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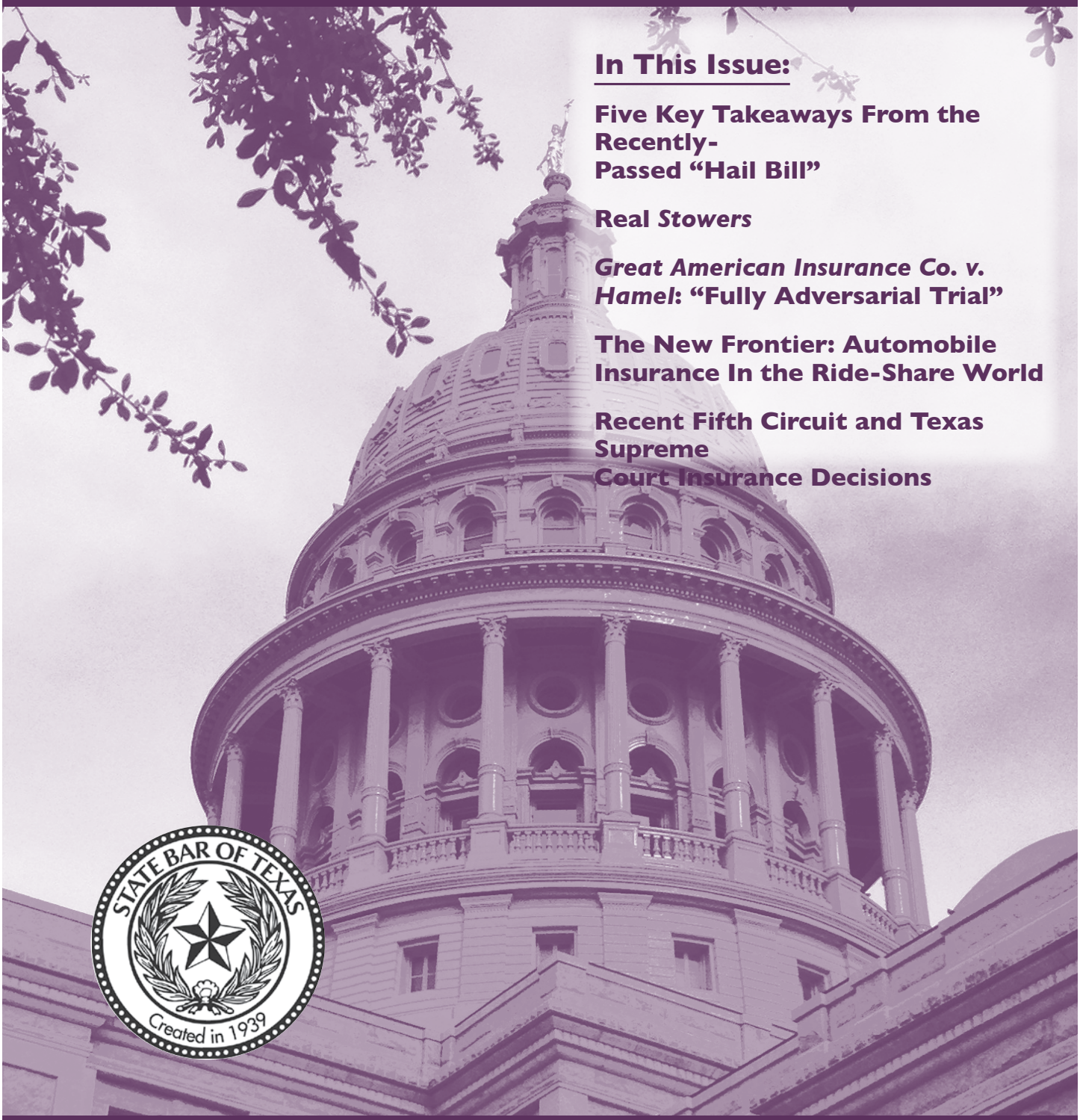

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Official publication of the Insurance Law Section of the State Bar of Texas

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The Journal of Texas Insurance Law is published by the Insurance Law Section of the State Bar of Texas. The purpose of the ***Journal*** is to provide Section members with current legal articles and analysis regarding recent developments in all aspects of Texas insurance law, as well as convey news of Section activities and other events pertaining to this area of law.

Anyone interested in submitting a manuscript for publication should contact Pamella Hopper, Editor In Chief, at (512) 617-4504 or by email at phopper@mcguirewoods.com. Manuscripts for publication must be typed double-spaced with endnotes (PC-compatible disks are appreciated). Replies to articles published in the ***Journal*** are welcome.

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MISSION STATEMENT

The Insurance Law Section serves to promote the understanding and development of Texas insurance law by providing high quality educational resources to the bench, bar, and public and by promoting collegiality among those with an interest in insurance law.

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Comments

FROM THE EDITOR

By Pamella A. Hopper
McGuireWoods LLP

For the past year it has been my great privilege to serve as the Editor In Chief of the *Journal*. As some of you may know, I served under Bill Chriss as his assistant from 2015 to 2016, including having the honor of putting together the memorial issue for our friend Mark Kincaid. Alas, it now is time to say goodbye. By the time you read this, it will be Rebecca DiMasi's turn.

My editorship journey began at South Texas College of Law (n/k/a South Texas College of Law Houston), where I served on the editorial board as an articles editor. My most daunting assignment in my last year on the editorial board was to edit an article entitled *Insurance Coverage Opinions*, authored by Michael Sean Quinn and L. Kimberly Steele. 36 S. Tex. L. Rev. 479 (Apr. 1995). I split Michael's infinitives in my first round of editing, which he promptly sent back to be repaired before going to print. Happily, that was not the last Quinn article I edited; but it was the last Quinn infinitive I split. Little did I know then, Michael would become a mentor and colleague, and Kim, our current Past Chair of the Insurance Law Section, would become a dear friend. I did, however, have an inkling I would become a coverage lawyer.

In this, my last issue as editor of the *Journal*, I am pleased to include Mark Ticer's informative article setting out guidelines for writing a *Stowers* demand letter that is valid and enforceable, even under the trickiest of circumstances. Catherine Hanna tackles the challenges of insuring Uber and other transportation network companies in the new gig economy. Jennifer Kelley explains how the *Hamel* case prompted the Texas Supreme Court to refine the definition of a "fully adversarial trial" under the *Gandy* rule. Also in this issue, Emily Buchanan outlines five aspects of Texas House Bill 1774, known as the "Hail Bill," that will affect the Prompt Payment Act, including a Hurricane Harvey post script. Rachelle Glazer and John Atkins provide their always-helpful review of recent insurance law decisions in the Fifth Circuit and the Texas Supreme Court.

Thanks go to these authors, and to Assistant Editor Rebecca DiMasi, who now will capably carry the Editor In Chief torch. I extend one last special thank you to Alyson Wagner, whose assistance in getting the *Journal* to print the past couple of years has been indispensable.

Pamella A. Hopper
Editor In Chief

Pamella A. Hopper, ranked a Top Attorney for Insurance in *Chambers USA 2017*, is Senior Counsel in the Austin office of McGuireWoods LLP. Her over 20-year practice is devoted exclusively to representing corporate policyholders in a wide variety of first- and third-party insurance coverage-related disputes and litigation, including environmental and other long-tail claims, construction, business interruption, and directors and officers. Her previous experience includes working for numerous years as an insurance coverage lawyer and adjuster on behalf of the insurance industry.

Comments

FROM THE CHAIR

By Meloney Perry

I am honored to serve as Chair of the Insurance Law Section for the 2017–2018 year. I would like to thank Past Chair, Kimberly Steele, the Section's Executive Committee and Council, and our Committees and volunteers, for continuing the Section's ongoing efforts to meet our yearly goals, which are tailored after our mission statement.

Our mission is to promote the understanding and development of Texas insurance law by providing high quality educational resources to the bench, bar, and public and by promoting collegiality among those with an interest in insurance law.

This year the Section continues to offer the following ways for our members to have the opportunity to broaden their understanding of current Texas insurance law and at the same time get to know other members:

- By providing among other things this seasonal Journal you are reading now;
- by the weekly "Right Off The Press" email blasts that provide summaries of and links to the most recent Texas state and federal decisions which touch upon insurance-related issues;
- by providing a website, www.insurancelawsection.org, where you will find a calendar of upcoming events, links to biographical information about the Section's members, additional case links and summaries, informative articles, Section-related news, a listing of upcoming webinars, podcasts and CLE's and links to prior issues of the Journal. Section members also have access to additional archived materials, including legal education course materials, that the general population does not;
- by hosting timely webinars on hot topics and by offering a rotating one-day insurance basics course, which this year will be held in Brownsville in February 2018; and
- by the Section co-sponsoring the Advanced Insurance Law Course (and Casino Night networking event), which will be held at the wonderful Hyatt Hill Country Resort & Spa in San Antonio on June 28–29, 2018.

In addition, this year we have several special projects to focus on increasing our membership, especially among the Bar's younger attorneys. We are also working on the creation of additional task force committees and sub-committees, such as a Young Lawyers Committee, a West Texas CLE Committee, and others, to ensure that the Insurance Law Section remains responsive to the needs of its membership and to serve your Section. We are off to a great start with our first Young Lawyers Committee's Happy Hour Networking event on October 10, 2017 in Dallas.

Although our numbers have grown over the past several years to meet the definition of a large section (2,000 members), the continued success and development of our Section depends upon the involvement and participation of new members—members with fresh perspectives and new ideas—members just like you. There are no contributions too small and no practice, locale or age restrictions. We welcome any ideas you may have.

I look forward to serving you and hopefully working with you this year!

Best,

Chair, Insurance Law Section

By Emily Buchanan

FIVE KEY TAKEAWAYS FROM THE RECENTLY-PASSED "HAIL BILL"

On May 26, 2017, Texas Governor Greg Abbott signed House Bill 1774, also referred to as the "Hail Bill," which took effect September 1, 2017. Advocates of the Hail Bill claimed that the bill was intended to curb litigation abuses arising from severe hail storms that swept through Texas and left residential and commercial properties in a state of disrepair.

However, when the Hail Bill was first filed on February 13, 2017, the original version never mentioned hail.[1] Instead, the original bill would have applied to all insurance claims (not just real property claims) and gutted the effectiveness of the Prompt Pay statute by reducing the damages assessed against insurance companies from 18% interest to effectively 8% for all first-party insurance claims. The original version of the bill also unnecessarily restricted the opportunity to bring a claim under the Deceptive Trade Practices Act and the Texas Insurance Code, and imposed onerous requirements on insureds regarding inspection, attorneys' fees, abatement, and more.

Opponents of the filed version of the Hail Bill, including several prominent Texas attorneys who routinely represent policyholders, voiced concern over its long-term ramifications, especially to the Texas business community. These concerns stemmed, in part, from the fact that a wholesale reduction in the interest under the Prompt Pay statute—the primary statutory safeguard for Texas businesses—would provide a disincentive for insurers' prompt payment of first party claims and exceed the bill's intended purpose of reducing hail-storm specific litigation.

In the end, the Hail Bill underwent significant changes to allay Texas commercial policyholders' concerns before it finally passed. The Hail Bill retained the 18% interest under the Prompt Pay statute for all first party claims (e.g., business interruption, data breach, auto and trucking, and real property loss not caused by a "force of nature"). The final version also removed the restrictions to bring a claim under the DTPA or the Texas Insurance Code.

Despite these modifications, the Hail Bill still applies to more than just hail, and imposes new requirements and limitations for insureds with first-party real property claims. Here are five key takeaways from the recently-passed legislation:

1. The new "Chapter 542A" of the Texas Insurance Code applies to claims for property damage caused by "forces of nature."

The Hail Bill adds a new chapter to the Texas Insurance Code called "Chapter 542A Certain Consumer Actions Related to Claims for Property Damage," and it applies to first-party real property claims for damage or loss caused "wholly or partially" by "forces of nature"—including damage caused in part by earthquakes, wildfires, floods, tornados, lightning, hurricanes, hail, wind, snowstorms, or rainstorms.[2]

Takeaway: If an insured's real property is damaged by hail or another "force of nature" and the insurance company refuses to pay the insured for the damage, Chapter 542A applies to any lawsuit the insured brings against the insurer or its agent even if the insured does not sue the insurer under the Texas Insurance Code. Put differently, an insured must follow the requirements set forth in Chapter 542A even if she decides to sue the insurer or an insurer's agent for a breach of contract or a breach of a common-law duty. Given that "forces of nature" are not specifically limited to only the weather-related events expressly listed in the statute, we may also see additional litigation regarding what other events qualify as a "force of nature" for purposes of Chapter 542A's requirements and limitations.

2. Chapter 542A requires the insured to give notice and an opportunity to inspect the property before the insured files a lawsuit.

Chapter 542A requires the insured to give every "person" he intends to sue notice at least sixty-one days before filing a lawsuit.[3] A "person" is broadly defined to include a corporation, association, partnership, or other legal entity or individual—encapsulating insurance companies and their employees, agents, representatives, or adjusters.[4] The notice must include (1) a statement of the acts or omissions giving rise to the claim; (2) the specific amount the insurer owes on the claim, and (3) the amount of attorneys' fees the insured already incurred at the time notice is given.[5] After receiving the notice, the "person" who received notice has thirty days to send a written request to inspect, photograph, or evaluate the property that is subject to the claim and must complete

Emily Buchanan is an associate in the litigation and insurance recovery practice groups in the Dallas office of Haynes and Boone, LLP. Her practice focuses primarily on representing commercial clients in insurance coverage litigation. Emily received a B.A. in speech communication from Baylor University in 2010, and graduated summa cum laude from the University of Tennessee College of Law in 2016.

the inspection, photography, or evaluation no later than sixty days after it received the notice.[6]

Takeaway: If an insured intends to sue the insurer and its agents to pay for property damage caused by a force of nature, the insured will have to give the pre-suit notice to each "person" and include an estimate of the value of his property claim. This poses significant challenges for commercial claims, where the amount the insurer owes on the claim is complex and involves various types of damages which cannot fully be appreciated at the beginning of a claim. Moreover, the insured's estimated value of the claim in the notice can subsequently affect the amount of attorneys' fees the insured can receive during litigation, as discussed in more detail in section 4 below. An insured must also allow the insurer to inspect the property, and any refusal to inspect could result in the lawsuit being abated, as discussed in section 3 below.

3. Chapter 542A allows an insurer to abate the lawsuit or remove it to federal court.

If the insured does not give the insurer pre-suit notice or an opportunity to inspect the property, Chapter 542A provides that an insurer can abate the lawsuit[7]—effectively pausing the lawsuit until the insured gives the pre-suit notice or allows the insurer to inspect the property.

The insurer also can elect to take responsibility for its agent's acts or omissions related to the claim.[8] An "agent" is broadly defined to include an employee, agent, representative, or adjuster who performs "any act" on behalf of an insurer.[9] If the insurer assumes responsibility for its agent before a lawsuit is filed, the insured cannot later sue the agent. If the insurer elects responsibility after a lawsuit is filed, the court must dismiss the lawsuit against the agent with prejudice.[10]

Takeaway: The insurer now has the opportunity to pause litigation until the insured has followed the pre-suit notice requirements or gives the insurer a chance to inspect the property. Also, by allowing the insurer to assume liability for an agent, the insurer may be able to remove the case from state to federal court, which can often provide a more favorable forum for insurance companies. As written, Chapter 542A's broad definition of an insurer's "agent" may encompass insurance brokers involved in placing a policy and insurance consultants evaluating claims—since they both perform "any act" on behalf of an insurer. Thus, we also expect to see a rise in litigation regarding who qualifies as an "agent" for purposes of assumed liability under Chapter 542A.

4. The insured may not get all her attorneys' fees under Chapter 542A.

Chapter 542A modifies the amount of attorneys' fees an insured is entitled to receive to the lesser of:

(1) Reasonable and necessary fees shown at trial with evidence and determined by the trier of fact to have been incurred in bringing the action;

(2) The amount of attorneys' fees that may be awarded to the claimant under other applicable law; or

(3) The amount to be awarded in the judgment divided by the amount stated in pre-suit notice multiplied by the total amount of reasonable and necessary attorneys' fees determined at trial.[11]

The court must award the full amount of attorneys' fees if the amount to be awarded in the judgment divided by the amount stated in pre-suit notice is greater than or equal to .8 and not otherwise limited or prohibited under law.[12] The court may not award attorney's fees if the amount to be awarded in the judgment divided by the amount stated in pre-suit notice is less than 0.2.[13] The court also has discretion to not award attorneys' fees incurred after the date the insurer files a pleading with the court that it did not receive pre-suit notice.[14]

Takeaway: The insured must provide pre-suit notice in order to receive attorneys' fees, and the amount stated in the pre-suit notice will affect how much the insured gets. If the amount stated in the pre-suit notice is significantly less than what the insured receives through a judgment, the insured should be entitled to a complete recovery of attorneys' fees. But if the pre-suit notice overestimates the amount of the claim, the insured may run the risk of losing complete recovery of attorney's fees.

This new law is best demonstrated through the following example:

- **You are awarded $500,000 for your real property claim, but your pre-suit notice stated the value of the claim was $250,000. You may receive the full amount of your attorneys' fees because $500,000 ÷ $250,000 = 2, which is greater than 0.8.**
- **You are awarded $500,000 for your real property claim, but your pre-suit notice stated the value of the claim was $1 million. You may receive 50% of your attorneys' fees.**
- **You are awarded $500,000 for your real property claim, but your pre-suit notice stated the value of the claim was $5 million. The court may not award any attorneys' fees because $500,000 ÷ $5 million = .1, which is less than 0.2.**

Obviously, the goal here is to curb aggrandizing damages. As written, the statute encourages an insured to underestimate, or "low ball," the value of his property claim in the initial stages of litigation to ensure full recovery of attorneys' fees—a strenuous requirement for complex commercial

insurance claims with the attendant risk that the carrier may agree to pay the insured's "low ball" estimate.

5. The insured may not get as much money in damages for his real property claims.

The Prompt Pay statute in Chapter 542 of the Texas Insurance Code encourages insurance companies to promptly pay an insured's claim for damages and requires the insurers in violation of Chapter 542 to pay 18% interest in the amount of the claim per year as damages, along with reasonable attorneys' fees. Before House Bill 1774, the Prompt Pay statute applied to all first-party insurance claims. However, the Hail Bill changes the interest under the Prompt Pay statute for a real property claim that falls under Chapter 542A. If a claim qualifies as a real property claim caused by a "force of nature," the interest is limited to 5% plus the prime interest rate.[15] The prime rate varies, but will have a base of 5% and a cap of 15%.[16] Given the historical data of interest rates, the interest rate likely will be no more than 10% instead of the previously-guaranteed 18%.

Takeaway: If you have a first-party property claim caused at least in part by a "force of nature," be prepared to not receive 18% interest per year as damages. Given the Prompt Pay statute's lower interest rate for claims falling under Chapter 542A, we may start to see additional litigation disputing causation of property damage, especially if insurers find more "forces of nature" at work in causing property damage claims after September 1, 2017.

Conclusion

Come rain or shine, policyholders and their attorneys will need to pay close attention to the new requirements under the recently-passed Hail Bill to ensure that the insureds receive the full statutory benefits provided by the Texas Insurance Code. While Texas weather can be unpredictable, Texas's statutory safeguards should not be. Given the changes under the recently-passed Hail Bill, we may see additional litigation on the rise regarding proper notice, calculation of attorneys' fees, and how to define "agents" and "forces of nature." In sum, policyholders should watch the forecast and prepare for these statutory changes hitting Texas September 1, 2017.

Author's Post Script

After this article was submitted for publication, Hurricane Harvey swept through the Texas coastline, destroying property in its path. Unfortunately, the timing of Hurricane Harvey overlapped with the effective date of House Bill 1774, creating a flurry of debate regarding whether insureds needed to report their claims by August 31, 2017 to avoid the statutory changes going into effect September 1, 2017.

Many attorneys and law firms encouraged their clients affected by Hurricane Harvey to report their property claims with their insurance companies before September 1, 2017 to secure the 18 percent interest rate on any late-paid or non-paid claims under the former Prompt Pay statute. But others, including HB 1774's sponsor Senator Kelly Hancock (R–North Richland Hills), advised against "filing a claim" immediately: "There is no need to rush to file a claim," Sen. Hancock stated, and "prompt pay penalties awarded through a lawsuit will now be calculated on a floating basis tied to interest rates, with a 20 percent ceiling, rather than a static 18% penalty."[17] However, Senator Hancock failed to highlight that based on current interest rates, the new penalty amount would be around 10% instead of the previous 18%. Sadly, in the end, Texans were left wading through the rubble of both their property damage and misinformation regarding what to do about their property claims.

1 The Hail Bill's text and legislative history can be found at: http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=85R&Bill=HB1774.

2 Tex. Ins. Code section 542A.001(2), eff. Sept. 1, 2017.

3 *Id.* § 542A.003(a).

4 *Id.* § 542A.001(5).

5 *Id.* § 542A.003(b).

6 *Id.* § 542A.004.

7 *Id.* § 542A.005.

8 *Id.* § 542A.006.

9 *Id.* § 542A.001(1).

10 *Id.* § 542A.006(b).

11 *Id.* § 542A.007.

12 *Id.* § 542A.007(b).

13 *Id.* § 542A.007(c).

14 *Id.* § 542A.007(d).

15 Tex. Ins. Code § 542.060(a), (c), as amended, eff. Sept. 1, 2017.

16 *See* Tex. Fin. Code § 304.003.

17 *See* http://www.senate.texas.gov/members/d09/press/en/p20170828a.pdf.

By Mark A. Ticer

REAL *STOWERS*

I. INTRODUCTION

The term *Stowers* conjures up various things for different people, including misinformation and misconceptions. Most practitioners probably view *Stowers* as a way to make a liability insurer pay more than the insurer's policy limits. Some think *Stowers* means the plaintiff—the judgment creditor—can go directly against the liability insurer to collect any excess amount over policy limits. (Wrong.) Others think big damages automatically translates into *Stowers*. (Wrong again.) And still others discount issues of coverage and other necessary elements, thinking *Stowers* means making a demand for "limits." (Equally wrong.)

But how do you get to *Stowers*? What are the elements? How do you write a valid and enforceable *Stowers* demand letter? What are the defenses to *Stowers*? Can you just borrow a form from someone on the listserv and plug in the policy limits? These questions and the answers thereto seem simple but it is surprising to see how many self-described *Stowers* demands do not meet the strict requirements for making an insurer satisfy its *Stowers* duties. The intent of this article is to assist you in composing a valid and enforceable *Stowers* demand letter and avoid the numerous errors frequently found in such settlement offers.

II. WHAT IS *STOWERS*?

The origin of *Stowers* is the 1929 Texas Commission Appeals' case of *G.A. Stowers Furniture Co. v. American Indemnity Co.*[1] Its critical holding is more than about just paying policy limits but provides reasons why the *Stowers* duty exists:

> The provisions of the policy giving the indemnity company *absolute and complete control of the litigation*, as a matter of law, carried with it a corresponding duty and obligation, on the part of the indemnity company, to exercise that degree of care that a person of ordinary care and prudence would exercise under the same or similar circumstances, and a failure to exercise such care and prudence would be negligence on the part of the indemnity company.[2]

Stowers duties emanate from an insurer's control over the litigation and claim.[3] Because the liability insurer typically controls the litigation in terms of defense and settlement, a corresponding duty of settling a covered claim within the policy limits necessarily accompanies such right to control.[4]

Stowers is a tort based on negligence.[5] The *Stowers* duty is owed to the insured and consequently a *Stowers* claim belongs to the insured, not the plaintiff or judgment creditor.[6] A *Stowers* claim or cause of action can only result from an actual judgment.[7] A *Stowers* claim accrues when the underlying judgment is final and all appeals have been exhausted.[8] A *Stowers* claim is assignable and also subject to a turnover order, absent public policy concerns or where the insured contends there was no breach of the *Stowers* duty.[9]

Stowers requires technical compliance; substantial compliance is not enough.[10] Stated differently, all elements of a *Stowers* demand must be satisfied.[11] Waiver is not part of a *Stowers* analysis.[12] A failure to point out a flaw in a *Stowers* demand does not waive the defect in a *Stowers* demand or result in satisfaction of *Stowers* requirements.[13] It does not matter if the insurer supposedly knew what the plaintiff meant in its demand and did not protest; the required elements of *Stowers* must be met and the demand's terms and language must be clear and undisputed.[14]

As a threshold matter, a *Stowers* demand "must propose to release the insured fully in exchange for a stated sum of money, but may substitute 'the policy limits' for a sum certain."[15] A *Stowers* claim has three mandatory requirements.[16] First, the claim must be within the scope of coverage when the offer is made.[17] Second, the demand must be within policy limits.[18] Third, the offer's terms are such that an ordinary prudent insurer would accept it when considering the likelihood and exposure of the insured to an excess judgment.[19] Stated simply, *Stowers* requires: (1) coverage; (2) a demand for the actual and correct policy limits; and (3) given the exposure to the insured and the likelihood of an excess judgment, a reasonably prudent insurer would accept the offer.[20] It is the second element which typically causes the most problems, particularly where multiple policies and insurers are involved or when the policy is a wasting policy.

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It is important to reiterate: a *Stowers* demand must be clear, unambiguous, and undisputed—leaving no room for speculation, uncertainty, or missing terms.

[A]t a minimum we believe that the settlement's terms must be *clear and undisputed.* That is because "settlement negotiations are adversarial and . . . often involve hard bargaining on both sides."[21] . . . Given the tactical considerations inherent in settlement negotiations, an insurer should not be held liable for failing to accept an offer when the offer's terms and scope are *unclear or are the subject of dispute*.[22]

A *Stowers* demand also must be unconditional.[23] The *Stowers* offer must include a complete unconditional release of the defendant.[24] The released parties must specifically be identified.[25] Assuming no disagreement on the terms of a *Stowers* demand, the time given to respond must be reasonable.[26] A *Stowers* demand need not be formal, although oral or informal offers invite disputes of what was offered, which defeats *Stowers*.[27]

III. WHAT MAKES A VALID AND ENFORCEABLE *STOWERS* DEMAND?

Many lawyers work to obtain a verdict in excess of policy limits, believing they have made a valid and enforceable *Stowers* demand before the trial so that the insurer is accountable for any excess judgment. If the insured/judgment debtor cannot personally pay any excess judgment, the judgment becomes uncollectible unless the liability insurer is held accountable for the excess. Whether the insured pursues the *Stowers* claim or the plaintiff/judgment creditor does so pursuant to a turnover order, it makes little difference if there is no valid and enforceable *Stowers* offer, which is a condition precedent to recovery under a *Stowers* cause of action. With no valid and enforceable *Stowers* demand, you will face an almost certain summary judgment motion for any *Stowers* lawsuit, resulting in defeat, because whether a valid *Stowers* demand exists is a question of law for the court.[28]

In drafting a *Stowers* demand to impose *Stowers* duties on the liability insurer, adhere to the *KISS* rule—Keep It Simple Stupid. By making and keeping a *Stowers* demand simple, the terms almost by definition become unambiguous, clear, and undisputed. The chance for speculation and uncertainty in the demand is minimized with simplicity and your *Stowers* letter can and should be Exhibit 1 to your *Stowers* lawsuit. Without a compliant *Stowers* demand, any *Stowers* lawsuit is DOA.

A. Determining Limits

In many cases, there is a single liability policy with known limits, so the demand for limits—the second element of *Stowers*—is readily known and can be easily identified and stated. In *Garcia*, the Texas Supreme Court held that a claimant may identify wither "a stated sum of money or substitute the term 'policy limits for a sum certain.'"[29] A demand for more than limits, no matter how reasonable, will not invoke *Stowers* obligations on the insurer.[30] Even a good faith mistake or compelling argument for more than limits invalidates the *Stowers* demand.[31] Because a mistake in limits is fatal to a *Stowers* demand, it is mandatory and outcome determinative that the amount demanded is accurate and correct for the applicable coverage.[32]

Things get complicated when there is more than one primary policy or both primary and excess liability policies apply. An aggregate demand to all insurers that *correctly* adds up all limits of applicable policies will not satisfy the *Stowers* element of a demand within limits.[33] What this means is that if you have three primary liability policies with limits of $100,000, $200,000, and $300,000 respectively, and all three policies apply, a demand for $600,000 (the sum of the three policies) to all three primary insurers does not satisfy the *Stowers* requirement of a demand within limits. Why? Because *Stowers* requires a demand to each insurer be within the limits of each insurer's policy; global aggregate demands in such circumstances are therefore not *Stowers* compliant.[34] In the example, no one insurer could pay $600,000 and thus a global demand for $600,000 is above limits for each individual insurer.[35]

Attempting to make a *Stowers* demand by adding up the limits of the primary and excess insurers would not satisfy *Stowers*, either. Excess policies have exhaustion requirements before any duty to settle (or defend) arises. An excess insurer has no obligation to pay—*Stowers* duty—until the underlying applicable primary policy limits either are exhausted (paid out) or tendered to the excess insurer.[36] When the primary insurer tenders its limits to the excess insurer, it gives the excess insurer complete control over settlement, which is the basis for *Stowers* liability.[37]

In most cases, in order to trigger *Stowers* as to an excess insurer, the primary insurer's limits must be tendered to the excess insurer. Typically, the tender option is not something that the claimant can easily accomplish; however, an offer for tender of the primary limits to the excess insurer may be something a claimant can demand followed by demanding all limits from the excess to impose *Stowers* obligations on the excess insurer. (This strategy is discussed later in the article.) Usually, a primary insurer will tender its limits to

the excess where it becomes clear the claim cannot be settled for its limits and the primary insurer wants to avoid liability to an excess insurer on an equitable subrogation theory; i.e., the excess insurer sues the primary insurer for not settling the case within the primary insurer's limits, thereby exposing the limits of the excess insurer.[38]

When the primary insurer has tendered its limits to the excess insurer, the excess insurer then has complete control over all limits—primary and excess—which implicates *Stowers* duties.[39] In rare circumstances, the excess insurer can be subject to *Stowers* duties when it has voluntarily assumed a defense or inserted itself into settlement negotiations even before the primary limits have been tendered.

Perhaps the most complicated situation for evaluating limits is where there are multiple insurers (primary and excess), multiple claimants, each insurer's policy has different limits, and the excess policies providing coverage have separate exhaustion requirements. In these circumstances, the strategy may well be to have one claimant seek payment from one or more policies and other claimants pursue other policies, avoiding complications such as exhaustion and aggregate offers. This strategy works when there are different lawyers making separate demands for separate clients and agreements to focus on specific policies, which puts actual pressure on the insurers to avoid *Stowers* liability. However, this approach is fraught with all sorts of conflicts of interest when one lawyer represents multiple claimants and particular policies are targeted for each of the lawyer's separate clients, particularly where there are differing limits and triggers of coverage.

Regardless of the number of claimants and policies involved, a mistake on limits means no *Stowers* liability, no matter how reasonable the demand might be.

Regardless of the number of claimants and policies involved, a mistake on limits means no *Stowers* liability, no matter how reasonable the demand might be.[40] Determining accurate policy limits and how to make the correct offer may well be the hardest legal requirement to satisfy for a compliant *Stowers* demand.

B. Make the *Stowers* Demand Unmistakably Clear and Certain.

In addition to making sure the correct limits, coverage, policies, and insurers are correctly identified and demanded, a *Stowers* letter requires unmistakable clarity: "Given the tactical considerations inherent in settlement negotiations, an insurer should not be held liable for failing to accept an offer when the offer's terms and scope are unclear or are the subject of dispute."[41] Sloppy writing translates into no *Stowers* duties being imposed on a liability insurer.

Clear and undisputed terms mean avoiding the use of pronouns such as "he" or "she" or generic references such as "insured" rather than specific names of persons or entities. For example, if the policy's named insured is Smith but the negligent driver is Jones, do not demand policy limits for a release of the insured who could be either Jones or Smith. If Smith is not exposed to negligent entrustment liability, a demand for limits for Smith's release could be senseless and unreasonable with no real exposure to the insurer. The reasonably prudent insurer does not pay policy limits on behalf of an insured who does not have excess exposure.[42]

In *Home State County v. Horn*, the plaintiff offered to "'fully release your *insured* from all liability' in exchange for policy limits."[43] The letter defined Berry as the insured and Hulett as Home State's driver.[44] Significantly, it was the estate of the deceased driver (Hulett) who had the excess exposure, not "the insured" Berry.[45] Consequently, there was no *Stowers* demand because Horn's demand for limits to release "the insured" (Berry) was not reasonable because there was no excess exposure.[46] It was Hulett or his estate that had the exposure, and the inartful demand saved the insurer from *Stowers* liability.[47]

It is no excuse or exception that the insurer allegedly knows what a demand means in spite of contradictory or unclear terms or even an admission by an insurer that it seemed to know what the plaintiff meant.[48] This is precisely the unsuccessful argument the plaintiff used in *Horn* when it used "insured" instead of naming Hulett specifically as the party to whom a release was being offered.[49] The appellate court in *Horn* held that although a formal demand may not be necessary for making an insurer liable under *Stowers*, "there still must exist evidence that the settlement proposed to fully release the proper party."[50] Disputed and ambiguous oral negotiations and discussions cannot supply the required certainty to impose *Stowers* liability on an insurer.[51]

Assuming that the driver and named insured on the liability policy are different and there is only a single liability policy covering the incident, a *Stowers* offer should include both parties identified by name by proposing to release both unconditionally, unless there is significant negligent entrustment exposure for the named insured because the named insured has assets to satisfy a significant judgment. Including and specifically naming both the driver and insured eliminates any uncertainty and addresses all exposure, leaving no one without the benefit of a release. Again, clarity and certainty are mandatory—no exceptions.

Likewise, language suggesting or stating conditions to a demand dooms a valid and enforceable *Stowers* offer. Words or terms such as "assuming," "if," "on the condition that," "provided that," "based on your representation," or "according to your discovery responses" suggest or, at least, imply conditions.[52] A *Stowers* offer may not be expressly or impliedly conditional.[53]

In *Webster*, the appellate court held that the following language was a predicate conditional offer: "Based upon your representation, Donna Johnson has authorized me to offer to settle her case against Webster for $100,000. Obviously, *if* there is other insurance, this offer shall be null and void."[54] While *Webster*'s holding appears harsh, potentially allowing an insurer to escape payment of other limits or benefit from a misrepresentation or fraud, its holding remains well-settled law. Eliminating conditional words and terms is a must to have an enforceable *Stowers* demand.

C. Must All Insureds Be Unconditionally Released?

For years, *Stowers* law suggested that a *Stowers* demand did not have to offer the release of all insureds.[55] Indeed, the Texas Supreme Court encouraged settlement even if it exhausted a policy and went so far as to provide insurers who settled with one insured or claimant protection from *Stowers* liability.[56]

But along came *Patterson*, an unpublished case out of Houston where the First Court of Appeals held there was no *Stowers* demand because the offer never included the release of all insureds.[57] Even more concerning and inexplicable was that *Patterson* appeared inconsistent with *Soriano* and the Texas Supreme Court denied review of *Patterson*. Furthermore, *Patterson* was at odds with federal precedent on this same theory.[58]

Patterson though has one crucial fact different from all other *Stowers* cases: the named insured demanded the insurer not accept any settlement demand unless all insureds were released.[59] Simply, the insured opposed acceptance of the *Stowers* demand unless all insured defendants were released. The insured was telling the insurer not to settle and essentially saying it would hold the insurer accountable for *Stowers* liability by refusing to pay limits for the release of one insured. In *OneBeacon Insurance Co. v. T. Wade Welch & Associates*, the Fifth Circuit noted this distinction in *Patterson* in affirming a *Stowers* verdict where the insurer argued that *Patterson* changed the necessary elements to impose *Stowers* duties on an insurer by requiring a *Stowers* offer to include a release of all insureds.[60] In soundly rejecting this argument, the Fifth Circuit was steadfast that *Patterson* did not change *Stowers* law, but instead noted *Patterson* could not be a *Stowers* case because the insured opposed acceptance of the policy limits demanded and therefore the insured would have no *Stowers* complaint.[61]

While the Texas Supreme Court is not bound to follow the Fifth Circuit in cases interpreting Texas state law, the treatment of *Patterson* in *Welch* makes great legal sense, especially when considering other Texas authorities such as *Charles v. Tamez* regarding the propriety of turning over a *Stowers* claim when the insured takes the position there is no such claim or turning over such a claim would be against public policy.[62]

Of course, the safest route for imposing *Stowers* duties on an insurer is to offer a release all insureds; but when the facts will not permit it, *Patterson* represents an aberration on highly distinguishable and critical facts. Requiring all insureds to be included in any release undermines the holding of *Soriano* and its progeny of encouraging settlements and allowing insurers to make reasonable settlements. And unless there are facts quite similar to *Patterson,* well settled law supports the notion that all insureds do not have to be offered a release in any *Stowers* demand.

D. Addressing Hospital Liens to Comply with *Stowers*

Another area where clarity has proven problematic is dealing with hospital liens.[63] Insurers often use as a defense to *Stowers* liability a plaintiff's confusing language regarding hospital liens, where hospital liens were not properly addressed or even ignored. Nowhere is the *KISS* rule more important than in addressing hospital liens.

When the Texas Supreme Court decided *Bleeker* in 1998, a whole new set of requirements were added to *Stowers* demands. *Bleeker* holds that there is no effective *Stowers* offer unless the plaintiff includes an offer to release or actually releases all hospital liens.[64] There is no distinction for *Stowers* purposes whether the hospital lien is valid, enforceable, or not.[65] Where a hospital lien exists, valid or not, it must be addressed in the *Stowers* offer.

A hospital lien can be released in three different ways:

> (a) A release of a cause of action . . . to which a lien under this chapter may attach is not valid unless:
>
> (1) the charges of the hospital or emergency medical services provider claiming the lien were paid in full before the execution and delivery of the release;

> (2) the charges of the hospital or emergency medical services provider claiming the lien were paid before the execution and delivery of the release to the extent of any full and true consideration paid to the injured individual by or on behalf of the other parties to the release; or
>
> (3) the hospital or emergency medical services provider claiming the lien is a party to the release.[66]

The Texas Supreme Court, in *McAllen Hospitals, L.P. v. State Farm County Mutual Insurance Co*., recently examined the hospital lien statute and provided unmistakable and invaluable guidance on dealing with hospital liens even though the case did not involve a *Stowers* demand.[67]

Lest there be any doubt that hospital liens have to be released to release a cause of action (claim), the Texas Supreme Court has construed section 55.007(a) and held there can be no release of a hospital lien absent compliance with this statute.[68] This decision, while not a *Stowers* case, has demonstrated the importance of satisfying this statutory lien in order to meet *Stowers* requirements.

In *McAllen Hospitals*, the court held, consistent with the unambiguous statutory language in section 55.007(a), that a cause of action could *not* be released to which a hospital lien attaches unless there is satisfaction (release) of the lien.[69] Stated in terms of *Stowers*, where a hospital lien exists, as a matter of law, there can be no unconditional release of a claim or cause of action unless the hospital lien is released. Consequently, a plaintiff cannot offer an unconditional release for *Stowers* purposes without resolving an existing hospital lien.[70] Therefore, if a hospital lien may exist, it must be satisfied for *Stowers* purposes and there is no implicit offer to deal with it merely by demanding policy limits.[71]

Offers to indemnify or anything less than satisfaction of the lien will not meet the *Stowers* requirement of a complete release.[72] A *Stowers* demand must include a release of the hospital lien pursuant to section 55.007(a).[73] There can be no implicit understanding to deal with a hospital lien by vague terms such as protecting, indemnifying, and/or alleging invalidity of the lien. In every case where a hospital lien issue exists and it has not specifically been addressed, there can be no *Stowers* demand.[74]

Because ignoring a hospital lien does not make it go away, the safest (and perhaps only) choice is to include a release of the hospital lien in exchange for limits in the *Stowers* demand. In many cases, this may seem impossible because the lien dwarfs the amount of limits if the *Stowers* offer is accepted. Of course, a plaintiff in such circumstances is hoping the insurer declines the policy-limit offer because the potential for recovery is greater.

The obvious strategy to make a compliant *Stowers* demand is to work out an arrangement with the hospital pre-demand in situations where the lien dwarfs the limits or leaves the client with little recovery. Logically, if the plaintiff does not litigate the liability case involving the lien, the hospital will in all likelihood get nothing towards its "lien." This makes legal sense because the Texas Supreme Court has not decided whether the hospital can pursue the cause of action to enforce its lien in its own right.[75] Indeed, the court has suggested a hospital would not have its own cause of action to obtain payment of its lien in spite of a court of appeals' opinion holding otherwise.[76]

On a more practical level, given the cost, manpower, and amounts in controversy, it is doubtful many hospitals would file their own lawsuit against the defendant. In the many years since the statute was enacted, there is little evidence suggesting hospitals are pursuing their own claims, assuming they have them at all.

As a result, it would appear that many hospitals may be willing to work with plaintiffs to recover some of the hospital's charges. There is no question that some hospitals have shown themselves to be what can generously be called uncooperative, but an enforceable *Stowers* demand in cases where the lien dwarfs the limits will require creativity, risk, and cooperation. There is no cookie-cutter way to confront the release of a hospital lien to satisfy *Stowers*. Best advice: Make contact and friends with the hospital's general counsel and/or lawyers when a hospital lien is involved.

E. Other Issues That Should Be Considered for *Stowers*

A *Stowers* demand must be only for covered claims and damages.[77] An insurer has no obligation to consider noncovered claims and damages in the context of *Stowers* or that an insured might be willing to contribute to the noncovered claims/damages in the context of *Stowers*.[78] Likewise, *Stowers* liability may not be imposed on an insurer for refusing to settle covered claims that results in significant damages or a verdict for uncovered claims and damages, such as punitive damages.

Another unsuccessful tactic for *Stowers* purposes is pairing a weak claim with a strong claim, which can disqualify the stronger claim from *Stowers* treatment when the offer is treated as a bulk offer. Coupling a weak claim with a strong

claim when seeking aggregate policy limits will not impose *Stowers* duties on the liability insurer.[79]

This strategy, often termed a "bulk offer" or "bundling," seeks to obtain the aggregate limits of a liability policy and avoid the per person limit by bundling a serious claim with a weaker claim by trying to create excess exposure in order to be paid both per person limits or the aggregate policy limit. The type of offer is made in "bulk" rather than separately and these types of offers are often treated as conditional offers, which cannot satisfy *Stowers*.[80] To settle in a bulk situation, the insurer must settle both claims as a package for the policy limits—the condition being that one cannot be without the other.

Bundles or bulk offers also present serious ethical issues when all plaintiffs demand a single sum from an insurer—an aggregate offer or settlement. Unless the parties have decided in advance how to divide any offer or settlement, a single lawyer representing all of the plaintiffs/claimants may find herself in a breach of fiduciary duty lawsuit facing fee forfeiture.[81] If an aggregate offer is made where one lawyer represents all plaintiffs, the percentages of any aggregate offer for each plaintiff should be decided before any such offer is made through a neutral party.

A *Stowers* claim is not a claim for "bad faith," but rather a cause of action premised on negligence.[82] There is no duty of good faith and fair dealing owed to an insured in the context of a third-party claim.[83] However, chapter 541 (previous article 21.21) provides an insured a cause of action against its insurer for failing to settle a third-party claim where liability is reasonably clear and the insured has been damaged.[84] The same *Stowers* requirements for a first-party claim outlined in *Rocor* are virtually identical to *Stowers*.[85] Those requirements are: (1) the policy covers the claim; (2) the insured's liability is reasonably clear; (3) the claimant has made a proper demand within limits; and (4) the demand is such that an ordinarily prudent insurer would accept it.[86]

Notably, there is no good faith defense to a *Stowers* claim.[87] *Stowers* is not negated by the insurer's mistake—good faith or not—about coverage.[88] If the insurer is wrong about coverage, there is no bona fide or good faith defense to avoid *Stowers* liability.[89] Either the demand satisfies *Stowers* or it does not. The test is whether the offer was reasonable at the time it was made.[90]

Whether the insurer acted as a reasonably prudent insurer is inherently a fact-driven question—whether considering the terms of the offer at the time it was made as well as the liability of the insured, the insured should pay the limits.[91] Simply because there is a judgment in excess of limits and a valid and enforceable *Stowers* demand was made does not automatically translate into *Stowers* liability.[92]

A *Stowers* cause of action belongs to the insured, not the plaintiff or judgment creditor.[93] It may be assigned or obtained by turnover order so long as either does not violate public policy.[94] A *Stowers* cause of action accrues when the underlying judgment becomes final either with no appeal or after all appeals are exhausted.[95] A judgment which is subsequently reversed or modified to fall within policy limits or completely taken away defeats a *Stowers* claim.[96]

F. Stowerizing the Primary and Excess Insurers

Now that we have discussed the general principles, we turn to how to make a *Stowers* demand involving more complex situations, including demands involving primary and excess policies; how to deal with multiple policies, including when several primary policies are in play; and when the primary refuses to tender. Because no court has effectively dealt with these questions except in cases of rejecting various non-*Stowers* compliant aggregate offers, we must rely on prior experiences or smart people who have some logical strategies.

As a reminder, an offer for a primary policy limits and an excess policy limits is conditional until the primary has actually tendered its limits to the excess.[97] The offer to the primary in such situations would be in excess of limits because by definition the excess covers the amount over the primary.[98] The solution may be a bifurcated offer, which may be conditional so long as the excess insurer, who would then have exclusive control over settlement, would have sufficient time to respond when the condition is satisfied ("the Huddleston principle").[99] The Texas Supreme Court intimated the use of this approach in *State Farm Lloyds Insurance Co. v. Maldonado*.[100] In *Maldonado*, the court suggested that an insurer could face *Stowers* duties if a demand was made that exceeded policy limits but one part of the demand was for policy limits and the rest was to be paid by the defendant.[101] But if *Stowers* duties were to be imposed in such a situation, the insurer must have a reasonable time to respond to the demand and to determine if in fact the defendant would and could pay noncovered amounts or amounts over limits.[102]

While the *Maldonado* circumstances are factually different, the intent of a bifurcated offer is to provide a conditional requirement, the mechanism to have it satisfied, and give a reasonable time after the condition is satisfied for the insurer to accept the policy limits demand. The approach is intended to avoid *Webster*'s conditional prohibition and the bifurcated approach has some implied support by the Texas

Supreme Court involving *Stowers*.

Consider the following hypothetical: There is a primary policy (A) that provides $1 million in coverage and an excess policy (B) that has $5 million in coverage. An offer is made for A to tender its $1 million primary limits to the excess insurer (B). Thirty days is given to A to accept this part of the offer, which if accepted, would give the excess insurer exclusive control over settlement. If A accepts the offer to either tender the $1 million primary to B or to plaintiffs, then the next part of the offer to the excess (B) becomes unconditional. If the $1 million has been tendered to the excess insurer, the onus is then on the excess because it now has no condition precedent to avoid payment and the excess insurer has exclusive settlement control—the underlying premise for *Stowers* liability.

This strategy can also apply to a self-insured retention situation. However, defendants contributing their own money is often more problematic because the defendant with a self-insured retention does not operate as a liability insurer and is paying its own money.

This same approach might also be used with multiple primary policies with varying limits. A set-up of one or more of the primaries is possible. For example, there are three policies of $100,000 (A), $200,000 (B), and $300,000 (C). The same staggered approach would be: (1) demand a tender of the $100,000; (2) when the $100,000 is tendered then the $200,000 has fourteen days to tender; and (3) if the first two tender their limits, the third insurer (C) would be given fourteen days to accept a demand for its limits. The pressure is on C, not A and B, creating *Stowers* obligations on C because insurer C has the exclusive authority to pay.

As discussed earlier, if there are multiple claimants and policies, attack can be made on each separate primary policy in accordance with the amount of damages/exposure of each plaintiff. In this situation, plaintiffs may place tremendous *Stowers* exposure on various primary insurers where each primary is confronted with a single demand from one plaintiff.

Multiple policies (primary or excess), limits, and claimants create problematic *Stowers* dilemmas. But the *KISS* rule still applies and aggregate offers (adding up all policy limits for a single demand) almost certainly will not invoke *Stowers* concerns for an insurer.

G. Can a Minor's Claim Be Stowerized?

If a minor plaintiff is involved, can an enforceable *Stowers* demand be accomplished when a minor settlement inevitably requires court approval? It would seem patently unfair, if not abusive, if an enforceable *Stowers* demand cannot be made on behalf of a minor because a condition of court approval must occur.

One might argue that the condition of court approval is not the type of condition contemplated in *Webster*. If there is no more insurance other than limits to pay a demand from an insurance policy, it is hard to believe a court would not approve such a settlement. But likelihood does not necessarily take away the requirement of court approval—a condition.

Does making such a demand without mentioning the need for court approval for a minor settlement make it any better? That is doubtful, as insurers are quite sophisticated and are certainly aware of the need for court approval to have a binding settlement with a minor. An alternative is making a *Stowers* demand on behalf of another plaintiff such as the estate of a person or parent. But such a demand would have to be reasonable—the insurer would have to be facing excess exposure for these plaintiffs separately.[103]

One option, which may be unworkable as an advisory opinion, is seeking court approval for a policy/demand in advance of the offer being made. Such an option would be unusual and could be viewed as legally inappropriate. However, it could negate the conditional nature for settling a minor's claim.

In any case, making an enforceable *Stowers* offer on behalf of a minor plaintiff represents a daunting challenge. It would be no different than making a policy limits demand and not mentioning a hospital lien that the insurer knows exists.[104]

IV. CONCLUSION

If you intend to preserve *Stowers* accountability for an insurer on a claim, you should become fluent on *Stowers*, its requirements, how it works, and be certain of the policy limits and coverage. It begins with mastering *Garcia*, *Bleeker*, and their progeny. It includes careful, detailed, and certain drafting of a *Stowers* demand. Hospital liens must be addressed and released. Technical compliance is a must—no exceptions.

Stowers is alive and well, but there is no margin for error.

1 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved).

2 *Id.* at 547 (emphasis added).

3 *Id.*; *see also Rocor Int'l v. Nat'l Union Fire Ins. Co. of Pittsburgh,*

P.A., 77 S.W.3d 253, 263 (Tex. 2002).

4 *G.A. Stowers Furniture*, 15 S.W.2d at 547.

5 *Ford v. Cimarron Ins. Co.*, 230 F.3d 828, 831 (5th Cir. 2000); *Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 847–850 (Tex. 1994).

6 *Nationwide Mut. Ins. Co. v. Chaney*, 2002 WL 31178068, at *2 (N.D. Tex. Sept. 30, 2002); *Charles v. Tamez*, 878 S.W.2d 201, 204–06 (Tex. App.—Corpus Christi 1994, writ denied).

7 *Street v. Second Court of Appeals*, 756 S.W.2d 299, 301–02 (Tex. 1988).

8 *Id*. at 301–03.

9 *Charles*, 878 S.W.2d at 208.

10 *Rocor Int'l*, 77 S.W.3d at 253.

11 *Garcia*, 876 S.W.2d 848–49; *Trinity Universal Ins. Co. v. Bleeker*, 966 S.W.2d 489, 490–91 (Tex. 1998).

12 *Chaney*, 2002 WL 31178068, at *3–4.

13 *Id.*

14 *Garcia*, 876 S.W.2d at 851; *McDonald v. Home State Cty. Mut. Ins. Co.*, 2011 WL 1103116, at *5–7 (Tex. App.—Houston [1st Dist.] Mar. 24, 2011, pet. denied); and *Home State Cty. Mut. Ins. Co. v. Horn*, 2008 WL 2514332, at *4–5 (Tex. App.—Tyler, June 25, 2008, pet. denied).

15 *Garcia*, 876 S.W.2d 848–49.

16 *Id.* at 849.

17 *Id*.

18 *Id.*

19 *Id.*

20 *Id.*

21 *Id*.

22 *Rocor Int'l*, 77 S.W.3d at 253.

23 *Ins. Corp. of Am. v. Webster*, 906 S.W.2d 77, 80 (Tex. App.—Houston [1st Dist.] 1995, writ denied).

24 *Bleeker*, 966 S.W.2d at 491.

25 *Horn*, 2008 WL 2514332, at *4–5.

26 *Allstate Ins. Co. v. Kelly*, 680 S.W.2d 595, 608–09 (Tex. App.—Tyler 1984, no writ) (14-day limit is reasonable); *see also Am. Ins. Co. v. Assicurazioni Generali SpA*, 228 F.3d 409, 2000 WL 1056143, at *3 (5th Cir. July 24, 2000) (unpublished table decision).

27 *Birmingham Fire Ins. Co. v. Am. Nat'l Fire Ins. Co.*, 947 S.W.2d 592, 599–600 (Tex. App.—Texarkana 1977, writ denied); *but see Rocor Int'l*, 77 S.W.3d at 253 (discouraging informality for *Stowers* because of the likelihood of disputes).

28 *Garcia*, 876 S.W.2d at 849–52; *Bleeker*, 966 S.W.2d at 491; *AFTCO Enters., Inc. v. Acceptance Indem. Ins. Co.*, 321 S.W.3d 65, 70–72 (Tex. App.—Houston [1st Dist.] 2010, pet. denied); *Webster*, 906 S.W.2d at 80–81; *McDonald*, 2011 WL 1103116, at *3–6; and *Horn*, 2008 WL 2514332, at *3–5.

29 876 S.W.2d at 848–49.

30 *Id.* at 849; *Yorkshire Ins. Co. v. Seger*, 279 S.W.3d 755, 768 (Tex. App.—Amarillo 2007, pet. denied).

31 *Garcia*, 876 S.W.2d at 849.

32 *Id.*

33 *AFTCO Enters.*, 321 S.W.3d at 70–72.

34 *Id*.

35 *Id.* This reasoning would not apply if one insurer did have $600,000 in limits or greater and the other *Stowers* requirements were met.

36 *Keck, Mahin & Cate v. Nat'l Union Fire Ins. Co.*, 20 S.W.3d 692, 700 (Tex. 2000).

37 *Id.* at 700, 701–02; *see also Pride Transp. v. Cont'l Cas. Co.*, 804 F. Supp. 2d 520, 529–30 (N.D. Tex. 2011), *aff'd*, 511 Fed. Appx. 347 (5th Cir. 2013).

38 *See Am. Centennial Ins. Co. v. Canal Ins. Co*., 843 S.W.2d 480 (Tex. 1992).

39 *Pride Transp*., 804 F. Supp. 2d at 529–30; *Keck, Mahin & Cates*, 20 S.W.3d at 701–02.

40 *Garcia*, 876 S.W.2d at 849.

41 *Patterson v. Home State Cty. Mut. Ins. Co.*, 2014 WL 1676931, at *7 (Tex. App.—Houston [1st Dist.] 2014, pet. denied) (citing *Rocor Int'l.*, 77 S.W.2d at 263).

42 *Rosell v. Farmers Tex. Cty. Mut. Ins. Co.*, 642 S.W.2d 278, 280 (Tex. App.—Texarkana 1982, no writ).

43 2008 WL 2514332, at *3.

44 *Id.*

45 *Id*. at *3–4.

46 *Id.* at *4.

47 *Id.*

48 *Id.* at *4–5.

49 *Id.*

50 *Id.* at *4.

51 *Id.*

52 *Webster*, 906 S.W.2d at 80–81.

53 *Id.*; *Willcox v. Am. Home Assur. Co.*, 900 F. Supp. 850, 858–59 (S.D. Tex. 1995). There is perhaps an exception to this rule when the condition can be satisfied before the *Stowers* offer expires, which will be addressed later in this paper.

54 *Id.* at 80 (emphasis added).

55 *See Travelers Indem. Co. v. Citgo Petroleum Corp*., 166 F.3d 761, 764 (5th Cir. 1999); *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312, 314–15 (Tex. 1994).

56 *Soriano*, 881 S.W.2d at 314–15.

57 2014 WL 1676931, at *9.

58 *Citgo*, 166 F.3d at 764.

59 2014 WL 1676931, at *10.

60 *See OneBeacon Ins. Co. v. T. Wade Welch & Assocs.*, 841 F.3d 669, 678–79 (5th Cir. 2016).

61 *See Charles*, 878 S.W.2d at 207–08.

62 878 S.W.2d at 207–08; *see also Chaney*, 2002 WL 31178068, at *2–5.

63 *See Bleeker*, 966 S.W.2d at 491.

64 966 S.W.2d at 491.

65 *McDonald*, 2011 WL 1103116, at *5.

66 Tex. Prop. Code Ann. § 55.007(a).

67 433 S.W.3d 535, 538 (Tex. 2014).

68 *Id.* at 538–39.

69 *Id.* at 538–39.

70 *Bleeker*, 966 S.W.2d at 491.

71 *McDonald*, 2011 WL 11031116, at *4–6.

72 *McAllen Hosps.*, 433 S.W.3d at 538; *Bleeker*, 966 S.W.2d at 491.

73 *Bleeker*, 966 S.W.2d at 491; *McDonald*, 2011 WL 1103116, at *5.

74 *Bleeker*, 966 S.W.2d at 491.

75 *McAllen Hosps.*, 433 S.W.3d at 541–42.

76 *Id.* at 541.

77 *St. Paul Fire and Marine Ins. Co. v. Convalescent Servs., Inc*. 193 F.3d 340, 343–44 (5th Cir. 1999).

78 *Id*. at 343.

79 *Rosell*, 642 S.W.2d at 280 (holding no *Stowers* liability where there is an aggregate policy limit demand for two claims where one claim may expose the insured to an excess verdict while the other would not); *Pullin v. So. Farm Bureau Cas. Ins. Co.*, 874 F.2d 1055, 1057 (5th Cir. 1989) (holding no breach of duty of good faith by insurer that refuses to pay more for less serious claim that would benefit plaintiff with more serious claim through demanding the liability policy's aggregate limits).

80 *See Jones v. Highway Ins. Underwriters*, 253 S.W.2d 1018, 1022 (Tex. Civ. App.—Galveston 1952, writ ref'd n.r.e.).

81 *See Burrow v. Arce*, 997 S.W.2d 229 (Tex. 1999).

82 *Garcia*, 876 S.W.2d at 847.

83 *Maryland Ins. Co. v. Head Indus. Coatings and Serv. Inc.*, 938 S.W.2d 27, 28 (Tex. 1996).

84 *Rocor Int'l*, 77 S.W.3d at 260–62.

85 *Id.* at 262.

86 *Id.*

87 *Welch*, 841 F.3d at 679.

88 *Id*.

89 *Am. W. Home Ins. Co. v. Trestar Convenience Stores, Inc*., 2011 WL 2412648, at *4 (S.D. Tex. June 2, 2011). In *American Western Home*, the federal court rejected the notion that a mistake about coverage was a defense to the coverage element of *Stowers*, but the court did suggest that it could fall under the third *Stowers* element—whether a reasonable insurer would have accepted the settlement at the time it was made. *Id.* at *4.

90 *Id.*

91 *Mumford v. State Farm Mut. Auto Ins. Co*., 2015 WL 11121529, at *4–5 (E.D. Tex. April 29, 2015); *Bramlett v. Med. Protective Co*., 2013 WL 796725, at *4–5 (N.D. Tex. Mar. 5, 2013).

92 *Highway Ins. Underwriting v. Lufkin-Beaumont Motor Coaches, Inc*., 215 S.W.2d 904, 928 (Tex. Civ. App.—Beaumont 1948, writ ref'd n.r.e.).

93 *Chancey*, 2002 WL 31178068, at *2; *Charles*, 878 S.W.2d at 204–06.

94 *Charles*, 878 S.W.2d at 204–06.

95 *Street*, 756 S.W.2d at 302.

96 *Prostok v. Browning*, 112 S.W.3d 876, 924 (Tex. App.—Dallas 2003), *rev'd in part on other grounds*, 165 S.W.3d 336 (Tex. 2005).

97 *Keck, Mahin & Cates*, 20 S.W.3d at 701–02.

98 *AFTCO Enters.*, 321 S.W.3d at 69–70.

99 This proposition has been advanced by Michael Huddleston, an outstanding Texas insurance coverage lawyer, who is a frequent writer and lecturer on insurance coverage and just an exceptional human being. Mike has written about this strategy for several years, most recently in "The Duty to Settle in Texas" presented to the Dallas Bar Association Tort and Insurance Practices Section earlier this year.

100 *See State Farm Lloyds Ins. Co. v. Maldonado*, 963 S.W.2d 38 (Tex. 1998).

101 *Id.* at 41.

102 *Id.*

103 *See Rosell*, 642 S.W.2d at 280.

104 *See Horn*, 2008 WL 2514332, at *4–5.

By Jennifer Kelley

GREAT AMERICAN INSURANCE CO. V. HAMEL: "FULLY ADVERSARIAL TRIAL"

In *Great American Insurance Co. v. Hamel*, a highly anticipated decision, the Texas Supreme Court defined in greater detail what constitutes a "fully adversarial trial" under the *Gandy* rule.[1] In doing so, the court provided direction as to the precise circumstances under which a judgment entered against a policyholder will be recoverable from the judgment debtor's insurer.

The underlying case involved plaintiffs Glen and Marsha Hamel, who sued their builder for failing to finish the construction of their single-family home in a "good and workmanlike manner."[2] The builder, Terry Mitchell Builders Inc., was not the original builder of the home but conceded it had a duty to inspect the original builder's work, as well as the work of its subcontractors and to ensure the work was performed in a "good and workmanlike manner."[3] A few years after the Hamels lived in their home, they noticed signs of water damage and sued the builder for problems allegedly related to defective materials or improper installation of synthetic stucco cladding on the exterior of their home.[4] The builder tendered the claim to Great American Insurance Company, its commercial general liability insurer, but Great American denied the builder a defense on the basis that discovery of the alleged damages fell within the policy period in which Exterior-Stucco-related damages were excluded.[5]

The builder and the Hamels entered into a Rule 11 agreement before trial under which the Hamels agreed not to pierce the corporate veil and to only enforce a favorable judgment against the builder's insurer in exchange for the builder's agreement to appear at trial without seeking a continuance and to stipulating to certain facts that were important to establishing the builder's liability.[6] The trial court found in favor of the Hamels and awarded $365,089.70 in damages, plus interest and court costs.[7] The builder, in turn, assigned most of its rights against Great American to the Hamels.[8]

The Hamels filed suit against Great American for breach of contract and declaratory relief, seeking to recover the judgment against the builder under the CGL policy.[9] The Hamels ultimately prevailed and were awarded $355,838 in damages, plus interest, court costs, and attorney's fees.[10] Great American appealed, arguing it was not bound by the judgment entered in the liability/damages trial under *Gandy* because the trial did not meet the requirements of a fully adversarial trial.[11] The court of appeals upheld most of the trial court's decision, holding Great American had breached its duty to defend, the trial had been fully adversarial, and the assignment of the builder's claims against Great American to the Hamels was valid.[12]

On appeal to the Texas Supreme Court, although Great American admitted it had wrongly refused to defend the builder in the liability/damages trial, it maintained the trial was not fully adversarial because the pretrial agreement between the Hamels and the builder ensured the builder "had no real stake" in the outcome of the trial.[13] The Texas Supreme Court reaffirmed the general rule that "an insurer that wrongfully refuses to defend its insured is barred from collaterally attacking a judgment or settlement between the insured and the plaintiff."[14] It also affirmed *Gandy's* holding, however, that when a plaintiff seeks to enforce a judgment against an insurer as the insured's assignee, the assignment is invalid if (1) it was made prior to adjudication of the plaintiff's claim in a fully adversarial trial, (2) the defendant's insurer tendered a defense, and (3) the insurer either accepted coverage or made a good faith attempt to adjudicate coverage issues before adjudication of underlying claim.[15] The court therefore looked at whether the judgment in the underlying liability/damages trial was the result of a fully adversarial trial.

Rejecting the court of appeals' approach that determining whether a judgment is the result of a fully adversarial trial requires a post hoc analysis, the court held "the controlling factor is whether, at the time of the underlying trial or settlement, the insured bore an actual risk of liability for the damages awarded or agreed upon, or had some other meaningful incentive to ensure that the judgment or settlement accurately reflects the plaintiff's damages and thus the defendant-insured's covered liability loss."[16] Applying this approach, the court concluded the liability/damages trial had not been fully adversarial, explaining when parties reach a pretrial agreement that "deprives one of the parties of its incentive to oppose the other, the proceeding is no longer adversarial."[17] Under these circumstances, the court declined to enforce the judgment against Great American.[18]

Importantly, the court refused to "suggest that a formal, written pretrial agreement that eliminates the insured's financial risk will always be either necessary or sufficient to

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disprove adversity."[19] Instead, it held "the presence of such an agreement creates a strong presumption that the judgment did not result from an adversarial proceeding, while the absence of such an agreement creates a strong presumption that it did."[20] The court then pointed out how each party might overcome their respective presumptions: (1) the insurer may "demonstrat[e] that, even though the plaintiff and insured defendant did not enter into any formal, written agreement, the evidence nonetheless establishes that the defendant had no meaningful stake in the outcome of the underlying litigation"; and (2) "the plaintiff (acting as the defendant's assignee) may overcome the presumption by submitting evidence demonstrating that the defendant retained a meaningful incentive to defend the underlying suit despite an agreement that eliminated the defendant's financial risk."[21]

Finally, although the court declined to enforce the judgment against Great American, it also would "not preclude the parties from properly litigating the underlying liability issues in a subsequent coverage suit."[22] After holding the coverage suit "provided a vehicle to remedy the problems associated with the lack of adversity in the Damage Suit," the court remanded the case in the interest of justice so the parties could properly litigate liability issues.[23]

TAKE-AWAYS FROM *HAMEL*:

- An assignment of claims against an insurer is valid if (1) it is made after an adjudication of the underlying plaintiff's claim against the defendant insured in a fully adversarial trial; (2) the defendant's insurer has not tendered a defense; and (3) the defendant's insurer has not either accepted coverage or made a good faith effort to adjudicate coverage issues prior to adjudication of the underlying plaintiff's claim.

- In order for a judgment against an insured defendant to be enforceable by a plaintiff-assignee, the judgment must be the result of a fully adversarial trial.

- Whether a judgment is the result of a fully adversarial trial does not depend on a post hoc analysis of the parties' conduct and motives during trial. Instead, a trial is fully adversarial if "the insured bore an actual risk of liability for the damages awarded or agreed upon, or had some other meaningful incentive to ensure that the judgment or settlement accurately reflects the plaintiff's damages and thus the defendant-insured's covered liability loss."

- A formal written pretrial agreement eliminating the defendant insured's financial risk creates a strong presumption that the judgment did not result from a fully adversarial trial. The absence of an agreement creates a presumption that the judgment did result from a fully adversarial trial.

- The presumptions can be overcome by evidence indicating (1) the defendant insurer had no meaningful stake in the outcome of the underlying litigation; or (2) the defendant insured retained a meaningful incentive to defend the underlying suit despite an agreement eliminating the defendant insured's financial risk.

- Liability issues that are not properly litigated in the underlying litigation may be litigated in separate trial over coverage.

1 *Great Am. Ins. Co. v. Hamel,* No. 14-1007, 2017 WL 2623067, at *4 (Tex. June 16, 2017); *State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696, 714 (Tex. 1996) (prohibiting enforcement of judgments in an action by plaintiff as the insured's assignee, if rendered without a fully adversarial trial).

2 *Hamel*, 2017 WL 2623067, at *1.

3 *See id.* at *1–3.

4 *See id.* at *1.

5 *See id.* at *2.

6 *See id.* at *2–3.

7 *See id.* at *3.

8 *Id.*

9 *See id.* at *4.

10 *Id.*

11 *Id.*

12 *Id.*

13 *Id.* at *5.

14 *Id.*

15 *Id.*

16 *Id.* at *7.

17 *Id.* at *8.

18 *See id.* at *9 ("Accordingly, under *Gandy*, the Damage Judgment is not binding against Great American in the present suit brought by the Hamels as judgment creditors and assignees.").

19 *Id.* at *9.

20 *Id.*

21 *Id.*

22 *Id.* at *10.

23 *Id.* at *11.

By Catherine L. Hanna

THE NEW FRONTIER: AUTOMOBILE INSURANCE IN THE RIDE-SHARE WORLD

The gig economy is empowerment. This new business paradigm empowers individuals to better shape their own destiny and leverage their existing assets to their benefit. John McAfee

In today's gig economy, where jobs have been replaced by 'portfolios of projects,' most people find themselves doing more things less well for two-thirds of the money. Tina Brown

I. Blurred Lines: Insurance for Personal and Commercial Activities

Historically, insurance policies sold in the United States could not contain more than one line of insurance.[1] As state legislatures allowed insurance carriers to sell multi-line policies, carriers categorized their lines of business into two major groupings: personal lines and commercial lines.[2] Personal-lines policies generally exclude coverage for activities seen as business risks. For example, homeowners policies typically contain a "business pursuits exclusion," and personal automobile policies exclude coverage when the covered auto is being used to carry persons or property for a fee—the so-called "livery exclusion."

The gig, or sharing, economy, which involves individuals marketing their time and assets directly to other individuals, challenges the traditional dichotomy between personal and commercial activities and the insurance assumptions that go along with them. The underwriter who priced and sold a personal automobile insurance policy to a suburban commuter likely did not factor in the increased exposure that occurs when that suburbanite drives passengers for a fee in a crowded entertainment district on Friday and Saturday night.

This is not a completely new challenge. In the homeowners insurance context, in-home day care arrangements have presented challenging coverage questions, with courts struggling to distinguish between casual babysitting relationships and full-time, for-profit, state-regulated residential child care business. Compare *State Farm Fire & Casualty Company v. Vaughan*,[3] which found no coverage for a child who died as a result of the negligence of the day care operator, with *State Farm Fire & Casualty Company v. Reed*, which held that coverage was not excluded for a toddler who drowned in a swimming pool after climbing through a fence at a home day care because the death "was caused by an activity that was ordinarily incidental to non-business pursuits."[4] In his dissent in Reed, Chief Justice Philips highlighted the sometimes murky nature of this distinction. While noting that "it is not the responsibility of the four million other Texans who have homeowners policies to subsidize the business risks of the homeowner who initiates an at-home enterprise subject to certain risks without purchasing appropriate coverage," he recognized that other child-care activities for profit, such as part-time babysitting, would not fall into the same category.[5]

Likewise, long before companies like Uber arrived to further complicate matters, personal automobile carriers had to distinguish between business and personal pursuits. The issue arises frequently in cases involving delivery drivers, with employees who use their personal automobiles. For example, in *Dhillon v. General Accident Insurance Company*,[6] a driver, Sukhedev Dhillon, was rear-ended by an uninsured motorist while returning to the store after delivering a pizza. Dhillon's personal insurance carrier denied his uninsured/underinsured motorist (UM/UIM) claim, citing the livery exclusion. Summary judgment was granted in favor of the carrier and Dhillon appealed. The Houston Court of Appeals initially reversed the trial court's summary judgment because there was no evidence showing that Dhillon was carrying property for a fee.[7] However, the court forecast and provided a roadmap for its ultimate decision, noting that the proceeds a driver possesses from the sale of the pizza on the return trip would constitute "property" within the meaning of the exclusion.[8] When the case returned after remand, the court was satisfied with the evidentiary record, rejected Dhillon's argument that the livery exclusion was ambiguous, and held that the claim was excluded: "[Dhillon] was being paid to use his car to deliver pizzas. This is clearly excluded under the policy."[9]

A significant factor in the Houston court's reasoning in Dhillon was the delivery driver's salaried compensation. Because Dhillon was being paid for the entire trip, the question of when the accident occurred during that trip

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was not relevant. Other courts, applying the exclusion to situations that do not involve salaried drivers, have held that the presence of the passenger or good in the vehicle at the time of the accident is determinative of coverage. In Fort Worth Lloyds Insurance Company v. Lane, the insured's son, Harlan, had used her car with permission to carry three passengers from Dallas to Little Rock, charging each passenger $10.[10] On the way home from Little Rock, after dropping off his passengers, young Harlan failed to negotiate a turn and crashed the car, causing a whopping $354 of damage. Fort Worth Lloyds denied Lane's claim, citing the livery exclusion. The trial court and Dallas Court of Appeals disagreed, holding the exclusion applied only while the passengers were actually being carried and not otherwise.[11] In fact, this exclusion applies only "if [the] insured vehicle has been held out to the general public for carrying passengers, and at the time of the accident was actually so used."[12]

II. Trouble Ahead: The Uber Problem

The group of businesses known as Transportation Network Companies (TNCs) began with the founding of Uber in San Francisco in 2008. Uber originally was created as a means to hail black car services using a smart phone, but later developed into the ride-sharing business that allows drivers to use their own cars to transport passengers. TNCs connect customers with nearby drivers through a smartphone app which is downloaded by both drivers and customers. Customers request a ride and local drivers using the app can accept the request. After the ride is complete, the app automatically charges the fare to the customer's credit card. TNCs profit by taking a percentage of the fares and leaving the remainder to the drivers. Uber began service in 2011, and its biggest competitor, Lyft, began operations in 2012.

The Uber story took a tragic turn in 2013 when 6-year old Sofia Liu died after she, her younger brother, and their mother were hit by a car in a San Francisco cross-walk on New Year's Eve.[13] At the time of the crash, the driver was logged on to the UberX smartphone app and was available to provide rides but did not have a passenger in the car. Uber initially took the position that it was not responsible for the accident because the driver was not carrying a passenger at the time. The case ultimately settled for a confidential amount, but it raised questions regarding Uber's liability, insurance coverage, and gaps.

After the Liu tragedy, there was significant political pressure on the TNCs to make sure liability insurance coverage was available to their drivers. This pressure resulted in a legislative solution in many states. Uber wisely participated in crafting this solution, and most states, including Texas, have adopted legislation based on a model compromise bill developed by insurers, insurance industry trade groups, and the TNCs themselves.[14]

In Texas, the Legislature adopted House Bill 1733, which became effective January 1, 2016, and is codified in chapter 1954 of the Texas Insurance Code.[15] This legislation ensures that insurance is available to accident victims even if not provided by the driver's personal automobile insurer. It also addresses the question of what insurance coverage is required during the time the driver is logged on to the TNC's digital network, but does not yet have a passenger. Unlike previous "carrying passengers for a fee" cases, this new period—which is generally known as Period 1—creates coverage questions for personal automobile carriers. There is no passenger in the car, but the active use of the app suggests commercial activity in a way that pre-Uber cases did not. Accidents occurring during this time may be excluded under the driver's personal automobile policy.

The new law requires that the TNC driver, or the TNC on the driver's behalf, maintain primary automobile insurance with bodily injury limits of $50,000 per person and $100,000 per accident, and $25,000 in property damage coverage for this period.[16] In addition, the TNC or the TNC driver is required to maintain insurance to cover the time which begins "at the time a driver accepts a ride requested by a rider through a digital network controlled by a transportation network company" and ends when "the last requesting rider departs from the driver's personal vehicle."[17] The insurance limits required for this period, known as the "prearranged ride" period, are significantly higher than the limits required for the period between prearranged rides: TNCs are required to maintain coverage with a total aggregate limit of liability of $1 million for death, bodily injury, and property damage for each incident.[18] For both periods, the statute further requires that the TNC or driver provide UM/UIM and personal injury protection (PIP) coverage as required by statute.[19] In other words, just as with personal automobile insurance, insurance carriers must obtain a written rejection of UM/UIM or PIP coverage or the coverage attaches.[20]

In all cases, the liability coverage required is not contingent on a driver's personal automobile insurer initially denying a claim.[21] And if the insurance maintained by a TNC driver has lapsed or does not provide the required coverage, "the transportation network company shall provide the coverage required by this subchapter beginning with the first dollar of a claim against the driver."[22] The statute does not require that the TNC or driver maintain insurance to cover property damage to the driver's vehicle.

The statute allows personal automobile insurance carriers to exclude coverage for both periods; i.e., when the driver is simply logged on and when the driver is in the prearranged-ride period.[23] It also specifically provides that personal automobile carriers with authorized exclusions do not have a duty to defend or indemnify a claim "arising from an event subject to the exclusion."[24] Presumably foreseeing some of the fact questions that might arise from the two-period distinction, the statute requires a TNC or insurer providing

coverage to assist each insurer involved in the claim by providing the following information to "directly interested persons" and an insurer of the TNC driver:

> (1) the precise times that a driver logged on and off of the transportation network company's digital network in the 12-hour period immediately preceding and the 12-hour period immediately following the accident; and
>
> (2) a clear description of the coverage, exclusions, and limits provided under an automobile insurance policy maintained under Subchapter B.[25]

In spite of the fact that the statute allows personal automobile insurers to exclude coverage, some have seen an opportunity to provide specific policies or riders for TNC situations. For example, GEICO advertises a hybrid policy that includes coverage for personal use, as well as "the added level of protection for ridesharing; all for a competitive price."[26]

III. The Road Ahead: Coverage Questions on the Horizon

Although TNCs continue to face litigation and regulatory issues, the model legislation adopted by Texas and other states should provide useful clarification to insurance professionals. There are, however, questions remaining. Texas insurance carriers must determine whether the standard livery or "carrying passengers for a fee" exclusion in their automobile policy is sufficient, or whether they should add endorsements tracking the specific exclusionary language contained in the statute. When personal automobile insurance carriers do provide coverage, how will their "other insurance" clauses interact with the TNC policy? Does the requirement to provide "clear information" regarding insurance coverage to "directly interested persons" open the door to third-party misrepresentation claims? Some drivers also have complained that Uber misrepresents the scope of insurance coverage, including the fact that the Uber policy will not cover the driver's own bodily injuries or property damage under any circumstance.[27] Uber passengers may also complain about being misled. For example, we have seen TNC policies that exclude coverage for accidents that occur on public airport property, an exclusion that we have not seen addressed in any public discussion of TNC insurance coverage.

Another potential area for abuse and concern is manipulation of the driver's status to maximize (or minimize) available insurance coverage or create extra-contractual exposure, as demonstrated by a recent case from Washington state. In *Trofimovich v. Progressive Direct Insurance Co.*, Lyft driver Trofimovich sued for bad faith after his personal automobile insurer initially denied his claim.[28] On first reporting the accident, Trofimovich stated, "I was working and I was driving for, uh, what's it called, Lift [sic]." He confirmed that he had a passenger in the car at the time of the accident.[29] The following day, however, Trofimovich told Progressive that he was doing the passenger a favor and that he had clocked out of Lyft an hour before he drove her home.[30] Although Progressive ultimately accepted the claim and provided coverage to Trofimovich, it initially had denied coverage based on the fact that he was driving for Lyft.[31] Trofimovich submitted ride history on the day of the accident showing an 11:26 a.m. ride as his latest.[32] However, it also appears that Trofimovich told Progressive he had passengers after his noon lunch break: "I had like one or two passengers, and then I was meeting a friend for lunch and then I had . . . to pick up some stuff at the store, and on the way back I picked them up."[33] From a subpoena to Lyft, Progressive obtained further records showing that Trofimovich logged onto Lyft at 1:51 p.m., off at 2:18 p.m., and back on again at 2:42 p.m.[34]

The court dismissed the case, finding that Progressive's initial denial of the claim was reasonable and rejecting Trofimovich's suggestion that Progressive had a duty to inquire whether his passenger was a paying customer.[35] The court noted that the confusion created by the evidence and Trofimovich's "App on. App off" history, was to Progressive's benefit.[36] Insurance carriers can expect that will not always be the case, and adjusters should be carefully trained in how to investigate claims involving these new technologies.

As we continue to grapple with the insurance complexities created by the ride-sharing gig economy, we need to prepare for a potentially larger host of issues presented by the next frontier: driverless cars. Stay tuned.

1 Gary L. Johnson, *The Practical Art: On the Archaeology and Architecture of Liability Insurance Contracts*, 78 Def. Couns. J. 143, 149–50 (2011).

2 *Id.*

3 *State Farm Fire & Cas. Co. v. Vaughan*, 968 S.W.2d 931, 932 (Tex. 1998).

4 *State Farm Fire & Cas. Co. v. Reed*, 873 S.W.2d 698, 701 (Tex. 1993).

5 *Id.* at 704 & n.4.

6 *Dhillon v. Gen. Acc. Ins. Co.*, 789 S.W.2d 293 (Tex. App.—Houston [14th Dist.] 1990, no writ).

7 789 S.W.2d at 294.

8 *Id*.

9 *Dhillon v. Gen. Acc. Ins. Co.*, No. C14-90-00714-CV, 1991 WL 51470, at * 2 (Tex. App.—Houston [14th Dist.] Apr. 11, 1991, writ denied).

10 *Fort Worth Lloyds Ins. Co. v. Lane*, 189 S.W.2d 78 (Tex. Civ. App.—Dallas 1945, no writ).

11 *Id.* at 79.

12 *Canal Ins. Co. v. Gensco, Inc.*, 404 S.W.2d 908, 909 (Tex. App.—San Antonio 1966, no writ) (emphasis added).

13 Dan Levine, *Uber Settles Wrongful Death Lawsuit in San Francisco*, Reuters, July 14, 2015, http://www.reuters.com/article/us-uber-tech-crash-settlement-idUSKCN0PO2OW20150715.

14 See Mark R. Goodman, *Insurance for the Sharing Economy*, 26 Westlaw Journal Insurance Coverage 1 (2015).

15 Tex. Ins. Code Ann. § 1954.001 *et seq.*

16 *Id.* § 1954.052.

17 *Id.* § 1954.053.

18 *Id*.

19 *Id*.

20 *See id.* § 1952.101 (UM/UIM) and § 1952.152 (PIP).

21 *Id.* § 1954.055.

22 *Id.*

23 *Id.* § 1954.151.

24 *Id.* § 1954.153.

25 *Id.* § 1954.154.

26 https://www.geico.com/information/aboutinsurance/ride-sharing/faq/.

27 Jennie Davis, *Drive At Your Own Risk: Uber Violates Unfair Competition Laws By Misleading UberX Drivers About Their Insurance Coverage*, 56 B. C. L. Rev. 1097, 1103 (2015)**;** *see also* Randy Wallace, *Accident Leaves Houston Uber Driver with Regrets*, MY FOX HOUSTON, Jan. 4, 2015, 10:30 PM, http://www.myfoxhouston.com/story/27656550/accident-leaves-houston-uber-driver-with-regrets, *archived at* http://perma.cc/8KDM-7XS6 (reporting that a Houston UberX driver who caused a collision was unable to get compensation for his own injuries through Uber's insurance).

28 *Trofimovich v. Progressive Direct Ins. Co.*, No. 2017 WL 3424980, 2017 WL 3424980 at * 1 (W.D. Wash. Aug. 8, 2017).

29 *Id.* at *1.

30 *Id*. at *2.

31 *Id*.

32 *Id*. at *3 n.2

33 *Id*.

34 *Id*.

35 *Id.* at *3.

36 *Id*. at *3 n.2.

34 *Id.*

35 *Id.* at *3.

36 *Id*. at *3 n.2.

By Rachelle H. Glazer and John P. Atkins

RECENT FIFTH CIRCUIT AND TEXAS SUPREME COURT INSURANCE DECISIONS

TEXAS SUPREME COURT

Trials are "adversarial" if the defendant has something at stake.

***Great American Insurance Co. v. Hamel*, No. 14-1007, 2017 WL 2623067 (Tex. June 16, 2017)**

After deciding several insurance-related cases in its latest session, including the important *USAA Texas Lloyds Co. v. Menchaca*,[1] the Texas Supreme Court issued another sure-to-be influential decision clarifying its prior decision in *State Farm Fire & Casualty Co. v. Gandy*.[2] In *Gandy*, the court had invalidated an insured defendant's prejudgment assignment of a claim to a plaintiff because the assignment served only to distort and prolong litigation by incentivizing the parties to take positions contrary to their traditional interests.[3] The court famously held that in no event would an insurer be bound to a liability judgment unless it was the product of a fully-adversarial trial.[4] A great deal of ink has been spilled discussing the scope of *Gandy*'s fully-adversarial requirement. The court aimed, in *Hamel*, to settle those questions.

This case arose from a home construction dispute. Glen and Marsha Hamel sued their contractor, Terry Mitchell Builders, for improper installation of exterior stucco, which resulted in significant water damage to their home. The contractor's insurer, Great American Insurance Company, declined to defend, arguing that the applicable policy excluded coverage for losses resulting from installation of exterior stucco. The contractor lacked the funds to meaningfully contest the Hamels' lawsuit.[5]

Instead, the contractor's attorney entered into a Rule 11 agreement with the Hamels. In exchange for a promise that the contractor would not ask for a continuance, the Hamels agreed to not attempt to pierce the corporate veil or enforce any judgment against the contractor's "personal tools of the trade and truck," which, ultimately, constituted all of the contractor's assets at the time. Then, the day before trial, the parties agreed to a series of stipulations, in which the contractor essentially conceded liability. The parties also stipulated that none of the damages at issue in the case arose from exterior stucco.[6]

Although the stipulations were not admitted into evidence at trial, the contractor's owner (whom the Hamels called) testified consistently with the stipulations, including that he had made some "honest mistakes." The Hamels' other witnesses testified to the same. The contractor called no witnesses, and did not submit findings of facts and conclusions of law at the close of trial. Unsurprisingly, the trial court found for the Hamels, awarding $365,089 in damages. The contractor then assigned its claims against Great American to the Hamels.[7]

The Hamels then sued Great American for breach of contract and declaratory relief. The record of the liability suit was presented to the court, as were the stipulations, Rule 11 agreement, and contract. Though Great American put on witnesses, the judgment in the liability case proved insurmountable, and the court found that (1) the liability trial was an adversarial proceeding, and (2) the result of that trial was binding on Great American. The court further found that Great American had breached the policy by not tendering a defense and indemnifying the contractor's loss. The court found $355,838 in covered damages. Great American appealed this judgment, alleging that the liability trial was not fully adversarial under *Gandy* and therefore not binding on Great American, but lost on appeal as well. Great American appealed to the Texas Supreme Court.[8]

The court's opinion, which Justice Lehrmann wrote, was a model of efficiency. Great American did not dispute that it wrongfully refused to defend the contractor, but argued that, under *Gandy*, it should not be bound by the liability judgment because the liability judgment was not the product of a fully adversarial trial. The court noted that *Gandy*'s primary rule, regarding factors for determining when an assignment by an insured to a plaintiff is invalid, was inapplicable on these facts—the parties did not dispute that the contractor could assign its claims against

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Great American to the Hamels. The question was *Gandy*'s secondary rule: what constituted a fully-adversarial trial on the merits that was binding against an insurer? The Hamels contended that there was no evidence of fraud or collusion with respect to the liability judgment, while Great American argued that the pretrial agreement and stipulations between the Hamels and the contractor rendered the liability trial essentially a sham.[9]

The court first reviewed two cases that have often been considered in conflict with *Gandy's* pronouncement regarding the need for an adversarial trial. Before *Gandy*, in *Employers Casualty Co. v. Block*,[10] the court had enforced an agreed judgment against an insurer, finding the insurer's wrongful failure to defend barred it from collaterally attacking the judgment.[11] After *Gandy*, in *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*,[12] the court held that *Block* rather than *Gandy* governed in a case in which an insurer tried to contest a settlement after it wrongfully failed to defend, because *Gandy*'s policy concerns were not implicated and the insured directly sued its insurer.[13] The court explained that the question on which all three cases turned was this: how accurately does the underlying judgment reflect both the plaintiff's damages and the insured's covered loss?[14]

Justice Lehrmann explained that the fully-adversarial test was one way to make certain that judgments reflected real policyholder damages: If the parties fully and effectively contested one another's positions, then one could trust that the result was as accurate as the legal system could reliably produce. However, how does one accurately determine whether a particular trial was fully adversarial? The court noted that the court of appeals had decided, based on its review of the proceedings at the liability trial, that the process satisfied *Gandy*. The court disapproved of this mode of review; it noted that it had (in other contexts) held that an appellate court's review of the strategies and tactics of litigators often produces inaccurate results.[15]

The court found that the court of appeals' approach was, essentially, a misunderstanding of what the court meant by "fully adversarial" in *Gandy*. What mattered, ultimately, is not the actions of the parties at trial, but whether the parties to the litigation truly opposed one another—whether they had truly contrary interests. *Atofina* involved contrary interests because the insured retained the risk of loss. (There was no assignment of benefits: If the insured could not recover against the insurer, the insured was on the hook for the judgment.) In *Gandy*, by contrast, the assigning insured had no incentive to litigate. A proceeding is adversarial, the court explained, when the insured defendant has a genuine financial stake in avoiding a judgment.[16]

Synthesizing this holding, the court summarized:

> When the parties reach an agreement before trial or settlement that deprives one of the parties of its incentive to oppose the other, the proceeding is no longer adversarial. Stated another way, proceedings lose their adversarial nature when, by agreement, one party has no stake in the outcome and thus no meaningful incentive to defend itself.[17]

The court determined that on the facts before it, the insured contractor had no financial stake in the outcome of the liability trial. By agreeing to not attempt to pierce the corporate veil, and to not pursue any judgment against a specific class of assets that encompassed all of the assets in the contractor's possession, the Hamels had eliminated any incentive on the part of the contractor to oppose them at trial. As a result, the proceeding was not adversarial, and Great American was not bound by it.[18]

The court did not completely shut the door on pre-trial agreements by insureds, however, or even on pre-trial agreements that eliminated an insured's financial interest in defending itself. The court noted that a defendant's lack of financial stake merely creates a "strong presumption" that a proceeding is not adversarial, while the existence of a financial stake creates a strong presumption that the proceeding is fully adversarial. The court theorized that an insured or plaintiff could rebut the former presumption by showing the existence of a non-financial incentive on the part of the defendant to litigate, whereas an insurer could rebut the latter presumption with evidence that the defendant, while ostensibly financially at risk, really had no incentive to defend itself.[19]

The court then turned to the question of whether the coverage proceedings cured any problems with the liability trial. The court was sympathetic to both Great American and the Hamels' positions. On the one hand, Great American should not be held to a plainly non-adversarial result in the liability trial, and the liability trial could not be undone. On the other hand, it was unfair to render judgment in Great American's favor, because Great American, by failing to defend, had forced the contractor to proceed to trial without a defense or the resources to defend itself. The only solution the court could identify was to allow relitigation of the liability and damages issues at the coverage trial.[20]

The court found that liability and damages were not adequately addressed in the coverage litigation because the prior liability trial and its holdings necessarily forced the focus of the coverage litigation away from the general liability and damages issues. Concordantly, the court could only remand for new trial for reconsideration of liability and damages.[21]

Although the court's decision in this case was admirably clear, it is still likely to engender substantial controversy. One significant area of concern is the court's new presumptions for and against meeting the fully-adversarial test. The

quantum of evidence required to overcome a presumption that a trial is adversarial (because a defendant had some financial stake in the outcome) or that it is not adversarial (because the defendant lacked any financial stake) is likely to be a source of some disagreement in future litigation.

FIFTH CIRCUIT

Umbrella insurer with subrogation rights has power to pursue reformation against another umbrella insurer.

***Associated International Insurance Co. v. Scottsdale Insurance Co.*, 862 F.3d 508 (5th Cir. 2017)**

This short case teaches an important lesson about the scope of a subrogation under Texas law. The case arises from an assault in an apartment complex resulting in litigation against the owner of the complex and the complex's property manager. The complex owner's primary policy also covered the property manager, but each had separate umbrella insurance. The matter settled for an amount in excess of the primary coverage, and the complex owner's umbrella insurance company, Associated International Insurance Company, paid the loss in excess of primary coverage. Associated then sued the property manager's umbrella insurer, Scottsdale Insurance Company, for reimbursement, despite the Scottsdale umbrella policy not specifically listing the apartment complex on its schedule of covered properties.[22]

Associated contended it could seek reformation of the Scottsdale policy because the policy gave Associated subrogation rights regarding any claims the property manager might have that Associated paid for. The district court was unconvinced, holding that Associated lacked privity and could not seek reformation of the Scottsdale policy. Associated appealed.[23]

The court began its analysis by acknowledging that no Texas court had yet squarely addressed the question of whether a subrogation clause can allow a subrogee to demand reformation of a policy between an insurer and a third party. However, the court pointed out that the law is very clear that Texas recognizes subrogation to the "fullest extent" and that Texas courts have good policy reasons for so doing.[24]

The question of whether subrogation rights include a right to seek reformation of a contract turned, the court decided, on whether Associated was in privity with the property manager, not whether it was a party to the Scottsdale policy. The district court had held that Associated lacked privity because it did not have a direct connection to the Scottsdale policy, but this was the wrong approach; what mattered, the court held, was whether a subrogation relationship itself created privity.[25]

Citing significant persuasive authority, the Fifth Circuit answered that question in the affirmative. Subrogation relationships, because they enable the subrogee to stand in the shoes of the subrogor, create—or, more analogously, assign—the necessary privity to demand reformation. Essentially, because the subrogor (the property manager) could have demanded reformation, so could its subrogee (Associated).[26]

The court also addressed Scottsdale's argument that subrogation clauses were not pure assignments: They did not, for instance, allow subrogees to pursue punitive or statutory damages. The court held, however, that such restraints existed to avoid subrogees obtaining a windfall by recovering more than they paid. But the proposed reformation did not threaten such a windfall—Scottsdale only sought to recover what it had paid.[27]

Because Scottsdale's complaint had been dismissed before any consideration of the merits, the actual merits of the reformation claim were not before the court, and remand was the only option. However, this case sends a strong message nonetheless: The scope of subrogation clauses in Texas will be construed liberally in favor of subrogees, even where the subrogee first must seek non-standard remedies like contract reformation before pursuing reimbursement.

Insurer had no duty to defend under advertising injury coverage for claim of federal trademark infringement.

***Laney Chiropractic & Sports Therapy, P.A. v. Nationwide Mutual Insurance Co.*, 866 F.3d 254 (5th Cir. 2017)**

This case arises out of a lawsuit for federal trademark infringement and related claims. The defendant, Laney Chiropractic & Sports Therapy, P.A., had long offered a type of massage therapy trademarked by Dr. Michael Leahy, called "Active Release Techniques" or "ART." Originally, Laney provided these services pursuant to a license with Leahy's ART Companies. Eventually, Laney lost the license and began to compete with the ART Companies. The facts show that Laney had ceased labeling its services as ART by the time of the suit, but was otherwise describing the services as it had before. The ART Companies sued Laney for federal trademark infringement, among other things.[28]

Laney tendered the ART Companies' complaint to Nationwide Mutual Insurance Company, its insurer. The Nationwide policy covered:

> Personal and advertising injury… arising out of one or more of the following offenses:
>
> ...
>
> f. The use of another's advertising idea in your "advertisement"; or
>
> g. Infringing upon another's copyright, trade dress or slogan in your "advertisement"

Nationwide denied a defense, contending the federal trademark allegations did not allege facts that would fall within the scope of this coverage. The parties both moved for summary judgment and Nationwide prevailed. Laney appealed.[29]

After setting the stage by laying out the eight corners rule, the Fifth Circuit turned to Laney's three arguments on appeal. These were that the ART Companies' lawsuit fell within the scope of the policy's advertising injury coverage in three ways: (1) by alleging use of the ART Companies' advertising ideas; (2) by alleging trade dress infringement; and (3) by alleging slogan infringement.[30]

On the first argument, the court started by noting that the policy did not define the term "advertising idea." Citing both Texas authority and persuasive federal authority, the court found that advertising ideas were concepts or ideas related to promoting a product to the public. Laney argued that the ART Companies' complaint alleged use of the ART Companies' advertising ideas when it described Laney's use of phrases like "soft tissue techniques" and "more than 500 techniques," because the complaint similarly described ART as a "soft tissue system" that featured more than 500 techniques. However, the complaint did not indicate that ART advertised itself as featuring more than 500 techniques, or that the ART Companies used the phrase "soft tissue system" or anything similar in its advertisements. Essentially, the court found that the complaint could not allege use of an advertising idea because it did not allege that the ART Companies had any advertising ideas, or used any of the advertising phrases cited in the complaint.[31]

The court further found that the result would still hold even if all of the phrases descriptive of the ART product had been identical between Laney and the ART Companies, and the complaint had alleged such identity. This is because courts generally distinguish between advertisement and the product being advertised. What the complaint alleged was use of the ART Companies' product, and advertisement of that infringing product was not the same as making use of Laney's "advertising ideas." The court concluded:

> Because, without more, taking and then advertising another's product is different from taking another's "advertising idea," the Underlying Complaint does not allege that Laney used ART's "advertising idea."[32]

The court did not view Laney's trade dress argument any more favorably. Relevant authority held that trade dress referred only to incidental, arbitrary, or ornamental features of a product that serve merely to identify its source. A claim that a product was copied in toto, like that in the ART Companies' complaint, necessarily differed in kind from a trade dress infringement claim. Moreover, the ART Companies' trademark claims also did not state trade dress claims, because unlike trademarks, trade dress is a purely aesthetic question. Moreover, since the ART Companies' complaint did not allege any specific trade dress elements—distinctive to the ART Companies' advertisement or marketing of their product—that were purportedly infringed, it did not specify any specific trade dress elements it was seeking to protect. Finally, the allegations regarding Laney's website in the ART Companies' complaint did not assert any aesthetic similarities that would give rise to a trade dress claim.[33]

Laney's last argument was that the ART Companies had effectively alleged slogan infringement by referring to Laney's use of the terms "ART" and "Active Release Techniques" before 2014, and continued use of phrases like "soft tissue techniques" and "more than 500 techniques" thereafter. But brand names and product names are not advertising slogans, nor are mere descriptions of the product, however similar. A slogan is, the parties agreed, a "distinctive cry, phrase, or motto of any party, group, manufacturer, or person; catchword or catch phrase."[34]

Laney did not identify any catchy, stand-alone phrase that the ART Companies alleged it had stolen. In fact, the ART Companies had not, in their complaint, set forth anything that might qualify as a slogan. Consequently, the ART Companies complaint did not allege slogan infringement, and so coverage for a slogan infringement claim was not implicated. Having disposed of all Laney's arguments, the court affirmed the district court's grant of summary judgment to Nationwide.[35]

This case should be a cautionary tale for any insured relying on advertising injury coverage to protect them from trademark or other intellectual property claims. Unless the allegations in a complaint really do relate to the theft of advertising ideas, rather than the theft of the product being advertised, it is likely that the insurer does not have a duty to defend, much less a duty to indemnify.

Allegations that business could not undertake work without infringing on a patent constituted "disparagement" under personal and advertising injury coverage.

***Uretek (USA), Inc. v. Continental Casualty Co.*, No. 15–20104, 2017 WL 3225700 (5th Cir. July 28, 2017)**

In this case, Uretek (USA), Inc., a roadway maintenance company insured by Continental Casualty Company, sued its competitor, Applied Polymerics, for patent infringement. Applied asserted a counterclaim against Uretek for which Uretek sought a defense from Continental. Continental denied a defense, and the district court granted summary judgment in Continental's favor, holding that Applied's counterclaim did not allege personal or advertising injury.[36]

The policy at issue covered several types of advertising injury, including claims of disparagement of another business's "goods, products, or services." The parties agreed Texas state

law controlled the coverage dispute, and the court began by stating the traditional Texas rules, including the eight corners rule.[37]

The counterclaim at issue alleged Uretek was using a patent under its control—the "831 Patent"—to prevent competitors from bidding on certain construction projects, including those that would not implicate any of the processes covered by the patent. Among Applied's factual allegations was that it had entered into a construction contract to perform work on a highway for the Virginia Department of Transportation, and Uretek "falsely represented" to VDOT that the project was covered by the patent.[38]

Moreover, Applied argued that Uretek had deceived many government-authority customers, causing Applied to receive fewer contracts than it otherwise would have. Applied further alleged violations of the Sherman Act, referring again to the VDOT contract, and violations of North Carolina unfair competition laws. All of these claims essentially involved the following basic premise—Uretek was telling potential customers of Applied that Applied lacked the legal right to undertake their work because of Uretek's patent. Resolving, as Texas law required, all ambiguities regarding the definition of "disparage" in favor of coverage, the court found such statements constituted disparagement, and claims alleging such statements triggered Continental's duty to defend.[39]

The court distinguished a case Continental relied on, *KLN Steel Products Co. v. CNA Insurance Companies*,[40] in which a competitor had sued KLN for manipulating the bidding process to supply beds to a Navy training facility. KLN allegedly overstated its status as developer of the relevant bed; KLN contended that, essentially, its competitor was alleging that KLN was disparaging the competitor's products by claiming they were knock-offs of KLN's design.[41] But the court found these facts distinguishable. First, *KLN* did not deal with any specific statements made to any particular potential customer, while Applied had specifically alleged that Uretek had made disparaging representations to VDOT. Second, *KLN* did not involve an allegation that one company was legally unable to supply the beds involved in that case; Uretek allegedly told customers of Applied that Applied essentially had no right to take on the projects on which it was bidding. The statements in *Uretek* clearly were more disparaging than those at issue in *KLN*.[42]

Continental then argued that its policy was intended to limit coverage of disparagement claims to those that actually alleged the tort of business disparagement, but the court held that the language of the policy did not support this construction. "Disparage" was to be given its plain, rather than its legal, meaning, unless the policy specifically indicated otherwise.[43]

Finally, Continental argued that even if the counterclaim alleged disparagement, two exclusions applied: one for any act done "with the knowledge that the act would violate the rights of another and would inflict personal and advertising injury," and another for personal or advertising injuries resulting from oral or written publications of statements "with knowledge of [the statements'] falsity." The court first noted that, under Texas law, the insurer has the burden of showing an exclusion applies. Moreover, the court pointed out that Applied's counterclaim charged both intentional and negligent conduct, alleging Uretek "knew or should have known" certain representations were false. Because Applied could prevail by showing an unintentional misrepresentation, Uretek was entitled to a defense by Continental, since the counterclaim alleged some claims that could fall within the scope of coverage and not fall within either exclusion. The court therefore reversed the district court's grant of summary judgment in Continental's favor and remanded for further proceedings.[44]

This case shows that a statement impugning a business's right to sell certain goods or provide certain services can constitute business disparagement for the purposes of advertising injury coverage, even if the goods or services themselves are not criticized; something insurers covering patent-holders should keep in mind.

1 No. 14–0721, 2017 WL 1311752 (Tex. Apr. 7, 2017) (covered last issue).

2 925 S.W.2d 696 (Tex. 1996).

3 *Id.* at 711–14.

4 *Id.*

5 *Great Am. Ins. Co. v. Hamel*, 14–1007, 2017 WL 2623067, at *1–2 (Tex. June 16, 2017).

6 *Id.* at *2–3.

7 *Id.* at *3.

8 *Id.* at *4.

9 *Id.* at *5.

10 744 S.W.2d 940 (Tex. 1988), *disapproved of by State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996).

11 *Id.* at 943.

12 256 S.W.3d 660, 673 (Tex. 2008)

13 *Id.* at 673–74.

14 *Hamel*, 2017 WL 2623067, at *6

15 *Id.* at *7.

16 *Id.* at *7–8.

17 *Id.* at *8.

18 *Id.* at *8–9.

19 *Id.* at *9.

20 *Id.* at *10.

21 *Id.* at *10–11.

22 *Associated Int'l Ins. Co. v. Scottsdale Ins. Co.*, 862 F.3d 508, 509 (5th Cir. 2017).

23 *Id.*

24 *Id.* at 509–10.

25 *Id.* at 510.

26 *Id.* at 510–11.

27 *Id.* at 511.

28 *Laney Chiropractic & Sports Therapy, P.A. v. Nationwide Mut. Ins. Co.*, 866 F.3d 254, 258 (5th Cir. 2017).

29 *Id.*

30 *Id.* at 259.

31 *Id.* at 260.

32 *Id.* at 261.

33 *Id.* at 262.

34 *Id.* at 263 (quoting *Cincinnati Ins. Co. v. Zen Design Grp., Ltd.*, 329 F. 3d 546, 556 (6th Cir. 2003)).

35 *Id.* at 263.

36 *Uretek (USA), Inc. v. Cont'l Cas. Co.*, No. 15-20104, 2017 WL 3225700, at *1 (5th Cir. July 28, 2017).

37 *Id.*

38 *Id.* at *2.

39 *Id.* at *3.

40 278 S.W.3d 429 (Tex. App.—San Antonio 2008, pet. denied).

41 *Id.* at 438.

42 *Uretek*, 2017 WL 3225700, at *3.

43 *Id.* at *4.

44 *Id.*

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