ANNUAL SURVEY OF TEXAS INSURANCE LAW 2020

By Suzette E. Selden,* Jonathan D. Selden,** & Dennis L. Grebe***

I. INTRODUCTION

2020 is definitely a year we will all remember. There were not as many Texas court opinions as usual, as attorneys, clients, courts, and staff figured out how to navigate the new normal during this global pandemic caused by COVID-19.

In 2021, we will likely see a large number of business interruption insurance cases decided after COVID-19 shut down numerous businesses for an extended period of time. Many of these cases are currently underway, with just a few reported opinions. One federal district court held a "virus" did not fall under the "forces of nature" provision in Texas Insurance Code Chapter 542A and remanded the case to state court, holding the insurer could not accept liability for the adjuster to defeat diversity jurisdiction.[1] This gives us a glimpse of where these business interruption cases may be decided.

Additionally, courts continue to analyze Texas Insurance Code section 542A.006(a), reviewing the proper timing for an insurer to elect to accept potential liability for its adjuster, and determining when it will allow the insurer to remove the case to federal court asserting diversity jurisdiction.[2]

The Texas Supreme Court reversed and remanded several cases in light of its holdings in *Barbara Technologies Corporation v. State Farm Lloyds*, 589 S.W.3d 806 (Tex. 2019) and *Ortiz v. State Farm Lloyds*, 589 S.W.3d 127 (Tex. 2019), enforcing its holding that an insured has a right to damages under the Texas Prompt Payment of Claims Act even after an appraisal award is paid.[3]

A worker's compensation case decided by the Texas Supreme Court found a deputy sheriff killed when driving home from an extra-duty assignment with a private employer was in the course and scope of his employment while driving his patrol car.[4] Similarly, the Texas Supreme Court found the intentional-injury exception to the Texas Workers' Compensation Act did not apply to an egregious act by an employer that resulted in the death of an employee.[5]

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II. FIRST PARTY INSURANCE POLICIES & PROVISIONS

A. Automobile

The San Antonio Court of Appeals took the unusual step of creating a new tort claim against insurance companies while reversing itself after en banc reconsideration of its 2019 opinion in *Kenyon v. Elephant Insurance Company, L.L.C.*, No. 04-18-00131-CV, 2019 WL 1779933 (Tex. App.—San Antonio April 24, 2019, pet. filed). The case concerns the tragic circumstances and novel legal arguments of a widow whose husband was killed while he took pictures of her one-car collision after their auto insurer instructed her to "go ahead and take pictures." Evidence showed the insurer trained its "first notice of loss" (FNOL) employees to ask insureds to take pictures at collision scenes "'on every FNOL call, every time,'" even though a police officer testified "'we have more issues with people getting out of cars to [take pictures of] crash scenes than anything else.'" The insured sued her insurance company for negligence, among other things, and the insurer moved for summary judgment, arguing "an insurance company owes no duty to protect its insureds' physical safety." The trial court granted summary judgment to the insurer, but permitted interlocutory appeal on the insured's negligence claims. A three-judge panel originally sided with the trial court, refusing to create a new duty of care for insurers. But, after the insured moved for and the court ordered en banc reconsideration, the court withdrew its prior opinion and substituted a new one holding the exact opposite—that there was indeed a fact issue whether the insurer owed a legal duty of care to its insured. "Because [the insurer] instructed [the insured] to take pictures to process [the insured's] insurance claim, the special relationship duty that applies in claims processing 'extends' to or 'implicates' the instruction to take pictures." The court also reversed itself and the trial court's dismissal of the insured's negligent undertaking, negligent training, and gross negligence claims, holding there was a fact issue "whether [the insurer's] investigative request—instructing [its insured] to take pictures—and the manner in which it provided roadside assistance increased the risk of harm." The insurer has filed a petition for review with the Texas Supreme Court complaining the decision "created a new extra-contractual cause of action against insurance companies." *Kenyon v. Elephant Ins. Co.*, L.L.C., No. 04-18-00131-CV, 2020 WL 1540392 (Tex. App.—San Antonio April 1, 2020, pet. filed).

B. Commercial Property

The insurer issued a property insurance policy to a business that travels to ports to inspect barges and the policy provided coverage for business interruption and real estate. The relevant clause stated, "coverage for earnings and/or extra expense is extended to loss of earning or extra expenses that 'you' incur during the 'restoration period' when 'your' 'business' is interrupted by direct physical loss or damage, caused by a covered peril, to property at a 'dependent location' described on the schedule." The policy also provided coverage for interruption by order of civil authority if the order is a "result of direct physical loss of or damage to property, other than at a 'covered location' and must be caused by a covered peril." After a hurricane, although the insured property did not sustain damage, the insured brought a claim for business interruption and extra expense incurred as a result of port closures. Insurer denied the claim explaining that there was no loss as a result of denial of access by an order of civil authority as a result of physical loss or damage. Both parties moved for summary judgment on the issue of coverage. The court noted the general rule for civil authority coverage to apply is in cases where access to the insured's property is prevented by order of civil authority as a direct result of physical damage to other premises close to the insured's property. However, in this case, the civil authority order was not issued as a result of direct physical loss to any property. The port closures occurred before the hurricane made landfall or had done damage. Because the port closures were not made "as a result of direct physical loss of or damage to property," the court held the insured's claim was not covered under the policy. Therefore, the court granted summary judgment in favor of the insurer. *Evanston Ins. Co. v. Amspec Holding Corp.*, No. 4:19-CV-1498, 2020 WL 6152190 (S.D. Tex. Oct. 20, 2020).

The developer of a commercial building hired a general contractor to build a building. The general contractor hired a subcontractor for the erection of the structural steel. The developer purchased a commercial inland policy that included builder's risk insurance as the general contractor required, and the general contractor was an additional insured on the policy. The structural steel subcontractor installed a metal plate that fell down the side of the building damaging exterior glass windows on lower floors. A claim was submitted to the insurer for the damage. The insurer denied the claim explaining the loss was excluded. The contractors replaced the windows themselves at a cost of almost $700,000, and sued the insurer for breach of contract and violations of the Texas Insurance Code. The district court found in favor of the insurer, granting its motion for summary judgment. The parties agreed that the claim fell within the policy exclusion because it resulted from an act of construction, workmanship, or installation. The issue was whether an exception to the exclusion applied. The exception states, "[I]f an act, defect, error, or omission as described above resulted in a covered peril, 'we' do cover the loss or damage caused by that covered peril." This is an ensuing loss clause. The Fifth Circuit upheld summary judgment in favor of the insurer holding that an "ensuing loss provision like the one presented here is only triggered when one (excluded) peril results in a distinct (covered) peril." The court stated in this case the welding operation involved falling slag which damaged the exterior glass, and stated the falling slag was not an independent event that resulted in a covered peril. Moreover, the court said even if the falling slag was separable from the welding operation, it is not a "covered peril" under the policy. Therefore, the Fifth Circuit held the policy does not provide coverage for the claim, and affirmed summary judgment in favor of the insurer. *Balfour Beatty Constr. v. Liberty Mut. Fire Ins.*, 968 F.3d 504 (5th Cir. 2020).

III. FIRST PARTY THEORIES OF LIABILITY

A. Breach of Contract

During a hurricane, a tree fell on insureds' house and damaged the roof, home, fence, and shed. The adjuster provided a check to cover various repairs; however, he did not provide compensation for interior damage. Further, the insureds did not receive a written explanation for the insurer's denial of their claim for interior damage.

During the breach of contract claim, a dispute arose whether the insureds failed to comply with their insurance policy. The jury found insureds failed to comply with the insurance policy, and the insurer moved for judgment in its favor on the extra-contractual claims based on the theory that the claims did not survive as insureds did not prevail on their contract claims. Insureds asked the trial court to disregard the jury findings that they failed to comply with the policy. In its final judgment, the trial court disregarded the jury's answer to the questions regarding insureds' compliance with the policy, and rendered judgment in the insureds' favor.

The appellate court explained the jury findings not challenged by the insurer indicate there was no breach by the insureds with regard to notice, documentation of their claim, or that such breach was excused. Further, the court noted the record did not reflect evidence that any breach detrimentally affected the insurer's rights and/or obligation under the policy. To support the insurer's affirmative defense of prior material breach, there had to be evidence that the insurer would have been in a better position had the insureds complied with the policy. The court explained because there was not legally-sufficient evidence to support the jury's answers to questions regarding compliance with the policy by the insureds, and the questions were immaterial and should not have been submitted, the trial court did not err by disregarding these findings. As such, the insureds prevailed on their breach of contact claim.

Next, the court went through the rules promulgated by *USAA Texas Lloyds Company v. Menchaca*, 545 S.W.3d 479 (Tex. 2018) and highlighted mental anguish damages are available as damages for an independent injury. Therefore, the court upheld the insureds' $27,000 award for their mental-anguish damages as it met the independent-injury rule. *State Farm Lloyds v. Fuentes*, 597 S.W.3d 925 (Tex. App.—Houston [14th Dist.] 2020, no pet.).

B. Prompt Payment of Claims – Article 21.55

An insured's property was damaged during a hail storm. The insurer denied the claim after inspecting the property stating the damage was less than the deductible. The insured asked for an appraisal after the insurer did a second inspection and still held the damage was less than the deductible. However, the insurer refused, saying it was the only one that could invoke the appraisal process. The insured sued alleging breach of contract, bad faith and violations of the Texas Prompt Payment of Claims Act (TPPCA). Over eight months later, the insurer invoked the appraisal process where the loss was set at $168,808, well above the deductible. The insurer then paid the appraisal award, and both parties filed summary judgment motions. The court granted summary judgment in favor of the insurer. The appellate court affirmed holding that the insured's bad faith and prompt payment claims failed because it did not allege an injury independent from the policy benefits and did not demonstrate policy benefits were withheld after the appraisal award was paid. The Texas Supreme Court reversed the appellate court and remanded the case to the trial court to consider in light of *Barbara Technologies Corporation v. State Farm Lloyds,* 589 S.W.3d 806 (Tex. 2019) (insurer's payment of appraisal value does not foreclose TPPCA damages under Tex. Ins. Code § 542.060). Additionally, the Texas Supreme Court noted that although the appellate court's holding regarding breach of contract and bad faith violations comported with *Ortiz v. State Farm Lloyds,* 589 S.W.3d 127 (Tex. 2019), *Ortiz* did not have a unilateral appraisal clause. Therefore, the Court said it had not considered whether payment of an appraisal award under a unilateral clause would have the same effect as to these claims. *Biasatti v. Guideone Nat'l Ins. Co.*, 601 S.W.3d 792 (Tex. 2020).

The court remanded the case to the trial court to consider the insured's prompt payment claims because "payment in accordance with an appraisal is neither an acknowledgment of liability nor a determination of liability."

The Texas Supreme Court reversed an appellate court decision that an insured's extra-contractual claims under the Texas Prompt Payment of Claims Act were barred as a matter of law because the insurer paid a full appraisal award. Citing its one-year-old precedents in *Barbara Technologies Corporation* and *Ortiz*, the court remanded the case to the trial court to

consider the insured's prompt payment claims because "payment in accordance with an appraisal is neither an acknowledgment of liability nor a determination of liability," *Barbara Technologies Corporation* at 820, and "an insurer's payment of an appraisal award does not as a matter of law bar an insured's claims under the Prompt Payment Act." *Ortiz* at 135. *Perry v. United Servs. Auto. Ass'n*, 602 S.W.3d 915 (Tex. 2020).

C. Automobile liability insurance

Insureds involved in a car accident sought damages under their employer's UM/UIM policy with Great American Insurance Company after receiving permission from the insurer to settle any claims against the tortfeasor for policy limits. The policy outlined that "coverage shall not apply directly or indirectly to benefit…[a]ny insurer or self-insurer under any workers' compensation, disability, or similar law." Great American requested the insureds provide copies of their medical records to the workers' compensation insurance carrier, Texas Mutual Insurance Company. Further, Great American requested the insureds provide a letter of rejection from Texas Mutual before Great American would issue payment.

Following suit, Great American sought abatement so that insureds could seek reimbursement from Texas Mutual and provide proof, such that the condition precedent to Great American's contractual obligations was met. The court granted the motion and abated the case for sixty days to allow insureds an opportunity to obtain a final determination from Texas Mutual on workers' compensation benefits.

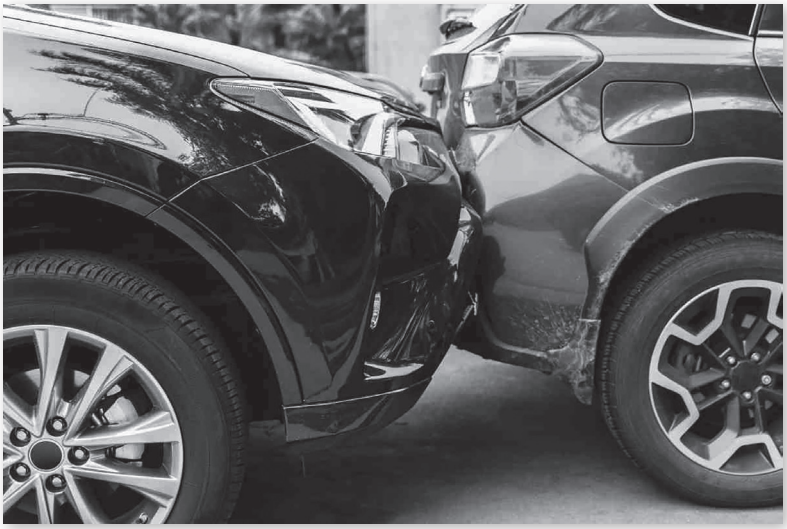
Four months later, Great American filed a motion for summary judgment. In granting the motion, the court highlighted Great American is not yet obligated to pay because it must first receive proof there is no coverage available under a workers' compensation policy, a condition precedent to its obligation to pay. Great American argued it had never denied UM/UIM coverage, but was merely waiting on insureds to provide information with respect to Texas Mutual's coverage decisions.

In granting the motion for summary judgment, the court highlighted Great American met its burden to provide the applicability of an exclusion permitting it to deny coverage, where payments could be made by a workers' compensation carrier. As such, the burden shifts back to insureds to prove that the exclusion does not apply. Despite the abatement, insureds failed to obtain the necessary evidence that Texas Mutual was denying workers' compensation benefits. Therefore, insureds had no evidence that the exclusion did not apply, so summary judgment was appropriate. *Sanchez v. Great Am. Ins. Co.*, No. SA-18-CV-804-XR, 2020 WL 2086552 (W.D. Tex. April 29, 2020).

I. DUTIES OF LIABILITY INSURERS

A. Duty to defend

A child died in an ATV accident at his paternal grandparent's house. The child's mother sued the grandparents who looked to their homeowner's insurer for a defense. The insurer refused and the court granted a declaration that the insurer did not have a duty to defend its insured. The Fifth Circuit reversed and remanded, noting Texas' well-established eight corners rule, which states an insurer's "duty to defend is determined by the claims alleged in the petition and the coverage provided in the policy." The appellant did allege facts that possibly implicated coverage under the policy. The Fifth Circuit sent a certified question to the Supreme Court of Texas asking, "Is the policy-language exception to the eight-corners rule articulated in *B. Hall*



Contracting Inc. v. Evanston Ins. Co., 447 F. Supp. 2d 634 (N.D. Tex. 2006), a permissible exception under Texas law?" The Texas Supreme Court answered, "The 'policy-language exception' to the eight-corners rule … is not a permissible exception under Texas law." Therefore, the lower district court erred in applying the policy-language exception, as no allegations of collusive fraud by the insured were alleged. The insurer attempted to prove that exceptions to coverage applied but could only do this by using extrinsic evidence outside of the allegations in the petition. This is not allowed under the eight-corners rule. Therefore, the Fifth Circuit reversed the district court's ruling that the insurer did not have a duty to defend or indemnify the grandparents. *State Farm Lloyds v. Richards,* 966 F.3d 389 (5th Cir. 2020).

An insured's husband was explicitly excluded from coverage under his wife's car insurance policy. The husband was in an accident while moving his wife's car, and he, his wife, and the injured party all agreed to tell the police officer that the wife was driving the car at the time of the accident. The insured wife disclosed the lie to her attorney provided by her insurance company. The insurer responded by withdrawing its defense and coverage. The trial court awarded a large sum to the injured party, and the insured wife assigned her rights against her insurer to the injured party. In the suit against the insurer, the trial court granted summary judgment in favor of the insurer remarking that the injured party was asking the court to perpetuate fraud. The appeals court reversed holding that "as logically contrary as it may seem," the insurer had a duty to defend under the eight corners rule. However, the Texas Supreme Court held that in this case an exception to the eight corners rule applied stating, "an insurer owes no duty to defend when there is conclusive evidence that groundless, false or fraudulent claims against the insured have been manipulated by the insured's own hands in order to secure a defense and coverage where they would not otherwise exist." Moreover, the court stated a summary judgment was a proper course of action for the insurer to have the court decide regarding duty to defend, and said an insurer faced with undisputed evidence of collusive fraud should not be required to pursue a declaratory judgment action before withdrawing its defense. Therefore, the Texas Supreme Court reversed the appellate court's decision and reinstated the trial court's summary judgment in favor of the insurer. *Loya Ins. Co. v. Avalos*, No. 18-0837, 2020 WL 2089752 (Tex. May 1, 2020).

B. Breach of policy condition by insured

The Fourteenth Court of Appeals continued Texas' hardline rule that a third-party beneficiary of an insurance policy cannot give an insurer actual notice of a pending lawsuit. The

third-party beneficiary, a woman and her two minor children, notified the insurer when she sued and served its insured and sent it a courtesy-copy of her subsequent motion for default judgment. After judgment, she sued the insurer, and it moved for summary judgment because its insured did not notify it about the lawsuit or request a defense. The trial court granted summary judgment in favor of the insurer, and the third-party beneficiary appealed. Citing the Texas Supreme Court's earlier decision in *National Union Fire Company of Pittsburgh, PA v. Crocker*, 246 S.W.3d 603 (Tex. 2008), the court found an insurer is prejudiced as a matter of law when its insured fails to notify it of a lawsuit or request a defense. This is because, as outlined in *Crocker*, the notice provision serves two purposes: (1) to notify the insurer of the suit *and* (2) to "inform the insurer that an insured expects the insurer to provide a defense." Regardless of whether the third-party beneficiary "step[ped] into the shoes" of the insured, she could not get around the insured's failure to comply with the policy's notice provision. "[T]he consequences of the insured's failure to request a defense," it held, "is binding on the third-party beneficiary." Therefore, the appellate court affirmed the trial court's ruling. *Lewis v. ACCC Ins. Co.*, No. 14-19-00197, 2020 WL 4461338 (Tex. App.—Houston [14th Dist.] Aug. 4, 2020, pet. filed).

This case dealt with another third-party beneficiary who attempted to get around the strict notice requirements of a claims-made-and-reported insurance policy. The claimant, the winner of a default judgment against a bankrupt hospital for employment discrimination, alleged contractual, Texas Insurance Code, and conspiracy claims against the hospital's insurer after it denied coverage because the hospital did not report the claim within the policy reporting period. The court dismissed the claimant's summary judgment evidence that the insurer was somehow aware of the claim during the reporting period as "mere suspicion." The claimant also argued the hospital's bankruptcy stayed the notice provision, but the court roundly noted the stay did not "stop the passage of time" and had nothing to do with the reporting period. The court reiterated the Texas Supreme Court's holding in *Prodigy Communications Corporation v. Agricultural Excess & Surplus Insurance Company*, 288 S.W.3d 374 (Tex. 2009), that a showing of prejudice was not required for claims-made-and-reported policies if notice is given after the reporting period (prejudice required for insurer to deny coverage for failing to give notice "'as soon as practicable'"). Having rejected all his other arguments, the court denied the claimant's conspiracy allegation as a derivative claim that failed with the others. *Valentine v. Fed. Ins. Co.*, No. 14-18-00438-CV,
2020 WL 1467352 (Tex. App.—Houston [14th Dist.] March 26, 2020, pet. filed).

The Fifth Circuit reversed a trial court's grant of summary judgment to an insurer who denied coverage because its insured did not report a claim to the proper department. In what will offend kindergarten teachers everywhere, the court's reasoning hinged on the insurer's use of the "precatory ('please')" rather than the "mandatory ('shall')" in its "Notice of Claim" provision in its policy. This courtesy, the court said, permitted the insured to give notice in a policy renewal application supplement to the insurer's underwriting department rather than to its claims department as specified in the policy. Therefore, the court said, the insurer's "direction of notice to the claims department cannot be considered a material condition" and it could only deny coverage if it could show it was prejudiced. Because the trial court did not reach that issue, the court remanded for further proceedings. *Landmark Am. Ins. Co. v. Lonergan Law Firm, P.L.L.C.*, 809 Fed. Appx. 239 (5th Cir. 2020).

IV. PRACTICE & PROCEDURE

A. Parties

A man was struck by a pipe and sustained fatal injuries while working at a business. An insurer provided workers' compensation and employer liability insurance coverage for the business. The insurer asserted the deceased was an employee of the business, so the man's beneficiaries were entitled to death income benefits and the employer was entitled to the exclusive remedy provision in the Texas Workers'Compensation Act. The deceased's beneficiaries argued he was an independent contractor and the exclusive remedy did not apply. At a contested case hearing at the Division of Workers' Compensation, the deceased was determined to be an independent contractor. Therefore, his beneficiaries were not entitled to death income benefits. The insurer sought judicial review of the decision in order to establish the deceased was an employee; therefore, the exclusive remedy provision applied. The beneficiaries moved to dismiss the insurer's request for lack of statutory standing. The district court converted the motion to dismiss into a motion for summary judgment and granted it in favor of the beneficiaries, and the insurer appealed. The insurer argued that it is aggrieved and has standing to seek judicial review of an adverse workers' compensation decision that it is not liable for workers' compensation benefits. The beneficiaries argued that the insurer's aggrievement argument was premised on a nonexistent injury or loss. The insurer asserted it was aggrieved because it may have to reimburse some workers' compensation premiums to the business in the future. However, Texas courts have said that "…[a] possible future injury or loss as a consequence of a panel decision is not sufficient to show aggrievement." The Fifth Circuit dismissed the appeal stating the insurer did not have standing to seek judicial review as it was not liable for workers' compensation benefits, and had not refunded any premiums nor paid any benefits. Moreover, the court noted the insurer could not establish that any such possible future injury would result from the final decision. *Sentinel Ins. Co. v. Ortiz*, 802 F. App'x 864 (5th Cir. 2020).

B. Jurisdiction

The Texas Supreme Court reversed an appellate court and dismissed an insured's claim of standing after his personal injury protection (PIP) insurer paid him the reduced rates negotiated by his health insurance company rather than his medical provider's full billed charges. Relying on the court's 2006 decision in *Allstate Indemnity Company v. Forth*, 204 S.W.3d 795 (Tex. 2006) illuminated by its landmark 2011 holding in *Haygood v. De Escabedo*, 356 S.W.3d 390 (Tex. 2011), the supreme court held the plaintiff lacked standing because he "failed to allege an actual or threatened injury." Like in *Forth*, the court said the insured did not have any "unreimbursed, out-of-pocket medical expenses" after his health insurer's negotiated adjustments and payments to his medical providers. Unlike in *Forth*, it said it did not matter the insured was seeking only money damages rather than injunctive relief because the "standing question in both cases is exactly the same: Did the litigant plead an injury sufficient to invoke the trial court's jurisdiction? The answer to this question should be the same in both cases, notwithstanding the difference in the relief sought." The court stiff-armed the insured's collateral source arguments because, like in *Escabedo*, it said the insured's health insurer's adjustments were not a collateral source of benefits. *Farmers Tex. Cnty. Mut. Ins. Co. v. Beasley*, 598 S.W.3d 237 (Tex. 2020).

This insurance dispute occurred due to state and local orders requiring the closure of certain businesses during the COVID-19 pandemic. The insureds owned several restaurants and had purchased business insurance for the restaurants. As a

result of the shelter-in-place orders and closure of all "nonessential" businesses by the state, the insured sustained heavy income losses. The restaurants were limited to take-out or delivery services under these orders. After reporting a business interruption claim to its insurer, an adjuster investigated and denied the claim. The insurer stated the loss was not covered because the policy contained exclusions for losses caused by a virus and there was no showing of direct physical loss or damage to property. Insured filed suit against the insurer and adjuster in state court. The insurer elected under Texas Insurance Code section 542A.006(a) that it was accepting any potential liability for the adjuster, and then removed the case to federal court asserting diversity jurisdiction. The insured moved to remand the case to state court arguing Chapter 542A of the Texas Insurance Code did not apply to its claim, as that section limits its coverage to weather events. The Chapter defines "claim" as "a first party claim that 'arises from damage to or loss of covered property caused, wholly or partly, by forces of nature, including an earthquake or earth tremor, a wildfire, a flood, a tornado, lightning, a hurricane, hail, wind, a snowstorm, or a rainstorm.'" Tex. Ins. Code § 542A.001(2)(c). The insurer argued "forces of nature" is not limited to weather and could include "acts of God" which is defined in the dictionary as forces so unexpected that no human skill could reasonably be expected to anticipate it. The court disagreed and stated a virus is not a "force of nature," especially when used in a list of items only involving weather and not diseases. Insurer then argued the adjuster was improperly joined because the claims the insured made against him under Chapter 541 and 542 of the Texas Insurance Code regulate the conduct of the insurer, not an adjuster. The court again disagreed holding the insureds' claims against the adjuster of improper investigation and misrepresentations do apply to insurance adjusters, not just the insurer. Therefore, the court remanded the case to state court holding that Chapter 542A of the Texas Insurance Code did not apply, the adjuster was properly joined and diversity jurisdiction did not exist. *Jada Rest. Grp., L.L.C. v. Acadia Ins. Co.*, No. SA-20-CV-00807-XR, 2020 WL 5362071 (W.D. Tex. Sept. 8, 2020).

Insured's property was damaged in a hailstorm, and he submitted a claim to his insurer. Insurer assigned adjuster to the claim, which was then denied. Insured had property re-inspected and submitted additional evidence to insurer and adjuster, neither of which responded. Then insured filed suit for violations of the Texas Insurance Code and the Texas Deceptive Trade Practices-Consumer Protection Act against insurer and adjuster in state court. Insurer then filed its Texas Insurance Code section 542A.006(a) election of responsibility for its adjuster in state court, and removed the case to federal district court. The insurer refiled before the state court acknowledged the election and dismissed the adjuster from the case. The federal district court was concerned about the effect of the timing of the election on the court's subject matter jurisdiction and ordered the insurer to "show cause for why this case should not be remanded to state court." The court analyzed cases holding both ways on this issue and sided with the majority view holding that, "an election alone does not render the non-diverse Defendant improperly joined when the election is made after an action is brought." Moreover, in this case the non-diverse defendant was not dismissed by the state court prior to removal. Therefore, the federal district court lacked subject-matter jurisdiction and remanded the case to state court. *Stowell v. United Prop. & Cas. Ins. Co.*, No. 3:20-CV-0527-B, 2020 WL 3270709 (N.D. Tex. June 16, 2020) (mem. op.).

Two insurance claims were made for hail damage to commercial properties, the Pera Property and Maxwell property. The insurer provided two different claim numbers for the separate losses. The insurer hired an adjuster for the claim, who in turn hired an engineer to inspect the Pera Property. The retained engineer determined there was no wind or hail damage to the Pera Property. Therefore, the claim was denied. Insureds retained their own expert who determined damages were in excess of $500,000. Insureds sent separate demands for the two properties. Subsequently, the insurer sent a letter to insureds, pursuant to Section 542A.006(a) of the Texas Insurance Code, to serve as a notice of its election to accept its adjuster's liability, if any. Insureds brought suit in state court against the insurer and its adjuster for alleged insurance code violations. Following suit, the insurer removed the action to federal court based on diversity jurisdiction. The insurer argued the adjuster was improperly joined because it previously sent a letter to accept his negligence, if any. Therefore, the insurer requested the federal court to assume jurisdiction and dismiss the adjuster.

The insurer stated the loss was not covered because the policy contained exclusions for losses caused by a virus and there was no showing of direct physical loss or damage to property.

Insureds argued the letter sent to them had several errors with respect to property name, claim number, and date of expert report. The insurer argued the letter provided adequate notice despite typographical oversights. The court highlighted the plain language of Section 542A.006(a) suggesting that an insurer's election of its agent's liability is effective as to a specific claim. The court determined there was an ambiguity in the letter as to whether the election of liability was made for the Pera Claim or the Maxwell claim; therefore, remand was appropriate. The insurer argued remand was unnecessary, as it would adopt the adjuster's liability and render the case removable again. Therefore, remand would only delay litigation. The court explained there is a split among courts in this circuit over the effect a Section 542A.006(a) election's timing has on the improper joinder analysis. One line holds that an election made after a lawsuit commences but before removal renders the adjuster improperly joined. However, the majority view concludes that the touchstone of the improper joinder inquiry focuses on whether the parties were improperly joined at the time of joinder. Therefore, the court remanded the case noting that a post-lawsuit election does not by itself establish improper joinder. *Project Vida v. Phila. Indem. Ins. Co.,* No. EP-20-CV-00082-DCG, 2020 WL 2220193 (W.D. Tex. May 7, 2020) (slip op.).

CBX Resources, L.L.C. v. ACE American Insurance Company, 959 F.3d 175 (5th Cir. 2020) deals with the "finality trap" involving claims non-suited without prejudice. Initially, CBX brought suit against Espada Operating, L.L.C. An insurer defended Espada at the outset of the litigation, but ultimately withdrew its defense. CBX obtained a default judgment against Espada, who in turn assigned its claims against its insurer to CBX. CBX lost a declaratory judgment that the insurer had a duty to defend, which negated elements of its claim. Therefore, CBX dismissed its Texas Insurance Code claims without prejudice and brought an appeal. As these claims were not resolved on

the merits, CBX could bring a later suit on the same cause of action. The court dismissed the appeal for lack of jurisdiction as there is not yet a final appealable judgment. The court reiterated there is not an appealable final judgment when some claims are dismissed without prejudice. Parties can pursue a Rule 54(b) partial summary judgment in an attempt to create a final appealable judgment. The court explained CBX apparently was hoping to reverse the district court's "no duty to defend" decision which was an attempt to obtain a quasi-interlocutory appeal. Allowing these appeals would allow plaintiff to "have his cake (the ability to refile the claims voluntarily dismissed) and eat it too (getting an early appellate bite at reversing the claims dismissed involuntarily)." The court also rejected CBX's argument that the district judge made clear his intention that an appeal of his ruling be available immediately. In order to succeed, CBX would have to demonstrate unmistakable intent in the judgment itself or in the document the judgment references. As there was no unmistakable intent in the judgment, the court dismissed the appeal as it did not have jurisdiction.

C. Pleadings

Insureds sued their homeowner's insurer after it denied their claim for windstorm damage to their home. The court granted summary judgment in favor of the insurer on several causes of action but allowed the insured's breach of contract claim to be presented to the jury, which granted a verdict in favor of insureds. The insureds sought attorney's fees and statutory interest of 18 percent, but the district court after originally granting this relief ruled that the failure of the insureds to specifically plead relief under Texas Insurance Code section 542.060, the Texas Prompt Payment of Claims Act, barred the requested relief. The court reversed its previous ruling stating it was following a recent decision in *Chavez v. State Farm* Lloyds, 746 F. App'x 337 (5th Cir. 2018) which concluded that because the "bad faith insurance code claims had been properly dismissed by the district court, Chavez could not recover under [section] 542.060." Applying *Chavez*, the trial court only awarded the amount of the breach of contract damages awarded by the jury along with pre-judgment and post-judgment interest. The insureds appealed. The insured's pleading asked for an '"18% [p]enalty [i]nterest pursuant to Ch. 542 of the Texas Insurance Code'" and "'[a]ttorney's fees.'" The Fifth Circuit noted the only relevant statute entitling an insured to 18% penalty is section 542.060 of the Texas Insurance Code. While the pleading could have been more detailed, the court said the *Twombly/Iqbal* "plausibility" standard does not require magic words. *See Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009); *Bell Atl. Corp. v. Twombly*, 550 U.S. 544 (2007). Moreover, the court stated the insurer was not surprised by the insured's request. As to the question *Chavez* addressed of whether a violation of the bad faith provisions of the Texas Insurance Code is a necessary prerequisite to section 542.060 relief, the Fifth Circuit looked to a recent Texas Supreme Court decision holding, "'[n]othing in the TPPCA would excuse an insurer from liability for TPPCA damages if it was liable under the terms of the policy but delayed payment beyond the applicable statutory deadline[.]'" *Barbara Techs. Corp. v. State Farm Lloyds*, 589 S.W.3d 806 (Tex. 2019). Following recent case law, the Fifth Circuit held it is not necessary for the insured to prove the insurer acted wrongfully or in bad faith. Therefore, the Fifth Circuit held that the district court was wrong in holding that *Chavez* barred the insureds' claims for the 18% penalty and attorney's fees under Chapter 542, reversing the lower court's ruling and remanding for a new judgment. *Agredano v. State Farm Lloyds*, No. 5:15-CV-1067 (5th Cir. Sept. 16, 2020).

D. Discovery

An insured injured in a car accident sued her insurer to recover her uninsured motorist benefits after settling with the party that caused the accident. The insured sought to take the deposition of the insurer's corporate representative on nine topics. The trial court ordered the insurer to produce its corporate representative for deposition. The insurer filed a writ of mandamus contending the trial court abused its discretion because the relevant issues were not within the insurer's personal knowledge and producing a corporate representative would be unduly burdensome. The appellate court held that the insurer did not agree to the amount of damages at issue or that the other driver had deficient coverage. Because the amount of damages was in dispute, the court of appeals concluded the trial court did not abuse its discretion by granting the insured's motion to compel the deposition of the insurer's corporate representative. However, the appellate court did limit the deposition to matters relevant to damages and the insurer's defenses in the pending lawsuit, noting that certain topics such as information regarding the nature of the insured's injuries were not appropriate for the deposition of an insurer's corporate representative. *In re Garrison Prop. & Cas. Ins. Co.*, No. 12-20-00190-CV, 2020 WL 6164982 (Tex. App.—Tyler Oct. 21, 2020, no pet. h.).

An appellate court held a tort claimant was entitled to discovery from a liability carrier as a third-party beneficiary even though he had not established its insured gave the insurer notice of suit under the policy. The third-party beneficiary had sued and obtained a default judgment against the tortfeasor, who did not appear or answer the suit even though he had liability insurance coverage. By coincidence, the third-party beneficiary also had an uninsured or underinsured motorist (UM/UIM) policy with the same insurer. The third-party beneficiary sued the insurer as third-party beneficiary of the liability policy and said he was "not seeking UM/UIM benefits" and did not plead them. Nonetheless, he sought discovery from the insurer about both the liability coverage and his own UM/UIM coverage because, he said, the "UM/UIM representative may have information regarding the status of the liability coverage." The trial court denied the insurer's motion to quash and for protective order, and the insurer sought mandamus relief. The appellate court granted the insurer relief from the UM/UIM discovery requests, but let stand the requests about the underlying liability policy. The appellate court agreed with the third-party beneficiary's argument that "'[a]lthough proof of a condition precedent may be required before liability is ultimately imposed,' it is not a prerequisite to obtaining discovery." *In re GEICO Cnty. Mut. Ins. Co.*, No. 05-20-00259, 2020 WL 2537249 (Tex. App.—Dallas May 19, 2020, pet. filed).

E. Experts

A mother brought a claim after her son died while in the course and scope of his employment. Following his death, a toxicology screen was performed that indicated he had marijuana metabolites in his blood at the time of death. Under Texas law, intoxication is defined as "not having the normal use of mental or physical faculties resulting from the voluntary introduction into the body of a controlled substance." Further, a positive drug screen creates rebuttable presumption that an injured worker is intoxicated at the time of the accident; therefore, he did not sustain a compensable injury. The Division of Worker's Compensation upheld the insurer's denial of the claim, and the mother sought judicial review. At trial, the mother presented evidence from her son's co-worker, as well as, expert testimony from a toxicologist in order to establish her son had the normal use of his mental or physical faculties. The expert for the mother said the results of the blood test were unreliable and should not be considered when

determining intoxication. The expert for the insurer said the blood test led him to conclude the deceased was likely intoxicated at the time of the accident. The co-worker testified the deceased performed physical tasks on the day of the accident. Further, he did not smell like marijuana and the co-worker had never seen the deceased use drugs. Lastly, the co-worker asserted the deceased acted normal and appeared to have the normal use of his mental and physical faculties.

The jury found that the deceased was not intoxicated at the time of his death. The insurer appealed arguing the jury determination that the deceased was not intoxicated at the time of the accident was legally and factually insufficient. With respect to this point, the court highlighted a lay person is competent to testify to whether a person was acting normally at the time of his injury. Therefore, the court held it was reasonable for the jury to give the co-worker's testimony sufficient weight to conclude that the deceased was not intoxicated at the time of the accident that caused his death. *Tex. Mut. Ins. Co. v. Mendez,* No. 07-19-00087-CV, 2020 WL 2786675 (Tex. App.—Amarillo May 26, 2020, no pet.).

F. Appraisal

The insured's home sustained damage during a hailstorm. Initially, the insurer said there was no property damage from the storm, then later it said the damage was less than the deductible. An appraisal was completed, which exceeded the insurer's prior estimates. The insurer paid the award and moved for summary judgment on the remainder of the insured's claims which the trial court granted and the appellate court affirmed. The Texas Supreme Court reversed the lower courts' holdings. The court noted two prior Texas Supreme Court decisions from 2019 both holding the payment of an appraisal award did not as a matter of law bar an insured's claim under the Texas Prompt Payment of Claims Act. *See Barbara Tech. Corp. v. State Farm Lloyds,* 589 S.W.3d 806 (Tex. 2019); *Ortiz v. State Farm Lloyds*, 589 S.W.3d 127 (Tex. 2019). Therefore, the court held the insured's prompt payment claim was not extinguished after the payment of the appraisal award. *Marchbanks v. Liberty Ins. Corp.*, 602 S.W.3d 917 (Tex. 2020).

The Texas Supreme Court again reversed and remanded the lower courts' holdings that an appraisal award entitled an insurer to summary judgment on all of the insured's contractual and extra-contractual claims. In *Lazos v. State Farm Lloyds*, 601 S.W.3d 783 (Tex. 2020), an insured's property sustained wind and hail damage. Following two inspections, the insurer said the damage fell below the deductible. The insured sued and the insurer compelled an appraisal, where the damage amount was found to be more than the deductible. The insurer paid the appraisal award, and moved for summary judgment on all of the insured's claims. The trial and appellate courts granted the motion in favor of the insurer. The insured appealed the decision. During this time period, the Texas Supreme Court decided two cases specifically on this issue, one holding that "an insurer's payment of an appraisal award does not as a matter of law bar an insured's claims under the Prompt Payment Act." *Ortiz*, 589 S.W.3d 127 (Tex. 2019); *see also Barbara Tech. Corp. v. State Farm Lloyds*, 589 S.W.3d 806 (Tex. 2019). Therefore, the Texas Supreme Court reversed the decision of the appellate court and remanded the case to the trial court to consider the prompt payment claim in light of the recent rulings.

Again *Ortiz and Barbara Technologies Corporation*, resulted in the reversal and remand of an appraisal award case. In *Alvarez v. State Farm Lloyds*, 601 S.W.3d 781 (Tex. 2020), the insured's property sustained wind and hail damage. The insured sued the insurer after he believed the offered damage amount was undervalued. The insurer obtained an appraisal which exceeded the insurer's prior estimates. The insurer paid the appraisal award and moved for summary judgment on the insured's claims. The trial court granted summary judgment with the appellate court affirming. Looking to its prior rulings, the Texas Supreme Court reversed the judgment of the court of appeals and remanded the case to the trial court to consider the prompt payment claims.

G. Motions for Summary Judgment

A woman sustained a work-related injury and was ultimately dissatisfied with the results of a contested case hearing. She filed a judicial review challenging the Division of Workers' Compensation's findings on the disputed issues. The insurer filed a no-evidence summary judgment motion, and the worker filed a response with several exhibits. However, her exhibits were not authenticated and contained hearsay. The exhibits were struck and the trial court granted summary judgment in insurer's favor. On appeal, the worker argued the trial court abused its discretion in excluding her evidence and the evidence was legally insufficient to support the court's summary judgment order. The appellate court highlighted that as a prerequisite to presenting a complaint for appellate review, the record must show the complaints were made to the trial court by a timely request, objection, or motion. A party may not argue "any and every new issue" she can think of on appeal. Rather, by failing to raise complaints as to the merits of the trial court's ruling on the objections, the worker failed to preserve error for appeal. Further, the insurer urged the worker's exhibits be excluded under several avenues, and the worker failed to appeal her evidences' exclusion on all grounds. Therefore, the worker waived the issue for appeal because she failed to challenge all possible grounds for the trial court's ruling that sustained the objection to her summary judgment evidence. *Davila v. Tex. Mut. Ins. Co.*, No. 03-19-00366-CV, 2020 WL 1174190 (Tex. App.—Austin Mar. 12, 2020, no pet. h.).

H. Severance & Separate Trials

Brainard v. Trinity Universal Insurance Company, 216 S.W.3d 809 (Tex. 2006) continues to cause headaches for insurers and insureds and add to the tsunami of appellate litigation trying to decipher it and develop work-arounds. In one of the latest examples, the Houston Court of Appeals rejected an insured's attempt to pursue extra-contractual claims for bad faith, Texas Insurance Code, and Texas Deceptive Trade Practices Consumer

Protection Act violations. The general consensus, initiated by *Brainard* and settled by subsequent appellate decisions, is that extra-contractual claims must be severed and abated from underlying declaratory judgment actions to determine whether insureds are "legally entitled" to underinsured motorist (UIM) benefits. Then, and only then, can insureds pursue common law and statutory remedies outside their UIM contract. In this case, the insured argued her insurance company did not respond to her UIM claim—at all—rather than "satisfactorily respond." This, however, was a "distinction without a difference," the court held, and stated the insured's extra-contractual claims must be severed and abated pending resolution of her declaratory action. *In re State Farm Mut. Auto. Ins. Co.*, No. 01-19-00821-CV, 2020 WL 1264184 (Tex. App.—Houston [1st Dist.] March 17, 2020, no pet.).

I. Evidence

An appellate court upheld a trial court's denial of judgment notwithstanding the verdict to two plaintiffs who received drastically reduced medical expense damage awards from a jury. The plaintiffs proved-up over $15,000 in past medical expenses with uncontroverted affidavits admissible under Sec. 18.001 of the Texas Civil Practice and Remedies Code, but the jury awarded just $500 to each plaintiff. Because the plaintiffs' injuries were subjective and some of their treatment delayed, the court ruled "the jury [was] within its discretion to award zero or minimal damages." *Espinoza v. Ruiz*, No. 13-18-00273-CV, 2020 WL 2776716 (Tex. App.—Corpus Christi-Edinburg 2020, pet. filed) (mem. op.).

J. Excess & Primary Coverage

The jewelry retailer Zales had a primary layer of insurance coverage from Liberty for directors' and officers' liability, and then two excess insurers. Zales announced a merger with Signet to which a minority of shareholders dissented, arguing the directors and officers failed to maximize stockholder value. Then Zales extended its insurance policies for the next six years and added run-off endorsements, which stated the policies would not include coverage for wrongful acts that occurred on or after the merger date. The dissenting shareholders brought appraisal actions after the merger was completed, and Zales and Signet settled with these shareholders without the insurers' consent for over $34 million. Zales then demanded payment from the two excess insurers, which the insurers denied. Zales filed suit alleging breach of contract and unfair settlement practices against the excess insurers. The excess insurers moved for summary judgment. The court stated the alleged "wrongful act" was the merger execution, and did not agree with the petitioners that the "wrongful act" was the entire merger process. Therefore, summary judgment in favor of the insurers was granted because the execution of the merger did not occur until the day of the merger which was the day after coverage ended under the insurance policy period. The appellate court affirmed. *Zale Corp. v. Berkley Ins. Co.*, No. 05-19-00730, 2020 WL 4361942 (Tex. App.—Dallas July 30, 2020, no pet. h.) (mem. op.).

K. Worker's Compensation

The Texas Supreme Court overcame a "troubling" fact-pattern to constrict the intentional-injury exception of the Texas Workers' Compensation Act to apply only to an employer that "believe[s] that its actions are substantially certain to result in a particular injury to a particular employee." The employer, according to a manager, systematically required its truck drivers to work insomniaic hours ("'routinely working 100 hours or more per week' and '19 to 24 hours straight—day after day'") while "encourag[ing] them to 'alter their work logs to appear that they were in compliance with DOT sleep and rest regulations.'" Alerted by the manager that one of its drivers "'was going to get killed,'" another manager said "'we will cross that bridge when we come to it.'" They came to it when one of their drivers was killed when he fell asleep at the wheel and ran off the road at three-in-the-morning after working 19-hours the day before. The deceased employee's parents and sister (he had no spouse or children) sued the employer for wrongful death, alleging the "intentional injury" exception allowed them to get around the workers' compensation statute. The trial court dismissed their claims on summary judgment, but the appellate court reversed and remanded before the Texas Supreme Court granted review. The Texas Supreme Court, citing its prior decision in *Reed Tool Co. v. Copelin*, 689 S.W.2d 404 (Tex. 1985) and quoting the RESTATEMENT (SECOND) OF TORTS § 8A (1965), acknowledged the century-old intentional injury exception requires "specific intent to inflict injury" but said that intent could be shown by an employer who believed bad consequences were "substantially certain." Recognizing "[s]ubstantial certainty will always be hard to quantify," the court said it could only apply to "specific consequences" and not general dereliction like the employers' "awareness of the commonsense notion that fatigued drivers are more likely to be involved in a crash than well-rested drivers." Its purpose, the court said, was to maintain the integrity of the workers' compensation scheme and "prevent the intentional-injury exception from devolving into a standard of exceptionally egregious gross negligence." Therefore, the court held the beneficiaries' evidence did not raise a fact issue under the intentional-injury exception, so the claims were barred by the exclusive-remedy provision in the act. Therefore, the court reversed the appellate judgment in favor of the estate, and rendered judgment for the employer. In a concurring opinion, Justice Eva Guzman stated that although precedent compelled her to concur in the court's conclusion, she made the case for changes to be made in regards to cases like this, stating:

> In a perfect world, employers would do the right thing simply because it is the right thing to do. But we don't live in a perfect world. We live in a world that requires laws, regulations, and disincentives to help ensure employers don't do the wrong thing. Without meaningful consequences for engaging in prohibited conduct, laws are not effective. On that score, the Worker's Compensation Act has a loophole that unwittingly permits employers to engage, with impunity, in unsafe practices. I believe the tragic circumstances presented here make a strong case for aligning the Workers' Compensation Act with the Wrongful Death Act, and I call on the Legislature to do so.

Mo-Vac Serv. Co., Inc. v. Escobedo, 603 S.W.3d 119 (Tex. 2020).

A deputy sheriff died in a car accident while driving his patrol car. At the time of the accident, he was driving home from an extra-duty assignment with a private employer. Pursuant to the local sheriff's manual, this extra-duty employment was permissible, but must be approved. Further, it was anticipated law enforcement powers might be utilized in this type of activity. The deceased sheriff wore his uniform, badge, and gun while performing security at a local football game. Following the end of the game, the deputy sheriff checked in through his laptop and notified dispatch he was available for assignment while on his way home. His surviving spouse filed a claim for worker's compensation benefits with the county of El Paso, a self-insurer under the Texas Workers' Compensation Act. The county denied

the claim believing deceased was not in the course and scope of his employment at the time of the accident. The widow brought her claim to a contested hearing where the hearing officer ruled in the widow's favor, concluding her husband was in the course and scope of his employment at the time of the accident. The county appealed, and the administrative panel reversed, holding deceased was not in course and scope of his employment at time of his death. The widow sought judicial review with the trial court and won. The county appealed, and the court of appeals reversed, rendering judgment that the widow take nothing. The Texas Supreme Court noted the daunting history of the case as it determined its ruling.

The court concluded the patrol car amounted to employer-provided travel, and the fact he was required to notify dispatch indicated his transportation was under the control of the employer.

For an injury to be within the course and scope of employment, it must both arise out of a risk or hazard that has to do with and originates in the work of the employer and that is performed by an employee while engaged in the furtherance of the employer's affairs. A risk or hazard arises out of employment when a causative factor peculiar to the work and not common to the general public results in the injury.

Travel from work to home is statutorily excluded from course and scope. This exclusion is commonly referred to as the "coming and going" exclusion. The coming and going exclusion rule is provided for in section 401.011(12)(A) of the Texas Labor Code:

> (12) "course and scope of employment" means an activity of any kind or character that has to do with and originates in the work, business, trade, or profession of the employer and that is performed by an employee while engaged in or about the furtherance of the affairs or business of the employer. The term includes any activity conducted on the premises of the employer or at the other locations. The term does not include:
>
> (A) transportation to and from the place of employment unless:
>
> (i) the transportation is furnished as part of the contract of employment or is paid for by the employer;
>
> (ii) the means of transportation are under the control of the employer; or
>
> (iii) the employee is directed in the employee's employment to proceed from one place to another place.

Second, dual purpose travel which is both for personal and business reasons is excluded from the course and scope of employment, absent certain conditions.

The court found the travel originated in the employer's business and highlighted the patrol car on the public streets being an activity that clearly relates to the department's work. Further, the presence of uniformed deputies in marked patrol cars furthered the department's work in preserving peace and responding to citizens in need of assistance. As the deputy's authorized operation of a marked patrol car on a public street is considered an official business activity of the department, the deceased deputy was in the course and scope of his employment.

Notably, the employer argued different exclusions at various levels of the dispute. These exclusions are mutually exclusive; therefore, if one applies, the other cannot. Ultimately, the court decided the coming and going exclusion applied; therefore, the dual purpose exclusion did not need to be analyzed. Without providing detailed analysis, the court also found two exceptions to the coming and going analysis applied. Essentially, the court concluded the patrol car amounted to employer-provided travel, and the fact he was required to notify dispatch indicated his transportation was under the control of the employer. Therefore, the deputy's travel was not excluded from course and scope of employment. *Orozco v. Cnty. of El Paso*, 602 S.W.3d 389 (Tex. 2020).

Generally, workers' compensation providers reimburse medical providers in accordance with fee guidelines promulgated by the Division of Workers' Compensation. When the Division has not adopted an applicable guideline, the insurer must reimburse the provider for its services up to a "fair and reasonable" amount. To date, the Division has not provided a fee guideline for air ambulance services.

In this case, the insurer reimbursed an air ambulance service at 125% of the Medicare rate for their services, which is consistent with the Division's fee guideline for providers other than hospitals and pharmacies. The air ambulance service disagreed with this adjustment and argued it was entitled to the full billed amount. The Division determined the air ambulance service was entitled to 149% of the Medicare rate and both parties sought judicial review. This amount is the average amount paid to the air ambulance service for services in Texas during the relevant period in dispute. The trial court awarded summary judgment in favor of the Division and insurers. The appellate court reversed, holding the Texas Worker's Compensation Act reimbursement provisions are preempted by the Airline Deregulation Act (ADA), finding in favor of the air ambulance service. The Division and insurers sought review with the Texas Supreme Court.

The Texas Supreme Court held the ADA did not preempt workers' compensation law. The Court highlighted Texas' retained police powers include the power to provide a compensation system for injured workers. As part of this system, Texas requires insurers to reimburse providers up to a "fair and reasonable" amount. The court held the air ambulance services failed to demonstrate the "fair and reasonable" standard had a significant effect on its prices for carrying injured customers by air. The court explained the full amount billed for services is not the starting point for measuring significant effect on cost as the ADA does not guarantee any payment of air-ambulance claims. Certainly, the ADA does not demand payment for whatever the air carrier deems appropriate. Further, the billed amount is not part of a transactional relationship since the air ambulance service's customer generally has not agreed to pay it. Absent an agreement on price, the court explained the ADA implies a fair or reasonable price. As Texas has enacted this standard for reimbursement, preemption does not apply. Therefore, the court reversed the appellate court's ruling and reinstated the trial court's

summary judgment declaring no preemption. *Tex. Mut. Ins. Co. v. PHI Air Med., L.L.C.,* No. 18-0216, 2020 WL 3477002 (Tex. June 26, 2020).

The underlying disputes were the long-running series between Vista hospitals and carriers of workers' compensation policy holders over reimbursement of medical expenses. In Texas, the Department of Insurance is tasked with development fee guidelines that govern reimbursement for different types of medical care. Once the Division adopts a guideline, workers' compensation carriers must reimburse providers in accordance with the guideline. If no fee guideline applies to a certain type of care, the carrier must reimburse at "a fair and reasonable reimbursement amount."

In over fifty-three instances, Vista billed pursuant to procedure codes and the carriers paid a portion of the bill. Vista requested the carriers to reconsider and reimburse Vista at 100% of the billed charges. Ultimately, Vista sought contested case hearings before the State Office of Administrative Hearings (SOAH) and the disputes remained on SOAH's docket for several years. In the meantime, the Division promulgated new rules and guidelines which affected Vista's reimbursement amounts. Vista changed its methodology for calculation "fair and reasonable" in the fifty-three disputes which resulted in lower overall amounts requested for reimbursement. SOAH agreed with the new calculations and ordered carriers to pay additional benefits. The carriers filed suit in district court seeking judicial review of the decision and order. The trial court affirmed the decision and order and rendered judgment against the carriers for the amounts SOAH had ordered to be paid. The carriers appealed.

The appellate court rejected the carriers' arguments that the amended reimbursement amounts constituted new medical bills. Rather, the court explained the calculation process was merely a different way to assert "fair and reasonable" reimbursement. The court explained the new calculations complied with the Division's recent Fee Guidelines and the evidence supported SOAH's determination on all issues. Therefore, the appellate court affirmed the trial court's judgment. *Facility Ins. Co., et al. v. Vista Hosp. of Dallas,* No. 03-18-00663-CV, 2019 WL 6603168 (Tex. App.—Austin Dec. 5, 2019, pet. denied).

** Suzette E. Selden is an attorney at Selden & Company PC in Austin, focusing on insurance litigation. She was selected by Thomson Reuters for inclusion in 2012-2015, 2017-2019 Texas Rising Stars® publication. Suzette currently is a committee member of the State Bar of Texas Women in the Profession Committee. She previously served as the President of the Capital Area Trial Lawyers Association. In 2002, Suzette graduated with highest honors from Brigham Young University with a B.A. in Communications, and with high honors from the University of Houston Law Center in 2006.*

***Jonathan D. Selden is an attorney at Selden & Company PC in Austin, focusing on consumer and personal injury litigation. He currently serves as a committee member of the State Bar of Texas Jury Service Committee. He received a J.D. degree from Gonzaga University School of Law in 2003 and a B.A. degree in Political Science from Brigham Young University in 2001.*

****Dennis Grebe is an attorney at Burns Anderson Jury & Brenner, L.L.P. in Austin, focusing on workers' compensation defense. In 2010, he graduated from Trinity University with a B.A. in Economics and received his law degree from the University of Texas School of Law in 2014.*

1 Jada Rest. Grp., L.L.C. v. Acadia Ins. Co., No. SA-20-CV-00807-XR, 2020 WL 5362071 (W.D. Tex. Sept. 8, 2020).

2 *See* Jada Rest. Grp., L.L.C., No. SA-20-CV-00807-XR, 2020 WL 5362071; Stowell v. United Prop. & Cas. Ins. Co., No. 3:20-CV-0527-B, 2020 WL 3270709 (N.D. Tex. June 16, 2020) (mem. op.); Project Vida v. Phila. Indem. Ins. Co., No. EP-20-CV-00082-DCG, 2020 WL 2220193 (W.D. Tex. May 7, 2020) (slip op.).

3 Perry v. United Servs. Auto. Ass'n, 602 S.W.3d 915 (Tex. 2020); Marchbanks v. Liberty Ins. Corp., 602 S.W.3d 917 (Tex. 2020); Alvarez v. State Farm Lloyds, 601 S.W.3d 781 (Tex. 2020); Biasatti v. Guideone Nat'l Ins. Co., 601 S.W.3d 792 (Tex. 2020); Lazos v. State Farm Lloyds, 601 S.W.3d 783 (Tex. 2020).

4 Orozco v. Cnty. of El Paso, 602 S.W.3d 389 (Tex. 2020).

5 Mo-Vac Serv. Co., Inc. v. Escobedo, 603 S.W.3d 119 (Tex. 2020).