ZELLE LLP LONESTAR LOWDOWN

Dedicated to Texas First-Party Property Claims

The Zelle Lonestar Lowdown | Tuesday, July 28, 2026 | ISSUE 38

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

In 2025, we focused on Collaboration. We had people reach out with article ideas, their own articles, and ideas for industry events. In 2026, we will continue that effort. We continue to invite our readers to let us know what they are worried about, legal topics that pique their interest, and new advances in the industry – all with a Texas twang.

As always, if you are interested in more information on any of the topics below, please reach out to the author directly. 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!

August 4 – Steven Badger will present at the American Ag Conference in Schaumburg, IL.

August 11 – Steven Badger will present "Battle of Merlin vs Badger" with William “Chip” Merlin at the IAUA Appraisal Conference in Ft. Lauderdale, FL.

August 13 – Zelle LLP and J.S. Held will host a summer networking happy hour at Mesero (5505 Belt Line Rd, Dallas, TX 75254) from 5:00 – 8:00 pm. RSVP here.

August 19 – Jennifer Gibbs will present “AI in Claims: Risks and Rewards” during a webinar hosted by the Windstorm Insurance Network.

September 15 – 16 – Jessica Port will present "The Ethics of Automation: Avoiding Bad Faith Claims in AI-Driven Claims Handling" for the 2026 PLRB Regional Innovation Summit in Allen, TX.

September 18 – Jennifer Gibbs will present “Implications of AI in the Insurance Industry, Risks, Regulations, and Future Trends” at the Oklahoma Claims Association (OCA) Fall Conference in Midwest City, OK.

September 27 – 30 – Steven Badger, Lindsey Davis, and Jessica Port will present at the NAMIC 131st Annual Convention in Denver, CO.

1. Retain a qualified Cause & Origin Investigator to determine when, how and where the fire started.

2. Obtain a copy of the Fire Marshall’s report and records. Interview the Fire Marshall if necessary.

3. Obtain competent weather data, if you determine the fire may have been caused by a weather event, i.e., lightning during a storm.

4. Request maintenance records for appliances and electrical systems if you determine the fire may have been caused by an electrical short.

5. Take and request photos and videos. Photos from before and after

News from the Trenches

by Steven Badger

I am not a social media person. I’ve never had a Facebook page. And couldn’t tell you how to access Instagram.

But, yes, I am an avid LinkedIn user. And here’s why….

Over a decade ago my law firm required all of us to set up LinkedIn profiles. Being the rule follower that I am, of course I created a profile. I got on and started to read insurance industry related posts that would show up on my feed (yes, I learned that word early). Every day – every single day – I saw post, after post, after post by people bashing insurance companies. The same old “delay, deny, defend” rhetoric. Posted by storm chasing contractors, public adjusters, and even a few policyholder attorneys.

What I did not see were posts by anyone defending insurance companies. Or anyone in turn bashing so-called policyholder advocates. So on March 3, 2015, I put up my first post. A simple congrats to an insurance company for a favorable jury verdict in a Hidalgo County hail trial. And to my surprise, it got a lot of attention. So I kept posting. Mostly just simple informational posts. But over time I realized that the most read posts were the ones where I directly raised industry issues – especially the ones where I pointed out concerns about abuse on the policyholder side of the claim process. Those would take off. 5,000 views. 10,000 views. Even 30,000 views. More importantly, the posts generated a lot of comments about the topics.

And then it hit me…..

My LinkedIn page was the first in the hail/hurricane/storm damage insurance world to actively defend insurance companies and, more importantly, raise concerns with abuses and outright fraud by bad storm chasing contractors, bad public adjusters, and bad policyholder attorneys. I also realized that insurance company employees, independent adjusters, and even consultants retained by insurance companies weren’t able to post, as their posts would be used against them in claims and litigation. But I, on the other hand, as an old attorney had the freedom to speak openly about industry issues.

the fire will be helpful in determining the amount of the loss.

6. Request the Insured's Inventory List of contents that were damaged during the fire, as well as proof of ownership for the items. Proof of ownership can include owner's manuals, receipts, photos, credit card statements, bank records and invoices.

7. Request the Insured's list of contents that can be saved and cleaned.

8. Retain a professional Fire Damage Restoration company that can provide an estimate of damage – preferably one that is also willing to do the work should the Insured decide to hire them.

9. Interview the Insured and the individuals at the scene of the fire. Obtain a recorded statement of each, if necessary.

10. Involve SIU and/or coverage counsel if you suspect arson.

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.

So that's exactly what I started doing. And boy did it take off. I even hit my first post with over 100,000 views a few weeks ago. I even get texts from people asking me if I'm ok when I don't post for a few days. LOL.

Every one of my posts fall into one of three categories…

Educate
Embarrass
Advocate

My Educate posts are simply intended to bring awareness to issues – such as a recent court decision, a new policy form, or an emerging trend. These are typically non-controversial and intended simply to inform.

My Embarrass posts are probably the most enjoyed by readers. Every week people send in nominees for my "SSPPI Award" (figure it out yourself). I think these are important as they call-out really dumb posts, on any social media forum, that all professionals on both sides of the industry can agree are counterproductive. In fact, I hear people are now more careful about what they put online so they don't "appear in a Badger post." If that is true, these posts have served their purpose.

My Advocate posts are the most important. These posts are specifically intended to advance the discussion on industry issues that I believe warrant attention and action. As an example, I realized a few years ago that invoking Our Option and the use of preferred contractor networks is the best way to end abuse by certain contractors and public adjusters – as there is no role for them in the claims process if the damage is being fixed by a reputable contractor sent out by the insurance company or agreed to in advance by the insured. Once I started posting about the topic, I could see the attention it received across the industry, on both sides. Another issue involves the need to raise the bar to become a public adjuster. After many posts on the issue, it is now finally receiving warranted attention.

So, yes, I am a LinkedIn junkie. It serves an important purpose in my work. And, I must admit, it's fun.

AI Update

Texas Department of Insurance Issues AI Bulletin

by Jennifer Gibbs

On June 12, 2026, the Texas Department of Insurance (TDI) issued Commissioner's Bulletin No. B-0003-26, addressing the use of AI (and other advanced analytical and computational technologies) by regulated entities and their agents and representatives. The bulletin reminds industry participants that any decision or action affecting consumers, whether made or merely supported by AI, must comply with all applicable insurance laws and regulations, including those governing unfair trade practices and unfair discrimination.

Purpose and Scope

TDI's stated goal is consumer protection. The bulletin sets expectations for how regulated entities should govern the development, acquisition, and use of AI across their operations, and these expectations extend to any third party working with a regulated entity. TDI points to the NAIC's 2020 Principles on Artificial Intelligence and the Texas Department of Information Resources' AI Code of Ethics and Minimum Standards as useful frameworks, noting that the latter promotes human oversight, fairness, accuracy, redress, transparency, data privacy, security, and accountability.

Applicable Legal Framework

The bulletin catalogs the existing statutory provisions that TDI expects regulated entities to keep in mind when deploying AI, including Texas Insurance Code Chapters 541 (Unfair Methods of Competition and Unfair or Deceptive Acts or Practices), 542 (Processing and Settlement of Claims), 544 (Prohibited Discrimination), 560 (Prohibited Rates), 831 (Corporate Governance Annual Disclosure), 4001 (Agent Licensing), 4101 (Insurance Adjusters), 4201 (Utilization Review Agents, which expressly bars using AI to make an adverse determination), 751 (Market Conduct Surveillance), and 401 (Audits and Examinations). Notably, TDI is not creating new obligations but confirming that these existing laws apply regardless of the technology used.

Key Expectations

TDI's guidance emphasizes several core expectations:

- AI-driven decisions must not be inaccurate, arbitrary, capricious, or unfairly discriminatory, and compliance with these standards is required irrespective of the tools used.
- Regulated entities should implement controls and guardrails to mitigate the risk of adverse consumer outcomes.
- For consequential decisions made using AI, a human must review and agree with the decision before any action is taken.
- Strong governance, risk management, and internal audit functions—along with verification and testing methods to catch errors and bias—are viewed as central to compliance.
- TDI will monitor AI use through examinations and product filings, will investigate consumer complaints about AI, and expects entities to be able to produce their AI governance procedures and protections upon request.

Practical Takeaway

The bulletin does not prescribe specific practices or documentation formats. Instead, it puts regulated entities on notice that TDI examinations and market conduct reviews may probe AI governance frameworks, risk management processes, data privacy protections, and internal controls, including questions about specific AI applications. Entities using AI in underwriting, claims, rating, or other consumer-facing functions should be prepared to demonstrate human oversight and documented controls.

What This Means for the Industry

In plain terms, the bulletin states that an insurer cannot point to an algorithm as the reason a decision was fair, accurate, or lawful. Existing legal standards still apply in full, and insurers must now be prepared to demonstrate how those standards were met. For companies already using AI in underwriting, pricing, claims triage, or customer service, this bulletin is a signal to take a hard look at whether a human is genuinely reviewing and signing off on significant decisions, not just rubber-stamping outputs the system already produced. It is also a reminder that vendor tools count too. If a third-party AI platform is doing the heavy lifting, the company using it remains accountable if the outcome discriminates unfairly or cannot be explained.

Practically, this means maintaining a governance file documenting what the AI tool does, how it was tested for bias and accuracy, who reviews its outputs, and how errors are corrected if they occur. Entities that already maintain model governance programs in other contexts, such as credit or fraud models, have a head start, but should extend those programs specifically to insurance decisions such as underwriting and claims handling.

One Contamination, One Occurrence: The Sixth Circuit Deals with Salmonella-Contaminated Peanut Butter Amid the Cyclospora Summer

by Alexander Masotto

The summer of 2026 has become, for the food industry and the insurers who underwrite it, the Cyclospora Summer. As of mid-July, a multistate cyclosporiasis outbreak has sickened consumers across approximately 34 states, including Texas, with the microscopic parasite proving as elusive to trace as it is unpleasant to contract. Cyclospora's notoriously long incubation period, about a week from ingestion to symptom onset, makes traceback to a specific food product or production lot extraordinarily difficult, a reality that compounds the uncertainty facing food manufacturers and their liability carriers alike.

On July 17, 2026, Taylor Fresh Foods voluntarily recalled iceberg lettuce sourced from central Mexico "out of an abundance of caution," even though the FDA's traceback pointed to a single independent farm representing less than one percent of the U.S. iceberg lettuce supply. The following day, the FDA reported that a sample of shredded iceberg lettuce supplied by Taylor Farms de Mexico had tested positive for Cyclospora. However, FDA laboratory experts have just concluded that the positive finding was a false positive: "As of July 19, 2026, there are no confirmed positive sample results for product testing for Cyclospora." Taylor Fresh Foods echoed this in its newsroom statement: "To be clear, at this moment, FDA has not identified a single positive product test result for Cyclospora." The episode underscores how quickly contamination allegations, even unconfirmed ones, can trigger costly recalls and set the stage for coverage disputes between food manufacturers and their insurers. Against this backdrop, the Sixth Circuit's recent decision in *J.M. Smucker Co. v. ACE American Insurance Co.*, No. 25-3799, 2026 WL 1893804 (6th Cir. July 1, 2026), arrives with particular timeliness for insurers grappling with contamination-driven occurrence questions.

Relevant Facts

Smucker manufactures food products including peanut butter. It purchased year-long commercial general liability policies from the insurer for 2021 and 2022, each carrying a self-insured retained limit of $250,000 "per occurrence," meaning Smucker bore defense costs and liabilities up to that threshold before the insurer's indemnity obligation attached. The policies defined "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." In 2022, Smucker recalled peanut butter

produced at its Lexington, Kentucky facility due to potential salmonella contamination. Thousands of consumer claims followed, alleging bodily injury and property damage.

The insurer denied coverage, advancing the position that each claimant's exposure to salmonella-contaminated peanut butter was a separate occurrence. The insurer further argued that a "Lot Endorsement" aggregated these thousands of individual occurrences into 225 lot-based occurrences organized by "lot" defined as a 24-hour period of production at a single facility. Under the insurer's reading, the Lot Endorsement provided that bodily injury or property damage (a) included in the products-completed operations hazard, (b) arising from substantially the same general harmful condition, and (c) arising out of any one "lot" of the insured's product, constituted a single occurrence deemed to occur when the first claim from that lot was made. The financial stakes were enormous: the insurer's interpretation could have required Smucker to satisfy up to $56,250,000 in retained limits per policy ($112,500,000 total) before any payment obligation attached. Smucker sued for breach of contract and a declaratory judgment that the salmonella contamination constituted a single occurrence with a single $250,000 retained limit. The Northern District of Ohio granted Smucker's motion for summary judgment, and the insurer appealed.

Court Analysis

The Sixth Circuit ultimately affirmed. The court first addressed the meaning of "occurrence" under the policies and then turned to whether the Lot Endorsement altered that determination.

Ohio courts employ the "cause test" for number-of-occurrences questions. Under that test, "the number of occurrences is determined by reference to the cause or causes of the damage or injury, rather than by the number of individual claims." *Cincinnati Ins. Co. v. ACE INA Holdings, Inc.*, 886 N.E.2d 876, 885 (Ohio Ct. App. 2007). Moreover, "where there is but one proximate, uninterrupted and continuous cause, all injuries and damages are included within the scope of that single proximate cause." *Progressive Preferred Ins. Co. v. Derby*, No. F-01-002, 2001 WL 672177, at *3 (Ohio Ct. App. 2001). Critically, the court relied on *Scott Fetzer Co. v. Zurich American Insurance Co.*, 769 F. App'x 322, 328 (6th Cir. 2019), to confirm that "accident" is assessed from the insured's point of view, examining what the insured did unintentionally to expose itself to liability, not the intentional or independent acts of third parties.

Applying these principles, the court found that Smucker's only identifiable "accident" was its unintentional production of salmonella-contaminated peanut butter (i.e. a single, continuous event). Each claimant's independent act of consuming the product was not Smucker's conduct, was not accidental from Smucker's perspective, and therefore could not multiply the number of occurrences. To hold otherwise would collapse the number of occurrences into the number of claims, precisely what the cause test prohibits.

The Sixth Circuit held that the salmonella contamination was a single, continuous accident constituting one occurrence, not one occurrence per claimant and not one occurrence per production lot. Turning to the Lot Endorsement, the court found it ambiguous. The endorsement never expressly stated that it replaced the base policy definition of "occurrence." Its operative phrase, bodily injury or property damage that "arises out of any one 'lot,'" was reasonably susceptible to two interpretations: a limiting reading (multiple injuries from the same harmful condition within one lot remain one occurrence) and an aggregating reading (the insurer's view, converting per-claimant exposures into per-lot occurrences and thereby multiplying the retained limits).

The analysis would arguably look different under Texas law. The Texas Supreme Court has defined "accident," the operative term within most CGL definitions of "occurrence" as "a fortuitous, unexpected, and unintended event." *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, 242 S.W.3d 1, 8 (Tex. 2007). But the Fifth Circuit implements the cause theory through a distinct "liability-triggering event" lens: rather than asking only what the insured did that was unintentional, courts focus "on the events that cause the injuries and give rise to the insured's liability, rather than on the number of injurious effects." *H.E. Butt Grocery Co. v. National Union Fire Insurance Co.*, 150 F.3d 526, 530 (5th Cir. 1998); *see also Evanston Ins. Co. v. Mid-Continent Cas. Co.*, 909 F.3d 143, 147–48 (5th Cir. 2018). Applied to facts like Smucker's or the Cyclospora outbreak, the liability-triggering-event framework could point toward a materially different result than the Sixth Circuit. Of course, the underlying policies will help determine how coverage responds when applying the relevant provisions to the underlying contamination loss.

Significance

This decision underscores that precise "occurrence" and "loss" definitions are critical to how a liability policy reacts to contamination claims. When contamination losses are reported, insurers should carefully and promptly analyze: (a) the main coverages and endorsements implicated, including whether any lot, batch, or aggregation endorsement clearly and unambiguously states whether and how it redefines "occurrence"; (b) potential government-mandated recall costs; (c) recall costs tied to both affected and unaffected product (product recalled out of an abundance of caution even absent confirmed contamination), a dynamic on vivid display in the Taylor Farms Cyclospora situation; and (d) accounting costs associated with tracking and allocating claims across production lots and policy periods. Contamination claims can carry significant financial consequences, and carefully understanding how a policy's occurrence language applies, together with the governing jurisdiction's law, is paramount to making an ultimate coverage determination.

Texas Courts Say, "Don't Tread on Me": Northern District Reiterates Limitations of Appraisal Testimony

by McKenna Ledbetter (Law Clerk)

Earlier this month, the Northern District of Texas reiterated Texas' sentiments surrounding the scope of appraisal, holding that appraisers may determine the amount, but not the cause, of loss. *Abesu v. Allstate Vehicle and Prop. Ins. Co.*, 2026 WL 1959123 (N.D. Tex. July 6, 2026).

Factual Background

Girma Abesu owned a home insured by Allstate that evidenced long-term water damage. In September of 2023, Abesu filed a claim with Allstate, alleging that a water leak caused damage to the interior of the property. There was a dispute and the parties went to appraisal. An issue that arose was whether the damage was caused by the long-term water leaks, which was excluded, or the recent water leak that was the basis of the claim.

Allstate retained an expert who determined that some of the damage pre-dated Abesu's policy and that the remaining damage was likely caused by long-term, ongoing failure of the water supply lines. Based on its expert's findings, Allstate denied coverage.
Abesu disagreed with Allstate's findings and denial of coverage, and she filed suit. Abesu relied on his appraiser to provide an expert opinion concerning causation.

The Court's Analysis

Allstate filed summary judgment challenging Abesu's claims for breach of contract, prompt payment liability, and bad faith allegations. The Northern District of Texas looked at the arguments and evidence of each in turn and granted summary judgment for Allstate.

First, the court rejected Abesu's appraiser's opinion because well-settled Texas law holds that appraisers "cannot establish causation." This limitation harkens back to the primary function of appraisers: to determine the amount of loss. In other words, an appraiser may only determine the monetary value of property damage, not what caused that damage. In contrast, the issue of causation pertains to liability, which is a legal issue that falls within the purview of the court. Appraisers may not trespass on the court's territory.

Based on these well-settled principles, the court refused to consider the appraiser's opinion in determining whether the cause of damage was a covered peril. Without the appraiser's testimony, Abesu had insufficient evidence to contravene Allstate's. Nor could Abesu segregate the covered from non-covered causes of loss as required by Texas' concurrent causation doctrine. Ultimately, the court found that without any evidence to present a genuine issue of material fact on the causation issue, the exclusions prevailed to preclude coverage.

And because there was no breach of contract, Allstate was also not liable for bad faith or prompt payment penalties.

Conclusion

Abesu reiterates the parties' respective burdens concerning causation following appraisal. The Northern District, like other courts in Texas, maintained the boundary between amount of loss determinations, which fall within the purview of appraisers, and causation determinations, which fall within the purview of courts. When an insured's only evidence pertaining to causation comes from an appraiser, insurers will more easily meet their burden to refute the insured's sole reliance on an appraiser's opinion. In true Texas-fashion, in maintaining their jurisdiction over causation analysis, courts will continue to shout, "Don't tread on me!"

No Clean Break: Court Finds Fact Issues on Roof Seam Damage

by Mikalyn Greenzweig (Law Clerk)

Courts sometimes seem to bend over backwards to avoid summary judgment on cosmetic damages issues. That seemed to be the case in *Smith v. State Farm Lloyds*, where the Western District Court of Texas, Waco Division, found a fact issue as to whether damage to metal roof seams sufficed to avoid a cosmetic damage exclusion.

In *Smith*, the insured homeowner claimed her roof sustained hail damage to the "seams" of her metal roof, which is the area located between each individual roof panel. *Smith*, 2026 WL 1954925, at *2. The policy contained a Metal Roof Endorsement that excluded coverage for damage that did not result in an opening that completely penetrated through an individual roof component. *See Id.* (stating that "the policy only affords metal roof coverage for hail if 'hail creates an opening that completely penetrates through' any individual component of the roof"). By this definition, the insurer stated that each metal panel on the roof was an "individual metal component," and since there was no complete penetration through any individual metal panel, coverage was denied. *Id.* at *1. The insured disagreed and argued that the insurer relied on its expert's assumptions in that a "seam" itself is not an individual roof component, and further argued that a hailstone opening a seam qualifies as an "opening that completely penetrates" an individual component of the roof. *Id.* at *2.

The Court denied summary judgment on the issue, holding that whether damage to the "seams" constitutes an opening that completely penetrates an individual roof component presents a factual question that could not be determined as a matter of law at this stage in the case. *Id.*

Separately, the insurer moved for summary judgment on the insured's breach-of-contract and bad-faith claims, arguing that its reliance on the Metal Roof Exclusion and condition of the roof created a bona fide coverage dispute sufficient to bar all of the insured's claims. *Id.* The insurer relied on *Weiser-Brown Operating Co. v. St. Paul Surplus Lines Ins. Co*., asserting that it had a reasonable basis for denying coverage. *Smith*, 2026 WL 1954925, at *2 (quoting *Weiser-Brown Operating Co.*

v. Paul Surplus Lines Ins. Co., which stated that an insurer "will not be faced with a tort suit for challenging a claim of coverage if there was *any reasonable basis* for denial of that coverage).

The insured, however, argued that a jury could reasonably find bad faith because there were visible holes in the roof and the insurer had photos demonstrating this, which could raise questions as to the functionality of the roof. *Id.*The insured also argued that under the insurer's interpretation, only a "ballistic" hail penetration could trigger coverage and this was evidence demonstrating bad faith. *Id.*

Ultimately, the Court also denied summary judgment on the bad-faith claims, concluding that a jury could find bad faith rather than a bona fide dispute. *Id.*Notably, the Court held that the insurer's "ballistic" hail penetration standard for denying coverage was unreasonable. *Id.*

The Lowdown: This case will come down to a battle of the experts at trial. And given that there was reportedly evidence of punctures and "holes" in the roof at the seams, the insurer's reliance on the Metal Roof Endorsement and its cosmetic damage exclusion may appear unreasonable to a jury. Insurers should be ready to respond to allegations of damage at all areas of a metal roof, including seams, and should ensure its investigation appropriately details the extent (or lack) of damage and harm caused by hail, even with cosmetic damage exclusions.

BEYOND THE BLUEBONNETS

Proposed Bad Faith and Appraisal Legislation Makes Waves in the Ocean State

by Elizabeth Reidy (Boston office)

A series of property insurance-related bills introduced in the Rhode Island General Assembly's 2026 Legislative Session could significantly reshape the state's regulatory framework governing property insurance claims. Taken together, these measures would expand regulatory obligations and potentially increase exposure to claims related litigation. Each of these bills was referred to Committee and have been "held for further study," enabling legislators to evaluate the testimony submitted and consider potential amendments. These bills include:

- S.B. 2204 and S.B. 2205, and their companion bills of H.B. 7515 and 7512, introduce new definitions, including "claimant," which is defined to include third-party beneficiaries and assignees operating under assignments of benefits," "insurance adjuster" and "insurance claim handling services." These broad definitions require any person who evaluates, inspects, or offers opinions on damage, causation, repair scope, or replacement cost in connection with an insurance claim, regardless of job titles, to hold appropriate licenses and registrations.

- S.B. 2261, and the companion bill H.B. 7521, propose to overhaul Rhode Island's standard fire insurance policy (R.I. Gen. Laws. §§ 270503 and 27-5-9.1). Among other provisions, these bills substantially alter the statutory appraisal process by expressly permitting appraisal where coverage is disputed, impose detailed qualification standards for appraisers and umpires, and require insurers to bear the costs of both appraisers if they initiate the appraisal process. These bills also define replacement cost value to include all necessary labor, materials, and compliance costs without depreciation, while limiting the application of depreciation under actual cash value. Moreover, they mandate that awards include 12 percent interest calculated from the date of loss. Finally, these bills increase the statute of limitations for non-fire or lightening homeowners' claims to ten years.

- S.B. 2311, and the companion bill H.B. 7517, propose fundamental changes to "bad faith" liability in Rhode Island (R.I. Gen. Laws §§ 9-1-33 and 27-9.1-10), by removing the statutory requirement that there be a breach of contract prior to commencement of an action for bad faith. These bills also add a private cause of action for unfair claims settlement practices and authorize recovery of actual damages, attorneys' fees, and enhanced damages of up to twice the amount of actual damages. These bills further re-define "unfair claims practices" to include, among other practices: (a) assigning, permitting or relying upon adjusters or agents who lack the training, education or experience reasonably necessary to competently investigate, evaluate, negotiate or settle the loss; (b) using any business entity not properly registered with the state of Rhode Island or up to date with required annual filings; and (c) failing to account for consequential damage when calculating replacement cost or actual cash value.

- S.B. 2312, and the companion bill S.B. 7516, revise the statutory appraisal process in Rhode Island (R.I. Gen. Laws § 10-3-6, 10-3-15). These measures authorize courts to appoint appraisers or umpires when a party fails to act or causes unreasonable delay for both the non-complying party and the umpire or third arbitrator. These bills also reduce the time frame to move to vacate, modify or correct an award from 60 days to 30 days.

Industry groups have raised significant concerns about these bills. The Rhode Island Insurance Federation warned that "[t]ogether these are designed to make Rhode Island look more like Florida in their pre-2023 reform era, where assignment of benefit abuses ran rampant and significantly deteriorated the property insurance market." It further commented that, as a result of these bills,

Rhode Island "would become a true outlier in not requiring a breach of contract to accuse an insurer of operating outside their duty of Good Faith and Fair Dealings," which will "invite a flood of new cases from entrepreneurial attorneys, which will increase the cost of claims and thus increase premiums."

Likewise, the American Property and Casualty Insurance Association cautioned that the "ultimate goal of" the bills "is to empower practitioners of assignments of benefits (AOB) abuse"—while an "AOB can streamline the process from a homeowners' perspective," it is "also ripe for abuse as unscrupulous contractors may try to get as much money from the insurer as possible and complete the work for as cheaply as possible as they stand to gain the delta." These bills, according to APCIA, "would make Rhode Island one of the top assignment of benefits abuse states in the country" and would "generate explosive additional costs for Rhode Island residents."

These sentiments are echoed by the Rhode Island Joint Reinsurance Association (the RI Fair Plan), the National Association of Mutual Insurance Companies, the National Crime Insurance Bureau, the American Council of Life Insurers and Beacon Mutual, all of whom submitted written opposition to one or more of these bills. In addition, the Rhode Island Department of Business Regulation, the CRLB License Committee and others have submitted written opposition against these bills.

The written remarks in favor of one or more of these bills argue that the legislation is intended to strengthen consumer protections and claims-handling obligations. Notably, the only proponents of these bills are employed by New England Property Services Group, LLC, a Massachusetts-based storm restoration contractor that enters into home repair contracts and assignments of benefits from Rhode Island and other New England homeowners.

Although these bills have not progressed beyond committee at this time, they warrant close attention from insurers operating in Rhode Island. If enacted—whether individually or as a package—they would materially shift the state's insurance landscape, positioning Rhode Island among the more policyholder-friendly jurisdictions and increasing regulatory, operational, and litigation risk for insurers.

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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