute," began the Court with Shakespearean flair, in *Corval Builders & Erectors, Inc. v. Markel American Insurance Company*. The court considered whether the insurer was entitled to summary judgment on the basis of an exclusion in a first-party property policy for loss resulting from an act, error, or omission relating to the construction or workmanship of property, even though the exclusion contained an ensuing-loss clause. The court found the exclusion applied and the ensuing-loss clause did not, then granted summary judgment to the insurer.

The insured in this case, Paragon, was a subcontractor hired to fabricate piping (that is, manufacture and assemble pipe components) for the contractor and plaintiff, Corval. However, some of Paragon's work was defective, allegedly resulting in Corval being fired and fined over a million dollars by the client. Corval submitted a claim to the insurer, Markel American—though Corval was not the insured—because Paragon was in bankruptcy. Corval obtained an order from the bankruptcy court permitting it to make insurance claims on Paragon's policies, though the court stated that nothing in the opinion would deprive the insurer of any defense against liability under the policy. The insurer denied the claim based on the construction exclusion, among other reasons.

The court first considered whether the construction exclusion applied. The court held, based on the dictionary and case law, that the '"construction . . . of property' means the process, art, or manner in which the property was made or formed, and the 'workmanship . . . of property' means the quality imparted to the property in the process of making it." The court then found the damage all resulted from the subcontractor's defective construction and workmanship. This was true regardless of whether the damage was to the fully assembled pipes Paragon fabricated or to the pipe components it received to fabricate. In either case, the application of the exclusion was clear.

The court then considered whether the exclusion's ensuing-loss clause applied to reinstate coverage. That clause provided that "if a defect, error, or omission . . . results in a covered peril," the insurer "cover[s] the loss or damage caused by that covered peril." The court applied Fifth Circuit and Supreme Court of Texas case law holding that an ensuing loss provision is only triggered when the ensuing loss is distinct from the excluded loss, such as a construction defect that causes a fire or flood. The court rejected application of the ensuing-loss provision because "the damage to the individual pipe components was the direct and unmediated result of Paragon's defective construction and workmanship of the fabricated pipes."

The answer to the question, then, was no coverage. The damage was the direct result of defective construction and workmanship, placing it within the exclusion and outside of the ensuing-loss clause. The court therefore granted summary judgment to the insurer on breach of contract and bad faith, because the latter was derivative of the former.

Spotlight

Steven Badger named a *Texas Tort and Insurance Legend* by the Dallas Bar Association TIPS

Please join us in congratulating Steve Badger, who was honored last week by the Dallas Bar Association's Tort and Insurance Practice Section as an "Insurance Legend" for his more than 30 years of service "in making the world a better place for insurance companies".

As many of you know, Steve has represented the commercial property insurance industry in virtually every major catastrophic risk event facing the industry for the last 32 years. He began his insurance litigation career in 1992, pursuing subrogation claims arising from Hurricane Andrew. He continued his subrogation practice for the next decade, leading the industry in his recognition of subrogation opportunities for damage resulting from Mother Nature, even publishing the "Roofing Subrogation Handbook".

Steve's career took an unexpected turn in 2004, when he was asked to lead the multi-billion dollar subrogation action against the airlines and aviation security companies alleged to be responsible for the 911 Terrorist Attack. For eight years, Steve led the Plaintiffs Executive Committee in pursuing this historic subrogation action, which culminated in a $1.2 billion settlement in 2011--still the largest all cash subrogation recovery ever obtained by the insurance industry.

After his time in New York, Steve focused his efforts on an emerging trend that concerned him for the Texas insurance industry – a dramatic increase in lawsuits arising from hail events. He trademarked the phrase "What The Hail Is Going On?" and became the country's leading practitioner in this developing risk area. His 2014 article "The Emerging Hail Risk – What The Hail Is Going On?" was the second most read article of the year in the Claims Journal. Zelle's bi-annual "Texas Hail Claims Conference," which Steve created and helms, now draws over 700 attendees and gives him the opportunity to push his love for anything '80's onto his colleagues and clients.

Steve's LinkedIn posts routinely receive over 50,000 views. He is asked to appear as a subject matter expert to advocate for

insurance industry issues in most Texas legislative sessions. And he has become a sought-after Keynote Speaker for insurance industry events, bringing a unique combination of industry knowledge and entertainment to his speaking engagements.

Lovingly referred to by his friends and colleagues as Badge, he has single-handedly paved a path in hail litigation for our firm that is steeped in credibility, common sense, and fairness. His impact on the insurance industry and our firm cannot be overstated. We have always known you were legendary, but now you have the crystal trophy to prove it!

Congratulations on this well-earned recognition!

Appraisal Not Appropriate Until the Insured Cooperates with the Adjustment

by Alexander Masotto

The Southern District of Texas recently denied an insured's motion to compel appraisal because the insured failed to cooperate pursuant to the Policy's conditions.

In *Funes v. Allstate Vehicle and Property Insurance Company*, No. 4:24-CV-00808, 2024 WL 4294677 (S.D. Tex. Sept. 25, 2024), the insured submitted a claim for pipe damage resulting from the February 2021 Texas freeze. However, the insured swiftly withdrew his claim a month later. After approximately two years passed, the insured retained counsel, and resubmitted the same claim on February 7, 2023.

The insurer inspected the property and found that the subject piping was replaced. The insurer requested reports/invoices for the re-piping, but the insured failed to oblige.

Soon after, the insured's counsel invoked appraisal under the Policy to determine the "amount of loss;" however, the insurer refused to participate due to the insured's lack of cooperation and potential coverage issues. The Policy at issue included certain Conditions that required the insured to, among other things, "give [the insurer] all accounting records, bills, invoices, and other vouches, or certified copies, which [the insurer] may reasonably request to examine and permit [the insurer] to make copies."

The insured proceeded to file suit against the insurer, move to compel appraisal, and abate the suit until the completion of appraisal. Interestingly, the insured argued that appraisal was appropriate because appraisal is a condition precedent to filing suit under the Policy. In response, the insurer argued that the duty to cooperate was also a condition precedent, and that the "nature of the repairs makes it impossible to determine what damage was caused by a covered loss versus what was caused by non-covered events such as long-term deterioration of the pipes."

Relying on *State Farm Lloyds v. Johnson*, 290 S.W.3d 886 (Tex. 2009), the Court noted that appraisal may move forward when coverage issues exist in conjunction with a dispute over the amount of loss. Nonetheless, the Court denied the insured's motion to compel appraisal "until such time as [the insured] furnishes [the insurer] with the requested plumbing report, all photographs of the pipes and the area in question (if any), and/or all invoices and satisfies any other relevant conditions precedent."

Funes recognizes that insurers may refuse to participate in appraisal until an insured properly complies with the Policy's conditions, including the duty to cooperate and provide relevant documentation.

Insureds' Failure to Send Proper Presuit Notice Can Automatically Abate Case Against Insurers

by Zach Fechter

Before an insured can sue an insurer based on a claim for wind and hail damage to property, Texas Insurance Code § 542A requires the insured to send the insurer a presuit demand letter at least 61 days before filing suit, or else the case can be automatically abated. The Northern District of Texas, Amarillo Division recently reiterated this requirement in *Lotus Sky LLC v. Lexington Ins. Co.*, No. 2:24-cv-00085-Z-BR, 2024 WL 3906768, at *1 (N.D. Tex. Aug. 22, 2024, no pet.) (mem. op.).

In this case, Lexington Insurance Company ("Lexington") participated in a market program providing excess property insurance. Lotus Sky LLC d/b/a OYO Hotel ("Lotus Sky"), an additional insured on the policy, submitted a claim to Lexington and other excess market insurers for damage caused to its property by windstorm and hail. After Lexington denied the claim, Lotus Sky sent a presuit demand letter pursuant to Texas Insurance Code § 542A, which applies to claims for property damage caused by wind and hail. But Lotus Sky only sent a presuit demand letter to other market insurers, not Lexington. Nonetheless, Lotus Sky sued Lexington for breach of contract, breach of the duty of good faith and fair dealing, and violations of the Texas Insurance Code and Texas Business and Commercial Code. Lexington then filed a Verified Plea in Abatement and a Plea Invoking Texas Insurance Code § 542A.007(d), arguing the case was automatically abated by statute because Lotus Sky failed to give it proper presuit notice.

In analyzing Lexington's motion, the court noted that, when an insured does not give proper presuit notice under § 542A, an insurer may file a plea in abatement within 30 days of filing its answer. Tex. Ins. Code § 542A.005. The court further noted that a case may be abated automatically "and without court order if the [insurer] [1] verifies the plea in abatement," [2] alleges failure to comply with § 542A.003, "and

[3] the [insured] does not controvert the verified plea [by filing an affidavit] before the 11th day after the plea in abatement is filed." *Lotus Sky*, 2024 WL 3906768, at *2 *citing Rodriguez v. Metropolitan Lloyds Ins. Co.*, No. 5:15-CV-143-C, 2015 WL 12699855, at *4 (N.D. Tex. July 27, 2015, no pet.).

In its Motion to Abate, Lexington alleged Lotus Sky's presuit notice to a different market insurer was insufficient as to Lexington, and the court agreed. *Lotus Sky*, 2024 WL 3906768, at *2. The court found Lotus Sky failed "to dispute or oppose by reasoning" that it did not send proper presuit notice. *Id.* at n.4. The court therefore held that the case automatically abated eleven days after Lexington filed its verified plea and would remain in abatement for 60 days from the date Lotus Sky provides presuit notice. *Id*. at *3.

The Lowdown: *Lotus Sky* is a good reminder that an individual insurer – even if a participant in a larger market – is entitled to receive a presuit demand letter before an insured files suit. And when an insured does not send a presuit demand letter as required by § 542A, insurers should file a verified plea in abatement within 30 days of filing their answers so the case can be automatically abated.

BEYOND THE BLUEBONNETS

After the Storm: Causation Considerations for Commercial Property Insurance Claims in the Wake of Hurricane Helene

by Isabella Stankowski-Booker and Jackson A. Griner (Atlanta office)

While Georgia's coastline is vulnerable to exposure from tropical storms, most hurricanes miss the Peach State. Typically, these treacherous storms either dodge Georgia entirely, or fizzle out before they impact the State.

Hurricane Helene, however, was different. After barreling through the panhandle of Florida as a category 4 storm, with wind gusts reaching 140 miles per hour, Hurricane Helene slammed into Georgia and South Carolina, before moving north to Tennessee and North Carolina. In its wake, Hurricane Helene left behind a trail of destruction and loss of life, with billions of dollars in property damage and hundreds of fatalities throughout the Southeastern United States.

Helene impacted all 159 counties in Georgia causing widespread flooding and wind damage. Structures collapsed and trees toppled over, knocking down power lines and leaving millions without power for days. Heavy downpours caused rivers and creeks to rapidly swell and spill floodwaters. Atlanta, where Zelle's office is located, and the metro Atlanta area saw widespread dangerous flooding.

With the first claims coming in, one of the central questions that has been emerging is what peril caused the claimed damage. Below, we provide a high-level overview of Georgia law on causation in the first-party property context.

I. The Policy Language Controls

First and foremost, insurers will need to determine what perils are actually at play and what coverage the underlying policy affords for such perils. As a rule of thumb, the wording of the policy at issue, including its causation language, typically controls. If the policy language in an insurance contract is unambiguous, Georgia courts will enforce the policy as written. *Cincinnati Ins. Co. v. Magnolia Ests., Inc.*, 286 Ga. App. 183, 185, 648 S.E.2d 498, 500 (2007). This also holds true for policy exclusions. As one court recently explained: "If a policy exclusion is unambiguous, however, it must be given effect even if beneficial to the insurer and detrimental to the insured. We will not strain to extend coverage where none was contracted or intended. Whether ambiguity exists in a contract is a question of law for a trial court." *Frey v. Nationwide Mut. Ins. Co.*, 371 Ga. App. 590, 592, 901 S.E.2d 730, 733 (2024)(*quoting Sharma v. City of Alpharetta*, 361 Ga. App. 692, 695, 865 S.E.2d 287 (2021)); *Aldridge v. Travelers Home & Marine Ins. Co.*, 2018 WL 2056567 (N.D. Ga. Jan. 25, 2018). In contrast, ambiguous terms are typically construed against the carrier. *Certain Underwriters at Lloyd's of London v. Rucker Const., Inc.,* 285 Ga. App. 844, 848, 648 S.E.2d 170, 174 (2007).

With these rules of policy interpretation in mind, there are some initial questions to consider before embarking on the causation analysis. For example, if flood is covered, how is it defined? While some commercial property policies include narrow flood definitions, other policies have flood definitions that include the rapid accumulation of surface waters as well as the rising, overflowing or breaking of boundaries of lakes, reservoirs, rivers, streams or other bodies of water. Other policies also cover mudslide and mudflow under their definition of "flood." Yet other policies cover wind driven rain, storm surge, and flood that occurs in conjunction with a tropical storm under the "Named Windstorm" peril. Moreover, what causation language does the policy use for these perils? Finding answers to these questions is the first step in any causation analysis.

II. Georgia Applies The Efficient Proximate Cause Theory Where A Covered Cause And An Uncovered Cause Combine To Cause Loss Or Damage

Once the perils at play are identified, we can focus on the causation analysis. Where there is a single cause of loss, Georgia courts apply a basic proximate cause theory to determine whether there is coverage. *See Bowers v. Farmers Ins. Exch.*, 99 Wash. App. 41, 47 (2000)("When an insured can identify an insured peril as the proximate cause, then there is coverage even if subsequent events are specifically excluded from coverage."); *Bennett Int'l Grp., LLC v. Allied World Specialty Ins. Co.,* 2022 WL 94525 (N.D. Ga. Jan. 10, 2022).

Where a loss results from multiple potential causes, Georgia will apply the efficient proximate cause theory. *Burgess v. Allstate Ins. Co.*, 334 F. Supp. 2d 1351, 1361 (N.D. Ga. 2003). This theory applies specifically "when two or more identifiable causes contribute to a single property loss–at least one of them covered under the policy[,] and at least one of them excluded under the policy." *Id* at 1360 (citations omitted). The efficient proximate cause is "the one that necessarily sets the other causes in operation, [while] … causes that are merely incidental ... are not the proximate causes and the responsible ones, though they may be nearer in time to the result." *Dunbar v. Davis*, 32 Ga. App. 192, 122 S.E. 895 (1924).

Assume, for example, that a policy covers winds but does not cover flood. Where the claimed loss results from both perils, a court applying Georgia law would likely apply the efficient proximate cause theory to determine coverage. In this regard, the court would assess whether "a risk specifically insured against sets other causes in motion in an unbroken sequence between the insured risk and the ultimate loss. In such situations, the insured risk is regarded as the proximate cause of the entire loss, even if the last step in the chain of causation was an excepted risk." *Burgess*, 334 F. Supp. 2d at 1360 (quoting *TNT Speed & Sport Ctr., Inc. v. Am. States Ins. Co.*, 114 F.3d 731, 733 (8th Cir. 1997).

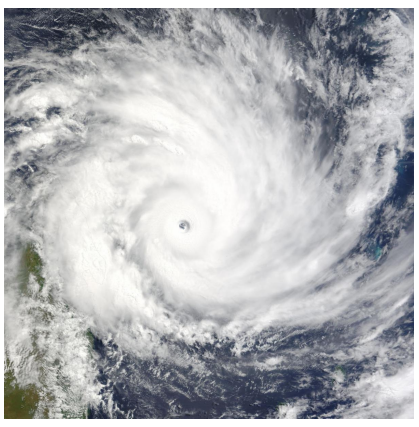
III. Georgia Likely Enforces Anti-Concurrent Causation And Anti-Sequential Causation Clauses

While the efficient proximate cause theory sounds straightforward in theory, in practice it has led to disputes regarding which cause, or causes, may have contributed to a loss and which can be deemed the efficient proximate cause. Accordingly, in an effort to reduce these disputes and provide contract certainty, parties often negotiate anti-concurrent causation language into their policies. Under those provisions, the loss will be excluded if any cause of loss is excluded, regardless of whether a covered cause of loss qualifies as the efficient proximate cause. *See In re Covington Lodging Inc.*, 635 B.R. 675, 697 (Bankr. N.D. Ga. 2021)

Georgia seemingly enforces anti-concurrent causation clauses. *See In re Covington Lodging Inc.*, 635 B.R. 675, 697 (Bankr. N.D. Ga. 2021)("Parties . . . can contract around these default rules with an anti-concurrent cause ("ACC") provision. When damage arises from multiple causes, an ACC provision circumvents the doctrine of efficient proximate cause and bars coverage [, even] where the loss is caused by a combination of covered and excluded perils."); *Nationwide Prop. & Cas. Ins. Co. v. Hampton Ct., L.P,* 2024 WL 2193348 (N.D. Ga. May 15, 2024).

Georgia also allows similar anti-sequential clauses aimed at barring recovery where two causes operate in succession to cause a loss. *Id*; *citing Downs Ford, Inc. v. Zurich Am. Ins. Co.* , 2021 WL 1138141, at *6 (D.N.J. Mar. 25, 2021)("An anti-concurrent causation or anti-sequential causation clause will exclude coverage when a prescribed excluded peril, alongside a covered peril, either simultaneously or sequentially, causes damage to the insured.").

In sum, we anticipate that the legal issues arising from Hurricane Helene will build on the existing Georgia case law on causation. Having experienced Hurricane Helene firsthand, the Zelle Atlanta office is now actively monitoring the legal landscape as the claims adjustment process continues. In addition to questions regarding causation, we are analyzing other legal issues that may materialize in the immediate aftermath of the storm, including the application of different deductibles and sublimits related to different perils, notice requirements, and assignments of benefits. We are available to assist our clients as they navigate the legal landscape in Georgia.



Hurricane Milton First-Party Property Claims Checklist

by Giorgia Rivasi and Christine Renella (Ft. Lauderdale office)

Hurricane Milton, which is predicted to be a catastrophic major hurricane, is rapidly strengthening and approaching Florida. According to the National Hurricane Center, Hurricane Milton is forecasted to become a Category 5 hurricane by the time it hits the west coast of Florida. On October 6, 2024, Governor Ron DeSantis issued an Executive Order (EO 24-215) declaring a state of emergency in 51 counties in the State of Florida.

With the arrival and in the aftermath of Hurricane Milton, below is a checklist that Florida admitted carriers and surplus lines carriers should keep in mind when handling property claims. Florida admitted carriers are subject to the provision of Chapter 627. However, surplus lines carriers are exempt from Chapter 627, unless otherwise specified in the provision.

- **Acknowledgment of the insured's claim**. Upon receipt of communication from an insured, or the insured's representatives, with respect to a claim, the insurer shall have 7 calendar days to respond to the communication, unless payment is made within that period of time. An exception to this time frame is made when the insurer's failure to acknowledge the claim is caused by factors beyond the control of the insurer. If the acknowledgment is not in writing, then the insurer shall create a notification in the insured's claim file indicating the acknowledgment. Fla. Stat. § 627.70131(1)(a). *This section also applies to surplus lines insurers.*
    - If the insured's communication constitutes a notification of a claim, the insurer's acknowledgment must provide all necessary claim forms and instructions and include an appropriate phone number. The insurer is not required to provide claim forms and instruction if the acknowledgment reasonably advises the insured that the claim is not covered. Fla. Stat. § 627.70131(2). *This section also applies to surplus lines insurers.*

- **Claim investigation**. Unless otherwise provided by the policy or by law, the insurer shall begin investigating the claim within 7 days after the insurer receives proof of loss statements. An exception is made if the insurer is unable to timely begin the investigation due to factors beyond the control of the insurer. Fla. Stat. § 627.70131(3)(a). *This section also applies to surplus lines insurers.*
    - If the investigation involves a physical inspection of the property, the insurer's assigned licensed adjuster must provide the insured with printed or electronic communication including the adjuster's name and license number. The insurer must conduct the inspection of the property within **30 days** of receipt of proof of loss statements. Fla. Stat. § 627.70131(3)(b). *This section also applies to surplus lines insurers.*
    - If the insurer's adjuster generates an estimate, the insurer must send a copy of the estimate to the insured within **7 days** after the estimate is generated. Fla. Stat. § 627.70131(3)(e). *This section also applies to surplus lines insurers.*

- **Homeowner Claims Bill of Rights**. Within 14 days after receiving an initial communication with respect to a claim, an insurer issuing a personal lines residential property policy must provide a Homeowner Claims Bill of Rights. Fla. Stat. § 627.7142.

- **Reservation of Rights**. Within 30 days after an insurer knew or should have known of a coverage defense, written notice of reservation of rights shall be given to the insured. § 627.426(2)(a).

- **Claim payment**. If the insurer receives notice from the insured of an initial, reopened or supplemental claim, the insurer shall pay or deny the claim or a portion of the claim within 60 days after the insurer's receipt of the claim. Again, an exception to this time frame is allowed if the insurer's failure to pay is caused by factors beyond the insurer's control. Fla. Stat. § 627.70131(7)(a). *This section also applies to surplus lines insurers.*

- **Payment of settlement**. If the insurer and the insured agree, in writing, to a settlement of the claim, the insurer shall tender payment according to the terms of the agreement no later than 20 days after the settlement is reached. If payment is not tendered within 20 days, it shall bear interest at a rate of 12% per year from the date of the agreement. Fla. Stat. § 627.4265.

If you have any questions, please feel free to reach out to Christine M. Renella in the Ft. Lauderdale Office of Zelle LLP.

For more information on any of the topics covered in this issue, or for any questions in general, feel free to reach out to any of our attorneys. Visit our website for contact information for all Zelle attorneys at zellelaw.com/attorneys.

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