THE ZELLE LONESTAR LOWDOWN

Dedicated to Texas First-Party Property Claims

The Zelle Lonestar Lowdown | Tuesday, December 12, 2023 | ISSUE 8

Welcome to The Zelle Lonestar Lowdown, our monthly newsletter bringing you news from the trenches on everything related to Texas first-party property insurance claims and litigation. 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.

INSIDE THIS ISSUE

Upcoming Events

You don't want to miss this!

2024 *WHAT THE HAIL?* Conference February 8-9, 2024!!

REGISTRATION IS FILLING UP - SECURE YOUR SPOT NOW!!!

The **2024 *WHAT THE HAIL?* Conference** will be held on February 8-9, 2024 at the Irving Convention Center at Las Colinas in Irving, Texas. Here are the details:

Key Information

- **Cost:** $100 (inclusive of all classes/meals/events)
- **Dates:** Thursday, February 8 and Friday, February 9, 2024 - Two-day seminar format (all day Thursday/half-day Friday)
- **Location:** Irving Convention Center at Las Colinas
- **Continuing Education:** Approved for 12 hours of Texas CE credit (10 General and 2 Ethics)
- **Rooms:** The Westin Irving Convention Center. Book your rooms **here!**
- **Events:**
  - Welcome Reception Wednesday, February 7, 2024 for all attendees 6:00 pm - 9:00pm.
  - The legendary 80's Party will return on Thursday evening (February 8, 2024) at the Toyota Music Factory, with a full concert by *The Molly Ringwalds* band... and a few other special surprises.

A few sponsorship opportunities remain available! (contact abannon@zellelaw.com)

Register

December 13, 2023: **Steven Badger** will be presenting at the Property Loss Appraisal Network (PLAN) appraiser/umpire training seminar in Naples, Florida. More information is available at **https://www.theplanonline.org/**.

February 27, 2024: **Jennifer Gibbs** will be co-presenting "Succeed with Empathy: How Being Empathetic Wins Customers and Cases" at the ALM PropertyCasualty360 2024 Complex Claims & Litigation Forum on Tuesday, February 27th, 2024 from 10:45 am - 11:30 am PT in Las Vegas, NV.

1. The Notice of Loss should always be in the Claim File and if the Notice of Loss is ambiguous, requests for clarification should be added to the Claim File.

2. A timely written acknowledgment of the claim.

News From the Trenches

by **Steve Badger**

One word describes what we have all been talking about over the past month -- CHANGE. I have focused several of my recent LinkedIn posts and my presentation last week at the First-Party Claims Conference (thanks to NAPIA for the invite) on changes coming to our industry. The response has been loud. Wow!!! It is very apparent that some people just don't like change. And for some of those people the reason is obvious -- because it could impact their financial self-interests in the claims process. Here are a few changes that are coming to our industry, whether you like them or not:

1. The Appraisal Process – Use of the appraisal process has skyrocketed. And so have the abuses. A significant number of appraisals are no longer about getting to the fair and accurate amount of loss, but instead figuring out ways to game the process to maximize the award (yes, there are some carrier-side abuses by as well). The simple one paragraph appraisal clause worked great when everyone in the process shared the intended objective of getting to a fair number. But now that isn't enough for some. They are

3. Copies of all written correspondence to the insured or its representatives related to the investigation and adjustment of the loss as claimed, including requests involving the investigation and fact finding for the loss as claimed.

4. A certified copy of the applicable policy should be in the Claim File. It shows that the adjuster considered coverage and was looking at the correct forms.

5. Claim notes or evidence of discussions with the insured should be part of every Claim File. This can be through formal claim notes applications or by emails confirming agreements, meetings, and discussions with the insured. First, these records memorialize all conversations with the insured and/or its representatives and avoid allegations those conversations never occurred. Second, the records show the progress of the claim and the efforts the adjuster put into the investigation and adjustment of the loss as claimed.

6. Documents and information received from the insured reportedly sent to support the loss as claimed, especially documents that impact coverage and outline the amount of loss.

7. Documents and information outlining a measure of loss or how the carrier arrived at that measure, including reports received from experts and consultants retained by the insurer sent to assist with the investigation and adjustment of the loss claimed.

8. A reservation of rights letter, if issued and if necessary, should be included in the Claim File.

9. Copies of any letter sent to the insured or their representative that outline a loss measure, coverage position, provide a coverage analysis, or communicate a denial (in whole or in part) should always be in the Claim File.

10. Claim payment information, including a segregation of the coverage payment was made under (i.e., Building, Business Personal Property, Business Income) should be in the Claim File. It is also helpful to have copies of payments checks cashed by the insured in the Claim File in the event the insured claims it

taking advantage of the simplicity of the 100+ year old appraisal clause to abuse the process. I recently shared on LinkedIn a copy of Zelle's proposed revised appraisal clause intended to address all known abuses. It generated quite the discussion. One insurer's revised version of our proposed clause was recently approved by the Texas Department of Insurance. Sorry scammers. But this revised appraisal clause prevents many of your favorite schemes – significantly increased damage measures, addition of new damage components, unilateral umpire appointments, etc. As I used to tell contractors when I spoke at Win The Storm, you killed your golden goose.

2. Parametric Insurance – Insurance companies require predictability. Their models are all based on knowing, more or less, what claims are likely to occur when they underwrite a book of business. That allows them to set premiums and purchase levels of reinsurance. But climate risk has made it more difficult to predict what storm events are likely to occur. That combined with inflation, litigation abuse, supply chain issues, and other variables have all disrupted the traditional insurance model. Many of those variables go away with parametric insurance, where claims are paid not based on actual damage but instead on predicted damage based on the severity of a storm event. Parametric insurance restores much of the certainty insurance companies require. Imagine a world where we don't have to argue about the scope of damage or cost to fix that damage. That world is coming with parametric insurance.

3. Preferred Contractor Programs – There is nothing more frustrating than arguing in a claim (or appraisal or litigation) about nothing more than the fair price to fix agreed damage to a roof. Why is it so darn hard to come up with a price when we all agree the roof is damaged? The answer is simple. The insurance company wants to pay only the reasonable competitive market cost to fix the roof (yes, I admit some residential insurers seem to have a problem paying even that much). The roofing contractor wants a higher price to maximize profit on every job. That conflict in objectives leads to appraisal demands and litigation. Those disputes all go away with preferred contractor programs. We have recently been asked by some of our insurer clients to draft endorsements and the necessary documents to create these programs. In some of these programs, a contractor is selected by the insurance company to complete the work. In others, the contractor is selected by the insured from a list of local approved contractors. Under either approach, certain safeguards are in place to ensure that the contractor completes the work for the reasonable competitive market cost to fix the roof. And cost disputes go away. I am a strong proponent of certain programs that take into account the interests of all three involved stakeholders (insured |insurer |contractor). Those programs exist.

4. Invocation of Right To Repair - Most policies contain a clause giving the insurance company the right to repair the damage at issue. Insurance companies have traditionally been loath to invoke this right, as it essentially puts them in the construction business. But given the abuses our clients are facing in the appraisal and litigation process, some have realized that it is not difficult to find qualified contractors who will install a quality roof for a fair price. And because of that, insurance companies are less reluctant these days to invoke their right to repair. We recently worked on a program for a regional residential insurer in which they planned to invoke the right to repair for every agreed roof replacement in the DFW area. Imagine being the roofing contractor or public

was not paid.

If you would like to further discuss any of these policy provisions and endorsements, please contact me at ttippett@zellelaw.com or **214-749-4261.**

adjuster engaged by the insured in those claims.

5. Additional Exclusions – I promise you, I really do, that insurance companies do not sit around thinking about how to change their policies to pay less on claims. They really don't. As I stated above, insurance companies want predictability. Changed forms lead to uncertainty. So insurance companies prefer the status quo. But as Newton said, every action has an equal and opposite reaction. And because of actions of some so-called "policyholder advocates" to stretch the limits of fair compensation, insurance companies are reacting and changing their policy forms. The cosmetic damage endorsement is one example. There is no reason to replace a low-sloped metal roof that is slightly dented by hail and not leaking. We all know that roof will never rust through and leak. For 30 years I have been asking someone to send me a picture of a metal roof rusted through at a hail dent. No one ever has. But those claims kept coming and now we have an endorsement excluding dents. A current example involves small dents to insulation below TPO and EPDM membranes. Everyone agrees the membrane itself is fine. But the "policyholder advocate" tells us that the minor dents or facer sheet cracking to the insulation below the membrane will decrease R-value, increase fire spread risk, reduce wind uplift resistance, and lead to membrane deterioration from ponding water. None of this is actually true. But it doesn't stop the lawsuits from rolling in. So now what? Predictably, the insurance industry is responding. Zelle has recently written a "Roof Dents Endorsement" addressing all possible denting issues on a roofing surface. Both to the roof and rooftop equipment. Watch for a LinkedIn post about this soon. I can only imagine the discussion this one is going to create.

Just a few of the big-time changes coming to our industry. 2024 is certain to be an interesting time in the first-party property insurance industry.

AI Update

Understanding Machine Learning and Deep Learning

by **Jennifer Gibbs**

The global Artificial intelligence (AI) market is expanding at a rapid pace – with experts predicting that the AI market will be worth $1.35 trillion by 2030.[1] It is thus very important that all consumers are aware of the basics behind the types of AI and how they work.

At its basic form, artificial intelligence is a field combining computer science and robust datasets to enable problem-solving.[2] AI research deals with the question of how to create computers that are capable of intelligent behavior. AI includes the sub-fields of machine learning and deep learning.

Machine learning (ML) focuses on using data and algorithms to imitate how humans learn, gradually improving its accuracy.[3] In ML, it's important to distinguish between supervised vs. unsupervised learning, and a hybrid version named semi-supervised learning.

Supervised learning is where the algorithm is given a set of training data. Supervised models learn from ground truth data labeled manually by data scientists.[4] **Example: Spam detection software which differentiates between official mail and spam mail.**

Unsupervised learning is where the algorithm is given raw data that is not annotated. Here, the algorithm is not explicitly told what to do with it and must learn how to make predictions by itself. This type of ML model is suitable for performing specific tasks on distinct data types.[5] **Example: Fraud detection software based on identifying unusual patterns or deviations from normal behavior in data.**

Semi-supervised learning (SSL) is a machine learning technique that uses a small portion of labeled data and lots of unlabeled data to train a predictive model.[6] **Example: Speech recognition software using both human-annotated audio data plus unlabeled speech data.**

Deep learning (DL) is a subset of machine learning, which is a subset of artificial intelligence. Deep learning is concerned with algorithms that can learn to recognize patterns in data. The term "deep" of "deep learning" refers to the fact that DL models are composed of multiple layers of neurons, or processing nodes. The deeper the model, the more layers of neurons. [7] **Example: Virtual assistants such as Alexa and Siri which understand natural language voice commands and tend to provide a better user experience based on past experiences using DL algorithms**.

In conclusion, because AI is a part of nearly all industries – and the insurance industry is no exception – obtaining a basic knowledge regarding these models will be essential in obtaining a solid understanding of this transformative technology.

[1] https://www.techopedia.com/artificial-intelligence-statistics (last visited Dec. 4, 2023).
[2] https://www.ibm.com/topics/artificial-intelligence (last visited Dec. 4, 2023).
[3] https://www.ibm.com/topics/machine-learning (last visited Dec. 4, 2023).
[4] https://viso.ai/deep-learning/ml-ai-models/ (last visited Dec. 4, 2023).
[5] *Id.*
[6] https://www.altexsoft.com/blog/semi-supervised-learning/ (last visited Dec. 4, 2023).
[7] https://viso.ai/deep-learning/ml-ai-models/ (last visited Dec. 4, 2023).

Lassoing Liability
with Megan Zeller

How To Be a Reasonably Prudent Insurer Under the *Stowers* Doctrine

Everything is bigger in Texas, and this includes the common law duties that insurers have when presented with settlement demands for liability claims. For over ninety years, Texas has required insurers to exercise ordinary care in the settlement of covered claims to protect insureds from excess judgments under the *Stowers* doctrine. *See G.A. Stowers Furniture Co. v. American Indemnity Co.*, 15 S.W.2d 544, 547 (Tex. Comm'n App. 1929, holding approved). Despite nearly a century of caselaw, insurers nonetheless face significant coverage concerns and consequences when assessing *Stowers* demands. In this month's issue, we will focus on what it means to be a "reasonably prudent insurer" under the *Stowers* doctrine.

As a brief refresher, an insurer's *Stowers* duty is not triggered by a settlement demand

unless all three of the following prerequisites are met:

1. the claim against the insured is within the scope of coverage,
2. the demand is within the policy limits, and
3. the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment.

See Am. Physicians Ins. Exch. v. Garcia, 876 S.W.2d 842, 848–49 (Tex. 1994). While the determination of what an "ordinarily prudent insurer" is often fact-dependent, there are nonetheless a few key issues that insurers can look out for when assessing the reasonableness of a demand. Although we don't address every issue that insurers should review for, we've provided a few tips and tricks for insurers during the initial review of an alleged *Stowers* demand.

a. Is there a reasonable time to respond to the demand?

Although Texas courts have set no definitive rule for what constitutes a reasonable amount of time, generally speaking, the less time an insurer has to review the demand, the more unreasonable the demand is. Typically, insurers should have at least two weeks to review a *Stowers* demand. However, bear in mind that this will be dependent upon what the insurer knows at the time of the demand. In a recent – and alarming case – a jury found that a *Stowers* demand made at mediation where the insurer had a mere 45 minutes to respond was reasonable, based on the facts known at the time by the insurer. *See Westport Insurance Corporation v. Pennsylvania National Mutual Casualty Insurance Company*, 2023 WL 2574982 (S.D. Tex. 2023).

b. Is there an unconditional offer?

A *Stowers* demand must be unconditional. Any demand that is conditioned on any set of facts, including information requests for excess insurance, may be viewed as conditional. Moreover, any offer that is premised on "facts currently known to date" may be viewed as conditional. Look out for terms like "based on," or "in reliance on." If these terms are in the offer of release, it is very likely that a court in Texas will determine these offers to be conditional.

c. Is there an offer of a complete release?

Insurers should look out for a few issues when reviewing if an offer of release is actually complete. First, if there are medical damages attached to a claim, make sure that the demand proposes to release all hospital liens. Second, if the claim involves multiple claimants, make sure the release includes every single individual claimant as part of the release. The broader the release, the more likely it is to be deemed unreasonable.
While analyzing a *Stowers* demand is always tricky, these are a few quick and easy ways to initially determine if a reasonably prudent insurer would accept the demand.

Cosmetic or Functional Hail Damage? Who Gets to Decide?

by **Paige Tackett**

In *Horton v. Allstate Vehicle & Prop. Ins. Co.* , the Fifth Circuit Court of Appeals addressed whether a district court's exclusion of expert testimony on covered functional damage to a metal roof precluded a fact issue in favor of summary judgment. 2023 WL 7549507, at *1 (5th Cir. Nov. 13, 2023). The Fifth Circuit held that the district court's evidentiary rulings did not exclude the

policyholder's expert testimony on whether his roof damage was cosmetic or functional, which created a triable issue of fact improper for summary judgment.

The facts forming the basis of this lawsuit are not unique: the policyholder reported a claim to Allstate for hail damage to a metal roof. The policy had an exclusion for "[c]osmetic damage caused by hail to the surface of a metal roof . . ." After investigating the loss and determining that the damage was cosmetic in nature, Allstate denied the claim. The policyholder sued for breach of contract.

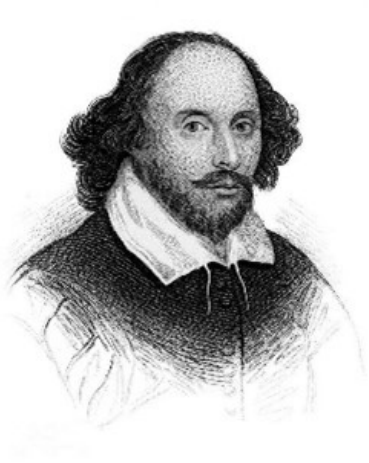
Relevant here, Allstate filed two motions: (1) a motion to exclude the expert testimony of the policyholder's expert witness; and (2) a motion for summary judgment on the application of the cosmetic damage exclusion.

In the motion to exclude, Allstate argued that the expert's report lacked sufficient analysis. The district court barred testifying on several of the topics in the expert report—but *did not* address whether the expert could offer his expert opinion as to the functional roof damage. Notably, Allstate filed the motion to exclude before deposing the expert on his opinions and never amended the motion to include his deposition testimony.

In the summary judgment motion, Allstate did not dispute the existence of hail damage; it argued that the damage to the roof was cosmetic and thus excluded. By contrast, the policyholder argued that there was a disputed question of fact on whether the damage was functional or cosmetic. In doing so, the policyholder cited to his expert's deposition testimony, specifically that photos of the roof showed functional damage to the roof. Even so, the district court ruled in Allstate's favor, holding that the policyholder did not submit any competent summary judgment evidence raising an issue of fact that the damage was not cosmetic.

The Fifth Circuit determined that Allstate did not move to exclude the deposition testimony; therefore, it had not been disputed or otherwise challenged by Allstate. Further, because the district court's exclusionary rulings did not address whether the policyholder's expert could testify that the roof sustained functional damage, the Fifth Circuit found that his deposition testimony constituted competent summary judgment evidence. This testimony was evidence sufficient to create a "battle of the experts," which presented a question of fact for a jury's determination.

To Award Fees, or Not to Award Fees, That is the Question



by **Ashley Pedigo**

Far from the soliloquy given by William Shakespeare's Prince Hamlet ("to be, or not to be, that is the question") courts today are often faced with issues regarding the right to recover attorney's fees for cases that arise under Chapter 542A of the Texas Insurance Code. Courts across the state have grappled with the question of whether proper pre-suit notice was provided, and whether it is appropriate to award (or not to award) attorney's fees to an insured in a claim that is subject to Chapter 542A.

Three recent cases—two out of the Northern District of Texas and one out of the Southern District of Texas—provide additional guidance regarding what does and does not suffice as proper pre-suit notice under Chapter 542A. Although these courts reached different

decisions regarding whether the insured was precluded from recovering attorney's fees, the courts' decisions can be read together to provide some clarity concerning Chapter 542A's pre-suit notice requirement.

Briefly, Chapter 542A of the Texas Insurance Code applies to any first party claim, made by an insured under an insurance policy providing coverage for real property, that arises from damage to or loss of covered property caused by weather-related events. This requirement was implemented to discourage litigation and encourage settlement of consumer complaints by assuring that defendant-insurers have time to assess claims and make a settlement offer, if appropriate.

Pursuant to Section 542A.003, "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." Tex. Ins. Code § 542A.003. The notice must include: (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. *Id.* § 542A.003(b).

If a claimant fails to provide the required pre-suit notice to the defendant-insurer, "the court may not award to the claimant any attorney's fees incurred after the date the defendant files the pleading with the court." *Id. § 542A.007(d).* Thus, the claimant is precluded from receiving its attorney's fees after the date in which the defendant-insurer pleads and proves it did not receive the required pre-suit notice. *See id.*

In ***Brohlin v. Meridian Security Insurance Company***, Magistrate Judge Lee Ann Reno in the Northern District of Texas, Amarillo Division considered whether to grant the insurer's motion to deny the insured's claim for attorney's fees. The facts of this case are not remarkable—it involves a first-party insurance coverage action brought by homeowners against their insurer for hail related damages sustained to their property. In *Brohlin*, the insurer claimed that the insured did not provide proper pre-suit notice under Section 542A prior to filing their lawsuit. The court's analysis did not involve the substance of the pre-suit notice; instead, the court analyzed the exceptions to the pre-suit notice requirement under 542A to determine whether they apply.

There are two enumerated exceptions to 542A's pre-suit notice requirement: "[a] presuit notice … is not required if giving notice is impracticable because: (1) the claimant has a reasonable basis for believing there is insufficient time to give the pre-suit notice before the limitations period will expire; or (2) the action is asserted as a counterclaim." *Id.* § 542A.003(d).

The only argument that the insureds made in this case was that they should not be precluded from recovering attorney's fees because their claim subsequently went to appraisal after suit was filed and the litigation was abated during the appraisal process. The court found this argument unconvincing and noted that nothing that happens after a suit implicating Chapter 542A is filed is relevant to the court's inquiry on whether the claimant can recover attorney's fees for failure to give the required pre-suit notice. Thus, the insurer-defendant's motion was granted, and the Plaintiff was precluded from recovering attorney's fees.

Less than a month after the *Brohlin* ruling, Judge Ed Kinkeade in the Northern District of Texas, Dallas Division, also granted a motion to preclude attorney's fees under 542A. In ***H5R, LLC v. Scottsdale Insurance Company a/k/a Nationwide Insurance*** , the court ruled that the insured was precluded from recovering attorney's fees because its purported

pre-suit notice was insufficient. This case involved water-related damage to the insured's residential property. Prior to filing suit—and before the claim was denied by the insurer—the insured provided the insurer with a cost estimate for the alleged damage. Additionally, the insured had ongoing communications with the insurer, via text messaging, prior to the claim being denied. The insured did not argue that an exception to the pre-suit notice requirement applied. Rather the insured argued that the estimate and text messages sent to the insurer prior to filing suit qualified as pre-suit notice under Chapter 542A. The court disagreed. The court reaffirmed established precedent concluding that estimates submitted prior to an insurer's final denial of coverage cannot operate as pre-suit notice. The court's reasoning was that an estimate could not provide the required pre-suit notice to a claimant's legal claims before those claims even existed. Likewise, the court determined that the text messages sent well before the insurer denied the insured's claim did not effectively provide notice. The court's analysis here involved the substance of the notice itself, which cannot include simply a cost estimate and communications prior to the ultimate claim determination.

Lastly, in **Combs v. Allstate Texas Lloyd's,** Judge Keith Ellison in the Southern District of Texas, Houston Division, denied an insurer's motion to preclude attorney's fees. Like the court's analysis in *H5R*, the *Combs* court looked at the substance of the notice itself to determine whether it met the statutory requirements of 542A. The court in this case, however, ruled that the insured did in fact provide proper pre-suit notice and therefore could recover attorney's fees under Chapter 542A. This claim involved reported wind and hail damage to the insureds' residential property. The insureds timely provided their insurer with a purported pre-suit notice letter prior to filing suit. The letter, however, included language reserving the right to change the specific amount alleged to be owed on the claim, as well as language stating that the insureds would not agree to resolve the dispute for the damages outlined in the letter. The insurer took issue with boilerplate language in the letter and argued that it effectively negated the requirements of Chapter 542A and therefore was not compliant with the statute. The court disagreed. While the court empathized that the intent of the notice requirement is to effectuate settlement of claims, the court concluded that there is no requirement that the claimants include in a pre-suit notice letter the specific amount for which they would resolve the dispute. Furthermore, the court concluded that the statutory language does not mandate that the notice letter contain a fixed and final total dollar sum allegedly owed by the insurer. Therefore, the court denied the insurer's motion to preclude attorney's fees, finding that the pre-suit notice letter met the requirements of Chapter 542A. Interestingly, the *Combs* decision mentions but summarily dismisses the only state appellate court decision on the issue: **re Westchester Surplus Lines Ins. Co., No. 07-22-00329-CV, 2023 WL 4488269 (Tex. App. July 10, 2023).**

In *Westchester*, the insured claimant's counsel sent a letter to all the insurers, which the insured asserted was valid notice under 542A. The letter did not, however, refer to a date of loss or identify each insurers' liability. The letter also alleged that the insurers owed $20 million in actual damages (less any amounts paid and any applicable deductible). The insured then filed suit and the insurers filed pleas in abatement under 542A contending the notice letters did not meet the requirements of 542A. The trial court denied their pleas in abatement and the insurers appealed. The Amarillo Court of Appeals concluded that because the statute requires a claimant to state the "specific amount" owed by the insurer, a claimant could not *generally* allege any amount of money. Instead, the insured must state the specific amount allegedly owed by each insurer for each claim. Thus, the appellate court ruled that it was improper for the claimant to include a suggested estimate or a placeholder sum. What's more, because the insured sent the same demand to different insurers in a suit involving two alleged occurrences occurring a year apart, the court noted that if the claimant intended to recover for both storms, its letters were deficient because they did not provide notice of the amount each insurer owed for each claim and the letters' reference to a lump sum total failed to provide notice regarding the amount owed by each particular insurer. In doing so, the appellate court ruled that the

claimant failed to meet the statutory notice requirements under 542A, which precluded the insured's recovery of attorney's fees.

It appears we may have clarity on the issue soon as the insured in *Westchester* has filed a mandamus action in the Texas Supreme Court, which has ordered the insurance company defendants to file a response brief. Whether the Texas Supreme Court actually accepts the case for review remains to be seen. Should the Texas Supreme Court accept the case, it will likely provide clarity as to the meaning of the language in section 542A.003(b)(2) requiring the claimant to state "the specific amount alleged to be owed by the insurer on the claim for damage to or loss of covered property." We believe that the Texas Supreme Court will interpret the statute consistent with the conclusion of the Amarillo Court of Appeals— that the phrase "the specific amount alleged to be owed" means just that, that the specific amount alleged to be owed must be stated.

In the meantime, these cases serve as additional clarification regarding what qualifies as proper pre-suit notice under Chapter 542A of the Texas Insurance Code so policyholders and insurers alike can better answer the question: to award fees or not to award fees.

Insurer Did Not Breach Flood Insurance Policy Despite Insured's Claim of Nonreceipt of Renewal Notice

by **Crystal L. Vogt**

A magistrate judge for the Southern District of Texas recently ruled that an insurer did not breach its flood insurance policy by failing to renew coverage where the insured did not timely submit the premium for the renewal policy, despite a policy renewal section allowing for renewal in certain circumstances. In *Langston v. American Nat'l Property and Casualty Co.* , Magistrate Judge Andrew Edison granted summary judgment in favor of American National Property and Casualty Company ("American National") on an insured's claims for breach of contract, declaratory judgment, and violations of the Texas Deceptive Trade Practices Act. See *Langston v. Am. Nat'l Prop. & Cas. Co.*, No. 3:22-CV-00126, 2023 WL 8238178, at *1 (S.D. Tex. Nov. 28, 2023). American National mailed a Renewal Notice to the insured at the address of the insured property approximately two months prior to the policy's expiration. The day after the expiration of the policy, American National mailed a Flood Insurance Expiration Notice to the insured advising that the insured had thirty days to submit a renewal payment. The insured did not submit a payment and, therefore, the policy expired due to non-payment of the premium. Approximately eight months later, the insured's agent requested that the policy be renewed, stating that the insured did not receive the renewal or expiration notices. American National refused to renew the policy, and the insured instituted a lawsuit.

The insured argued that the policy's provision allowing for renewal of the policy up to one year after the premium due date in the event of American National's failure to mail the renewal notice or a mistake in the mailing of the renewal notice required American National to renew his policy. However, the Court found that American National's summary judgment evidence established that the Renewal Notice was timely mailed to the insured at his home. The magistrate found that even if it were true that the insured did not receive the Renewal Notice in the mail, it was immaterial. "Under the unambiguous terms of the policy, ANPAC was required to mail the Renewal Notice to Langston…The policy does not require that [the insured] actually receive the Renewal Notice."*Id.* at *3. In reaching this holding, the magistrate further stated that "[i]t is well established that 'the provisions of an insurance policy issued pursuant to a federal program must be strictly construed and enforced."*Id.* The Court also dismissed the insured's remaining claims. This case is a good reminder to all insurers to carefully document the issuance of all correspondence regarding premiums and cancellations. In the event of a lawsuit, the ability to set forth the actions taken as part of the cancellation or nonrenewal process in detail may be the key to an early resolution.

Spotlight:

For over twenty years, the attorneys in Zelle's Dallas office have taken photos together in different locations all around Dallas. We try to find new and creative spots each year to help our clients get the quintessential Dallas experience. This year, we chartered a trolley at Uptown Station. Happy Holidays!

Reach out to Zelle LLP if your organization would benefit from a presentation, class, discussion, or seminar from one of our attorneys.

Contact Us!

Thank you for reading this issue of The Zelle Lonestar Lowdown!

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The Lonestar Lowdown All Issues

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