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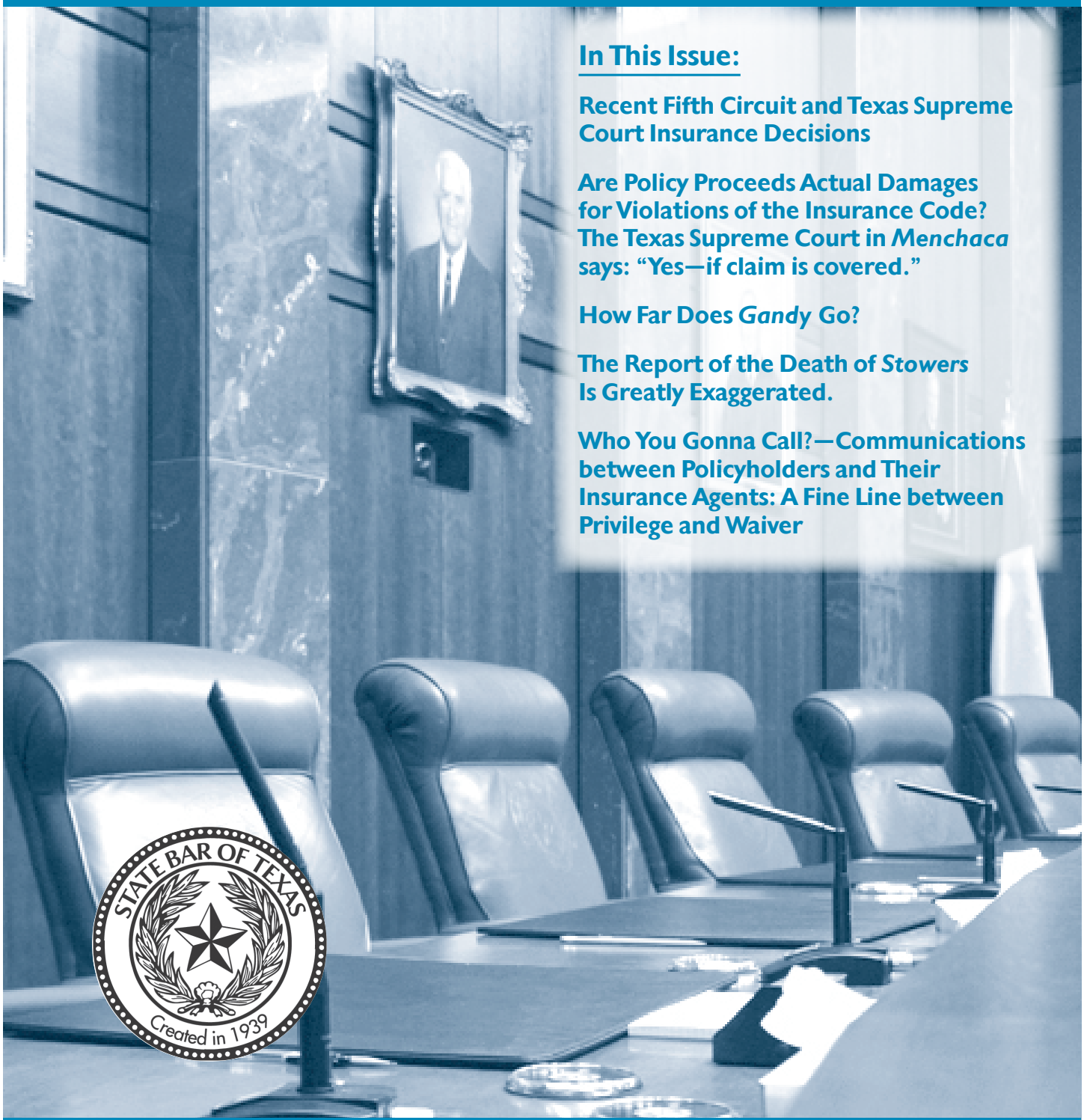

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The Journal of Texas Insurance Law is published by the Insurance Law Section of the State Bar of Texas. The purpose of the ***Journal*** is to provide Section members with current legal articles and analysis regarding recent developments in all aspects 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.

Journal of Texas Insurance Law

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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.

STATE BAR OF TEXAS
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Comments

FROM THE EDITOR

By Pamella A. Hopper
McGuireWoods LLP

In this issue of the *Journal*, I am pleased to include an array of cutting-edge commentary important to the jurisprudence of Texas insurance law, including Laura Grabouski's article on the Texas Supreme Court's recent ruling in *USAA Lloyds Co. v. Menchaca*. While we await the Texas Supreme Court's much-anticipated ruling in *Great American Insurance Company v. Hamel*, which will test the court's *Gandy* ruling on what constitutes an adversarial trial, you can read Marcus R. Tucker and Sara Nau's article discussing the possible outcomes, and why this case matters. Also in this issue are Tarron Gartner-Ilai and Katya Long's article on privilege between policyholders and their insurance brokers, Blair Dancy's update on the state of *Stowers* law, as well as Rachelle Glazer and John Atkins's always-illuminating review of recent Fifth Circuit and Texas Supreme Court insurance law decisions.

Thanks go to these authors, and to Associate Editor Rebecca DiMasi, whose editing skills once again have proved essential. As always, I extend a special thank you to Alyson Wagner, whose assistance in getting the *Journal* to print remains indispensable.

The *Journal* would be happy to publish similar articles relating to Texas insurance law for the benefit of the bench and bar. Please email articles or proposed topics to me at phopper@mcguirewoods.com.

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 L. Kimberly Steele

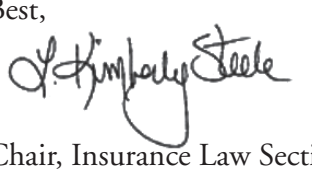
As my tenure as Chair of the Insurance Law Section comes to a close, I am pleased to report that the past year has been a really good one for the Section. Our membership numbers are higher than they've been in years, our finances are strong, our members are active and engaged, and our recent Advanced Insurance Law Course held at the Hyatt Hill Country Resort & Spa in San Antonio on June 8–9, 2017 drew record numbers.

The success of the Section is due entirely to the hard work and dedication of the Officers, Council and Committee Chairs, Co-Chairs, and members. In particular, I want to recognize Pam Hopper and her editorial staff. Pam has ably served as Editor-In-Chief of the Section's *Journal of Texas Insurance Law* and has done a wonderful job of ensuring that the *Journal* remains relevant and informative and is issued on a consistent and timely basis. Pam will join the Officer ranks this year as Treasurer of the Section—a much deserved advancement. I would also like to thank Executive Director, Donna Passons, and Bill Seward, both of the Texas Institute of CLE. They make the job of Chairing the Section immeasurably easier and keep the Section running smoothly.

I now turn the reigns over to incoming Chair, Meloney Perry. I have no doubt that Meloney will serve you and the Section very well. She is already busily outlining her committee selections and making plans for further improvements to the Section. So, expect great things.

It has been a privilege and an honor to serve as the Section's Chair this past year, just as it was to serve on the Executive Board, the Council, and as Publications Editor all the years prior. The Section has improved by leaps and bounds in recent years and I feel certain that it will continue on this trajectory going forward.

Best,



Chair, Insurance Law Section

By Rachelle H. Glazer and John P. Atkins

RECENT FIFTH CIRCUIT AND TEXAS SUPREME COURT INSURANCE DECISIONS

TEXAS SUPREME COURT

Five rules addressing the relationship between contract claims under an insurance policy and tort claims under the Insurance Code

***USAA Texas Lloyds Co. v. Menchaca*, No. 14–0721 (Tex. Apr. 7, 2016)**

The major headline of the Texas insurance world as this article went to press, the Texas Supreme Court's decision in *USAA Texas Lloyds Co. v. Menchaca* seeks to clarify some confusing precedent on the subject of the interrelationship between contract claims on an insurance policy and statutory claims under the Insurance Code.

At the center of this case was a claim by plaintiff Gail Menchaca under her homeowner's insurance policy with USAA Texas Lloyds Company. The claim, like that in many of the cases we have surveyed in this update over the past few years, arose from damage caused by Hurricane Ike. USAA adjusters found insufficient damage to exceed Menchaca's deductible, and so USAA paid nothing. Menchaca sued, both for breach of the policy and for unfair settlement practices under the Insurance Code. She sought only insurance benefits, court costs, and attorney fees as damages.[1]

At trial, the jury made findings that turned the case into the kind of problem that gave us all fits in law school. The jury found that USAA complied with the terms of its policy, but also that USAA had violated the Insurance Code by engaging in unfair and deceptive practices and failing to conduct a reasonable investigation. The jury awarded damages equal to the amount it calculated USAA should have paid under the policy. The trial court granted judgment to Menchaca, and the court of appeals affirmed.[2]

After certiorari, each side had Texas Supreme Court decisions to cite in support of their positions. USAA cited *Provident American Insurance Co. v. Castañeda*,[3] in which the court had held that "failure [of an insurer] to properly investigate a claim is not a basis for obtaining policy benefits." Menchaca, on the other hand, argued the jury had explicitly found that USAA *should* have paid her the damages they awarded, and therefore she was entitled to those damages under *Vail v. Texas Farm Bureau Mutual Insurance Co.*,[4] in which the court held that where an insurer unfairly refuses to pay a claim, the damages, as a matter at law, are at least equal to the policy benefits withheld. The court admitted that its opinions in these two cases seemed at odds, and had created considerable confusion among lower courts and with commentators.[5]

In an attempt to unwind the knot its precedents had created, the court turned back to first principles. After reviewing the basics of contract law, the court noted that while contract and statutory claims arising from an insurance claim are interrelated, they ultimately are independent. The precise nature of the interrelationship is complicated, however, and so the court reviewed its precedent to set forth five rules governing how claims under the policy and claims under the statute relate.[6]

First, the court enunciated what it called the "general rule." Under this rule, an insured cannot recover policy benefits for a statutory violation if the insured is not entitled, under the policy, to those benefits. The court explained that this rule arose from the Insurance Code's text, which provides that an insured is only entitled to damages "caused by" a statutory violation; if policy benefits were never available, a statutory violation cannot have caused the insured to lose those benefits. Although this rule originally arose in the context of a bad faith claim,[7] the court had extended the general principle to other extra-contractual causes of action sounding in the Insurance Code. The court traced its history of this rule through various cases, finding that it had never explicitly decided that the "general rule" applied to an insurer's failure to investigate a claim (although it came closest in *Castañeda*).[8]

The court determined that the argument on which Menchaca had prevailed before the court of appeals—that her extra-contractual claims were independent and that the value of the policy benefits was an award for that independent injury—was foreclosed by its precedent. No

Rachelle ("Shelley") H. Glazer is a Partner at Thompson & Knight LLP in Dallas and focuses her practice on business and contract disputes, including complex insurance contract disputes. She has previously chaired the Torts and Insurance Practice Section of the Dallas Bar Association and been named one of The Best Lawyers in America® in Insurance Law for 2012–2016 and a Texas Super Lawyer® in Insurance Coverage for 2012–2016. She can be reached at Rachelle.Glazer@tklaw.com.

John P. Atkins is an Associate at Thompson & Knight LLP in Dallas, and focuses his practice on commercial litigation, health, and insurance law.

statutory violation could have "caused" Menchaca to have lost her policy benefits if the jury had found she had no entitlement to such benefits in the first place. However, the court declined to find that the general rule applied in this case, because that very finding was unclear; although the jury did not find that USAA breached the policy, they also did not find that Menchaca was not "entitled to benefits" under the policy. The court explained:

> While an insured cannot recover policy benefits for a statutory violation unless the jury finds that the insured had a right to the benefits under the policy, the insured does not *also* have to establish that the insurer breached the policy by refusing to pay those benefits. . . . [I]f the jury finds that the policy entitles the insured to receive the benefits and that the insurer's statutory violation caused the insured to not receive those benefits, the insured can recover the benefits as "actual damages . . . caused by" the statutory violation.[9]

The court then turned to the second of its five rules, which it called the "Entitled-to-Benefits" rule. This rule is the mirror-reflection of the general rule: It provides that if an insured has the right to receive benefits under the policy, and an insurer's statutory violation causes it to lose those benefits, then the insurer can recover policy benefits for the statutory violation. USAA had argued that the general rule meant, essentially, that no policy benefits could ever be recovered through a statutory claim, because if the insured had coverage, the insured's remedy was for breach of contract—the statute only covered *truly* independent injuries imposed outside of the policy benefits. The court rejected this argument, noting it had never overruled *Vail*, and explaining that where an insured is entitled to benefits under the policy and has been denied them by an insurer's statutory violation, the insured can recover policy benefits in contract *or* through a statutory claim.[10]

The third rule the court announced it titled the "Benefits-Lost Rule." Under this rule, even if an insured does not have the right to coverage under an insurance policy, the insurer may still recover policy benefits under a statutory cause of action if the insurer's wrongful conduct caused the insured to lose the right to coverage. For instance, if an insurer misrepresents its coverage in violation of statute, that violation may entitle the insured to recover policy benefits under a statutory cause of action if the insured relied on the misrepresentation. The court gave as another example the fact situation in *JAW the Pointe, L.L.C. v. Lexington Insurance Co.*,[11] a case that involved a policy covering numerous apartment complexes but had an aggregate per-occurrence sublimit. After Hurricane Ike, the insurer was bombarded with claims. One of the claims it denied resulted in a lawsuit, and during the pendency of the suit, the policy hit its coverage ceiling. The insured argued that the insurer's statutory wrongful denial was the cause of his inability to get policy benefits. The court accepted this argument, but ultimately found against the insured because of the application of the exclusion. Still, this example shows how the "Benefits-Lost Rule" works: An insured cannot violate the statute in a way that causes an insured to no longer be entitled to coverage and then argue that policy benefits are not recoverable on the resulting statutory claim.[12]

The fourth rule the court examined was the "Independent-Injury Rule." Under this rule, an insured may recover non-policy benefit injuries incurred as a result of a statutory violation, even if the insured is not entitled to coverage under the policy. However, the injury must truly be independent—it cannot be derivative of the non-recovery of policy benefits. Second, this rule also means that a statutory violation does not allow recovery of anything more than the policy benefits denied unless the violation caused an injury independent of the loss of benefits. For instance, punitive damages are unavailable even in the event of bad-faith conduct if the insured suffers no independent injury.[13]

The court's fifth and final rule it christened the "No-Recovery Rule." Under this rule, no insured may recover any statutory damages unless the insured (1) has a right to receive benefits under the policy or (2) an injury independent of a right to receive benefits.[14]

Applying its five new rules to the case before it, the court found that it could not ultimately decide the matter. The court determined that both the trial court and the appellate court had erred in disregarding the jury's negative answer to the "breach" question, but did not find that, as a matter of law, this meant Menchaca was not entitled to recover. Instead, having clarified the relevant rules, the court remanded the case for a new trial consistent with its new rules.[15]

This case will quickly jump high up on the list of most frequently cited Texas insurance cases. In some ways, it provides much-needed clarity. However, "independent injury" remains elusive and defied the court's otherwise heroic efforts to research and find positive examples of its rules.

Fencing is part of a "dwelling" under a casualty policy.

***Nassar v. Liberty Mutual Fire Insurance Co.*, 508 S.W.3d 254 (Tex. 2017)**

This is yet another Hurricane Ike case. In this case, the hurricane damaged the Nassars' home, and in particular, the extensive fencing of various kinds enclosing and dividing their six-acre property. The Nassars had significant insurance, including $247,200 on their "dwelling" and $24,720 on

"other structures." The Nassars and their insurer, Liberty Mutual Fire Insurance Company, came into conflict when Liberty Mutual characterized the nearly $60,000 in damage to the fencing as damage to "other structures," thereby significantly limiting coverage.[16]

The Nassars sued, contending that damage to the fencing fell under the "dwelling" coverage of their policy. Each party moved for summary judgment, and the trial court granted it in favor of Liberty Mutual. The Nassars appealed, and the court of appeals (in a decision that drew a dissent) affirmed the trial court's determination. The Nassars appealed again.[17]

The Texas Supreme Court began by fully setting out the relevant provisions of the policy. Under its terms, the policy covered:

> 1. the dwelling on the residence premises shown on the declarations page including structures attached to the dwelling.
>
> 2. other structures on the residence premises set apart from the dwelling by clear space. This includes structures connected to the dwelling by only a fence, utility line or similar connection.[18]

The Nassars contended that their extensive fencing was attached to their residence by four bolts, and therefore fell under the "dwelling" provision. Liberty Mutual argued that the fencing was itself only connected by fencing, and that if other structures connected by fencing were to be counted as other structures, so was the fencing itself. The court of appeals had agreed with Liberty Mutual, and held that the Nassars' interpretation would have resulted in the "other structures" provision being rendered meaningless.[19]

The Texas Supreme Court found this reasoning unpersuasive. Indeed, the court even disagreed with the dissent at the court of appeals, which had argued that the policy was ambiguous and so should be construed in favor of the Nassars. Instead, the Texas Supreme Court found that the policy was unambiguously favorable to the Nassars, not Liberty Mutual.[20]

First, the court found that "structure" as used in both provisions and as the term is commonly used plainly encompasses fencing. As a result, considering only the first sentence of each provision, the fence was plainly covered under the "dwelling" provision as it was a structure attached (by bolts in four places) to the dwelling, and was not separated from the dwelling by clear space.[21]

But the court of appeals below, and Liberty Mutual, had both argued that this must be incorrect because of the second sentence of the "other structures" provision, which noted that structures connected to the dwelling by fences were still "other structures" which rendered fences a "connection" rather than a "structure." The court exposed the error in this argument efficiently, noting that it had no need to guess or look behind the plain language of the policy, since there was no reason to believe that "structures" and "connections" were mutually exclusive categories. The mere fact that connection by fencing could not render an "other structure" part of the dwelling did not make the fence itself, if connected to the dwelling, an "other structure."[22]

The Texas Supreme Court was not worried that this result could create any confusion where multiple types of fencing, each connected to the other, were implicated. This, the court noted, was fodder for fact determination, and the separate question of precisely which pieces of the fencing were connected to the dwelling and which were not was not before the court.[23]

Every once in a while, it is useful for an appellate court to remind lower courts how simple policy interpretation can ultimately be; it is not the province of the court to interpret policy language so as to resolve all potential questions between the parties. The court's job is simply to give effect to the plain language of the policy where it is possible to do so.

FIFTH CIRCUIT

Provision giving insurer right to conclusively determine reasonableness of attorneys' fees renders coverage illusory; insurer's duty to defend does not extend to affirmative claims by insured.

***Aldous v. Darwin National Assurance Co.*, No. 16-10537, 2017 WL 1032616 (5th Cir. Mar. 16, 2017)**

This case reasserts the traditional Texas law position that discretionary clauses—clauses that allow the insurer to pay or not to pay at their discretion—render coverage illusory, but also stakes out a strong position that the duty to defend is just that—a duty to *defend*—and does not extend to paying attorneys' fees related to affirmative claims by the insured.

The claim at the center of this case arose out of a professional liability suit between an attorney and a client. Aldous, the attorney, prevailed in the suit, but in the process came into dispute with her insurer, Darwin National Assurance Co. Darwin claimed it overpaid Aldous for her defense costs incurred in the suit, while Aldous claimed Darwin underpaid her. Aldous sued Darwin in Texas court, and Darwin removed the case to federal court.[24]

The federal district court decided largely in Darwin's favor at summary judgment, holding that Aldous's claims for attorney fees were limited by judicial estoppel to the amount

provided in a declaration by an expert in the original malpractice litigation. The district court also determined that Aldous's claims that the insurer breached its contract by imposing reductions to her recovery without a showing that such reductions were reasonable were not permitted by the terms of the insurance contract.[25]

The Fifth Circuit found the district court's reasoning on judicial estoppel questionable. Not only was it not at all clear that the court in the prior malpractice case had ever accepted and acted upon the purported prior inconsistent position that only $668,068.31 was due, but it was in fact quite clear from the record that this amount was never intended to represent the entire amount Aldous expended defending the relevant claims.[26]

The Fifth Circuit also determined that the district court's ruling on the breach of contract question was incorrect. While Darwin argued that the policy provided it was entitled to make reductions to the amount claimed, and that it did not require the insurer to make any showing that such reductions were reasonable, the Fifth Circuit noted that, even were this true, it would mean that coverage under the policy was illusory. As the court explained: "If the Policy provides Darwin with the unquestionable right to pay only to the extent it pleases, it is illusory."[27]

***Lamar Homes* construed defense costs as a first-party claim for statutory construction purposes, and no Texas court has yet found it revises the common-law duties of insurers.**

The court was particularly troubled by the insistence of both the district court and Darwin that evidence supporting the reductions the insurer applied were "unnecessary." The court explained that the insurer's reference to Darwin's billing guidelines and a reservation of rights letter, whereby Darwin informed Aldous of its intent to use those guidelines, were both irrelevant—neither document could give Darwin contractual rights not found in the policy, and again, even if the policy could be interpreted to give the insurer the rights claimed (which the court did not explicitly find), this would render the contract unenforceable.[28]

But even this was secondary to the court's distaste for how Darwin had actually calculated its reductions. Although Darwin apparently imposed some reductions based on its billing guidelines, the record reflected that Darwin had also arbitrarily cut the remaining claimed balance in half, against the counsel of its own adjuster.[29]

Aldous did not have it all her way, however. The court rejected her argument that she was entitled to a declaratory judgment giving her the right not only to expenses incurred in her defense, but also incurred in connection with her affirmative claim against her former client. Aldous alleged that her affirmative claim was "inextricably intertwined" with her defense in the malpractice suit, but the court found this unpersuasive. As a federal court applying Texas law, the Fifth Circuit could not invent new law, and so the fact that "[n]o Texas court had ever held that the duty to defend includes the duty to pay legal fees incurred in the course of prosecuting affirmative claims that are inextricably intertwined with the defense" was determinative.[30]

Nor did Aldous persuade the court that the insurer owed her a duty of good faith and fair dealing in connection with its duty to defend. Although under *Lamar Homes*[31] an insured's defense cost claims are first-party claims, this does not change the nature of the duty to defend, or upend years of precedent that an insurer owes no duty of good faith and fair dealing to investigate or defend third-party claims. *Lamar Homes* construed defense costs as a first-party claim for statutory construction purposes, and no Texas court has yet found it revises the common-law duties of insurers.[32]

The court's reversal of the district court's judicial estoppel ruling defeated Darwin's claim for equitable reimbursement. Darwin had argued that since it had disbursed more than the $600,000 the district court had said it owed, it was entitled to the balance. But since judicial estoppel was improper, so was the district court's award. The Fifth Circuit found the award was incorrect for another reason: In Texas, an insurer that settles an action on an insured's behalf is not entitled to equitable reimbursement if it is later determined that the third party's claims were not covered to begin with. Under relevant precedent, the Fifth Circuit found that Texas imposes no equitable right to reimbursement in insurance cases, absent a recovery provision in the policy itself.[33]

Ultimately, this case breaks little in the way of new legal ground, but does strengthen the library of cases holding that absolute discretion to pay or not renders coverage illusory, which is a proper reason to reject such a construction of an insurance contract.

The duty to defend extends to vicarious liability claims regarding a third party where such vicarious liability is, even tenuously, alleged.

***Colony National Insurance Co. v. United Fire & Casualty Co.*, No. 16-40676, 2017 WL 436042 (5th Cir. Jan. 31, 2017)**

This case involves a general contractor, two subcontractors, and the subcontractors' insurers. Carothers Construction, Inc., the GC, hired Self-Concrete, Inc. to form and pour concrete wall panels. Carothers hired Premier Constructors, Inc. to erect the wall panels, and Premier in turn hired Joyce Steel Erection to hoist the panels. An employee of Premier was severely injured when one of the panels being hoisted swung free and pinned him against a wall.[34]

The employee sued Carothers, Self-Concrete, and Joyce. United Fire & Casualty Co. insured Self-Concrete, with Carothers as an additional insured, while Colony National Insurance Co. insured Premier, with Carothers as an additional insured. Carothers asked for a defense from both insurance companies. Colony accepted, United declined, and the matter ultimately settled.[35]

Colony sued United for breach of contract, subrogation, and contribution. After both parties moved for summary judgment, the district court held that United was responsible for one-half of the costs Colony incurred in defending Carothers, disagreeing with United's argument that the employee had not pleaded facts that implied that Self-Concrete's liability might be imputed to Carothers vicariously. United appealed.[36]

On appeal, United had three arguments. First, that its duty to defend did not extend to the allegations in the employee's complaint because its policy only required it to defend actions in which the liability of its primary insured might be imputed to an additional insured. Second, that its policy should be considered secondary to Colony's in any case. Third, that Colony waived any right to subrogation.[37]

The Fifth Circuit treated the duty to defend first. United's policy contained language providing that additional insureds like Carothers were only additional insureds "with respect to your liability which may be imputed" to the additional insured. United argued that because the injury was caused by the hoisting of the wall, and hoisting was not part of Self-Concrete's duties, it had no duty to defend. [38]

But the employee had clearly alleged that Carothers more than sufficiently controlled Self-Concrete's work for it to be potentially held liable for any of Self-Concrete's negligence, and the court reminded the parties that the scope of the duty to defend is broad, encompassing even situations in which the petition does not specifically state facts that that would, if true, result in coverage, as long as there is "potentially" a case for coverage. The employee's allegations therefore fell within the scope of United's duty to defend.[39]

United next argued that its defense coverage was at least secondary to Colony's. Essentially, United argued that, on these facts, its policy was excess. Both policies contained "other insurance" provisions, though, and the Fifth Circuit invoked the general Texas rule that in such a situation, the mutually repugnant clauses cancel, resulting in equal sharing of defense costs between the insurers.[40]

But United argued that Colony's policy contained an endorsement rendering it primary. Colony's policy provided that its insurance would be primary with respect to liability for work performed by its named insured. The court caught United's sleight-of-hand, and showed that United's argument unraveled the moment one inserted the proper names of the parties into the text of the endorsement. Because Colony's named insured was Premier, and because United's duty to defend arose from imputation of its named insured's (Self-Concrete's) liability to Carothers, the endorsement plainly did not make Colony's defense of Carothers primary with respect to the allegations against *Self-Concrete*.[41]

United finally argued that Colony had waived its rights to subrogation via an endorsement that read:

> We waive any right of recovery we may have against the person or organization shown in the Schedule above because of payments we make for injury or damage arising out of your ongoing operations or "your work" done under a contract with that person or organization and included in the "products-completed operations hazard." This waiver applies only to the person or organization shown in the Schedule above.

The "schedule" simply read: "Any person or organization to whom or to which you are obligated by virtue of a written contract to waive your right to recovery." United argued that it was one of these persons or organizations; but again the court resorted to simply inserting the names of the parties into the policy language to show the flaw in this argument. The court generated the following redaction:

> Colony waive(s) any right of recovery Colony may have against Carothers because of payments Colony make(s) for injury or damage arising out of Premier's ongoing operations or 'Premier's work' done under a contract with Carothers and included in the 'products completed operations hazard.' This waiver applies only to Carothers.

The waiver, therefore, protected only Carothers, and did not protect Self-Concrete. Concordantly, the district court's decision had to be affirmed.[42]

The teaching of this case is more of a practice tip than it is the announcement of any new legal principle: In making an argument about the meaning of policy language riddled with pronouns, it is often illuminating to try to replace those pronouns with the names of parties, to see if the argument still holds up.

1 *USAA Texas Lloyds Co. v. Menchaca*, No. 14-0721, at 2–3 (April 7, 2016), *available at* http://www.txcourts.gov/media/1437878/140721.pdf (last visited Apr. 7, 2016).

2 *Id.* at 3–4.

3 *Provident Am. Ins. Co. v. Castañeda*, 988 S.W.2d 189, 198 (Tex. 1998).

4 *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 136 (Tex. 1988).

5 *Menchaca*, No. 14–0721, at 5–6.

6 *Id.* at 9–10.

7 The court found the source of this rule in *Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 341 (Tex. 1995).

8 *Menchaca*, No. 14-0721, at 10–14.

9 *Id.* at 18.

10 *Id.* at 18–22.

11 *JAW the Pointe, L.L.C. v. Lexington Ins. Co.*, 460 S.W.3d 597 (Tex. 2015).

12 *Menchaca*, No. 14–0721, at 22–25.

13 *Id.* at 26–29.

14 *Id.* at 29.

15 *Id.* at 30–26.

16 *Nassar v. Liberty Mut. Fire Ins. Co.*, 508 S.W.3d 254, 255–56 (Tex. 2017).

17 *Id.* at 257.

18 *Id.* at 256.

19 *Id.* at 256–57.

20 *See generally id.*

21 *Id.* at 258–59.

22 *Id.* at 259–61.

23 *Id.* at 261.

24 *Aldous v. Darwin Nat'l Assurance Co.*, No. 16–10537, 2017 WL 1032616 at 4–5 (5th Cir. Mar. 16, 2017).

25 *Id.*

26 *Id.*

27 *Id.* at *5.

28 *Id.* at *5–6.

29 *Id.* at *6.

30 *Id.* at *6–7.

31 *Lamar Homes, Inc. v. Mid–Continent Cas. Co.*, 242 S.W.3d 1, 17 (Tex. 2007).

32 *Aldous* at *7–8.

33 *Id.* at *8–10.

34 *Colony Nat'l Ins. Co. v. United Fire & Cas. Co.*, No. 16–40676, 2017 WL 436042, at *1 (5th Cir. Jan. 31, 2017).

35 *Id.*

36 *Id.*

37 *Id.* at *2–6.

38 *Id.* at *3.

39 *Id.* at *4.

40 *Id.*

41 *Id.* at *5.

42 *Id.* at *5–6.

By Laura Grabouski

ARE POLICY PROCEEDS ACTUAL DAMAGES FOR VIOLATIONS OF THE INSURANCE CODE? THE TEXAS SUPREME COURT IN *MENCHACA* SAYS: "YES—IF CLAIM IS COVERED."

I. Introduction

The question of whether an insured can recover actual damages under the Texas Insurance Code without showing that he or she suffered damages independent of the policy proceeds was answered back in 1988. In *Vail v. Texas Farm Bureau Mutual Insurance Company*, the court held that "an insurer's unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld."[1] State courts relied on this holding to award treble damages based on findings of a covered claim and an unfair claim settlement practice knowingly committed, despite lack of evidence of independent damage.[2] The Fifth Circuit, however, viewed the 1998 *Castañeda* decision[3] as having overruled *Vail* and required insureds to show "injury separate and apart from the denial of benefits" to maintain claims for breach of the duty of good faith and fair dealing or statutory violations.[4] As such, litigants faced differing results based on whether a suit was pending in state or federal court.

The Texas Supreme Court recently resolved the issue in a lengthy opinion, which sought to clarify the confusion: *USAA Texas Lloyds Co. v. Menchaca*.[5] Following a trial on the Menchaca's claim for damage to their home allegedly caused by Hurricane Ike, the jury found that USAA Texas Lloyds did not fail to comply with the policy but did fail to pay the claim without conducting a reasonable investigation in violation of section 541.060(a)(7).[6] As damages for the statutory violation, the jury awarded policy benefits.[7] Relying on *Castañeda*, USAA argued that Menchaca could not obtain policy benefits based solely on failure to reasonably investigate.[8] Menchaca relied on *Vail* to assert that the unfair refusal to pay the claim caused damages in at least the amount of the benefits wrongly withheld.[9]

In its opinion, the Texas Supreme Court reaffirmed *Vail*—"We did not reject the *Vail* rule in *Stoker* or in *Castañeda*"—but conceded that "we could have made the point more clearly."[10] To avoid further confusion, the court outlined five rules for overlapping contract and statutory causes of action. This paper examines the history of the *Vail/ Castañeda* divide, the court's clarification in *Menchaca*, and the five rules the court articulated to guide future cases.

II. Trebling Provisions of the Insurance Code and DTPA

One major significance of the "*Vail* rule" is the trebling provision found in both the Texas Insurance Code and the Deceptive Trade Practices-Consumer Protection Act (DTPA). Both statutes authorize recovery of up to treble damages based on evidence of intentional or knowing violations. The DTPA refers to "economic" and "mental anguish" damages and allows potential trebling of both:

> (b) In a suit filed under this section, each consumer who prevails may obtain:
>
> (1) the amount of economic damages found by the trier of fact. If the trier of fact finds that the conduct of the defendant was committed knowingly, the consumer may also recover damages for mental anguish, as found by the trier of fact, and the trier of fact may award not more than three times the amount of economic damages; or if the trier of fact finds the conduct was committed intentionally, the consumer may recover damages for mental anguish, as found by the triter of fact, and the trier of fact may award not more than three times the amount of damages for mental anguish and economic damages.[11]

Section 541.152 of the Insurance Code refers to "actual damages" but similarly authorizes up to treble actual damages as follows:

> (a) A plaintiff who prevails in an action under this subchapter may obtain:
>
> 1) the amount of *actual damages*, plus court costs and reasonable and necessary attorney's fees;
>
> 2) an order enjoining the act or failure to act complained of; or
>
> 3) any other relief the court determines is proper.

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> (b) Except as provided by Subsection (c), on a finding by the trier of fact that the defendant knowingly committed the act complained of, *the trier of fact may award an amount not to exceed three times the amount of actual damages*.
>
> (c) Subsection (b) does not apply to an action under this subchapter brought against the Texas Windstorm Insurance Association.[12]

Thus, if an insured is entitled to recover policy benefits as economic or actual damages based on a violation of either statute, and establishes that the insurer's violation was knowing and/or intentional, the statutes expressly authorize recovery of up to an additional two times the amount of its claim. The *Vail* case presented this scenario.

III. *Vail*

Vail involved a dispute over a homeowners' fire claim.[13] Texas Farm Bureau Mutual Insurance Company denied the Vails' claim after a fire destroyed their home.[14] The Vails sued for the full policy proceeds and for damages under the Deceptive Trade Practices–Consumer Protection Act and the Unfair Claim Settlement Practices Act of the Texas Insurance Code.[15]

The trial court awarded the Vails treble the amount of the policy proceeds as well as prejudgment interest and attorney's fees.[16] The appellate court reversed the treble actual damages portion of the judgment and reduced the judgment to include a single policy limit amount. The Texas Supreme Court reversed and reinstated the trebled policy limits.[17]

The court first affirmed the jury's findings that Texas Farm Bureau had violated then article 21.21-2 of the Insurance Code by failing to promptly and fairly settle the Vails' claim when its liability had become reasonably clear. The court also held that the Vails had proved a cause of action for unfair settlement practices under section 17.50(a)(4) of the DTPA.[18] Because the jury found that Texas Farm Bureau's conduct was intentional, the Vails were entitled to treble damages under the DTPA.[19]

The court then addressed Texas Farm Bureau's argument that because the Vails' only damages were the policy proceeds that were recoverable for breach of contract, such damages did not constitute "actual damages" in relation to a claim of unfair claims settlement practices.[20] The court squarely rejected the argument, stating that *"[w]e hold that an insurer's unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld.* "[21] The court continued:

> The Vails suffered a loss at the time of the fire for which they were entitled to make a claim under the insurance policy. It was not until Texas Farm wrongfully denied the claim that the Vails' loss was transformed into a legal damage. That damage is, at minimum, the amount of policy proceeds wrongfully withheld by Texas Farm.
>
> The fact that the Vails have a breach of contract action against Texas Farm does not preclude a cause of action under the DTPA and article 21.21 of the Insurance Code. Both the DTPA and the Insurance Code provide that the statutory remedies are cumulative of other remedies. . . . It would be incongruous to bar an insured—who has paid premiums and is entitled to protection under the policy—from recovering damages when the insurer wrongfully refuses to pay a valid claim. Such a result would be in contravention of the remedial purposes of the DTPA and the Insurance Code.[22]

Finally, the court stated that because the policy set the value of the insured property, the Vails were not required to prove actual damages.[23] Insureds have relied on *Vail* to seek recovery of up to treble the amount of the claim under the policy (based on a knowing and/or intentional violation of section 541.060 of the Insurance Code) without evidence of damages independent of the unpaid claim.

IV. *Castañeda*

In its 1998 *Castañeda* decision, the Texas Supreme Court made statements that have been construed to conflict with the "policy benefits as actual damages" holding of *Vail*.[24] The facts of *Castañeda* were distinguishable from those of *Vail*, notably that Castañeda did not allege a claim covered by the policy.[25] Nonetheless, the decision created uncertainty with regard to the evidentiary standard for recovery of additional damages, particularly in the Fifth Circuit.

Denise Castañeda sued her health insurer, Provident American Insurance Company, for alleged violations of the Insurance Code and Deceptive Trade Practices Act.[26] The jury found that Provident American had violated then article 21.21 of the Insurance Code by denying or delaying Castañeda's claim without a reasonable basis.[27] Castañeda did not seek or obtain any jury finding awarding relief *under the policy*.[28] The trial court awarded actual damages, treble damages, attorney's fees, and penalty interest; the appellate court affirmed except as to penalty interest.[29] The Texas Supreme Court reversed and held that the evidence was legally insufficient to support the jury's verdict for Insurance Code violations.[30]

Ms. Castañeda argued that the jury's findings that Provident American had engaged in "unfair settlement practices" (under then subsection 2(b)(5) of article 21.21-2) by making a deficient settlement offer, failing to acknowledge communications regarding the claim, and failing to adopt reasonable standards for investigation of claims authorized recovery of damages "equivalent to policy benefits."[31] The court rejected the argument based on the holding in *Stoker* that the failure to properly investigate a claim was not a basis for an award of policy benefits.[32] The court acknowledged the "*Stoker* exception" for liability for mishandling a claim which caused damages "other than policy benefits."[33] "We said: 'We do not exclude, however, the possibility that in denying the claim, the insurer may . . . cause injury independent of the policy claim.'"[34]

Based on the record, the court held that Provident American's conduct was not "the producing cause of any damage *separate and apart from* those that would have resulted from a wrongful denial of the claim."[35] The court observed that the only damages awarded that did not constitute policy benefits were for loss of credit reputation, which resulted from Provident American's denial of the claim, not the failure to communicate or investigate.[36]

The conclusion of the opinion reinforces the factual underpinning of the holding that recovery of damages under the Insurance Code is premised on a covered claim:

> In sum, there is no support in the evidence for any of the extra-contractual claims on which Denise Castañeda obtained findings. *Castañeda did not plead and did not obtain a determination from the trial court that Provident American was liable for breach of the insurance contract.* Accordingly, there is no basis on which Castañeda may recover based on this record.[37]

V. Fifth Circuit Post-*Castañeda:* Independent Injury Required

Four years later, in *Parkans International, L.L.C. v. Zurich Insurance Company*, the Fifth Circuit interpreted *Castañeda* as requiring proof of independent injury as a prerequisite to all extra-contractual damages.[38] Parkans sued Zurich Insurance Company for breach of contract, breach of the duty of good faith and fair dealing, and violations of the Insurance Code and DTPA.[39] The trial court held that Parkans' claim was covered on cross-motions for summary judgment; the jury was instructed that the loss was covered and that Zurich's failure to pay breached the policy.[40] The jury then awarded $1.34 million for breach of contract, $1.29 million on the extra-contractual claims, and attorney's fees; however, the trial court entered judgment solely for the contractual damages and attorney's fees.[41]

On appeal, the Fifth Circuit reversed the summary judgment in favor of coverage under the primary policy.[42] The court also held that Zurich's summary judgment on Parkans' claims for unfair settlement practices should have been granted because it had a reasonable basis for its denial; i.e., there was a *bona fide* coverage dispute.[43] Although the good faith dispute was dispositive of the issue, the court added, "the jury essentially found no tort injuries independent of the contract damages."[44] The court stated: "There can be no recovery for extra-contractual damages for mishandling claims unless the complained of actions or omissions caused injury independent of those that would have resulted from a wrongful denial of policy benefits."[45]

The decision comports with Texas law that a bona fide coverage dispute, without more, precludes extra-contractual damages. The rationale, however, is not the lack of independent damage to the insured, but rather the insurer's right to reject a claim so long as its acts reasonably in doing so, even if it subsequently is proven to have been mistaken as to its denial.[46]

Further, the decision imposed a requirement not found in *Vail* for recovery of extra-contractual damages in cases in which the claim was covered. Although not an issue in *Parkans*, the *AFS/IBEX* case squarely presented this conflict.[47] In that case, the district court ruled on summary judgment that coverage was provided by two successive crime protection policies, but the issue of damages was tried to the jury.[48] The district court dismissed AFS's extra-contractual claims at the close of evidence because AFS's damages "all potentially flowed from [Great American's] breach of its insurance contract [and] the same damages could not, as a matter of law, satisfy the damage element for AFS's extra-contractual claims."[49]

On cross-appeal, the Fifth Circuit affirmed the district court's judgment in favor of coverage.[50] It rejected AFS's assertion that it was not required to prove a separate injury to maintain its extra-contractual claims as inconsistent with "this court's case law," citing *Parkans*.[51]

VI. Foreshadowing *Menchaca's* Holding, State Courts Continue to Apply *Vail.*

In a recent case decided before *Menchaca*, the Houston Fourteenth Court of Appeals recognized the conflict presented by the *Parkans/AFS* line of cases in *AMJ Investments*, but reconciled *Castañeda* with *Vail* based on the existence of a covered claim.[52] Accordingly, the court affirmed the judgment for trebling of policy proceeds up to the statutory maximum without the need for damages independent of the benefits.[53] The same court in another Hurricane Ike-related suit also rejected, in dicta, a bright-line rule that would eliminate extra-contractual damages when the insured failed to recover on the contract.[54] Citing the appellate court decision in *Menchaca* and others, the

court noted that "the interplay of contractual and extra-contractual claims depends heavily on the particular circumstances of particular cases."[55] In other words, as the Texas Supreme Court's opinion in *Menchaca* would later explain, it's "complicated."[56]

VII. *Menchaca*

In *Menchaca*, USAA argued that because the jury found no breach of contract, the damages awarded for unreasonable investigation failed as a matter of law based on *State Farm Lloyds v. Page*, wherein the court stated: "There can be no liability under . . . the Insurance Code if there is no coverage under the policy."[57] The appellate court rejected USAA's argument for two reasons. First, the court reasoned that section 541.060(a)(7) imposed an independent duty to conduct a reasonable investigation prior to denying a claim. "It follows that USAA could have fully complied with the contract even if it failed to reasonably investigate Menchaca's claim."[58] Second, the court disagreed that the jury's answer to the breach of contract question definitively established that there was no coverage where USAA did not assert lack of coverage but rather that the amount of covered damage did not exceed the deductible.[59]

The Texas Supreme Court disagreed with both statements. Although it accepted the premise that "USAA could have complied with the policy even if it failed to reasonably investigate the claim," it rejected the conclusion that Menchaca could collect policy benefits based solely on that finding and without proving that benefits were owed under the policy.[60] Such a premise falls squarely within the "general rule" recognized in *Castañeda* and *Stoker*: "If the insurer violates a statutory provision, that violation—at least generally—cannot cause damages in the form of policy benefits that the insured has no right to receive under the policy."[61]

The court also disagreed, however, with USAA's position that an insured may never recover policy benefits as actual damages for a statutory violation.[62] In so doing, the court reaffirmed the *Vail* (or "entitled to benefits") rule[63] on the same premise recognized by the earlier state court decisions: "While we could have made the point more clearly, the distinction between the cases is that the parties in *Vail* did not dispute the insured's entitlement to the policy benefits, and the only issue was whether the insured could recover those benefits as statutory damages."[64]

The court also disagreed that the insured had to obtain a finding that the insurer "breached" the policy. While "breach" and "coverage" are often used interchangeably, a breach of contract finding is not a prerequisite to statutory damages assuming that the evidence establishes a covered claim.[65]

Against this backdrop, the court held the trial court had improperly disregarded the jury's answer to the breach question where USAA provided some evidence that damages were less than the deductible.[66] Accordingly, the court reversed the judgment in favor of Menchaca, but remanded for a new trial in light of the parties' "obvious and understandable confusion over our relevant precedent and the effect of that confusion on their arguments in this case."[67]

VIII. Beyond *Menchaca*: The Five Rules applicable to Coverage and Extra-contractual Claims

First, the "**general rule**" is that an insured cannot recover policy benefits as actual damages if there is no right to the benefits.[68]

Second, the "**entitled-to-benefits rule**" announced in *Vail* remains viable. As a corollary to the general rule, where an insured establishes that the insurer has unreasonably withheld covered benefits, those benefits are recoverable as actual damages under the Insurance Code.[69]

Third, policy benefits may be recoverable as actual damages under the "**benefits-lost rule**" if an insurer, through a misrepresentation of coverage,[70] waiver and/or estoppel,[71] or statutory violation,[72] causes the loss of benefits.[73]

Fourth, the **"independent-injury rule"** announced in *Stoker* remains viable, although extremely limited in application.[74] This is because the insured's statutory claim must be independent of the duty to pay contractual benefits,[75] *and* it must cause injury that is independent of the loss of such benefits.[76] It is worth repeating that the court has yet to find an independent injury in the twenty-two years since it issued the *Stoker* decision.

Fifth, the "**no-recovery rule**" is a natural corollary to rules one through four and holds that an insured cannot recover damages for a statutory violation absent a right to benefits or independent injury.[77]

IX. Conclusion

Post-*Menchaca*, the evidence needed to prevail on an extra-contractual claim should no longer depend on whether the suit is litigated in state court or federal court. If the insured proves that the claim for policy benefits is covered, it can assert those benefits as damages for a violation of the Insurance Code, and, if it proves that the violation was knowing or intentional, seek trebling of same.

Conversely, a finding of no coverage will preclude any damages unless the insured presents evidence sufficient to warrant the *Stoker* exception, which has proven elusive. In practice, courts should continue to grant motions to dismiss extra-contractual claims following a finding of lack of coverage where the insured has no evidence of damages independent of the policy.

Further, even assuming that the insured proves that the insurer failed to conduct a reasonable investigation, policy benefits cannot be awarded as actual damages for an Insurance Code violation unless the factfinder also finds that the claim was covered, which does not necessarily equate with a finding that the insurer "breached" the contract.

Alternatively, under the other rules outlined in *Menchaca*, an insured may concede lack of coverage but assert a claim based on a misrepresentation or a waiver/estoppel theory if the evidence supports it. In sum, the *Menchaca* opinion has provided needed guidance on the actual damages controversy and is a helpful manual for litigating coverage cases more generally.

1 754 S.W.2d 129, 136–37 (Tex. 1988).

2 *See, e.g.*, *United Nat'l Ins. Co. v. AMJ Inv., LLC*, 447 S.W.3d 1, 11 (Tex. App.—Houston [14th Dist.] 2014, pet. denied).

3 *Provident Am. Ins. Co. v. Castañeda*, 988 S.W.2d 189, 198 (Tex. 1998).

4 *See Great Am. Ins. Co. v. AFS/IBEX Fin. Servs., Inc.*, 612 F.3d 800, 808 n.1 (5th Cir. 2010).

5 *USAA Texas Lloyd's Co. v. Menchaca*, No. 14–0721, 2017 WL 1311752 (Tex. Apr. 7, 2017).

6 *Menchaca*, 2017 WL 1311752, at *2.

7 Specifically, the jury awarded $11,350, "the difference . . . between the amount USAA should have paid Gail Menchaca for her Hurricane Ike damages and the amount that was actually paid." *Id*.

8 *Id.*

9 *Id*.

10 *Id.* at *8.

11 Tex. Bus. & Com. Code Ann. § 17.50(b).

12 Tex. Ins. Code § 541.152 (emphasis added). The Texas Supreme Court has unified recovery of mental anguish damages under the Insurance Code with the DTPA requirement of a knowing or intentional finding. *See State Farm Life Ins. Co. v. Beaston*, 907 S.W.2d 430, 435–36 (Tex. 1995) (construing pre-1995 DTPA and observing Insurance Code provisions governing unfair and deceptive acts in business of insurance and DTPA are interrelated).

13 *See Vail*, 754 S.W.2d at 130.

14 The Act formerly was codified article under 21.21, and currently is codified in sections 541.051-061.

15 *See Vail*, 754 S.W.2d at 130.

16 *Id.*

17 *Id.*

18 *See id.* at 133–34.

19 *Id.* at 135.

20 *See id.* at 136.

21 *Id.* at 136 (emphasis added, internal citations omitted).

22 *Id.* (citations omitted).

23 *Id.* at 137.

24 *See Castañeda*, *supra*.

25 *See AMJ Investments, LLC*, 447 S.W.3d at 11 (distinguishing *Castañeda*).

26 *Castañeda,* 988 S.W.2d at 193.

27 *See id.*

28 *See id.* at 196.

29 *Id.* at 192.

30 *Id.* at 195–96.

31 *See id.* at 198.

32 *See id.* (citing *Republic Ins. Co. v. Stoker,* 903 S.W.2d 338, 341 (Tex. 1995)).

33 *Id.*

34 *Id.* (citing *Stoker*, 903 S.W.2d at 341).

35 *Id.* (emphasis added).

36 *See id.* at 199.

37 *Id.* at 201 (emphasis added).

38 *Parkans Int'l, L.L.C. v. Zurich Ins. Co.*, 299 F.3d 514, 519 (5th Cir. 2002).

39 *Id.* at 515.

40 *Id.* at 516.

41 *Id.*

42 *Id.* at 517.

43 *Id.* at 519. *See, e.g., State Farm Fire & Cas. Co. v. Simmons*, 963 S.W.2d 42, 44 (Tex. 1998) (evidence of mere *bona fide* dispute over coverage does not establish bad faith).

44 *Id.* (noting in n.5 that the same line items were submitted for both the contractual and tort damages questions, and the jury awarded lesser amounts for the tort items).

45 *Id.* (quoting *Castañeda*).

46 *See, e.g.*, *Lyons v. Millers Cas. Ins. Co. of Texas*, 866 S.W.2d 597, 601 (Tex. 1993) (evidence of valid claim might in some circumstances support a finding that insurer lacked reasonable basis for denial but in case at hand, plaintiffs offered no such evidence).

47 *See AFS/IBEX Fin. Servs., Inc.*, 612 F.3d at 808.

48 *Id.* at 803.

49 *Id.*

50 *Id.* at 806.

51 *Id.* at 808 n.1.

52 *See AMJ Investments, LLC*, 447 S.W.3d at 11.

53 *See id.* at 6 n.2; *see also* Tex. Ins. Code § 541.152(b).

54 *State Farm Lloyds v. Fuentes* No. 14-14-00824-CV, 2016 WL 1389831 (Tex. App.—Houston [14th Dist.] April 7, 2016, pet. filed) (memorandum op.).

55 *See id.* at *5 n.4.

56 *Menchaca*, 2017 WL 1311752 at *4.

57 315 S.W.3d 525, 532 (Tex. 2010). *See USAA Texas Lloyd's Co. v. Menchaca,* No. 13–13–00046–CV, 2014 WL 3804602, at *5 (Tex. App.—Corpus Christi-Edinburg 2014), *judgment rev'd*, 2017 WL 1311752.

58 *Id.* at *5.

59 *Id.* at *6.

60 *Menchaca*, 2017 WL 1311752, at *6.

61 *Id.* at *6.

62 *Id.* at *7.

63 *Id.* at *8.

64 *Id.* at *8.

65 *Id.* at. *7, *8 n.18 (noting circumstances of *Vail* wherein the insured pleaded and proved the amount of the policy's coverage and insurer, on appeal, admitted that the claim was covered: "*Vail* should not be read, however, as suggesting that an insured can recover benefits for a statutory violation when the insured fails to establish and the insurer does not concede that the insured has a contractual right to the benefits.").

66 *Id.* at *14.

67 *Id.*

68 *Id.* at *4.

69 *Id.* at *7.

70 *See, e.g.*, *Royal Globe Ins. Co. v. Bar Consultants, Inc.*, 577 S.W.2d 688, 693 (Tex. 1979) (distinguishing contractual liability with liability for statutory misrepresentation claim based on false promises of coverage); *see also In re Allstate County Mut. Ins. Co.*, 447 S.W.3d 497 (Tex. App.—Houston [1st Dist.] 2014, orig. proceeding) (severance required of bad faith-failure to settle- claim from contract claim for underinsured motorist benefits; no severance required for misrepresentation claims because such claims independent of contractual claims and will not be rendered moot if insurer prevails on breach of contract).

71 *See, e.g.*, *Ulico Cas. Co. v. Allied Pilots Ass'n*, 262 S.W.3d 773, 787 (Tex. 2008) ("In sum, if an insurer defends its insured when no coverage for the risk exists, the insurer's policy is not expanded to cover the risk simply because the insurer assumes control of the lawsuit defense. But, if the insurer's actions prejudice the insured, the lack of coverage does not preclude the insured from asserting an estoppel theory to recover for any damages it sustains because of the insurer's actions.").

72 *See, e.g., JAW the Pointe, L.L.C. v. Lexington Ins. Co.*, 460 S.W.3d 597, 602 (Tex. 2015) (observing insured's contention that policy covered ordinance-compliance costs and insurer should have paid those costs before it made other payments that exhausted policy limits).

73 *Menchaca*, 2017 WL 1311752, at *9–10.

74 *Id.* at *11–12.

75 *See, e.g.*, *Twin City Fire Ins. Co. v. Davis*, 904 S.W.2d 663, 666 n.3 (Tex. 1995) (some extra-contractual claims may not relate to duty to pay claims and may thus result in different damages).

76 *See id.* at 667 (where exclusivity of workers' compensation remedy required evidence of actual damages other than benefits to recover for breach of duty of good faith, absence of actual damages barred award of punitive damages).

77 *Menchaca*, 2017 WL 1311752 at *12.

By Marcus R. Tucker and Sara Nau

HOW FAR DOES *GANDY* GO?

I. Introduction

On February 28, the Texas Supreme Court heard oral argument in *Great American Insurance Company v. Glen Hamel*,[1] a case that will test whether the Texas Supreme Court's *Gandy* ruling that an insured's liability and damages must be the product of a fully adversarial trial extends to situations in which the insurer has denied coverage, and if so, what constitutes an adversarial trial. In the 1996 *Gandy* decision, the Texas Supreme Court held that an insured-defendant's assignment of his claims against his insurer to an underlying plaintiff is invalid if: (1) it is made prior to an adjudication of the underlying plaintiff's claim against the defendant in a fully adversarial trial, (2) the defendant-insured's insurer has tendered a defense, and (3) either (a) the defendant-insured's insurer has accepted coverage, or (b) the defendant-insured's insurer has made a good faith effort to adjudicate coverage issues prior to the adjudication of plaintiff's claim.[2] The Texas Supreme Court further held in *Gandy* that in no event is a judgment, rendered without a fully adversarial trial, binding on a defendant's insurer or admissible as damages in an action by the plaintiff as defendant's assignee against the insurer. The court's public policy reasons behind *Gandy* were to prevent collusive assignments and settlements that do not terminate, but rather extend and prolong litigation, and to curtail assignments and settlements that distort any resulting litigation between the insurer and the underlying plaintiff-assignee.

Great American's argument that *Gandy*'s fully adversarial trial requirement should be applied in *Hamel* is significant because, unlike in *Gandy*, Great American declined to provide a defense to its insured, meaning the insured proceeded through the litigation without the benefit of a defense. Unlike *Gandy*, there also was no pre-trial assignment in *Hamel*, which raises the issue of whether the fully adversarial trial requirement applies if the concerns *Gandy* addressed exist in cases not identical to *Gandy*. The fact that the *Hamel* insured had little or no assets to satisfy a judgment other than the Great American policy amplified these issues. Great American has argued that the fully adversarial trial requirement in *Gandy* should apply whenever a judgment results from collusive behavior, and that the Hamels and the insured colluded to enter a sham judgment after their bench trial. Great American's insured has countered that when there is a wrongful denial of coverage, and there is no pre-trial assignment, Gandy's "explicit and narrow" holding does not apply, and to the extent the adversarial trial requirement exists when the insured wrongfully denies coverage, a fully adversarial trial occurred. The questions before the Texas Supreme Court are therefore whether it should expand the reach of *Gandy* to situations in which the insurer has denied coverage, and if so, what will constitute an "adversarial trial" between the defendant-insured and underlying plaintiff sufficient to satisfy the *Gandy* standard.

II. The *Hamel* Decision

In *Hamel*, the Hamels hired construction company, Terry Mitchell Builders, Inc. (TMB), to complete construction of their home in Flower Mound, Texas, after the original contractor abandoned the project. During the time TMB worked on the Hamels' house, Great American insured TMB under general liability policies spanning May 1996 to May 2001. Starting in 1999, the policies excluded coverage for claims related to exterior insulation and finishing systems (EIFS). The Hamels later discovered water intrusion damage in their home, and an expert determined that the damage was partially caused by problems with the EIFS. The Hamels then sued TMB in state court, and when TMB tendered the suit to Great American, Great American declined to defend, citing the EIFS exclusion in the policies.

Before trial, the Hamels and TMB entered into a Rule 11 agreement in which TMB's owner, Terry Mitchell, agreed to testify in exchange for a promise that the Hamels would not seek to execute any judgment against him personally or against certain tools and equipment of TMB, would not pierce TMB's corporate veil, and would not contest certain transfer of assets from TMB to other companies. (As noted above, aside from the Great American policy, TMB likely had little or no assets). The parties also entered into stipulations primarily related to TMB's duties as a general contractor to ensure that the Hamels' home was constructed and completed in a good and workmanlike manner and to ensure that the house was properly inspected for commercial defects. TMB further stipulated that certain failures on its part were honest oversights. After a bench trial, the

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judge entered a judgment against TMB in the amount of $365,089.70 plus prejudgment interest. TMB's attorney did not call any witnesses during the trial, but rather cross-examined the Hamels' witnesses, eliciting evidence favorable to the defense. TMB then assigned its rights to pursue claims against Great American, and the Hamels sued Great American for the policy proceeds.

In the action between the Hamels and Great American, Great American argued that the court should follow the reasoning of *Gandy* and hold that the Hamels could not recover on the judgment based on collusion between the parties. As evidence of collusion, Great American noted that TMB had switched from disclaiming liability to claiming liability in full in its pretrial stipulations, and that TMB's counsel did not provide a meaningful defense at trial. Great American further pointed to evidence that the parties in the underlying litigation structured the proceeding to defeat the application of the EIFS exclusion in any ensuing action against Great American. The trial court was not persuaded by these arguments and held that the judgment was not collusive and had instead resulted from a fully adversarial trial. On appeal, the Eighth Court of Appeals in El Paso affirmed, holding that Great American was bound by the judgment because the *Gandy* facts were distinguishable (there was no pre-trial assignment and the insurer offered no defense), and the judgment was obtained through a fully adversarial trial without evidence of collusion or fraud. [3]

Great American then appealed the Eighth Court of Appeals' decision. It argued that the court had erred in finding that *Gandy* did not apply to its case because the intent of *Gandy* is to protect the judicial process and discourage collusion, and that these considerations should apply outside of *Gandy*'s specific fact pattern, such as in situations where the insurer denies coverage and assignment occurs after trial. Great American argued that the Hamels and TMB collusively entered into the Rule 11 agreement and stipulations without telling the court, and that the trial was set up to specifically avoid the application of the EIFS exclusion in the Hamels' later litigation against Great American. It further argued that the court had erred in finding that the underlying trial was adversarial and not collusive, as TMB had "no financial stake in the outcome" of the trial, and that the trial was merely a "brief evidentiary hearing crafted to manufacture insurance coverage."

The Hamels responded that *Gandy* should apply narrowly and should not be extended to situations in which the insurer has breached the duty to defend and there is no pretrial assignment. They further argued that there was plentiful evidence that the judgment was the result of a fully adversarial trial because: (1) TMB was represented by counsel; (2) TMB's counsel participated in trial, cross-examined witnesses, and secured evidence from witnesses; (3) the trial court (sitting as finder of fact) asked several questions; and (4) the court rendered judgment based on the evidence from the parties. With respect to the stipulations and agreements before trial, the Hamels argued that the stipulations were not instruments of collusion, but rather were entered into in lieu of responses to requests for admissions. The Hamels similarly argued that the Rule 11 agreement was meant to ensure TMB's owner's appearance at trial and prevent TMB from failing to appear and defaulting, as opposed to destroying adversity between the parties.

The Texas Supreme Court's ultimate decision in this case will have significant repercussions, depending on whether it agrees to extend *Gandy* to *Hamel*'s facts. Because Great American denied a defense to TMB, it cannot rely on the language in its policies that provide a judgment is not covered unless it is the product of an "actual trial." The big picture issue, however, is what recourse a policyholder has when the insurer denies coverage and the insured must resolve the lawsuit without funding from its policy. In some circumstances, an insured may have enough money to settle and can simply pursue its insurer afterwards, which would not appear to implicate *Gandy* concerns. In situations such as the *Hamel* case, however, in which the insured faces a potential judgment and has no assets to cover the judgment (save the policy proceeds), the insured likely will not have the resources to conduct a conventional defense, and the requirement that there be a fully adversarial trial potentially becomes a coverage defense after the insurer denies the duty to defend.

III. Understanding the *Hamel* Issue Requires Contrast of the *Gandy* and *ATOFINA* Decisions.

A. *State Farm v. Gandy*

In the *Gandy* case, the Texas Supreme Court issued a significant decision for insureds and insurers alike, holding that an insured's assignment of its claims against its insurer to an underlying plaintiff can be void as against public policy in circumstances in which the underlying litigation was collusively structured to pin liability on an insurer. As background, in *Gandy*, a woman (Gandy) sued her stepfather (Pearce) for damages resulting from his sexual abuse of her as a child. During the time of the abuse, Pearce had a homeowners insurance policy with State Farm, and it was alleged that some of the acts occurred at the home insured by the policy. Pearce gave notice of the suit to State Farm, as he believed the policy would cover any tortious acts he committed at his home. State Farm agreed to defend Pearce subject to a reservation of rights, agreeing to use

Pearce's attorney (Andrews) who was representing him in the related criminal action. Pearce replaced his attorney apparently without telling State Farm, and later claimed that State Farm ignored his complaints about Andrews. Claiming he was "fed up" with the case, Pearce decided to settle with Gandy. Gandy and Pearce subsequently entered into a pretrial agreed judgment awarding $6,000,000 against Pearce, which was approved and rendered by the court solely on the agreement of counsel and without the presentation of evidence. At the same time the parties entered into the agreed judgment, Pearce assigned all of his rights against State Farm to Gandy, and in exchange, Gandy entered into a covenant not to execute the judgment against any assets other than State Farm's policy. State Farm was unaware of the agreed judgment until it received a copy in the mail.

Gandy then filed suit against State Farm alleging that State Farm failed to defend Pearce or mishandled the defense and failed to settle her claims against him. After a jury trial, the trial court entered a $200,000 judgment against State Farm, plus fees, interest, and costs. The court of appeals affirmed, although it was critical of Gandy and Pearce's agreed judgment, holding that it "perpetrates a fraud on the court, because it bases the recovery on an untruth, i.e., that the judgment debtor may have to pay the judgment."[4]

On appeal to the Texas Supreme Court, State Farm argued that Pearce's assignment to Gandy was invalid for the reasons the appellate court expressed. The Texas Supreme Court agreed with State Farm for several reasons. First, it addressed four of its prior decisions that had held that other types of assignments were void as against public policy: (1) a client's assignment of its malpractice claims to another party; (2) Mary Carter agreements (in which a plaintiff settles with some defendants and then these settling defendants collusively participate with the plaintiff in the trial against the non-settling defendants); (3) a plaintiff's assignment to a tortfeasor of a claim against a joint tortfeasor; and (4) an assignment of interests in an estate.

With respect to the Gandy assignment, the Texas Supreme Court held that the assignment violated public policy for two reasons: (1) the settlement did not terminate litigation, but rather extended and encouraged future litigation and (2) the settlement distorted the ensuing litigation against State Farm. The Texas Supreme Court, however, declined to hold that all assignments between an underlying plaintiff and an insured are void as against public policy, instead holding that an assignment would be invalid only if: (1) it is made prior to an adjudication of the plaintiff's claim against the defendant in a fully adversarial trial; (2) the defendant's insurer has tendered a defense; and (3) either (a) the defendant's insurer has accepted coverage or (b) the defendant's insurer has made a good faith effort to adjudicate coverage issues prior to the adjudication of the plaintiff's claim. The Texas Supreme Court further held in *Gandy* that in no event is a judgment, rendered without a fully adversarial trial, binding on a defendant's insurer or admissible as damages in an action against the insurer by the plaintiff as defendant's assignee. The court left open the question of what exactly would constitute an "adversarial trial" that would satisfy the above standard.

B. *Evanston Insurance Company v. ATOFINA Petrochemicals, Inc.*

In *Evanston Insurance Company v. ATOFINA Petrochemicals, Inc.*, the Texas Supreme Court declined to extend *Gandy* to a situation in which an insurer denied coverage to an insured who subsequently entered into a settlement with a plaintiff, as opposed to assigning claims or entering into an agreed judgment.[5] Instead, the insured paid the settlement and pursued the insurer itself. The court held that *Gandy*'s holding was "explicit and narrow" and would not apply to *ATOFINA*'s fact pattern because the insured had made no assignment of its claim against the insurer—the insured sued the insurer directly. Further, the court held that there was no risk of prolonging disputes or distorting litigation or settlement motives, because settlements shorten disputes, and the insured in *ATOFINA* settled without knowing whether it would be covered by its policy, leaving in place the insured's motivation to minimize the settlement amount in case it was solely responsible for payment. The court concluded that it should instead adhere to the reasoning from the *Employers Casualty Co. v. Block*, in which it had held that if an insurer wrongfully denies coverage, and its insured then enters into an agreed judgment, the insurer is barred from challenging the reasonableness of the settlement amount.[6] The court acknowledged that *Gandy* expressly limited the rule in *Block* when an assignment exists and certain "unique" elements are met. Without the concerns of *Gandy*, i.e., no assignment and agreed judgment, the court applied *Block* and held that the reasonableness of the settlement could not be challenged, in order to encourage early intervention by insurers, who are best positioned to evaluate the worth of claims during settlement discussions.[7]

C. Differences between *Gandy* and *ATOFINA* Decisions

Unsurprisingly, the *Gandy* and *ATOFINA* decisions are heavily featured in the *Hamel* briefing before the Texas Supreme Court, with Great American arguing that *Gandy* should control the outcome of the case, and the Hamels arguing that *ATOFINA* forecloses application of *Gandy* because *ATOFINA* provided that Gandy's ruling was narrow and should only apply to identical scenarios. While there are arguments for adherence to both cases, the two cases are admittedly not on all fours with the facts in *Hamel.*

With respect to *Gandy*, the Hamels have relied on several key differences between their case and *Gandy* to argue that their judgment and post-trial assignment with TMB is on solid ground, unlike the scenario in *Gandy*. First and foremost, there was no agreed judgment in *Hamel*; rather, there was a fully adversarial trial (according to the Hamels), and a judgment entered after the bench trial. Second, the *Hamel* case does not concern a pre-trial assignment— while a Rule 11 agreement and stipulations were entered into before trial, TMB did not actually assign the right to pursue Great American to the Hamels until a few months after the trial court rendered judgment. As noted below, in instances in which the parties assign their claims pre-trial, courts usually find that there was no fully adversarial trial. Third, the *Hamel* case involved an insurer who denied coverage and declined to provide a defense to its insured, as opposed to *Gandy,* in which the insurer offered a defense.

Turning to *ATOFINA*, Great American has pointed to distinctions between *ATOFINA* and the *Hamel* case to rebut the Hamels' argument that *ATOFINA* limits *Gandy* to a very specific fact pattern. Namely, unlike in *Hamel*, the insured in *ATOFINA* never assigned its claims to the plaintiff, but instead settled and paid the settlement itself. Great American has argued that unlike *Hamel*, *ATOFINA* involved no collusion and, therefore, is not outcome determinative because the insured had a stake in the outcome and was motivated to settle on terms that were reasonable.

Ultimately, in deciding *Hamel*, the Texas Supreme Court will be required to find the right balance between preventing collusion that allows insureds to enter into sham judgments and allowing an insurance company to deny coverage and prevent the policyholder or an assignee-judgment creditor from obtaining coverage when there is no collusion but the policyholder cannot afford a conventional trial.

IV. Should *Gandy* apply outside the *Gandy* context?

A. Arguments for application of *Gandy*

There are several arguments in favor of applying *Gandy* to factual scenarios outside *Gandy*'s exact fact pattern involving pre-trial assignments. First, *Gandy*'s limitation against collusive behavior is needed in other scenarios that involve different types of efforts to enter judgments against an insured. In fact, since *Gandy*, there have been cases that are factually different than *Gandy* but involve collusion or sham judgments where the courts used the adversarial trial requirement to preclude the enforceability of the judgment. For example, in the *Yorkshire Insurance Company v. Seger* decision,[8] the plaintiff presented evidence of no more than $600,000 in damages, but the trial court awarded $7.5 million each to the deceased rig worker's parents. The insured was not represented at trial, but a general partner of the insured offered testimony as a witness. While the insurer denied coverage and the case is factually different than *Gandy*, the court of appeals held that the judgment and post-trial assignment of the insured's claims—including its *Stowers* claim—were invalid because there was no adversarial trial. As another example, in the *Polinard v. USAA* decision,[9] the insured settled during trial after the insurer denied it owed a defense, and the trial court entered an agreed judgment. The court of appeals held that the judgment did not result from an adversarial trial and would not be binding against the insurer. The *Hamel* case, if it involves collusive behavior, is yet another reason to have safeguards against sham judgments. As demonstrated above, the adversarial trial requirement is needed to prevent judgments resulting from collusion even in situations in which a defense is denied and *Gandy* is factually distinguishable.

Second, application of the adversarial trial requirement outside the *Gandy* context also promotes the goals of *Gandy*—to avoid prolonging litigation and distorting trial litigation motives. The ultimate purpose of litigation is to provide a mechanism to evaluate the merits and determine the value of the plaintiff's claim, but if an insurer asserts coverage defenses and adequate protections are not in place, the insurer is potentially faced with an agreed judgment that results from collusive behavior and generates extended litigation to resolve claims related to the judgment.

Third, if protection against collusive behavior does not exist outside the *Gandy* context, insurers may be forced to defend claims they otherwise would not have defended because a denial may create a situation where the insured and the underlying plaintiff manufacture a settlement or agreed judgment without the insurer's input or knowledge that manipulates otherwise uncovered claims into covered claims.

Fourth, if *Gandy*-type protection is not extended to *Hamel*, Hamel would provide a roadmap for insureds who wish to circumvent *Gandy*—instead of entering into an agreed judgment and assigning the claim to the underlying plaintiff before trial, insureds could enter into agreements (such as the stipulations and Rule 11 agreement in *Hamel*) which stop just short of a pretrial agreed judgment and assignment, but effectively perform the same functions. In essence, these agreements will effectively guarantee that the insured will not be pursued for any judgment, and that the plaintiff will be guaranteed a "deep pocket" to go after once a judgment is rendered. In such situations, while the insured may appear and be represented at trial, there is no real incentive for the insured to vigorously oppose the claims against it. This

would appear to frustrate *Gandy*'s public policy concerns regarding distortion of the underlying litigation and the prolongation of litigation, because the insurer would still be faced with an assignee or judgment creditor who worked with the insured to manipulate a claim into coverage.

B. Arguments against application of *Gandy*

Conversely, there are several reasons that *Gandy*'s adversarial trial requirement—or at least strict application of that requirement— should not apply to the *Hamel* case or cases like it.

First, *Gandy*'s adversarial trial requirement can encourage insurers to deny a defense to their insureds more often because an underlying judgment against the insured could be invalidated if the insured does not have the assets to present a defense. In essence, the insurer has incentive to deny a claim and stands to potentially be rewarded for doing so, when an insured cannot afford to defend the claim and the fully adversarial trial requirement can be asserted as a coverage defense in the subsequent coverage proceeding. In such a scenario, the insurer would be using the fully adversarial trial requirement as a sword rather than a shield.

Second, *Gandy*'s adversarial trial requirement is unfair to insureds who cannot afford to settle, whereas insureds who can afford to settle have protection under *ATOFINA*. *ATOFINA* allows an insured to settle a claim that its insurer has denied, and the insurer cannot later challenge the reasonableness of the settlement in the coverage action the policyholder brings against the insurer. On the other hand, an insured who cannot fund a settlement or a vigorous defense may be forced to resolve the claim through a bench trial like in *Hamel*, and the enforcement of the resulting judgment will be the subject of an adversarial trial defense. This does not appear to be fair to the insured when the only difference in the insureds is their net worth.

Third, the insured should not be expected to conduct a fully adversarial trial to determine the merits and value of a plaintiff's claim when the insurer denies the claim. In *Seger*, the Segers posed the following question: "If *Gandy* requires a 'fully adversarial trial' as a precondition to an underlying judgment amount being binding on a defendant's insurer, how can the value of the plaintiff's claim ever be fairly evaluated when the insurer has precluded a fully adversarial trial by its wrongful refusal to defend?"[10] The Segers arguably have a point if the insured cannot afford to pay for a defense to comply with the fully adversarial requirement. A resolution through a means that is less than a fully adversarial trial may be necessary.

Fourth, when a denial occurs, a different standard may be more effective than the fully adversarial trial requirement. The amici curiae for the insured interests in *Hamel* have advocated the *Block* rule be used when there is a wrongful denial of coverage with an exception as to a settlement or judgment obtained through fraud and collusion.[11] The amici curiae further suggest that in light of the importance of the duty to defend, the insurer must bear the burden of proving any fraud and collusion, *and* the insurer should be required to demonstrate prejudice. The *Block* case itself is cited in the dissent in *ATOFINA* to provide such an exception for collusion.[12] The amici curiae for insurer interests strongly object to the prejudice requirement, but it can be argued that the collusion exception provides a better approach than applying *Gandy*'s fully adversarial requirement in the denial context.

C. Texas Supreme Court likely will adopt some form of anti-collusion standard.

Gandy's fully adversarial trial requirement is structured such that the requirement could be applied outside of the assignment context. After setting forth *Gandy*'s elements, *Gandy* states that, "[in] no event, however, is a judgment for plaintiff against defendant, rendered without a fully adversarial trial, binding on defendant's insurer or admissible as evidence of damages in an action against defendant's insurer by plaintiff as defendant's assignee."[13] The "[in] no event" language could be interpreted to mean that the fully adversarial trial requirement applies when one of *Gandy*'s elements is not met, such as when there is a denial of coverage. The reference to "judgment" also could be interpreted to expand the fully adversarial trial requirement to cases that do not involve an assignment. To protect the insured, however, *Gandy*'s fully adversarial trial requirement may have to be modified in the denial context, or the *Block* rule could be applied with an exception for collusion. Whatever approach is adopted, the Texas Supreme Court will have to strike a balance between protecting the insured when there is a denial of coverage, and safeguarding the insurer from collusion.

V. What can an insured do to satisfy the fully adversarial trial requirement?

A. Cases discussing "actual trial" policy requirement may shed light on standard applied to whether a "fully adversarial trial" has occurred.

In *State Farm Lloyds v. Maldonado*,[14] the Texas Supreme Court provided clues as to what it would consider an "adversarial trial" satisfying the *Gandy* standard. In *Maldonado*, State Farm agreed to defend its insured under a reservation of rights. The underlying plaintiff made a settlement demand to State Farm, and when State Farm did not respond by the deadline, the plaintiff and insured entered into an

agreement in which the insured agreed to pay the plaintiff $1,000,000 in exchange for a covenant not to execute any judgment against the insured, and after the insured recovered $1,000,000 from State Farm in a bad faith suit, the insured and the plaintiff would split any remaining recovery. In the resulting bench trial, the plaintiff presented its case, but the insured's counsel presented no evidence, failed to cross-examine witnesses, and did not do an opening or closing statement. The resulting judgment against the insured was $2,000,000. The Texas Supreme Court considered whether the insured had satisfied the policy requirement that the judgment result from an "actual trial." The court concluded that the "actual trial" condition was not met, as the case was uncontested, the insured failed to appear at trial, and the insured's counsel had failed to do an opening or closing statement, present evidence, cross-examine witnesses, or contest the plaintiff's claims. Because the insured had not satisfied the "actual trial" condition, the court held that the plaintiff as a third-party beneficiary could not pursue State Farm for the policy proceeds. While this case addresses a policy's "actual trial" requirement, it seems likely that the evaluation of whether a "fully adversarial trial" occurred under *Gandy* would consider the same factors.

B. What has been found to be fully adversarial trial and what has not?

In the aftermath of *Gandy*, several courts have addressed whether a judgment was the result of a fully adversarial trial. First, courts typically hold that a judgment resulting from an agreed judgment and assignment before trial, [15] or even during trial,[16] are not the product of a fully adversarial trial. Conversely, in situations where there is no assignment of rights,[17] or the assignment occurs after trial,[18] courts typically find that the fully adversarial trial requirement has been met. Second, courts typically do not find that the fully adversarial trial requirement has been met in situations in which a default judgment is taken against the defendant in the underlying action.[19] More recently, however, in the Fifth Circuit's *Mid-Continent Casualty Co. v. JHP Development* decision, the Fifth Circuit held that a default judgment was the result of a fully adversarial trial when the insurer denied coverage and the suit was not an action against a defendant's insurer by a plaintiff as the defendant's assignee.[20] Both Great American and the Hamels rely on *JHP* to argue whether the fully adversarial trial requirement is or is not met— Great American argues that if the Hamels had simply done what JHP did, there would be no collusion, while the Hamels argue their bench trial was much more adversarial than the default judgment in *JHP*. Third, courts have found that a fully adversarial trial has not occurred in situations in which a party does not present evidence, provide opening or closing statements, or cross-examine witnesses.[21] When the insurer provides no defense, however, *Gandy*'s fully adversarial trial requirement becomes problematic and raises the issues that the Texas Supreme Court will have to resolve in *Hamel*. If *Gandy*'s fully adversarial trial requirement applies, whether the bench trial in *Hamel* will be considered a fully adversarial trial very well may turn on whether court considers the proceeding to involve collusion between the Hamels and the insured.[22]

C. *Hamel* case is on edge.

The issues in *Hamel* fall in between and present a conflict between the principle in *Gandy* that judgments should result from fully adversarial trials, not collusion, and the rule in *Block*, as recognized in *ATOFINA,* that an insurer who denies coverage should not be able to challenge the reasonableness of settlements. The Texas Supreme Court will likely have to modify *Gandy*'s fully adversarial trial requirement if it applies, or the *Block* rule to protect the insured from wrongful denials and the insurer from judgments resulting from collusion.

1 Texas Supreme Court Cause No. 14-1007.

2 *State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996).

3 *Great Am. Ins. Co. v. Hamel*, 444 S.W.3d 780 (Tex. App.—El Paso 2014, pet. granted). The Court of Appeals did, however, reduce the Hamels' award upon finding that the policy did not cover mental anguish damages awarded by the trial court.

4 *State Farm Fire & Cas. Co. v. Gandy*, 880 S.W.2d 129, 138 (Tex. App.—Texarkana 1994), *rev'd*, 925 S.W.2d 696 (Tex. 1996).

5 256 S.W.3d 660 (Tex. 2008).

6 744 S.W.2d 940 (Tex. 1988).

7 The court also found no practical difference between the denial of a duty to defend in *Block* and the wrongful denial of coverage in *ATOFINA*. 256 S.W.3d at 671–72.

8 *Yorkshire Ins. Co., Ltd. v. Seger*, 407 S.W.3d 435 (Tex. App.—Amarillo 2013), *order withdrawn* (Aug. 29, 2014), *aff'd on other grounds*, 503 S.W.3d 388 (Tex. 2016). The Texas Supreme Court ultimately did not resolve the adversarial trial issue on appeal, instead, affirming the court of appeals' reversal of the trial court's award of damages on the basis that the underlying claim was not covered.

9 *Polinard v. United Services Auto. Ass'n (USAA)*, 04-95-00425-CV, 1996 WL 460040, at *1 (Tex. App.—San Antonio Aug. 14, 1996, no writ).

10 Petitioner's Motion for Rehearing of their Petition for Review, at p. 1, *Seger v. Yorkshire Ins. Co.*, Cause No. 13–0673, Texas Supreme Court (Apr. 2, 2014).

11 Amicus Brief from Texas Building Branch of the Associated General Contractors of America, et al., at p. 14, *Great American Ins. Co. v. Hamel*, Cause No. 14–1007, Texas Supreme Court (Feb. 24, 2017).

12 *ATOFINA*, 256 S.W.3d at 671 ("An insurer that breaches its duty to defend a claim cannot later be heard to complain that the amount the insured paid in settlement was unreasonable, absent evidence of collusion. This is what we held in *Employers Casualty Co. v. Block* and as far as I can tell, it is uniformly the rule throughout the country.").

13 *Gandy*, 925 S.W.2d at 714.

14 963 S.W.2d 38 (Tex. 1998).

15 *See Burney v. Odyssey Re (London) Ltd.*, 2:04-CV-032, 2005 WL 81722 (N.D. Tex., Jan. 14, 2005); *First Gen. Realty Corp. v. Maryland Cas. Co.*, 981 S.W.2d 495 (Tex. App.—Austin 1998, pet. denied); *Heathcock v. So. County Mut.*, No. 14-97-00894-CV, 1999 WL 1041480 (Tex. App.—Houston [14th Dist.] Nov. 18, 1999, pet. denied); *Stroop v. N. County Mut. Ins. Co.*, 133 S.W.3d 844 (Tex. App.—Dallas 2004, pet. denied); *Vela v. Catlin Specialty Ins. Co.*, No. 13-13-00475-CV, 2015 WL 1743455 (Tex. App.—Corpus Christi Apr. 16, 2015, pet. denied).

16 *Polinard*, 1996 WL 460040.

17 *Mid-Continent Cas. Co. v. JHP Dev.*, 557 F.3d 207 (5th Cir. 2009); *Scottsdale Ins. Co. v. Sessions*, 331 F. Supp. 2d 479 (N.D. Tex. 2003); *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008); *Great American Lloyds Ins. Co. v. Vines-Herrin Custom Homes, LLC.*, No. 05-15-00230-CV, 2016 WL 4486656 (Tex. App.—Dallas, Aug. 25, 2016, no pet. h.).

18 *Burns Motors, Inc. v. Gulf Ins. Co.*, 975 S.W.2d 810 (Tex. App.—Corpus Christi 1998), *rev'd* (Apr. 20, 2000), *rev'd*, 22 S.W.3d 417 (Tex. 2000).

19 *Reyna v. Safeway Managing Gen. Agency for State & County Mut. Fire Ins. Co.*, 27 S.W.3d 7 (Tex. App.—San Antonio 2000), *review granted, judgment rev'd, and remanded by agreement* (Aug. 10, 2000); *Vang v. Delta Lloyds Ins. Co.*, 05-00-01164-CV, 2001 WL 722279, at *1 (Tex. App.—Dallas June 28, 2001, no pet.).

20 557 F.3d 207 (5th Cir. 2009).

21 *Maldonado*, 963 S.W.2d 38; *Vang*, 2001 WL 722279.

22 One possibility left open and argued by the Hamels is that the trial court in the coverage trial against Great American constituted a fully adversarial trial of all the issues in presented in the bench trial and that trial court held that there was no collusion involved in the bench trial such that Texas Supreme Court should affirm the court of appeal's decision.

By Blair Dancy

THE REPORT OF THE DEATH OF *STOWERS* IS GREATLY EXAGGERATED.

In April 2014, the First District Court of Appeals issued a *Stowers* opinion that sent insurance lawyers scrambling.[1] The *Patterson* decision has been hailed and decried.[2] But the truth lies, as with many contentious subjects, somewhere between, as the Fifth Circuit recently recognized in *OneBeacon Insurance Co. v. T. Wade Welch & Associates*.[3]

Understanding the facts in *Patterson* is critical to any attempt to reconcile it with extant law. A driver under the influence of cocaine, or in withdrawal, killed Diane Patterson by colliding into her car with an eighteen wheeler, according to the underlying allegations. The Patterson plaintiffs alleged the driver's employer, Brewer Leasing ("Brewer"), and the truck owner, Texas Stretch, Inc. ("Stretch"), negligently hired and supervised the cocaine-using driver.[4]

Home State solely provided Brewer's defense and shared the driver's defense with another insurer. Patterson sent two demand letters to Home State, the first requesting the $1,000,004 in policy limits to settle the two minor children's claims, and the second requesting the same limits to settle the widower's claims. Home State declined both offers.[5]

Home State then learned of additional claimants and attempted to interplead its limits into the registry of the court to release itself of liability beyond those limits. Patterson objected to Home State's request for relief, claiming Home State breached its *Stowers* duty. Pending resolution of the interpleader, Patterson tried again, demanding Home State's limits for all claims against Brewer, without mention of the driver. Home State declined, stating its limits were subject to the pending interpleader.[6]

The trial court granted the interpleader, accepting Home State's limits. As for the requested release, the trial court ordered Home State was "discharged from further liability with regard to the interplead funds" but expressly did not absolve Home State of potential *Stowers* liability prior to the deposit of the funds.[7]

The interpleaded funds were distributed among the claimants, and Home State withdrew its defense from both Brewer and the driver given the policy limits had been disbursed in full.[8] With an assignment in hand of Brewer's *Stowers* claims against Home State, Patterson proceeded through jury trial against Brewer, who was unrepresented, and the driver. A bench trial resulted in an award of over $8 million.[9]

Patterson sued Home State for breach of *Stowers* and other claims.[10] In the *Stowers* action, Home State moved for summary judgment, asserting that Home State had refused to settle the underlying claims unless both Brewer and the driver were released.[11]

The *Patterson* court found that no *Stowers* duty had attached to the three letters. In relation to the first two, the court noted the purpose of *Stowers* "is to shift the risk of an excess judgment onto the insurer *when the insurer has an opportunity to prevent an excess judgment by settling within the applicable policy limits*."[12] "The *Stowers* duty is not activated by a settlement demand unless three prerequisites are met: (1) the claim against the insured is within the scope of coverage, (2) the demand is within the policy limits, and (3) the terms of the demand are such that an ordinarily prudent insurer would accept it, *considering the likelihood and degree of the insured's potential exposure to an excess judgment*."[13]

The settlement offers at issue in *Patterson* were designed to potentially expose the same insured on whose behalf the settlement was demanded to an excess judgment.[14] Arguably, the circumstances did not meet the third prerequisite of *Stowers*, that "the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment."[15]

From this perspective, the insurer was damned if it did, damned if it didn't.

The Texas Supreme Court addressed a similar set of circumstances twenty years earlier in *Texas Farmers Insurance*

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Co. v. Soriano.[16] *Soriano* involved a settlement demand for a wrongful death claim of $5,000 on a $20,000 policy, which the carrier accepted, leaving only $15,000 for the remaining wrongful death and serious injury claims.[17] The non-settling claimants brought suit on assigned claims against the insurer, asserting negligence.[18] The court noted only two theories could support such a claim:

> (1) if the insurer negligently rejects a demand from the claimant within policy limits; or
>
> (2) if the settling claimant's "settlement was itself unreasonable."[19]

In recognizing this second standard, the court held:

> [W]hen faced with a settlement demand arising out of multiple claims and inadequate proceeds, an insurer *may* enter into a reasonable settlement with one of the several claimants even though such settlement exhausts or diminishes the proceeds available to satisfy other claims.[20]

The court appears to have conflated the concepts of a single insured with that of a single policy.

The court recognized that if the insurer had rejected the $5,000 demand, it would have faced a *Stowers* claim.[21]

One key difference between *Soriano* and *Patterson* is that the former involved a payment of less than limits, while the latter involved exhaustion of all available insurance. The exhaustion of limits would appear to disserve the public policy goal of preventing exposure to excess judgments, particularly where "by settling in the full amount of the policy limits with only one of the claimants, Home State could have potentially exposed Brewer to an excess judgment by one of the other claimants."[22]

The third demand can also be better understood through a *Soriano* lens. The insurer in *Soriano* had the opportunity to settle out one claimant and could have rejected the $5,000 wrongful death settlement demand, subject to facing *Stowers* liability itself.[23] But in *Soriano*, there was only one insured and the policy limits were not exhausted.

In contrast, there were two insureds in *Patterson* and the demands would have exhausted limits. The *Patterson* court identified two reasons for finding no *Stowers* duty in relation to this third demand. First, the court noted that despite the offer of a full release of Brewer, the offer did not include the driver, who was a permissive user and thus also an insured under the policy.[24]

The court appears to have conflated the concepts of a single insured with that of a single policy. It cited *Trinity Universal Insurance Co. v. Bleeker* for the proposition that the "third settlement offer did not constitute an unconditional offer to fully release the *insureds* [plural] in exchange for a settlement."[25] The pinpoint citation to *Bleeker* stands for the proposition that a valid release of hospital liens must be included in a settlement offer to trigger a *Stowers* duty, or there is no "full release."[26] But this first rationale in *Patterson* appears to depend on whether the *insurer* would have been fully absolved of exposure, not the insured.

Nevertheless, the *Patterson* court provides a second rationale: Brewer refused to settle out claims against itself and leave the driver exposed.[27] By insisting on a release involving both insureds, Brewer effectively created a single insured for purposes of a *Stowers* or *Soriano* analysis. In that circumstance, the same rationale concerning the first two demands would apply to the third demand; that is, a settlement that would leave an insured without any insurance does not serve the larger *Stowers* purpose of preventing an excess judgment.[28] As the Texas Supreme Court recognized: "The *Stowers* duty is not activated by a settlement demand unless … the terms of the demand are such that an ordinarily prudent insurer would accept it, *considering the likelihood and degree of the insured's potential exposure to an excess judgment*."[29]

The Fifth Circuit's *OneBeacon* opinion recently distinguished *Patterson* on this very basis.[30] *OneBeacon* involved a legal malpractice claim where the offending attorney had suffered a death penalty sanction due to discovery abuse.[31] The client demanded settlement within the professional liability policy limits but made the demand solely to the law firm, excluding the individual lawyer.[32] OneBeacon argued that the demand did not trigger *Stowers* by virtue of *Patterson*.[33]

The Fifth Circuit rejected this argument on two grounds. First, the court noted it had previously found that *Stowers* could be triggered by settlement offers to fewer than all of the co-insured parties.[34] Further, the court noted a decision from an intermediate state court of appeals is not binding on the Fifth Circuit.[35]

Second, the *OneBeacon* court distinguished *Patterson* because "the insured employer had explicitly indicated to its attorney that it 'did not want 'any settlement demands to be accepted that didn't involve a release of all of the claims against both" the employer and the employee.[36]

In contrast, in *OneBeacon*, the law firm never insisted that the individual lawyer also be released. As noted by the court: "Counsel for the Welch Firm wrote OneBeacon on June 27,

2011, formally requesting that OneBeacon settle DISH's claims against the Welch Firm for an amount within the Welch Firm's policy limits."[37] Thus, *Stowers* was triggered.[38]

Time will tell whether *Patterson* is treated as an outlier or a limited nuance in the prerequisites for triggering a *Stowers* duty. The question of whether an ordinarily prudent insurer would accept a settlement demand, considering the likelihood and degree of the insured's potential exposure to an excess judgment, is not always easily answered. In the circumstances in *Patterson*, the likelihood and degree of the insured's potential exposure appeared more likely if the insurer settled out only certain claimants, leaving the insured without any insurance whatsoever as to the remaining claimants. Potentially key to reconciling *Patterson* with other *Stowers* law is the fact that the first two demands left the same insured without any insurance in respect to other claimants.

Further, *Patterson* stands for the proposition that a settlement demand against an insured who insists that a co-insured also be released may not trigger *Stowers* due to the likely exposure of the co-insured to an excess judgment.

One thing is for certain: We can expect further attempts to distinguish and limit *Patterson*, as exemplified by the Fifth Circuit's analysis in *OneBeacon*.

1 *Patterson v. Home State County Mut. Ins. Co.*, 01-12-00365-CV, 2014 WL 1676931, at *1 (Tex. App.—Houston [1st Dist.] Apr. 24, 2014, pet. denied) (following *G.A. Stowers Furniture Co. v. Am. Indem. Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929)).

2 *Compare* Matthew Paradowski, "*Stowers* After *Patterson*: Same As It Ever Was?" available at http://insurancelawsection.org/articles/Stowers_After_Patterson_Same_As_It_Ever_Was_by_Matthew_Steven_Paradowski/184 (accessed March 2, 2017) ("*Patterson* confirms that in the context of multiple claimants or multiple insureds, a settlement demand that fails to settle all claims against all insureds does not constitute a proper *Stowers* demand at all.") *with* Amicus Brief of Texas Policyholder Coverage Lawyers, *Patterson v. Home State County Mut. Ins. Co.*, 2014 WL 6907586 (Tex.) (arguing *Patterson* "both undermines and contradicts two Texas Supreme Court precedents, *Stowers* and *Soriano*, and allowing the Court of Appeals' opinion to stand will undoubtedly create uncertainty and disrupt well-settled Texas insurance law").

3 *See* 841 F.3d 669, 678–79 (Nov. 14, 2016).

4 *Patterson*, 2014 WL 1676931, at *1.

5 *Id.*

6 *Id.*

7 *Id.* at *2.

8 *Id.*

9 *Id.* at *3.

10 *Id.*

11 *Id.*

12 *Id.* at *9 (emphasis added).

13 *Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 849 (Tex. 1994) (emphasis added) (citing *Stowers*, 15 S.W.2d at 547).

14 *See Patterson*, 2014 WL 1676931, at *9.

15 *See Garcia*, 876 S.W.2d at 849.

16 881 S.W.2d 312 (Tex. 1994).

17 *Id.* at 313.

18 *Id.* at 314.

19 *Id.* at 315.

20 *Id.* (emphasis added).

21 *See id.*

22 *See Patterson*, 2014 WL 1676931, at *9.

23 *See Soriano*, 881 S.W.2d at 315.

24 *See Patterson*, 2014 WL 1676931, at *10.

25 *Patterson*, 2014 WL 1676931, at *10 (emphasis added) (citing *Trinity Universal Ins. Co. v. Bleeker*, 966 S.W.2d 489, 491 (Tex. 1998)).

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

27 *See Patterson*, 2014 WL 1676931, at *10.

28 *See id.* at *9.

29 *Garcia*, 876 S.W.2d at 849 (emphasis added).

30 *See OneBeacon Ins. Co. v. T. Wade Welch & Assocs.*, 841 F.3d 669 (5th Cir. Nov. 14, 2016).

31 *Id.* at 673.

32 *Id.* at 674.

33 *Id.* at 678–79.

34 *Id.* at 678 (citing *Travelers Indem. Co. v. Citgo Petroleum Corp.*, 166 F.3d 761, 764 (5th Cir. 1999)).

35 *Id.* at 679 n.10.

36 *Id.* at 679.

37 *Id.* at 674.

38 *See id.* at 679.

By Tarron Gartner-Ilai and Katya Long

WHO YOU GONNA CALL?—COMMUNICATIONS BETWEEN POLICYHOLDERS AND THEIR INSURANCE AGENTS: A FINE LINE BETWEEN PRIVILEGE AND WAIVER

I. Introduction

Privilege between a policyholder and an insurance agent (or broker) is often like insurance itself: you don't need it until you need it, and by then it's too late. Think about it. The agency relationship often develops on the golf course, over dinner, or through social and community gatherings. Doesn't everyone know an insurance agent? Isn't an insurance agent the first person a policyholder might turn to in the event of a claim, especially if a coverage dispute erupts, or the insurer is untimely in paying the claim? Isn't it normal for a policyholder to expect that what he says to his insurance agent to stay between just the two of them? Isn't the insurance agent supposed to be on the policyholder's side?

Unfortunately, it's not quite that simple. The relationship between policyholders and insurance agents and brokers is complex. The agent is technically the agent of the insured—and might be considered by the policyholder to be a trusted confidant. However, the agent is paid by the insurer through commissions tied to the policy premium. This is not to say that there is anything untoward involved. Generally agents and brokers want to help their clients; and agents provide a valuable service that keeps the insurance industry, and rates, competitive.

However, due to the fact that policyholders purchase their policies from agents in the first instance, they might naturally assume once a claim occurs that communications subsequent to a loss are automatically privileged. Or, more likely, the policyholder doesn't think twice about discussing the particulars of the claim with the agent. However, once a claim occurs the landscape changes quite a bit. Facts related to the placement of the policy might be relevant to a determination of coverage. Or, coverage for the claims might hinge entirely upon facts the policyholder discloses to the agent or broker, sometimes in passing.

The policyholder's assumption is almost guaranteed—and probably justified—when his or her attorney is privy to or initiates the communication with the agent or broker. In truth, however, except in limited circumstances, most jurisdictions find that the attorney-client and work-product privileges do not apply to safeguard communications between the insured and his or her insurance agent or broker.

Jurisdictions that decline to extend the attorney-client privilege or the work-product doctrine to communications involving the insurance broker and the policyholder aim to maintain the truth-seeking aspect of a court-centered dispute resolution. These courts tend to view the attorney-client privilege or the work-product doctrine through a narrow lens. Communications between a policyholder and his or her insurance agent are more likely to be discoverable in the event a coverage dispute occurs, unless the policyholder can establish that the common-interest doctrine applies. Policyholders must be very careful not to disclose confidential information when communicating with an agent or broker.

By contrast, some jurisdictions view the attorney-client privilege and the work-product doctrine from a more liberal perspective. Courts in these jurisdictions tend to apply either the attorney-client privilege or the work-product doctrine to preserve the communications from discovery. Policyholders in these more liberal jurisdictions are naturally far freer in what they can say to their insurance brokers or agents.

It is nonetheless important to remember that even the more liberal jurisdictions recognize limits beyond which courts decline to traverse to apply the privilege or the work-product doctrine to shield the communications between the policyholders and their brokers or agents.

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II. Courts That Narrowly View the Attorney-Client Privilege and the Work-Product Doctrine

The courts that decline to apply the attorney-client privilege or the work-product protection derive their stance from an idea that the disclosure of privileged information to the insurance broker waives the attorney-client privilege because such a disclosure is voluntary. Such a view, however, hampers free communications between the policyholders and their brokers or agents because it discourages the policyholders from fully and honestly expressing their insurance needs to their brokers or agents.

However, a very narrow exception—known as the common-interest doctrine, the joint-defense doctrine, or the allied-litigant privilege—may be available to avoid the waiver of privilege. A court may determine that the common-interest doctrine applies to protect the communication only if all the parties involved share a common legal interest while exchanging information. If the relationship between the parties is determined to be primarily commercial as opposed to being purely legal, the exception will be inapplicable to preserve the communications under the attorney-client privilege or work-product doctrine.

The common-interest doctrine derives from criminal law, where it was most often applied when separate counsel in the multiple-defendant litigation shared information in the allied defense. The doctrine eventually was extended to civil law. Importantly, the doctrine does not grant protection. Rather, it helps counteract the waiver of the attorney-client privilege or the work-product privilege. Thus, before the doctrine may apply, either the attorney-client privilege or the work-product doctrine must exist.

For example, in *Progressive Casualty Insurance Co. v. Federal Deposit Insurance Corp.*,[1] the court declined to apply the common-interest doctrine because the information exchange occurred in furtherance of the business relationship. While the case involves a situation where the insurer—as opposed to a policyholder—sought to protect its communications with its reinsurers and brokers, the rationale under which the court rejected the exception and found the waiver of privilege is nonetheless applicable to the communications involving a policyholder and an insurance agent or broker. Further, while it is possible that the court was more willing to find that the privilege had been waived because the dispute involved the coverage for the Federal Deposit Insurance Corporation's claims, the court correctly held that the insurer's communications with its reinsurers and brokers concerning the coverage for the FDIC claims rested predominantly on its business relationship with its reinsurers and brokers. In other words, the insurer exchanged the information merely to ensure a continued availability of insurance coverage. Had the insurer demonstrated that it exchanged the information in furtherance of its legal strategy or defense in an anticipation of litigation, the *Progressive* court would most likely have applied the common interest doctrine to protect that type of information.

The corollary of the *Progressive* decision is that the party's mere assumption or expectation of confidentiality, in and of itself, will not suffice to sway a court that the attorney-client privilege, the work-product doctrine, or the common-interest doctrine should apply. However, so long as the party can demonstrate that the exchange of the information rested on a purely legal need or occurred based on a purely legal relationship between the parties involved, the court is more likely to find such a communication to be protected.

The decision in *Cellco Partnership v. Certain Underwriters at Lloyd's London*,[2] is an excellent example of what—in practicality—the policyholder should be able to demonstrate to justifiably claim the protection. The policyholder should be able to show the court that his or her communication with the broker's or agent's licensed attorney was necessitated in order to obtain competent legal advice regarding the claim, or to facilitate the attorney-client relationship.[3] In *Cellco*, the court observed that "the presence of an agent or interpreter does not automatically waive the attorney-client privilege. To protect the privilege, the party claiming a third party as an agent bears the burden of showing that the person in question worked at the direction of the lawyer, and performed tasks relevant to the client's obtaining legal advice, while responsibility remained with the lawyer. Moreover, when the third party is a professional, such as an accountant, capable of rendering advice independent of the lawyer's advice to the client, the claimant must show that the third party served some specialized purpose in facilitating the attorney-client communications and was essentially indispensable in that regard."[4]

After defining the parameters of the attorney-client privilege in the context of the tripartite relationship, the *Cellco* court declined to extend its protection to the insured's communication with its broker following the insured's declaratory and breach of contract actions that the insured filed after the carrier declined coverage.[5] The court explained that the mere presence of the broker's attorney in the communication between the insured and the broker fails to raise the privilege for three reasons. First, the insured and the attorney had no retainer agreement. While such an agreement is not dispositive, the court noted, it is nonetheless an important indicator of an attorney-client relationship. Second, the insured failed to show how or when the broker's role transitioned into being predominantly legal. Finally, the broker's attorney's correspondence with the insured plainly stated that the information he provided was not intended to be legal advice. As such, there could have been no reasonable expectation that the communications between the insured and its broker would fall within the purview of attorney-client privilege.[6]

However, the *Cellco* court upheld the protection of certain documents under the work-product doctrine, despite the fact that the same could not be protected from disclosure under the attorney-client privilege. The *Cellco* court elaborated on the parameters of the work-product doctrine, holding that the doctrine applies when it can be demonstrated that it "shelters the mental processes of the attorney, providing a privileged area within which he can analyze and prepare his client's case."[7] The court noted, however, that the doctrine—just as the attorney-client privilege—can be waived. The waiver, however, will never occur if the documents "were prepared in anticipation of litigation."[8] No mere potential for future litigation or the preparation of documents in the ordinary course of business will meet the standard. According to the *Cellco* court, the standard is met when the documents at issue "can fairly be said to have been prepared or obtained because of the prospect of litigation."[9]

Applying this standard, the *Cellco* court found that the documents that discussed legal advice by the insured's in-house counsel were prepared in anticipation of litigation because they were prepared subsequent to the declination of coverage. However, the documents that were prepared before the declination of coverage and those documents that did not involve legal advice or strategy in the pending suit could not be shielded from disclosure.[10]

III. Courts That Apply the Attorney-Client Privilege and the Work-Product Doctrine in the Tripartite Relationship

Few courts recognize the application of a privilege to the broker-policyholder communications and bar disclosure of such communications. Generally speaking, there is no separately recognized insured-insurer privilege. As such, courts have to creatively apply the attorney-client or work-product privilege to extend protection.

Some courts do so based on a pertinent state statute. For instance, in *Atmel Corp. v. St. Paul Fire & Marine Insurance Co.*,[11] the court protected from disclosure the communication between the policyholder and its insurance broker by applying the so-called statutorily mandated "business associates" exception within the attorney-client privilege. The policyholder sought to protect about eighty documents in possession of its insurance broker from disclosure to its insurance carrier. The carrier argued that the policyholder waived any privilege when it furnished the documents in dispute to its broker.

The *Atmel* court disagreed with the insurance carrier by explaining that disclosure of an attorney-client communication to a third party fails to automatically destroy the privilege when the disclosure occurs to "no third persons other than those who are present to further the interest of the client in the consultation or those to whom disclosure is reasonably necessary for the transmission of the information."[12] In reaching this conclusion, the court cited section 952 of the California Evidence Code. In accordance with this section, the court upheld the attorney-client privilege because the broker was present to further the interests of the policyholder and the disclosure of the documents at issue to the broker was reasonably necessary for the broker to properly negotiate an insurance policy with the carrier on the policyholder's behalf. Subsequent to the purchase of the policy, the court said, the broker acted as a "necessary advisor for both general coverage questions and regarding specific claims tendered to carriers."[13]

The *Atmel* court went on to hold that the policyholder was entitled to withhold the disputed documents on the basis of the work-product privilege because the documents contained the "mental impressions, conclusions, opinions, or legal theories of an attorney or other representative of a party concerning the litigation."[14] The *Atmel* court took an opportunity to broaden the traditional attorney-client privilege by unhesitatingly applying the "business associates" statutory exception. Perhaps it did so because the disputed documents did in fact contain mental impressions of the legal counsel. More likely, however, the court simply recognized California's interest in maintaining the business relationship between policyholders and brokers by allowing the free flow of information.

The court in *Tetra Technologies, Inc. Securities Litigation*[15] also unhesitatingly applied the attorney-client privilege to bar disclosure of communications between the policyholder, its attorney, and the insurance broker. The *Tetra* court, however, did so without venturing to the outskirts of the attorney-client privilege. Unlike the *Atmel* court, the *Tetra* court protected the communication precisely because it was made in confidence to gain legal advice. The court stressed that the Fifth Circuit recognizes the attorney-client privilege in the context of communications between an insurer and its insured because it helps in the defense of the insured's legal interest. Absent such an interest, the fact that broker-policyholder communication was helpful in furthering the policyholder's other interests will be dreadfully deficient for the application of the attorney-client protection.[16]

IV. Conclusion

Despite the possibility that a court may apply a privilege to bar disclosure of certain documentations or communications, policyholders should remain on guard when they exchange information or communicate with their insurance brokers or agents regarding claims and coverage. In other words, the policyholder's agent or broker might not be the first person to call in the event of a claim, but the last—at least for anything other than giving the agent a heads-up or to request that the agent provide notice to the insurer.

To increase the likelihood that the protection may apply, some brokers or agents began offering claim-assistance

agreements, all-purpose confidentiality agreements, or joint-defense or common-interest agreements. While these agreements may help establish the protection by governing the exchange of information, they are far from being a foolproof method of ensuring the preservation of any privilege. In certain cases, these agreements may even abrogate the policyholder's right of action against the broker should it be determined that the coverage was denied because of broker error. As such, policyholders should consult with an attorney before executing any legal document.

When the policyholder elects to execute such an agreement, they should evaluate how the agreement defines common interests and limits disclosures. For example, the agreement should explain that the exchange of confidential information is aimed to advance common interests between the policyholder and the broker or agent. The agreement should attempt to delineate the circumstances under which adversity between the signatories to the agreement may arise and state that no disclosure in these adverse areas can be expected.

Additionally, policyholders may wish to segregate their communications with the broker regarding a legal aspect of their policies from any type of business communication. Taking the pains to differentiate various communications with their broker—while undoubtedly tedious—will help policyholders bolster their argument in favor of the privilege's extension. To that end, policyholders may, for example, mark their legally oriented communication as "Privileged and Confidential." This will not, in and of itself, guarantee the security of the communication. It may help, however. At the end of the day, policyholders must be careful about what they say to their agents and brokers after a loss or a claim occurs. The fact that the policyholder and his or her agent played a round of golf "just the other week" doesn't count for anything once the policyholder is embroiled in a legal dispute.

1 *See Progressive Cas. Ins. Co. v. FDIC*, Cause No. 12-CV-04041 (N.D. Iowa Oct. 3, 2014).

2 *See Cellco P'ship v. Cert. Underwriters at Lloyd's London*, 2006 WL 1320067 (D. N.J. 2006).

3 *See id.* at *4.

4 *Id.* at *2.

5 *See id.* at *3.

6 *See id.*

7 *See id.* at *4–5.

8 *See id.* at *4.

9 *See id.* at *5.

10 *See id.*

11 *See Atmel Corp. v. St. Paul Fire & Marine Ins. Co.*, 409 F. Supp. 2d. 1180 (N.D. Cal. 2005).

12 *Id.* at 1181.

13 *Id.* at 1181–82.

14 *Id.* at 1182.

15 *See In Re Tetra Tech., Inc. Sec. Lit.*, 2010 WL 1335431.

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