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THE INSURANCE LAW SECTION OF THE STATE BAR OF TEXAS

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

Anyone interested in submitting a manuscript for publication should contact Linda M. Dedmani, Editor In Chief, at (214) 361-8885 or by email at ldedman@coveragelawdallas.com. Manuscripts for publication must be typed and double-spaced with endnotes. Replies to articles published in the ***Journal*** are welcome.

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Mission Statement

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

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Comments

FROM THE EDITOR

By Rebecca DiMasi
Shidlofsky Law Firm PLLC

As I write these comments, we have had yet another major event in Texas that warrants consideration in the Journal. The winter storm in February of 2021 has resulted in even more insurance claims, following the claims resulting from COVID-19. Two of the articles in this edition of the Journal address the coverage issues raised by those claims, one from the perspective of policyholders and the other from the perspective of carriers. We have also included two articles on the current state of the Stowers doctrine, with an interesting take on the interplay of common law and statutory claims as well as consideration of effect of American Guarantee and Liability Insurance Co. v. ACE American Insurance Co. Finally, we have included an article for practitioners new to the practice area, providing a breakdown on the analysis of an insurance policy.

This will be my last edition serving as Editor In Chief of the Journal, as I will be moving on to a different role within the Council. I have appreciated the opportunity to serve as the Publications Chair and Editor In Chief of the Journal for the last four years. As always, thanks to the authors and to Managing Editor Jason McLaurin for his invaluable assistance. Thanks also to all of the volunteer editors for their excellent editing skills.

The Journal is always open to publishing articles relating to Texas insurance law for the benefit of the bench and bar. If you have an article to submit, or a proposed topic, feel free to send me an email to the incoming Publications Chair, Linda Dedman at ldedman@coveragelawdallas.com, or Jason McLaurin at jmclaurin@mdlawtex.com.

Rebecca DiMasi
Editor In Chief

Comments

FROM THE CHAIR

By Pamella Hopper, Chair

By the time this issue of the Journal of Texas Insurance Law lands on your desk, I will be the Immediate Past Chair of the Section and your new officers and Council will be well into the new bar year, focusing on fresh goals and initiatives to improve the Section and the services provided to its members. I'm confident the Section is in good hands as the Council has been hard at work this year, meeting more frequently in a virtual format to address Section business, and to develop new projects for the coming years.

Although we have not been able to meet in person this bar year, our Young Lawyers Committee has hosted a number of virtual networking events to involve new members, provide mentoring, and promote the exchange of ideas. The Section continues to educate its membership and the bar with the publication of the Journal of Texas Insurance Law, the pre-eminent law review dedicated to Texas insurance law, along with weekly "Right Off the Press" email updates that provide summaries and links to the most recent Texas state and federal insurance law decisions, as well as current listings of insurance-related employment opportunities. The Section's website, insurancelawsection.org, also continues to offer new content.

The Section's newest initiative, the Texas Insurance Law Student Writing Competition, was held this past fall, in which students from all ten accredited Texas law schools were asked to submit articles on insurance-related topics. The Section awarded scholarships to the winners of the competition. The inaugural year was a great success, and we look forward to working with our statewide law schools next year to receive even more submissions from up-and-coming young lawyers.

The Section remains dedicated to providing quality CLE through webinars on cutting-edge issues. Because we wish to offer our annual Advanced Insurance Law Course and Casino Night live and in-person, we have moved this year's course to the fall, from September 29 through October 1, at the Hyatt Hill Country Resort & Spa in San Antonio. Please plan to attend and take advantage of this opportunity to renew friendships and reconnect with colleagues you haven't seen in over a year, all while earning valuable CLE credit as we address the latest topics in the field. We will also recognize the winners of the Law Student Writing Competition at the course.

Finally, I would like to express my profound gratitude to my fellow officers, Council members, and committee volunteers, past and present, all of whom worked tirelessly and with great zeal throughout my decade on the Council. I am grateful for your many contributions, as well as your friendship over the years. I and the other 2,200-plus members of the Section thank you for your commitment to fulfilling the Section's Mission of promoting collegiality and educating the bench, bar, and public about Texas insurance law.

Sincerely,

Pamella Hopper
Chair of the Insurance Law Section of the State Bar of Texas

By Nejat Ahmed, Lemaster & Ahmed PLLC

INSURANCE COVERAGE ISSUES EXPECTED IN THE AFTERMATH OF WINTER STORM URI

In February 2021, Winter Storm Uri swept through the southern parts of the US bringing with it some of the coldest temperatures in decades and several inches of snow and ice. Texas was hit hard with millions losing power and water. Experts in the insurance industry estimate that the insured loss caused by Uri could approach $20 billion.

With the loss of power and cold temperatures, commercial and residential properties suffered pipe breaks and resulting water damage. Businesses also suffered loss due to the power outages. As a result, policyholders turned to their insurance companies to cover the devastating loss. In this article we will look at the some of the coverage issues that have emerged.

Businesses throughout Texas experienced major losses from frozen pipes and the inability to access their premises. Generally, commercial property insurance policies provide that the insurer "will pay for direct physical loss of or damage to Covered Property" at the insured location. Business owners that sustained water or other damage to their commercial building will be able to meet the physical damage requirement of the insuring clause. Some commercial property policies, however, have different exclusions that may come into play.

Frozen Plumbing Exclusions

Some policies include exclusions which typically preclude coverage for loss or damage caused directly or indirectly by "water, other liquids…that leak or flow from plumbing, heating, air condition or other equipment (except fire protective systems) caused by or resulting from freezing" unless:

(1) *You do your best* to maintain heat in the building or structure; or

(2) You drain the equipment and shut off the supply if the heat is not maintained.[1]

While there is limited case law addressing this exclusion, our review indicates courts have ruled in favor of the insured.

In *American National Property & Casualty Co. v. Fredrich 2 Partners, Ltd.*, the insured owned several commercial buildings. During a severe winter storm, the temperatures remained below freezing for four consecutive days and an insulated copper pipe in one of the insured buildings froze and ruptured, causing water damage to the building's two interior units. At the time of the incident, one of the units was occupied and heated while the other was vacant and unheated. The pipe that froze was located in that attic of the vacant unit.

The insurer denied the claim, relying on the frozen plumbing exclusion, and litigation ensued. The insurer and insured filed competing motions for summary judgment. The insured argued that it did its best to maintain heat in the building and that the phrase "do your best" was ambiguous. The insured also argued that the pipe would have frozen and ruptured regardless of whether heat was maintained. The trial court granted the insured's motion without specifying basis for its decision.[2]

The El Paso Court of Appeals found that the insured provided electricity and gas to keep the building's occupied units heated during the ice storm and thus satisfied its obligation to do its best to maintain heat in the building. In its analysis, the court cited to the dictionary definition of "maintain" as "to keep in existence or continuance; preserve, retain".[3] The court also found that the policy language did not require the insured to maintain heat in each unit, but rather to heat the building.[4] Because the summary judgment evidence established that there was heating in the building, the El Paso Court of Appeals ruled in favor of the insured.[5]

In *Maine State Properties, LLC v. Chubb Custom Insurance Co.*, the insured was a lessee of a commercial building responsible for maintaining heat in the insured premises. The insured premises consisted of: (1) an unfinished basement, (2) a street level floor with a finished retail space and finished mezzanine floor, and (3) finished residential apartments on the second, third and fourth floors. At the time of loss, the first floor and mezzanine were vacant and the warm air furnace supplying heat to the retail space was turned off. Several pipes within the first floor vacant retail

Nejat Ahmed is the founding member of LeMaster & Ahmed PLLC. She focuses her practice on litigation of complex insurance coverage issues and first-party bad faith disputes involving commercial and residential property claims.

space froze and burst. The insurer denied coverage.

The *Maine* court addressed whether the exclusion requiring the insured to "do its best to maintain heat" was ambiguous. The insurer cited to *Continental Western Insurance Co. v. Paul Reid, LLP*,[6] and argued that the phrase "best efforts" was not ambiguous and should be construed it to impose an obligation on the insured to use "due diligence" or "reasonable efforts."[7] The insured cited to *Sonrob Hosts, LLC v. Lafayette Insurance Co*., arguing that the language at issue was ambiguous and set a subjective standard as to the meaning of an insured's "best effort."[8] The insured argued that the insurer could have, but did not, impose specific objective requirements on which coverage for water damage resulting from frozen pipes would depend, such as requiring the insured to wrap the pipes or install a fail-safe alarm system to maintain heat. Relying on *American National Property & Casualty Co. v. Fredrich 2 Partners, Ltd.*, the insured argued that it had satisfied the obligation to do its best by maintaining heat in the building without heating the vacant portions of the building.[9]

The *Maine* court found that the *Sonrob* court's construction of the phrase "do[its] best" is sensible and found that the phrase requires the insured to make reasonable efforts to maintain heat at an adequate level throughout the building, but it does not require the insured directly heat every room.[10]

Equipment Breakdown Coverage/Service Interruption

For business owners that suffered loss due to loss of power, the equipment breakdown coverage and corresponding service interruption coverage may also be implicated. Typically, the equipment breakdown provision provides coverage for "direct physical loss of or damage to Covered Property at the described premises caused by or resulting from a 'breakdown' to 'covered property.'" The definition of covered equipment could include electrical equipment "used in or associated with the generation of electrical power." An example of the definition of "breakdown" includes "mechanical failure" or "electrical failure including arcing." The definition of breakdown often excludes, however, the "functioning of any safety or protective device."

Business income and spoilage coverage may also be extended to include service interruption which applies to loss caused by or resulting from a "breakdown" to equipment that is owned or operated by a third-party. Some service interruption coverage clauses provide coverage for "equipment that is owned, managed or controlled by your landlord or landlord's utility or utility or other supplier with whom you have a contract, that directly supplies you with… electrical power …natural gas …water [or] internet access."

Coverage disputes will likely revolve around whether any power loss suffered by policyholders throughout Texas during the winter storm was the result of damage to the grid or the operation of safety features. Texas courts have not addressed this issue.

In *Wakefern Food Corp. v. Liberty Mutual Fire Insurance Co.*, the insureds, a group of supermarkets, made a claim for spoiled food and business interruption as a result of a four-day electrical blackout.[11] The insurer denied coverage contending that its policy only applied where there is physical damage to off-premises electrical plant and equipment and that, although the power grid was physically incapable of supplying power for four days, it suffered no "physical damage." The policy did not define the term "physical damage."[12] The trial court granted the insurer summary judgment, holding that the grid was not physically damaged because it could be returned to service after the interruption.[13] The trial court also found that the protective system within the grid worked to prevent damage to the equipment.[14]

The Superior Court concluded that the term "physical damage" was ambiguous and that the trial court construed the term too narrowly.[15] The Superior Court found that the electrical grid was "physically damaged" due to a physical incident or series of incidents, and the grid and its component generators and transmission lines were physically incapable of performing their essential function of providing electricity.[16] The court found that there was also undisputed evidence that the grid is an interconnected system and that, at least in some areas, the power could not be turned back on until assorted individual pieces of damaged equipment were replaced.[17] The court's decision, however, rested on the loss of function of the system as a whole.[18] The court explained that if the insurer intended its policy to not provide coverage for an electrical blackout, it was obligated to define its policy exclusion more clearly because an average policyholder would not be expected to understand the functioning of the power grid. In dicta and potentially an important issue for Texas insureds, the court explained that it would have reached a different result if a governmental agency had ordered that the power be shut off to conserve electricity.[19]

In *Four Stars Brothers, Inc. v. Allied Insurance Co.,* the insured, an owner and operator of a grocery store, made a claim for substantial losses of inventory and stock and some equipment as a result of an extended blackout.[20] The insurer paid for damage to equipment but denied coverage for the insured's loss of inventory and stock, relying on the "off-premises services" exclusion. The exclusion precluded coverage for the "failure of power or other utility service supplied to the described premises, however caused, if the failure occurs away from the described premises." The exclusion, however, provides that "if failure of power or other utility service results in a Covered Cause of Loss, we will pay for the loss or damage caused by that Covered Cause of Loss."[21] The insurer contended that the exception to the exclusion only provides

coverage where a separate and independent covered cause of loss occurred from the power failure.[22] The insured argued that the Utility Services-Additional Coverage endorsement provided coverage for the loss.[23]

The Utility Services-Additional Coverage endorsement provided coverage for loss caused by interruption of services to the premises and required that the "interruption must result from direct physical loss or damage by a Covered Cause of Loss" to the insured premises.[24] The insured argued that coverage existed because the loss of power being supplied to Detroit Edison constituted a direct physical loss to Detroit Edison. The court disagreed and found that the mere cessation of power supply does not demonstrate a direct physical loss. Looking to the investigation and report by a joint "U.S.-Canada Power System Outage Task Force," which found that the loss of power was due to the engaging of the protective equipment, the court held that there was no direct physical loss to Detroit Edison equipment. Furthermore, the court found that even if there was physical loss to the Detroit Edison equipment, that physical loss or damage did not result from a covered cause of loss. The court upheld the insurer's denial of coverage.

Scope and Cost Disputes and Appraisal

While it may be difficult to predict each policy provision a Texas insurer may rely upon in its coverage analysis of burst pipe claims, one prediction is easy to make—scope and cost will be hotly contested. The nature and scope of damage caused by a burst pipe and the cost to repair the that damage will very likely provide ample litigation in the months and even years to come. It is also likely that insurers and insureds will rely on the appraisal provision found in many policies to help narrow and settle these disputes.

Appraisal is available where the issue is amount of the loss or cost of the repair or replacement. It is generally not proper for an appraisal to include coverage issues. A common appraisal provision provides as follows:

> If you and we fail to agree on the actual cash value, amount of loss, or cost of repair or replacement, either can make a written demand for appraisal. Each will then select a competent, independent appraiser . . . . The two appraisers will choose an umpire. If they cannot agree upon an umpire… the choice [may] be made by a judge of a district court . . . . The two appraisers will then set the amount of loss, stating separately the actual cash value and loss to each item. If the appraisers fail to agree, they will submit their differences to the umpire . . . . Such award shall be binding on you and us . . . .

Although an appraisal award is binding, the Texas Supreme Court has recently held that extra-contractual claims survive even after an insurer has paid an appraisal award.[25]

Alas, just as coverage lawyers have learned during past extreme weather events, it is reasonable to expect coverage issues to be litigated on both sides for quite some time. Many Texas courts will construe policy provisions for the first time in the context of burst pipe claims incident to a historic freeze. Construction of the frozen plumbing and the equipment breakdown coverage/service interruption exclusions will yield new precedent for many jurisdictions.

1 Emphasis added.

2 *Id.*

3 *Id.* at 614.

4 *Id.*

5 *Id.*

6 715 N.W.2d 689 (Wis. Ct. App. 2006).

7 *Maine*, 2016 WL 8672924, at *9.

8 *Id.* (citing No. 3:11-CV-03094, 2012 WL 5336966, at *7–8 (W.D. Ark. Oct. 26, 2012)).

9 *Maine*, 2016 WL 8672924, at *9.

10 *Id.* at *11.

11 968 A.2d 724, 727 (N.J. App. 2009).

12 *Id.*

13 *Id.*

14 *Id.*

15 *Id.* at 734.

16 *Id.*

17 *Id.*

18 *Id.*

19 *Id.* at 734 n.7

20 No. 04-CV-73401-DT, 2006 WL 148754, at *1 (E.D. Mich. Jan. 19, 2006).

21 *Id.* at *3.

22 *Id.*

23 *Id.* at *4.

24 *Id.* at *5.

25 *See Barbara Technologies Corp. v. State Farm Lloyds*, 589 S.W.3d 806 (Tex. 2019); *Ortiz v. State Farm Lloyds*, 589 S.W.3d 127 (2019); *Alvarez v. State Farm Lloyds*, 601 S.W.3d 781 (Tex. 2020); *Lazos v. State Farm Lloyds*, 601 S.W.3d 783 (Tex. 2020); *Biasatti v. GuideOne National Ins. Co.*, 601 S.W.3d 792 (Tex. 2020).

By Genesis Reed & Matt Rigney, Tollefson Bradley Mitchell & Melendi

ICE ICE BABY: A PRIMER ON FROZEN PIPE CLAIMS ARISING FROM THE FEBRUARY FREEZE

Winter Storm Uri was the first billion-dollar disaster in 2021,[1] and it could end up being the costliest disaster in Texas history.[2] Uri had other unprecedent effects too. Democratic and Republican lawmakers stopped fighting to collaborate and listen to the decade-old warnings,[3] advancing legislation that would force plants to winterize.[4] Will this bipartisanship stop? We don't know. But one of Uri's certain effects will be insurance claims arising out of the freeze. Texas may not run across claims arising from freezing weather often, but, fortunately, the policy terms that address such claims are not a brand-new invention. This article will discuss the policy terms and the various considerations involved frozen plumbing claims, which is the most common type of cold-weather claim,[5] with the goal of providing a basic guide to handling these types of claims.

Frozen/Freeze Pipe Claims

While both homeowners and commercial property policies potentially provide coverage for frozen plumbing, the applicable policy provisions are somewhat convoluted. In many policies, the provisions specifically addressing frozen plumbing are exclusionary, with the coverage analysis turning on an exception to the exclusion.

While the specific terms may vary, one should approach the coverage analysis of a frozen pipe claim under either a commercial or personal lines property the same way as any other coverage question. Start with the insuring agreement. Then, look for relevant exclusions, including those added by endorsement. And finally, check the exclusion for exceptions that may bring the loss back within coverage.

To apply this process to a commercial policy, begin with the Commercial Property Coverage Form's insuring agreement, which covers direct risk of physical loss to covered property. The provision that addresses frozen pipes appears under the exclusions in the Causes of Loss – Special form:

> B. Exclusions
>
> * * *
>
> 2. We will not pay for loss or damage caused directly or indirectly by any of the following:
>
> * * *
>
> g. Water, other liquids, powder or molten material that leaks or flows from plumbing, heating, air conditioning or other equipment (except fire protective systems) caused by or resulting from freezing, unless:
>
> (1) You do your best to maintain heat in the building or structure; or
>
> (2) You drain the equipment and shut off the supply if the heat is not maintained.
>
> * * *

Under these particular terms, the three step process yields the following: First, the claim falls within the scope of the insuring agreement as a direct physical loss to covered

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Matthew Rigney is a partner at Tollefson, Bradley, Mitchell & Melendi, LLP. The focus of his practice is insurance coverage litigation and disputes. He has represented insurance carriers in matters involving general and professional liability, commercial property, and errors and omissions coverage. Matt is a member of the Dallas Bar Association and the Insurance Law Section of the State Bar of Texas, and he was named a 2019 and 2020 Super Lawyers Rising Star for insurance coverage.

property.[6] Second, however, this specific cause of loss—freezing—is excluded. Third, the exclusion contains an exception that brings the claim back into coverage if the insured "does its best" to maintain heat.

Similarly, a named perils homeowner policy might cover "[f}reezing of a plumbing, heating or air conditioning system, an automatic fire protective sprinkler system or a household appliance" but exclude losses that occur "when freezing results from a lack of utility services" at the insured property "unless you have used reasonable care to maintain heat in the building structure." While slightly more convoluted than the commercial form, the analysis and conclusion is the same. Barring other coverage issues, the loss will likely be covered as an exception to the exclusion, so long as the insured used reasonable care to maintain heat.

An all-risk homeowner's policy might contain the following provision, found in the "Losses We Do Not Cover" exclusionary provisions:

> LOSSES WE DO NOT COVER UNDER DWELLING PROTECTION AND OTHER STRUCTURES PROTECTION
>
> 1. Unless otherwise stated in 3. Below we do not insure damage consisting of or caused directly or indirectly by any of the following[:]
>
> * * *[7]
>
> a. Freezing of a plumbing, heating, air conditioning or automatic fire protective sprinkler system or of a household appliance, or by discharge, leakage or overflow from within the system or appliance caused by freezing. This exclusion applies only while the dwelling is vacant, unoccupied or being constructed and then, only if you have failed to:
>
> (1) Maintain heat in the building; or
>
> (2) Shut off the water supply and drain the system and appliance of water.
>
> * * *

The result of the three-step analysis under the homeowners policy is the same, though some may disagree over whether the typical frozen pipe claim is covered by virtue of the exclusion simply not being applicable, or whether the language limiting the exclusion constitutes an exception to the exclusion.

Whether coverage under an exception to an exclusion applies is not academic debate, because it affects what burden each party bears if the case proceeds to litigation. Under Texas law, the insured has the initial burden of proving its claim falls within the scope of the insuring agreement.[8] The burden then shifts to the insurer to prove that an exclusion applies.[9] If the insurer succeeds, the burden shifts back to the insured to prove that an exception to the exclusion brings the claimed damages back into coverage.[10] Therefore, under the provisions quoted above—except, arguably, the all-risk homeowners policy—the burden will ultimately fall on the insured to establish that it satisfied the "do your best" or "used reasonable care" exclusionary exceptions.

So, how might an insured do this, and how easy will it be? When the policy provides an objective standard, such as "maintain heat in the building" or "drain the equipment and shut off the supply," coverage will turn on a straightforward fact issue. Either the water was shut off and drained or it was not. Either the building had heat or it did not. At the risk of oversimplifying, this is an issue that should be easily discernable from the evidentiary record and potentially ripe for a summary judgment.

However, when the policy uses terms such as "best efforts," the standard is more subjective. In that case, be prepared for the insured to argue ambiguity. Ambiguity is found when a policy's language is susceptible to more than one reasonable interpretation.[11] Whether a policy is ambiguous is a question of law for the court.[12] Now, the "best efforts" or "do your best" language, is not necessarily ambiguous as a matter of law,[13] though there is very little law on the subject. One Wisconsin state appellate court found it to be no more ambiguous than terms like negligence or diligent."[14] It held that the facts of the insured's actions mattered, stating: "[a]ctions taken by an insured [that] may constitute negligence in one instance, may not be negligent when made under different circumstances."[15]As "such differing applications do not render the term negligence, ambiguous, [neither] does a range of possible results render the do-your-best standard ambiguous."[16] Another court in Illinois interpreted "best efforts" or similarly phrased policies to mean the insured has a duty to make a "reasonable effort" to prevent damage.[17] Ultimately, the phrases are probably not ambiguous, given that various

reasonableness standards are given definite legal meaning on a regular basis.[18]

But even if "do your best" is not ambiguous the dispositive factual question remains; did the insured "do its best" to maintain heat in the structure? The answer will depend on numerous factors and vary from case to case. For instance, compare the efforts of a large commercial insured with the average homeowner. If the commercial insured had access to a backup generator but did not turn it on, did the insured do its best? What if a landlord turns off the gas at an empty property mistakenly thinking the heat is electric? Does a homeowner have a duty to wrap pipes in freezing weather? Each of these questions illustrate the fact issues that must be resolved.

One of the few examples of this issue can be found in a recent Illinois decision, *Wells v. State Farm Fire and Casualty Insurance Company*, where the state appellate court affirmed the circuit court's ruling that the insured did not satisfy its burden to prove an exception to the frozen pipe exclusion,[19] plaintiffs owned a warehouse insured under a State Farm policy for accidental loss.[20] This policy included a bursting pipe damage exclusion and a heat exception to this exclusion requiring the insured to "do your best to maintain heat in the building or structure."[21] When below-freezing weather caused the pipes in the building to burst and flood the building, State Farm denied the claim, relying on this exclusion.[22] At trial, Plaintiffs presented evidence of their best efforts by showing they set up heaters during the freeze to protect the pipes in the building.[23] However, the court found these actions insufficient in light of the overall circumstances.[24]

Specifically, the Court determined that the insureds had known for years that the heating system in the building was inadequate to protect their pipes from freezing and eventually terminated water service at the property.[25] Prior to this storm and in the middle of winter, the insured restored water service but without fixing the heating system.[26] The Court found that although the insureds were not required to repair the building's heating system, they nevertheless turned the property's water back on under these circumstances at their own risk.[27] Accordingly, the Court concluded that Plaintiffs' actions failed to meet the reasonable standard required under the heating exception.[28]

In another case, *Van Natta v. Great Lakes Reinsurance (UK) SE*, a Connecticut court denied an insurer's motion for summary judgment on the freeze exclusion when the Plaintiff presented sufficient evidence that the heat exception applied.[29] Despite evidence that the insured's second home was left vacant for a month with no one to care for it, receipts and bills indicating the thermostats and/or heating systems were malfunctioning, and conflicting phone records and testimony that this vacancy period may have been longer,[30] the Court still denied the insurer's motion for summary judgment because it found "a reasonable juror could conclude that the insured took reasonable care to maintain heat at the property."[31]

As these cases demonstrate, whether the insured did its best is a fact-intensive question that will vary with each claim (and potentially from court to court). Moreover, depending on the facts of the claim, the policy language, and the disposition of the Court to rule, the parties may be left with a mix of legal and factual issues. In any event, prevailing on summary judgment may be very difficult.

As counsel for a party involved in such a dispute, the most important question you can ask your client is whether they are prepared to take these questions to a jury. While you cannot answer that question for them, you can help your client understand all of the pivotal factors on which the answer depends. If you regularly represent carriers, your client will be familiar with considering factors, such as the type of the policy, the amount of damages claimed, and any other coverage issues that may be present. But, for Texas claims that arise out of Winter Storm Uri, there may be other important facts that even sophisticated clients likely consider much less often. These involve the narrative behind the loss that an insurer, especially one that is out of state, may not immediately consider. Uri was a once-in-a-decade storm where thousands of people were without water, power, and heat for multiple days. It involved the failure of public infrastructure. People were frustrated and sometimes felt helpless. Your client should think about the effect of presenting its coverage case to a jury of people who were also likely affected. This is not to say that these claims should never be litigated. Sometimes it is not possible to avoid litigation. But Uri claims present a number of unique considerations that your average frozen pipe case might not.

Texas lawyers may not handle frozen pipe claims on a regular basis. But utilizing a standard methodology makes the coverage analysis of these claims familiar. Start with the insuring agreement, then look for exclusions and exceptions. Once the basic coverage analysis is complete, be prepared for additional unfamiliar legal and factual considerations, including the prospect of a fact-intensive discovery period and trial. Plus, the scale of the damage caused by the Uri makes litigating these claims, in particular, more challenging because nearly everyone in the jury pool was effected in some way by the storm. Helping your client understand all aspects of these claims will lead to a quicker and more efficient resolution, even if they are taken all the way to trial.

1 "Valentine's Week Winter Outbreak 2021: Snow, Ice, & Record Cold," Overview, National Weather Services: National Oceanic and Atmospheric Administration, https://www.weather.gov/hgx/2021ValentineStorm.

2 Mitchell Ferman, "Winter Storm Could Cost Texas More Money Than Any Disaster in State History," The Texas Tribune (Feb. 25, 2021), https://www.texastribune.org/2021/02/25/texas-winter-storm-cost-budget/.

3 Asher Price & Bob Sechler, "Did Texas Energy Regulators Fail to Mandate Winter Protections?," Austin American Stateman, (Feb 17, 2021), https://www.statesman.com/story/news/2021/02/17/state-energy-winter-protections-lacking-reports-have-suggested/6780847002/.

4 Shawn Mulcahy & Erin Douglas, "Sweeping Legislation to Overhaul State's Electricity Market in Response to Winter Storms Heads to Texas House After Senate's Unanimous Approval," The Texas Tribune, (March 29, 2021), https://www.texastribune.org/2021/03/29/texas-senate-electricity-power/.

5 Gordon Dickson, "Insurance Claims for Busted Pipes are Piling Up in Texas, as Winter Strom Ice Thaws," Fort Worth Star-Telegram, (Feb. 19, 2021), https://www.star-telegram.com/news/local/fort-worth/article249369045.html.

6 Note that underground pipes are not covered property under the standard ISO form, but check for endorsements that expand the definition of covered property.

7 The anti-concurrent causation provisions have been omitted for length.

8 *JAW The Pointe, L.L.C. v. Lexington Ins. Co.*, 460 S.W.3d 597, 603 (Tex. 2015); *see also Latray v. Colony Ins. Co.*, No. 07-19-00350-CV, 2021 WL 97204, at *3 (Tex. App.—Amarillo Jan. 11, 2021, no pet.); *Colony Ins. Co. v. Burleson County Saddle Club, Inc.*, No. AU-17-CA-01051-SS, 2018 WL 3946548, at *2 (W.D. Tex. Aug. 16, 2018).

9 *JAW*, 460 S.W.3d at 603.

10 *Id.*

11 *Nat'l Union Fire Ins. Co. v. CBI Indus.*, 907 S.W.2d 517, 520 (Tex. 1995).

12 *Id.*

13 *Tetra Techs., Inc. v. Cont'l Ins. Co.*, 814 F.3d 733, 747 (5th Cir. 2016) ("An ambiguity does not exist . . . simply because the parties interpret a policy differently. Instead, a policy is ambiguous if the contractual language is susceptible to two or more reasonable interpretations.") (cleaned up).

14 *See Cont'l W. Ins. Co. v. Paul Reid, LLP, GPS Inc.,* 715 N.W.2d 689, 690 (holding frozen pipes provision not ambiguous as applied to claim involving water damage to an unoccupied house).

15 *Id.*

16 *Id.*

17 *Wells v. State Farm Fire & Cas. Ins. Co.,* --- No. 5-19-0460 ---, 2021 WL 21782, at *7 ¶ 35; *see Stewart v. O'Neill*, 225 F. Supp. 2d 6, 11 (D.D.C. IL. App.(5th–Jan. 4, 2021) 2002) (holding, in context of settlement agreement requiring "best efforts" that best efforts means all reasonable efforts); *Soroof Trading Dev. Co. v. GE Fuel Cell Sys. LLC*, 842 F. Supp. 2d 502, 511 (S.D.N.Y. 2012) (holding that New York courts use the term reasonable efforts interchangeably with best efforts); *Coady Corp. v. Toyota Motor Distribs.*, Inc., 361 F.3d 50, 59 (1st Cir. 2004) ("'Best efforts' is implicitly qualified by a reasonableness test—it cannot mean everything possible under the sun . . ."); *Perma Research & Dev. Co. v. Singer Co.*, 308 F. Supp. 743, 748 (S.D.N.Y. 1970) ("'Best efforts,' like 'reasonable care,' is a term which necessarily takes its meaning from the circumstances.").

18 *See Wells,* 2021 WL 21782, at *7 ¶ 36 (holding "best efforts" standard is made in light of the specific circumstances they faced by insured).

19 *See id.*

20 *Id.*

21 *Id.*

22 *Id.*

23 *Id.*

24 *Id.*

25 *Id.*

26 *Id.*

27 *Id.*

28 *Id.*

29 462 F. Supp. 3d 113 (D. Conn. 2020).

30 *Id.* at 128–129. The court stated it was unaware of any precedent within its state that determined a insured's vacancy from his second home for one month to be unreasonable as a matter of law. The court also noted this decision was consistent with the insurer's supporting precedent, for summary judgment, which all involved instances in which an insured was absent from their property for much more time than one month.

31 *Id.*

By Steve Schulwolf, Schulwolf Mediation

AGLIC V. ACE: ANATOMY OF A *STOWERS* BREACH

In *American Guarantee and Liability Insurance Co. v. ACE American Insurance Co.*, the Fifth Circuit addressed several issues concerning the scope of a primary insurer's duty to settle.[1] This article analyzes the holdings in *ACE*, specifically whether settlement offers by a next friend satisfy the *Stowers* unconditionality requirement, whether an insurer can rely on appellate prospects when assessing settlement demands and the requirement that an insurer reevaluate its settlement position based on changed circumstances. Moving beyond what was addressed by the Court, this article poses hypotheticals and calculations based on *ACE*'s facts to flush out the *Stowers* negligence standard. Texas courts apply variations of the Restatements' two duty to settle standards depending on the circumstances at issue. The *Stowers* standard is both malleable and contextual. In *ACE*, the Fifth Circuit agreed that the primary insurer was responsible for millions above its limits and, in doing so, exclusively focused on its conduct. This article also discusses the equities of the excess insurer's equitable contribution claim in order to highlight litigation risks in future cases.

I. BACKGROUND

AGLIC, a first level excess insurer, brought an equitable subrogation action against ACE, the primary carrier, for negligent failure to settle within limits. The court found that ACE breached its *Stowers* duty and affirmed judgment in favor of AGLIC for almost $8 million.

A. Braswell v. Brickman

Mark Braswell sustained fatal head injuries when his bicycle hit a truck. Braswell's wife, Michelle, filed suit against the driver (Bermea) and his company (Brickman) in Harris County.[2] Michelle acted as next friend of the Braswells' minor children, Matthew and Mary. Liability was hotly contested. The defense presented compelling evidence that Braswell was not paying attention while cycling at high speeds. Braswell's injury was to the top of his head and his helmet was cracked down the middle and he dented the truck, strongly suggesting his face was down at the time of impact.[3]

The defense had its weaknesses. The Braswells argued that the truck "stopped short" and there was conflicting evidence concerning how long the truck had been parked and whether Bermea had activated safety flashers. Furthermore, Bermea did not place cones around the parked truck and testified that it was dangerous to park where he did.[4] The Braswells were sympathetic figures. Mark Braswell was a firefighter who had once heroically rescued a double amputee from a burning building.[5] Michelle provided compelling testimony concerning the family's mental anguish, particularly the suffering of their daughter.[6]

ACE handled the defense. Prior to trial, defense counsel prepared a memorandum stating it was likely a jury would find that the Defendants were not negligent and, under Texas law, would have to find Braswell less than 51% negligent before there could be any recovery.[7] Defense counsel predicted that 7 out of 10 times there would be no recovery and that in the three cases in which a jury might find that Braswell's negligence did not exceed 50%, his negligence would still likely be in the 30%–50% range.[8] Counsel estimated the range of a potential verdict between $6,000,000 and $8,000,000 and concluded that the case's settlement value was between $1,250,000 and $2 million.[9]

ACE issued a $2 million primary policy. AGLIC issued a $10,000,000 excess policy, and Great American issued a $40,000,000 second-layer excess policy directly above AGLIC.[10] ACE set the settlement value at $600,000 by multiplying the $2 million policy limits by 30%–the likelihood defense counsel believed a jury would find the defendants more liable than Braswell.[11] In September of 2016, ACE emailed AGLIC and Brinkman its thoughts about settlement in light of the results of two mock trials.[12] Neither panel found Defendants negligent, with one hung jury and one defense verdict assigning 100% of the responsibility to Braswell.[13] Twelve out of the sixteen mock jurors assigned Braswell more than 50% of the liability. The mock jury heard testimony that the truck driver did not break any laws and had not received any citations. They did not hear testimony concerning Mary Braswell's mental issues.[14] The mock jurors noted that whether the truck "stopped short" was a key issue. AGLIC adjuster Kerrigan noted that the case was "no more than $500K" and "not primary's 2M" and, later, after receiving expert reports,

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said she "love[d] our case."[15] The case failed to settle at two mediations, and Kerrigan testified that after investigating the judge, forum, and attorneys, she encouraged ACE to offer higher amounts closer to ACE's limits but that ACE had refused.[16]

After the failed second mediation, Plaintiff sent a $2,000,000 settlement demand ("the First Settlement Demand"), which AGLIC demanded that ACE accept.[17] ACE made a $500,000 counteroffer.[18] The case proceeded to trial, but settlement discussions continued with ACE offering a $250,000/$2 million high-low. AGLIC was aware of the discussions and again urged ACE to pay its $2 million limits. ACE refused, stressing defense counsel's valuation and the results of the mock trial.[19]

During trial, Judge Sandill issued several unfavorable rulings for the defense. First, he surprisingly excluded evidence that the truck was legally parked and had not received any citations.[20] Second, he permitted testimony concerning Mary Braswell's fragile mental state despite there being no medical records linking her issues to her father's death. An ACE supervisor called this "the most impactful" evidentiary ruling on the value of the case.[21] Finally, the judge overruled defendant's hearsay objection to Michelle Braswell's testimony that an employee of the trucking company told her that the truck "stopped short" even though he denied doing so.[22] Accordingly, the evidence and arguments allowed at trial were substantially different and more pro-plaintiff than those considered by the mock jurors.

Kerrigan emailed ACE, underscoring that ACE's prior rejection of the First Settlement Demand was unreasonable and advised providing notice to Great American.[23] Meanwhile, Plaintiffs were now demanding a $1 million/$3 million high-low deal (the "High Low Demand").[24] ACE rejected the demand while confirming that AGLIC had refused to contribute to any settlement.[25] After being advised that any high-low demand had to be within ACE's limits, counsel for the Braswells demanded a $1.9 million/$2 million high-low with taxable court costs ("the Second Settlement Demand").[26] ACE rejected the demand, "mistakenly" believing it included litigation fees and, therefore, exceeded limits.[27] In response, the Braswells reiterated their initial $2 million demand ("the Third Settlement Demand").[28] ACE rejected the demand and made a $650,000/$2 million high-low offer, which was declined.[29]

The jury returned a verdict for $39,960,000, assigning 32% of the liability to Braswell.[30] The court entered a $27,712,598.90 judgment against Brickman after reducing the verdict to account for Braswell's contributory negligence.[31] ACE tendered its $2 million limits and AGLIC "took control" of the post-verdict negotiations. AGLIC posted an appellate bond and then settled for $9.75 million, a discount of more than $2 million less than its limits.[32] AGLIC then filed suit demanding that ACE pay it the amount it was out-of-pocket for the settlement.

B. The District Court Ruling

Which insurer was liable for paying AGLIC's portion of the settlement turned on whether ACE breached its *Stowers* duty. The district court noted, "[u]nder Texas law, 'the duty of an insurer to exercise ordinary care in the settlement of claims to protect its insureds against judgments in excess of policy limits is generically referred to in Texas as the *Stowers* duty.'"[33] The court noted that "ordinary care is 'that degree of care and diligence which an ordinarily prudent person would exercise in the management of his own business' in responding to settlement demands within policy limits.'[34] *Stowers* requires an insurer 'to accept reasonable settlement demands within policy limits.'"[35] The Court noted, "[e]quitable subrogation permits an excess insurer to bring a *Stowers* claim against the primary carrier on behalf of the insured, effectively 'standing in the shoes' of the insured. *General Star Indem. Co. v. Vesta Fire Ins. Corp.*, 173 F.3d 946, 950 (5th Cir. 1999)."[36] The court then proceeded to analyze each settlement demand separately.

The court initially found that ACE "acted unreasonably" in setting the value of the case at $600,000 by multiplying a 30% chance of a plaintiff's verdict by ACE's $2 million limits.[37] By focusing on its policy limits, and not the potential verdict amount, which likely would exceed ACE's limits, ACE's valuation was "contrary to the purpose of *Stowers*."[38] This fact was not dispositive, however, and the court stressed, "the key issue is whether a reasonably prudent insurer would have accepted the offer."[39] Stated another way, ACE's conduct was "subsidiary to the ultimate issue of whether the claimant's demand was reasonable under the circumstances, such that an ordinary prudent insurer would accept it."[40] The court found that "ACE did not breach its duty under *Stowers* when it rejected the First Demand" because "a reasonable insurer could have been confident in a defense verdict."[41]

The Court found that ACE breached its *Stowers* duty when it rejected the Second and Third Settlement Demands.[42] When those demands were made ACE was aware of Judge Sandill's adverse rulings, "which exacerbated the known weaknesses in the case, [and] should have changed ACE's calculus."[43] Thus, "a reasonable insurer would have reevaluated the settlement value of the case" and accepted the Second and Third Settlement Demands.[44] After Judge Sandill's rulings, the District Court noted "there was little chance" the jury would find Braswell more than 50% liable and that "the award would likely be well above" the settlement demands.[45] As such, the Court found that AGLIC was entitled to recoup its settlement payments from ACE.

C. The Fifth Circuit Affirms

On appeal, ACE argued that it did not violate *Stowers*.[46]

AGLIC did not cross-appeal the ruling that ACE reasonably rejected the First Settlement Demand and the court did not address that issue.[47] The Fifth Circuit reversed the ruling that the Second Settlement Demand was clearly within limits because the reference to "costs" was ambiguous and not clearly unconditional, concluding, "accordingly, that 'the record reveals great confusion about that offer's terms,' and, lacking the clear statement of a sum certain, the offer did not invoke *Stowers*." [48] However, it affirmed the holding that ACE unreasonably rejected the Third Settlement Demand.[49] As such, the Fifth Circuit affirmed the ruling that ACE was obligated to reimburse AGLIC over $7 million.

1. The Third Settlement Demand was Unconditional

ACE argued the Third Settlement Demand was not unconditional under *Stowers* because Michelle was acting as her children's next friend and there was a potential conflict requiring a guardian *ad litem* and a court to approve a settlement.[50] The Court acknowledged cases that allowed a minor child to challenge a settlement entered into by a next friend parent.[51] However, the Fifth Circuit found the record "void of any specter of adverse interests between Michelle and her children" and concluded that all of the children would have been bound by the rejected settlement demands.[52] As such, the Fifth Circuit made an "*Erie* guess" that the Texas Supreme Court would find that the settlement demand satisfied *Stowers.*[53]

2. ACE Waived its Appellate Prospects Argument

Having found that the Third Settlement Demand triggered a *Stowers* duty, the question was whether the District Court had erred in determining that ACE was negligent in rejecting it.[54] ACE argued that the trial court's errors were likely to be reversed on appeal and therefore it was not negligent to reject the demand. According to the Fifth Circuit, ACE's appeal "hinges solely on whether the trial court's adverse rulings were likely to be reversed on appeal."[55] The Court found that "ACE cannot raise this novel legal theory for the first time on appeal, and we do not address it."[56] In other words, the Court found ACE had waived its sole argument. Arguably *dicta*, the Court went on to summarily agree with the District Court that "considering all of the trial circumstances" a reasonable insurer would have recognized that the defense's case had "materially worsened," would have reevaluated the settlement value, and have accepted the Third Settlement Demand.[57] As such, ACE bore full responsibility for AGLIC's post-verdict settlement.

II. ANALYSIS

ACE underscores the risks primary insurers face when rejecting a limits demand and the pressure excess carriers can apply to pay those demands.[58] This section discusses the Fifth Circuit's treatment of three questions, whether: (1) the Braswells' settlement demands were sufficiently unconditional; (2) ACE could rely on appellate prospects; and, (3) ACE reasonably responded to changing circumstances.

A. The *Erie* Guess

The Fifth Circuit initially issued its ruling on December 21, 2020.[59] On March 4, 2021, it reissued it with the same holdings, but with a revised discussion of its "*Erie* guess" concerning whether the lack of a guardian *ad litem* rendered the Third Settlement offer insufficiently conditional.[60] Initially, the Court said it "cannot conceive that every settlement generated in a case involving claims of a parent on behalf of herself and children violates *Stowers* because of a bare potential conflict of interest."[61] The revised opinion omitted that broad statement and included, for the first time, a discussion that the state court did appoint a guardian *ad litem* and that had ACE paid the Third Settlement Demand, the guardian "would have focused on assuring the children obtained their fair share."[62] Thus, the Fifth Circuit determined, "the issue of fairly dividing the proceeds arises only after the settlement is agreed upon, and Texas courts have the duty to scrutinize the apportionments."[63] Thus, the court held that an insurer cannot reject an otherwise reasonable settlement demand within limits due to concerns about apportionment.

The record contained multiple attempts to settle including two mediations and multiple demands and counteroffers between ACE and the Braswells. There was no suggestion that ACE ever raised concerns that the children would not be bound by a settlement. The Fifth Circuit analyzed a similar issue concerning whether a limits settlement demand was sufficiently unconditional in *American Insurance Co. v. Assicurazioni Generali S p A*, No. 99-20270, 2000 U.S. App. LEXIS 39922, at 24–25 (5th Cir. July 24, 2000). In that case, the court stressed the failure of the primary carrier to raise the issue prior to the excess carrier's equitable subrogation action and noted, "Generali's position in this litigation that the offer was conditional gives the impression of being a post-hoc rationalization."[64]

By holding that apportionment can be conducted after a settlement is consummated, the Court did not have to address the fact that one of the reasons the value of the Braswells' case had increased during trial was the testimony concerning Mary's trauma. There is no evidence concerning what portion of any of the settlement demands was earmarked for the children, including Mary.[65] Arguably, a guardian *ad litem* could have asserted that even though the Third Settlement Demand was for the exact dollar amount as the initial demand, a higher portion of any settlement should have been allocated to Mary based on the value she added to the case.[66] The Fifth Circuit determined that such factors do not go towards the question of a conflict of interest and can be resolved post-settlement.[67]

After *ACE* and *Assicurazioni Generali*, primary insurers

would be wise to make a record of any legitimate concerns they might have about whether a demand is unconditional, including the potential for any settlement to be set aside due to a conflict between a parent and minor child. Even if *ACE's Erie* guess is correct, under different facts, an insurer could raise concerns early in negotiations that a minor child could have rights to set aside any settlement.

B. Appellate Prospects

It is not uncommon for one party to believe that the other side has failed to fully appreciate the significance of a key interlocutory ruling. It is also not uncommon for parties to argue that incorrect rulings gives them "a free shot" at trial because they could successfully appeal. Stressing appellate rights is hardly "novel," yet that is how the Fifth Circuit characterized ACE's argument. Policyholders will likely argue that *ACE* means that "appellate prospects" are irrelevant to a primary carrier's *Stowers* obligations. However, any comments about the significance of "appellate prospects" were arguably *dicta*. If ACE had negligently rejected the First Settlement Demand, its "appellate prospects" would have been moot. However, if ACE reasonably rejected that demand, and if ACE had preserved its "appellate prospects" argument, the Fifth Circuit would have had to substantively address whether a primary carrier can consider the probability that adverse rulings would be overturned on appeal. The next section discusses issues not addressed by the court including different standards for assessing reasonableness and appellate prospects.

C. Cognitive Biases

ACE funded a mock trial. Normally, that would have been a good fact because mock trials often support the reasonableness of an insurer's settlement decisions. It did not assist ACE because circumstances changed once the real trial began. A key holding in *ACE* is to avoid cognitive biases in decision-making. *ACE* requires an insurer to recognize when its insured's case has "materially worsened" and "reevaluate" its settlement position. Many parties mistakenly ascribe significance to their first valuation or the Plaintiff's first demand, otherwise known as "anchoring". Relatedly, parties often suffer from "confirmation bias," where they view a case through the prism of their initial assessment, cherry-picking facts that confirm their theories rather than objectively reevaluating new information.[68] *ACE* penalizes insurers who succumb to these biases.

D. Issues Not Addressed by the Fifth Circuit

Case evaluations involve making informed predictions about the future that require a basic understanding of the law, math, and probability. *ACE* is an example of a decision where the court could have elaborated its logic mathematically, but chose not to do so. Consequently, the *Stowers* negligence standard is malleable, creating litigation risks for all parties.[69] This section analyzes the two failure to settle negligence standards discussed in the Restatements and presents hypotheticals and mathematical calculations to illustrate their application to the facts in *ACE*. Whatever terminology is used, the Texas negligence standard is varied and contextual.

1. The *Stowers* Reasonableness Standard

There are hundreds of cases analyzing *Stowers*, but very few of those cases illustrate mathematically what reasonable options the insurer could have chosen. Deriving case valuations formulaically can often help ensure that decisions are being made objectively and not due to cognitive biases.[70] The concept is not new. In 1947, Learned Hand described the duty of care as a formula.[71] In *ACE*, both the District Court and Fifth Circuit stressed that whether a primary insurer acted negligently in declining a limits settlement demand is judged by an objective standard considering the "likelihood and degree of the insured's potential exposure to an excess judgment."[72] But what exactly is required to avoid extra contractual liability?

In *ACE*, both the District Court and Fifth Circuit cited *General Star Indemnity Co. v. Vesta Fire Insurance Co.*, 173 F.3d 946 (5th Cir. 1999) in support of AGLIC's equitable subrogation claim.[73] In *General Star*, the Fifth Circuit found, "[t]he *raison d'etre* for the *Stowers* doctrine is that the insurer, when in control of the litigation, might refuse a settlement offer that its client, the insured, would want to accept if it had the option."[74] *General Star* also noted that the Texas Supreme Court reasoned if excess carriers were not subrogated to the claims of their insureds, primary insurers would have less incentive to settle within their policy limits and might be tempted to "gamble" with excess carriers' money when potential judgments approach the primary insurers' limits."[75] Parsing out a precise standard from these general concepts is difficult. Is it unreasonable for an insurer to reject a settlement if there is any possibility, no matter how remote, of an excess judgment? What exactly is "gambling" with an excess insurer's money?

a. Texas Hold-Em

Texas courts impose extra-contractual liability on a non-settling insurer to keep the insurer from gambling with someone else's money.[76] In doing so, some courts have noted that gambling is particularly disfavored "when potential judgments approach the primary insurers' limits."[77] One study illustrates the *Stowers* rationale with the following hypothetical and discussion: a defendant has a $1 million policy and limited personal assets. The plaintiff has $2 million in undisputed damages, a 90% chance of winning at trial and offers to settle for the $1 million policy limits. The authors note:

> If the insurer were liable for the full amount

> of damages, it would settle, because the offer ($1 million) is less than the expected loss if the case is tried ($1.8 million). However, if the insurer is only liable for the coverage limits, the insurer will not settle, because the $1 million offer exceeds the insurer's expected loss at trial ($900,000). The insurer will not take into account the defendant-insured expected out-of-pocket loss -- an additional $900,000 if the insured is fully solvent. By settling, the insurer gives up a 10% chance of prevailing, but pays the same amount as if the case was tried and lost ($1 million). Conversely, if the insurer tries the case, it benefits from the 10% chance of prevailing, while externalizing to the insured the risk of an above-limits verdict.[78]

All gambling is contextual.[79] Some cases seem to outlaw any gambling, while other courts focus on the size of the bet. *See e.g. Ranger County Mut. Ins. Co. v. Guin*, 704 S.W.2d 813, 820 (Tex. App. 1985)("Furthermore, if the insurance company could avoid the *Stowers* doctrine by taking the position that this offer was conditional then it could gamble a sizeable amount of the insureds' money in an effort to save a relatively small amount of its own by the slim chance that there might be comparative negligence").[80] *Ranger* suggests that under certain circumstances Texas courts will compare the potential benefit for the insurer in rejecting a settlement demand with the potential excess judgment. These notions are consistent with the national standards discussed below.

b. The Restatements and Two National Negligence Standards

Section 24 of the American Law Institute's Restatement of Liability Insurance ("RLI") addresses an insurer's duty "to make reasonable settlement decisions."[81] Two similar, but slightly different standards have emerged: the "disregard the limits" and "equal consideration" tests.[82] The disregard the limits test pretends that there is no insurance. The question is whether a single payer would have accepted the plaintiff's settlement demand.[83] If the case's expected value exceeds the settlement demand, the case should settle. The expected value of a case is the product of the likelihood of success and the estimated exposure.[84] The RLI endorses the disregard the limits test by noting, "[a] reasonable settlement decision is one that would be made by a reasonable person who bears the sole financial responsibility for the full amount of the potential judgment." RLI, §24(2).

Under the equal consideration test, the court compares the amount an insurer could have saved by rejecting a settlement demand (*i.e* the difference between the settlement demand and the expected value) with the amount of exposure the policyholder faces in addition to limits. The RLI's Reporters Note identifies equal consideration as the "majority" rule, but endorses the disregard the limits test as the more straightforward and utilized application. *See* Martinez, Leo P., *Restatement of the Law of Liability Insurance and the Duty to Settle*, Rutgers Univ. L. Rev. Vol. 68:155, 231; Syverud, Kent, *The Duty to Settle*, Va. L. Rev., Vol. 76, No. 6, 1113, 1122–23 (Sept. 1990)(Noting Professor Keeton's disregard the limits test had not been universally accepted and had only been adopted by sixteen states and that "the majority of states today require the insurance company to give 'equal consideration' to the interests of the insured and the company in evaluating settlements").

General Accident Fire & Life Assurance Corp. v. Little helps illustrate the differences between the two standards.[85] The case involved an accident between a car and a motorcycle. Like *ACE*, there was contributory negligence as there was no evidence that the speeding motorcyclist attempted to slow down.[86] The driver had $5,000 in insurance, and the insurer rejected a $4,000 demand.[87] The jury returned a $17,500 verdict.[88] The defense attorney estimated the probability of a defense verdict at 60%, while the claims adjuster believed it to be 75%.[89] Defense counsel estimated damages between $3,000 and $7,500 while the claims manager thought they could be as high as $10,000.[90] Under the disregard the limits test, an insurer relying on either the defense attorney or claims adjuster's estimates could reasonably have rejected a $4,000 settlement demand because it exceeded the case's expected value.[91]

However, the court found the insurer liable for the excess verdict because it failed to give equal consideration to the insured's interests. In doing so, the Court highlighted that the insurer would "only" have had to pay an additional $1,500 more than its offer to have avoided a significant excess verdict.[92]

1. Disregard the Limits Test and ACE

In *ACE*, Defense counsel believed that 7 out of 10 times the jury would assign the bulk of responsibility to Braswell, resulting in no exposure. In the three other trials, any verdict would be reduced by Braswell's contributory negligence ranging from 30%-50%. Taking these numbers into account, the chart below calculates the expected values using different jury verdicts ranging from $6 to $8 million.

TABLE 1

Verdict	70%	60%	50%
$6M	1,080,000	1,440,000	1,800,000
$7M	1,260,000	1,680,000	2,100,000
$8M	1,440,000	1,920,000	2,400,000
AVG	1,260,000	1,680,000	2,100,000

Under all jury verdict estimates the expected value was less

than the First Settlement Demand using either a 60% or 70% defense success rate. In fact, if Defendants had a 7 out of 10 chance to win at trial, the expected value would be less than $2 million even if the estimated verdict was $10 million (*i.e.* ($10,000,000 x .3) x .6 = $1,800,000). Thus, the District Court's determination that ACE was permitted to reject the First Settlement Demand is consistent with calculations using the disregard the limits test.

Both the district court and the Fifth Circuit determined that ACE acted negligently by not accepting the Third Settlement Demand. However, the Fifth Circuit did not explicitly utilize either RLI standard. If the Fifth Circuit was adopting a disregard the limits test and believed that the District Court was correct that ACE did not violate its *Stowers* duty when it rejected the First Settlement Demand (which it did not address) and had ACE not waived its "appellate prospects" argument (and it did) then a more detailed analysis would have been required.[93]

Furthermore, what if ACE had not waived its "appellate prospects" argument? Could a reasonable insurer have argued that at the time of the Third Settlement Demand, a proper valuation of the case should have considered the likelihood that "plaintiff-friendly" Judge Sandill's rulings could have been reversed?[94] In doing so, a reasonable insurer could have argued that if the appellate court reversed and ordered a new trial in which it permitted evidence demonstrating that the truck had been legally parked and barred evidence concerning Mary Braswell's undocumented mental state, the value of the case on remand would resemble defense counsel's lower estimates, *i.e.* $1,080,000 (*see* Table 1 above based on 70% defense verdict and $6 million verdict). Therefore, a reasonable insurer could have argued that the overall expected value of the case—assuming a 50% likelihood of reversal on appeal—would have resulted in an expected value below $2 million.[95] Thus, conceptually Judge Sandill's rulings could have significantly increased the value of the case but not to the extent that it was negligent to have rejected the Third Settlement Demand. Moreover, the Braswells apparently understood that they faced significant appellate risks because they settled for almost $19 million less than the judgment.[96]

c. The Equal Considerations Test

If the equal considerations test were applied, the District Court erred in allowing ACE to reject the First Settlement Demand because the most ACE would have reasonably expected to save by rejecting the demand ($2,000,000 - $1,080,00 = $920,000) is less than the lowest excess verdict ($6,000,000 x .6) - $2,000,000 limits = $1,600,000.[97] Thus, by rejecting the First Settlement Demand ACE failed to give equal consideration to its insured because it valued its potential $920,000 savings more than the insured's $1.6 million excess verdict risk. Thus, under the equal consideration test, primary insurers are required to settle more often than under the disregard the limits test, particularly in cases when the potential verdict is well in excess of limits.

The Fifth Circuit explicitly rejected the argument that an insurer must give equal consideration to its insured's interests in *St. Paul Fire & Marine v. Convalescent Serv.*[98] However, the issue in *Convalescent Serv.* was whether the insurer violated *Stowers* by rejecting a settlement demand that would have resolved an uncovered punitive damages claim. The Court found St. Paul had not violated *Stowers* because an insurer has no obligation to settle non-covered claims.[99] Thus, the language in *Convalescent Serv.* rejecting the equal consideration test arguably only applies to cases involving uncovered claims.

There is additional support that Texas is more aligned with the disregard the limits test than with equal consideration. As this article was being written, the Texas Supreme Court cited the District Court's ruling in *ACE* with approval. *In Re Farmers Texas County Mut. Ins. Co.*, No. 19-0701 (Tex. 2021) at 20, n. 16 (citing *ACE* for proposition that ACE reasonably rejected the First Settlement Demand despite the $27 million judgment). Elsewhere, the Texas Supreme Court has noted, "[t]o be unreasonable, [the insured] must show that a reasonably prudent insurer would not have settled the . . . claim when considering *solely* the merits of the . . . claim and the potential liability of its insured on the claim." *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312, 316 (Tex. 1994). The use of "solely" suggests that Texas allows an insurer to calculate the value of the case based on its merits and usually does not saddle an insurer with extra-contractual liability for failing to consider other factors.

d. *Stowers*, in Context

The *ACE* rulings underscore that the *Stowers* negligence standard is malleable and contextual. In Texas, when the expected value of a case is significantly less than the demand, as in *ACE* before Judge Sandill's rulings, it seems the insurer is allowed to reject the demand even if it would have been obligated to accept it under the equal considerations test. However, the Court applied a different standard when the expected value of the case was only slightly below the settlement demand and the potential excess verdict was significant. Under those facts, Texas courts will not allow the insurer to "gamble" with other people's money.

If the disregard the limits test applied in all contexts, then the Fifth Circuit would arguably have performed calculations. There is a reasonable explanation for why it did not—ACE unreasonably failed to pay the Third

Settlement Demand because the amount it sought to save was miniscule at best and significantly below what it risked by going to trial.

2. Equitable Subrogation

AGLIC's equitable subrogation action was premised on ACE missing three opportunities to settle within limits. Despite ultimately prevailing, two of AGLIC's three examples were rejected. This section presents some hypotheticals to demonstrate that excess carriers face significant risks.

The Texas Supreme Court has held that a primary insurer can raise the comparative responsibility of the excess carrier as a defense to an equitable subrogation claim. *Keck & Mahin v. Nat'l Union Fire Ins. Co.*, 20 S.W.3d 692, 696 (Tex. 2000). Other states agree. The Southern District of Indiana noted that an equitable subrogation action lies in equity and "that an excess insurer should not be allowed to recover against a primary insurer under the doctrine of equitable subrogation where such recovery would be inequitable and unjust."[100] These arguments were not considered in *ACE*.

a. Funding the High-Low Demand

High-low offers can be an effective tool and can address some of the concerns that led to the creation of the *Stowers* doctrine in the first place, namely, disincentivizing insurers from gambling with other people's money. The courts ignored the High Low Demand because it was not within ACE's limits and, therefore, not germane to a *Stowers* analysis solely focused on ACE. *See e.g. Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312, 314–15 (Tex. 1994)("A demand above policy limits, no matter how reasonable, does not trigger the Stowers duty to settle"); *Rocor Intern. v. National Union Fire Ins.*, 77 S.W.3d 253, 263 (Tex. 2002)(discussing *Stowers* and *Garcia* and noting, "shifting the risk of an excess judgment onto the insurer is not appropriate unless there is proof that the insurer was presented with a reasonable opportunity to settle within policy limits").

What if ACE been willing to fund $1 million for a defense verdict and then its $2 million limits for the "high" if the Braswells prevailed? If AGLIC then refused to contribute to the "high" because it believed that ACE had already missed an opportunity to settle within limits, it would be gambling that ACE's prior refusal violated *Stowers*. Had ACE told AGLIC that it was willing to fund its share of the High Low Demand, it would have raised the question of whether conditionally agreeing to pay limits in response to a plaintiff's high-low demand would have triggered any duties on behalf of AGLIC.[101] In *Keck*, the Texas Supreme Court said, "an excess insurer owes its insured a duty to accept reasonable settlements, but that duty is also not typically invoked until the primary insurer has tendered its policy limits."[102] Thus, ACE could have argued AGLIC had a duty to accept and contribute to the High Low Demand if its willingness to pay $2 million was considered the equivalent of tendering its limits.

Not all Plaintiffs are amenable to high-low solutions, but the Braswells were. The following table depicts various potential trial outcomes and demonstrates that AGLIC would have significantly benefitted from capping its contribution in funding the High Low Demand.

TABLE 2

Verdict	$8M	$8M	$8M	$8M	$8M	$8M	$8M	$8M	$8M	$8M	Ave
Braswell's Negligence	30%	40%	40%	50%	>50%	>50%	>50%	>50%	>50%	>50%	
Judgment	$5.6M	$4.8M	$4.8M	$4M	$0	$0	$0	$0	$0	$0	
Settlement	$3M	$3M	$3M	$3M	$1M	$1M	$1M	$1M	$1M	$1M	
AGLIC Saves	$2.6M	$1.8M	$1.8M	$1M	$0	$0	$0	$0	$0	$0	$720K
ACE Overpays	-	-	-	-	$1M	$1M	$1M	$1M	$1M	$1M	$600K

Under the assumptions depicted in the chart, if both insurers agreed to fund the high-low arrangement, on average, ACE would have "overpaid" while AGLIC would have realized a significant savings compared to going to trial. Yet AGLIC refused to contribute to such an arrangement presumably because it believed (incorrectly) that ACE had already breached *Stowers*. Moreover, once the trial began trending in a positive direction, it was unclear that the Braswells would ever again be willing to accept ACE's limits. Thus, at the time, rejecting the High Low Demand was a risky bet, and AGLIC was fortunate that the Braswells ultimately made the Third Settlement Demand and that the Court did not have to analyze whether AGLIC reasonably refused to fund the High Low Demand.

AGLIC was also fortunate that the Braswells accepted their settlement offer, which the Fifth Circuit noted avoided "appellate litigation."[103] It also kept Great American on the sideline. Had the case proceeded on appeal, Great American likely would have sought to avoid any possibility of paying $15 million if the judgment were upheld. Great American could have settled for a lower amount and brought its own equitable subrogation action against both AGLIC and ACE alleging that both unreasonably "gambled" with its money. The Fifth Circuit never even mentioned Great American, but its involvement would have fundamentally changed the dynamics of the case. ACE could have argued that there was no equitable reason to treat it and AGLIC differently because both carriers missed settlement opportunities because they sought to avoid paying full limits despite the risk of an excess judgment in Great American's layer. It is ironic that ACE funded the defense that created a credible appellate risk for the Braswells yet was unable to rely on its "appellate prospects." Perhaps ACE could have argued that as a matter of equity AGLIC should not have been able to use its "appellate prospects" to reduce its own liability while

simultaneously arguing that ACE could not do so. These are issues that future courts might ultimately decide.

3. Status Quo Bias

It seems pretty clear that ACE erred by conflating negotiating strategy with case valuation. Despite being advised that the settlement value of the case was between $1.25 million and $2 million, and despite Judge Sandill's adverse rulings, ACE never made a seven-figure offer pursuant to its reasoning that "Plaintiff refused to negotiate under policy limits."[104] Whether an insurer acts reasonably depends on the value of the case, not the parties' negotiating strategies. *Westchester Fire Ins. v. Admiral Ins.*, 152 S.W.3d 172, 197 (Tex. App. 2004)(expert testimony that an ordinary insurer would have rejected the first demand and attempted to negotiate a lower amount failed to satisfy insurer's burden where the expert also testified that the value of the case exceeded the demand).

Negotiators often make decisions based on status the quo bias. More particularly, "a negative consequence incurred by inaction causes less regret than the same negative consequence incurred by action." Rosenhouse, Jason, *The Monty Hall Problem* (Oxford Univ. Press 2009) at 136. In negotiations, this often translates to parties acting like ACE—refusing to make a move out of fear that it will lead to a bad result. While, it is perfectly legitimate for Defendants to be concerned about putting "too much money on the table," ACE did not provide the Braswells with an incentive to "negotiate under limits." Thus, ACE made it easy for Plaintiffs to stay above limits because ACE was comfortable with the status quo, which contributed to both sides never bridging the gap.

CONCLUSION

ACE is a significant contribution to the *Stowers* doctrine on many levels. It reinforces that primary insurers reject limits demands at their own risk. However, the *Stowers* negligence standard is malleable and contextual. Ultimately, ACE failed to give consideration to the ever-increasing possibility of a significant excess judgment after Judge Sandill's adverse rulings. While policyholders and excess carriers will likely cite *ACE* in support of the argument that a primary carrier cannot base a denial on "appellate prospects," that portion of the opinion is arguably *dicta*. *ACE* also is significant for its *Erie* Guess that the lack of guardian *ad litem* approval does not demonstrate conditionality in contravention of *Stowers*. Finally, *ACE* is significant for what it did not address: the High Low Demand, calculations of the negligence standard and various equitable arguments relevant to equitable subrogation. In the end, *ACE* underscores that all parties in a *Stowers* case face litigation risks and must be open to flexible solutions.

1 990 F.3d 842 (5th Cir. 2021).

2 *See Michelle Lynn Braswell, et. Al. v. The Brickman Group, Ltd., LLC*, Cause No. 2015-38679, 127th Judicial District of Harris County.

3 *Am. Guarantee & Liab. Ins. Co. v. ACE Am. Ins. Co.*, 413 F. Supp.3d 583, 586-87, ¶ 13 (S.D. Tex. 2019).

4 413 F.Supp. at 587, ¶¶ 14, 16.

5 *Id.* at ¶ 17.

6 *Id.* at ¶ 18.

7 *Id.* at 588, ¶ 20.

8 *Id.*

9 *Id.*

10 *Id.* at 585–86, ¶ 3.

11 *Id.* at 588, ¶ 21.

12 *Id.* at 589, ¶ 26.

13 *Id.* at 588–9, ¶ 22.

14 *Id.* at 589, ¶ 23

15 *Id.* at 589–90, ¶¶ 25, 29.

16 *Id.* at 590–91, ¶ 36.

17 *Id.* at 591, at ¶¶ 37, 40.

18 *Id.* at ¶ 41.

19 *Id.* at 592, ¶¶ 44–45.

20 *Id.* at ¶ 47.

21 *Id.* at ¶ 48.

22 *Id.* at ¶ 49.

23 *Id.* at 593–94, ¶¶ 55–56.

24 *Id.* at 594, ¶ 57.

25 *Id.* at ¶ 59.

26 *Id.* at ¶ 58.

27 *Id.* at ¶ 59.

28 *Id.* at ¶ 61.

29 *Id.* at ¶ 66.

30 *Id.* at ¶ 67.

31 *Id.* at 594–95, ¶ 67.

32 *Id.* at 595, ¶ 68.

33 *Id.* at ¶ 69 (citations omitted).

34 *Id.* at 848 (citing *Stowers*, 15 S.W.2d at 547).

35 *Id.* at ¶ 70 (internal citations omitted).

36 *Id.* at 595, ¶ 72.

37 *Id.* at 595–96, at ¶ 74.

38 *Id.* at 596, ¶ 75.

39 *Id.* at ¶ 77.

40 *Id.*

41 *Id.* at 597, ¶ 78.

42 *Id.* at ¶ 79.

43 *Id.*

44 *Id.* at ¶ 82.

45 *Id.* at ¶¶ 82–83.

46 990 F.3d 842, 846 (5th Cir. 2021).

47 *Id.*

48 *Id.* at 847.

49 *Id.* at 852.

50 *Id.* at 848

51 *Id.* at 849.

52 *Id.* at 850.

53 *Id.* at 848, 850.

54 The Fifth Circuit initially "pause[d] to note the lack of demarcation between whether the *Stowers* duty is triggered (*i.e.* was the offer reasonable) versus whether the *Stowers* duty, once triggered, is met (*i.e.* did the insurer reasonably respond to a reasonable offer)." *Id.* at 850, n. 44.

55 *Id.* at 851.

56 *Id.*

57 *Id.* at 851–52.

58 As one policyholder blog concluded, "this decision reminds us that excess insurers can pressure reluctant primary insurers to accept policy-limits demands." Bradly Arant Boult Cummings LLP, Under Pressure: Primary Insurer Must Reimburse Excess Insurer after Failing to Settle Case in Texas (Jan. 20, 2021). https://www.itpaystobecovered.com/2021/01/under-pressure-primary-insurer-must-reimburse-excess-insurer-after-failing-to-settle-case-in-texas/

59 *Am. Guarantee & Liab. Ins. Co. v. ACE Am. Ins. Co.*, 983 F.3d 203 (5th Cir. 2020).

60 990 F.3d 842.

61 983 F.3d at 212.

62 990 F.3d at 850.

63 *Id.*

64 *Id.* The revised decision in *ACE* stresses, "the only evidence points to ACE's having refused to settle because it was convinced it would win the case." 990 F.3d at 850. It is interesting that the Fifth Circuit added this language. When the District Court noted that ACE acted unreasonably when valuing its case by focusing on its own limits and not the full potential verdict range (something not addressed by the Fifth Circuit), it further noted that the insurer's valuation "is not the ultimate inquiry in a *Stowers* claim. The key issue is whether a reasonably prudent insurer would have accepted the offer." 413 F.Supp.3d at 598, ¶¶ 75-77. Logically, if the Fifth Circuit applied the same rule, the only issue would have been whether a reasonable insurer, not ACE, found the Third Settlement Demand to be unconditional. In other words, the fact that, for ACE, its argument was a *post hoc* rationalization would have been irrelevant.

65 *Id.* at 848 (The Third Settlement Demand "did not specify which plaintiffs would get what percent of the $2 million").

66 The District Court highlighted that an ACE representative called the ruling permitting testimony concerning Mary's mental state "the most impactful" on the case's value. 413 F.Supp.3d at 592, ¶ 48.

67 990 F.3d at 850.

68 Anchoring and confirmation bias are widely recognized cognitive biases that hinder negotiations. Two informative books discussing biases in the law are Keet, Heavin, Lande, *Litigation Interest and Risk Assessment: Helping Your Clients Make Good Litigation Decisions* (2020) at pp. 7, 9 and Robbennolt and Sternlight, *Psychology for Lawyers: Understanding the Human Factors in Negotiation, Litigation and Decision Making* (2nd Ed. 2021) at p. 88, 330.

69 Texas is not unique in this regard. *See* Martinez, Leo P., *Restatement of the Law of Liability Insurance and the Duty to Settle*, Rutgers Univ. Law Rev. Vol. 68:155, 160 ("The boundaries of the duty to settle can be best described as inexact").

70 I also fully understand that the mere fact a party quantifies its analysis does not mean its analysis is not tainted with bias. As the popular saying, often attributed to Mark Twain, goes, "there are lies, damned lies and statistics."

71 As Justice Hand suggests, "Possibly it serves to bring this notion into relief to state it in algebraic terms: if the probability be called P; the injury L; and the burden, B; liability depends on whether B is less than L multiplied by P…." *U.S. v. Carroll Towing*, 159 F.2d 169, 173 (2nd Cir. 1947).

72 413 F.Supp. at 595, ¶ 71; 990 F.3d at 850.

73 413 F.Supp. at 595, ¶ 72; 990 F.3d at 846, n. 7.

74 173 F.3d 946, 950 n. 15 (quoting *Foremost County Mut. Ins. Co. v. Home Indemn. Co.*, 897 F.2d 754, 761–62 (5th Cir. 1990).

75 *Id.*, n. 18 (discussing *American Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480, 483 (Tex. 1992)). As the Texas Supreme Court further noted, "the primary carrier should not be relieved of these [Stowers] obligations simply because the insured has separately contracted for excess coverage." *American Centennial Ins. Co.*, 843 S.W.2d 480, 483. In other words, the fact the insured had the foresight to obtain excess coverage does not relieve a primary insurer of its *Stowers* duties.

76 *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312, 319 (Tex. 1994)(discussing the *Stowers* negligence standard and noting "In such circumstances, every reasonable demand within policy limits should be accepted by the insurer, unless the insurer, by taking the case to trial, is willing to gamble with its own money").

77 *American Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480, 483 (Tex. 1992).

78 David A. Hyman, Bernard Black, and Charles Silver, *Settlement at Policy Limits and the Duty to Settle: Evidence From Texas*, 7 Journal of Empirical Legal Studies, 2010 at p. 1. On the other hand, if a Plaintiff only has a 10% chance for recovery, courts typically permit insurers to proceed to trial even when there are high damages. *See* e.g. Syverud, Kent, *The Duty to Settle*, Va. L. Rev., Vol. 76, No. 6, 1113, 1141 (Sept. 1990)("No state holds the insurance company strictly liable for the excess judgment when it rejects a settlement demand within the policy limits").

79 In poker the concept is known as "pot odds." Good poker players not only focus on their cards to calculate their probability

of winning, they also consider the size of the pot and what the payout would be if they were to win. Some risks are not worth taking unless the payout is significant.

80 The above quote is similar to *General Accident Fire & Life Assurance Corp. v. Little*, where the Arizona court compared the small amount of additional funds the insurer could have agreed to pay in settlement with the large excess verdict risked by going to trial. *See* Sec. II.D.1.b.

81 Texas has limited the impact of the RLI. Texas H.B. 2757 (2019) (codified Tex. Civ. Prac. & Rem. § 5.001(b))("[i]n any action governed by the laws of this state concerning rights and obligations under the law, the American Law Institute's Restatements of the Law are not controlling"). However, the Texas Supreme Court repeatedly discussed the RLI in determining that insurers can breach their contractual duty to indemnify by refusing to fully fund within-limits demands. *In Re Farmers Texas County Mut. Ins. Co.*, No. 19-0701 (Tex. 2021) at 8, 18 and 20.

82 Thomas, Jeffrey E., *The Standard for Breach of Liability Insurer's Duty to Make Reasonable Settlement Decisions: Exploring the Alternatives*, Rutgers Univ. L. Rev. Vol. 68:229 (Fall 2015).

83 Professor Keeton advocated for the disregard the limits test almost seventy years ago. Robert E. Keeton, *Liability Insurance and Responsibility for Settlement*, 67 Harv. L. Rev. 1136, 1148 (1954) ("with respect to the decision whether to settle or try the case, the insurance company must . . . view the situation as it would if there were no policy limit applicable to the claim").

84 Professor Syverud notes that while in the real world insurers consider defense costs, courts rarely do. Thus, to him, "[i]t would therefore be inaccurate to assert that current duty-to-settle doctrine requires the insurance company to behave in the same manner as a rational holder of the entire liability." Syverud, *The Duty to Settle*, Va. L. Rev. at 1141. In other words, the duty to defend is separate and does not impact duty to settle decisions.

85 443 P.2d 690 (Ariz. 1968).

86 *Id.* at 695 ("The physical evidence revealed no skid marks").

87 *Id.* at 691.

88 *Id.*

89 *Id.* at 696.

90 *Id.*

91 The highest expected value based on defense counsel's estimates was $3,000 ($7,500 x .4) while the claims adjuster's figure was $2,500 ($10,000 x .25).

92 *Id.* at 698.

93 As Professor Syverud noted, "Even in states that have endorsed the 'disregard the limits' standard, courts occasionally engraft upon the standard obligations to defer to the insured's interests in settlement even where an insurance company without policy limits might reasonably try the case." Syverud, Va. L. Rev. at 1123, n. 23. As this section concludes, this helps explain *ACE*. The higher the potential for an excess judgment, the more unreasonable it would be for an insurer to reject a demand even if it is slightly greater than the case's expected value.

94 What does it mean when the Fifth Circuit calls a judge "plaintiff-friendly"? 990 F.3d at 845. Perhaps it means that the judge has often been reversed for favoring plaintiffs. Arguably that would provide further support for the reasonableness of considering appellate prospects.

95 For illustration purposes, if after Judge Sandill's rulings the likelihood of a defense verdict decreased to 40% and the potential verdict increased to $8 million, the expected value would be $2,880,000. Accordingly, the expected value of the case considering a 50% likelihood of a reversal and remand would be calculated as follows: ($1,080,000 x .5) + ($2,880,000 x .5) = $1,980,000.

96 The Braswells settled a $27.7 million judgement for around $9 million even though Brickman had insurance limits sufficient to cover the entire award.

97 The calculation assumes Braswell's responsibility is set at 40% for purposes of contributory negligence.

98 193 F.3d 340, 344 (5th Cir. 1999).

99 *Id.* at 343.

100 *Phico Ins. Co. v. Aetna Cas. and Sur. Co.*, 93 F.Supp.2d 982, 991 (S.D. Ind. 2000). The Indiana court also determined that the excess carrier's action was barred by the doctrine of unclean hands citing *Hocker v. New Hampshire Ins. Co.*, 922 F.2d 1476, 1486 (10th Cir.1991). *Phico Ins. Co.*, 93 F.Supp.2d at 994.

101 The Texas Supreme Court has yet to decide such a case. *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 849, n. 13 ("Nor do we address the *Stowers* duty when a settlement requires funding from multiple insurers and no single insurer can fund the settlement within the limits that apply under its particular policy").

102 *Keck & Mahin v. Nat'l Union Fire Ins. Co.*, 20 S.W.3d 692, 701 (Tex. 2000).

103 990 F.3d at 846.

104 413 F.Supp.3d at 590–91 at ¶ 36.

By Katherine Knight and Davinder Jassal

DUTY TO SETTLE FOR LIABILITY INSURERS: *STOWERS* OR STATUTORY

The parameters of a third-party liability insurer's statutory duty to settle, if any, arising under Texas Insurance Code section 541.060 (the "statute"), which governs unfair and deceptive acts and practices in the business of insurance, remains indeterminate. Traditionally, the *Stowers* doctrine,[1] derived from the common law, has been the sole source of a third-party liability insurer's duty to settle. However, since the Texas Supreme Court announced its decision in *Rocor*[2] in 2002, a patchwork of decisions have inconsistently ruled on, or discussed in *dicta*, the source of a liability insurer's duty to settle: with some cases standing for the proposition that a liability insurer's duty to settle arises solely from the common-law duty discussed in *Stowers* and others expressing that the duty is derived from a hybrid of the *Stowers* duty and the statutory duty provided by the statute.

In practice, if *Stowers* and the statute are intended to work together, the interplay is far from seamless. Both *Stowers* and the statute impose a duty to settle, but the events that trigger the duty in each are quite different. While the elements of *Stowers* are well-defined, the application of the statute's triggering event to a third-party policy presents an impracticable result making it difficult for an insurer to know when the duty is triggered. Given the uncertainty of the application of the statute, perhaps *Stowers* as the sole source of the duty to settle is the better option, as it definitively provides for triggering elements and sufficiently protects an insured from an excess judgment.

This article will examine the elements of the *Stowers* doctrine, the terms of the predecessor to the statute, the *Rocor* decision, the statute and, finally, case law addressing the duty to settle in the context of third-party insurers. To begin the analysis, a review of the two major types of insurance coverages—first-party insurance and third-party insurance—is appropriate.

First-Party Insurance v. Third-Party Insurance

First-party insurance and third-party insurance provide coverage for different losses, and, for purposes of the duty to settle, the distinction is critical. Third-party liability insurance policies indemnify an insured against a loss suffered by an injured or damaged third party.[3] In the third-party insurance context, three parties are typically involved: (1) the insurer, (2) the insured, and (3) the third-party claimant. When a third-party liability policy is at issue, usually a third-party claimant makes a settlement demand or claim to the insurer to seek compensation for the claimant's injuries or damages, which the insured allegedly caused.

In contrast, first-party insurance protects an insured from his own loss.[4] In the first-party insurance context, only two parties are typically involved: (1) the insurer and (2) the insured or beneficiary named in the policy. When a first-party policy is at issue, usually the insured makes a settlement demand or claim to the insurer to seek compensation for the insured's own injuries or damages. In a first-party policy, it is the liability of the insurer that is at issue because the policy pays benefits to the insured.

The *Stowers* Doctrine

Under the *Stowers* doctrine, a duty to settle is imposed on a third-party liability insurer when: (1) a settlement demand is made; (2) the claim against the insured is within the scope of coverage; (3) the demand is within the policy limits; and (4) 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.[5] A settlement demand within policy limits must be made by the third party before any duty to settle arises. Because the insurer is to gauge the liability of its insured, *Stowers* obligations are necessarily imposed upon third-party liability insurers, not first-party insurers, who are not tasked

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with the same responsibility.

Stowers became the common law of the land nearly a century ago in 1929. The Insurance Code was originally enacted in 1973, and the statute was repealed, revised, and re-codified in 2005. Until the Texas Supreme Court rendered its decision in *Rocor* in 2002, the *Stowers* doctrine was the stand-alone source of a third-party liability insurer's duty to settle.

Texas Insurance Code Article 21.21-2

The *Rocor* decision, discussed *infra*, turned on the wording of the predecessor to the statute, Texas Insurance Code Article 21.21-2, section 2(b)(4) (the "former statute"). A failure of an insurer to properly settle under the former statute constituted "an unfair claim settlement practice."[6] The former statute was silent regarding (1) whether the duty was imposed on third-party insurers; (2) whose apparent liability would trigger the duty; and (3), assuming the statute meant to include third-party liability insurers, whether the *Stowers* elements were to be included. In relevant part, the former statute provided the following:

> (b) Any of the following acts by an insurer shall constitute unfair claim settlement practices:
>
> > (4) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear.[7]

The duty to settle, then, was triggered where undefined "liability" became reasonably clear. The word "liability" was not modified by either the term "insured's" or "insurer's." *Rocor*, however, interpreted the statute as if the word "insured's" modified the word "liability" and went on to impose all of the *Stowers* elements on the former statute.

The *Rocor* Decision

The *Rocor* decision, decided under the former statute, continues to be cited by courts analyzing a third-party insurer's duty to settle. In 2002, the Texas Supreme Court analyzed the duty to settle contained in the former statute, not solely on its own terms, but in light of the *Stowers* doctrine.[8] In its decision, the Court announced that an insured may make a claim against its excess liability carrier for damages suffered as the result of the insurer's unfair claim settlement practices.[9] In so holding, the Court imposed all the *Stowers* requirements upon the statutory cause of action:

> In sum, we hold that an insurer's liability is not reasonably clear, and liability may not be imposed under article 21.21 unless the insured shows that (1) the policy covers the claim, (2) the insured's liability is reasonably clear, (3) the claimant has made a proper settlement demand within policy limits, and (4) the demand's terms are such that an ordinarily prudent insurer would accept it. These elements comprise the statutory liability standard against which to measure legal sufficiency.[10]

The statute itself is silent about *Stowers*'s requirements, but the court's use of the word "unless" in its holding had the effect of imposing the *Stowers* requirements on the statutory duty to settle. Focusing on the statute's phrase "claims . . . in which liability has become reasonably clear," the Texas Supreme Court held that the third-party insurer's liability "is not reasonably clear," and that the statute does not impose a duty to settle, "unless" the *Stowers* elements have been met.[11] Thus, the Court interpreted the "liability" triggering event as the insured's liability.[12]

But because the imposition of the *Stowers* elements on the statute is not readily apparent from the language of the statute itself, given that the statute does not expressly address the *Stowers* elements, many courts have assumed that the statute is a wholly separate cause of action, not dependent upon the satisfaction of the *Stowers* requirements as a prerequisite to an insurer's duty to settle.

The Statute: Texas Insurance Code Section 541.060

Chapter 541 of the Insurance Code broadly regulates "trade practices in the business of insurance."[13] Although the statute is entitled: "Unfair Settlement Practices" and its application to third-party liability insurers is not expressly *excluded* or *precluded*, imposition of the duty to settle under the statute does not fit into the framework of a third-party liability policy. For example, the statute's application in the third-party insurance context unreasonably heightens the stakes because a failure to properly settle thereunder is deemed an "unfair method of competition or an unfair or deceptive act or practice in the business of insurance"—a weighty charge subjecting an insurer to damages beyond the policy limits, including actual damages, injunctive relief, and "any other relief the court determines is proper."[14]

In 2003, the Texas Legislature enacted House Bill 2922, which revised the former statute and re-codified it, in part, as the statute, effective April 1, 2005.[15] The statute addresses unfair claims settlement practices. The employment of various new terms in the statute may have been an attempt

to clarify that no statutory duty to settle is imposed on third-party liability insurers. In relevant part, Section 541.060 provides the following:

> (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to engage in the following unfair settlement practices with respect to a claim by an insured or beneficiary:
>
> . . .
>
> (2) failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of:
>
> > (A) a claim with respect to which the insurer's liability has become reasonably clear;[16]

Breaking it down, the statute imposes a duty, triggered by a "claim by an insured or beneficiary," to "attempt in good faith" to settle claims where "the insurer's liability has become reasonably clear."[17] Notably, the statute does not state that the duty to settle is triggered when the *insured's* liability has become reasonably clear, but when the insurer's liability has become reasonably clear. The 2002 *Rocor* decision, which turned on the undescribed word "liability," may have been the catalyst for the addition of the word "insurer's" to clarify whose liability must be reasonably clear before the duty to settle is triggered. Specifically, the insertion of the word "insurer's" clarifies that the statutory duty to settle arises only in the case of first-party insurance policies.

Reconciling *Stowers* and the Statute

Under the wording of the statute, none of the *Stowers* elements are included. For example, there is no requirement that a demand by a third-party claimant be made. Nor is there a requirement that a judgment in excess of policy limits exist before damages may be awarded against an insurer. The legislature could have, but did not, include the *Stowers* liability requirements in the statutory text, such as requiring that a settlement demand be within the policy limits. As a result, it makes little sense that the statute would impose a duty to settle on a third-party liability insurer (1) without a settlement demand having been made by the third-party claimant, (2) without consideration of the insured's potential exposure to an excess judgment, and (3) where the liability of the insurer (as opposed to the liability of the insured) triggers the duty to settle.

If an "insurer's liability" becoming "reasonably clear" under the statute means that both (1) the liability of the insured and (2) insurance coverage for the insured's liability, have become "reasonably clear," then that would require a third-party insurer, at some unknown point during the course of a third-party claim or a lawsuit, to make an offer to the third-party claimant.[18] The offer would have to be made irrespective of whether a demand has been made, whether all parties have been brought into the lawsuit, or whether the insured desired an offer be made. Making an unsolicited settlement offer seems more designed to protect an insurer than to realistically resolve a claim. The unsolicited settlement offer could be construed by the third-party claimant or plaintiff as tantamount to an admission of liability. Such an interpretation further demonstrates that the framework of the statute does not fit the interests of either the insured or the insurer in the context of a third-party liability policy.

The phrase "reasonably clear" in the statute bears some similarity to the *Stowers* element requiring settlement based on what an "ordinarily prudent insurer" would do. Perhaps the statute is meant to be a codified tort. If so, then, either there are two separate tort duties to settle imposed on a third-party liability insurer or the statute is designed to supplant the common law duty under *Stowers*. Or a third, and more likely, option is that the statute was not intended to apply to third-party liability insurers.

The application of subsection (b) to a third-party policy provides further argument that the statute's duty-to-settle requirement in subsection (a) does not neatly work for a *Stowers* situation. Subsection (b) provides as follows:

> Subsection (a) does not provide a cause of action to a third party asserting one or more claims against an insured covered under a liability insurance policy.[19]

Stated another way, a third-party claimant has no statutory cause of action against an insurance company providing liability insurance to an insured. An insured would have a cause of action against his or her own third-party liability insurer only after the *Stowers* elements are satisfied. The reference to a "liability insurance policy" is an unmistakable reference to a third-party liability insurer. The term is noticeably absent elsewhere in the statute. The wording of the statute is apparently constructed to apply to first-party insurers, and any application of the statute to a third-party insurer leaves more questions than answers.

Finally, the hybrid solution that combines *Stowers* elements with the statutory elements, provides a novel common-law-plus-statutory remedy. The hybrid context is problematic because the possibility, or even likelihood, of two damage awards for a single wrong exists—damages un-

der common law and damages under the statute. It is also theoretically possible that the hybrid solution leaves open the possibility that a plaintiff has a choice of remedies.

Rocor was decided before the re-codification of the statute. Under the statute, the legislature's inclusion of the word "insurer's" as an identifier of whose liability must become reasonably clear is significant. An *insurer's* "liability" will become "reasonably clear" in a first-party policy, but only the *insured's* "liability" will become "reasonably clear" in a third-party policy. Cases that continue to cite *Rocor* as a basis for deciding that a third-party liability insurer's duty to settle flows from a combination of the statute and *Stowers* have not fully flushed out this important change in the statute. Even though the former statute considered by *Rocor* has been repealed and replaced, a number of courts, as described *infra*, still look to *Rocor* for the duty-to-settle guiding principle. Although the decision in *Rocor* essentially combined the statute with the *Stowers* standard, *Rocor* has been interpreted by other courts, as described *infra*, to hold that there are in fact two separate sources of a third-party insurer's duty to settle—*Stowers* and the statute.

Case Law

Finding *Stowers* liability and violations of the statute against a third-party insurer

In *OneBeacon Insurance Co. v. T. Wade Welch & Associates*, the court considered the duty to settle in light of a lawyer's malpractice insurance policy (i.e., a third-party liability policy).[20] The insured alleged that the insurer violated both its *Stowers* duty and a duty to settle under the Texas Insurance Code.[21] Following a trial, the court entered a verdict against the insurer, ruling that it "knowingly" violated Chapter 541 and was grossly negligent in violating its *Stowers* duties.[22]

In *15625 Ft. Bend Ltd. v. Sentry Select Insurance Co.*, the court, considering an Error and Omissions Liability Policy and Commercial Excess/Umbrella Policy, agreed with the insurer that the *Stowers* duty to settle overlaps with the statutory duty to settle under the statute.[23] Thus, the court's holding, following *Rocor*'s analysis, leads to the conclusion that there are two sources of a third-party liability insurer's duty to settle—*Stowers* and the statute.

In *Ryan Law Firm, LLP v. New York Marine and General Insurance Co.*, the court construed a lawyer's malpractice insurance policy and, relying on *Rocor*, found that "third party claims under Chapter 541 and the common law *Stowers* doctrine 'are governed by the same standard of liability.'"[24]

In *Medallion Transport & Logistics, LLC v. AIG Claims, Inc.*, the court, in reliance on *Rocor*, denied the insurer's motion for summary judgment, holding that the statute is essentially a codification of *Stowers* complete with the *Stowers* elements, but including a bad-faith component.[25] The court found that the insurance company did not sufficiently explain why their approach to settlement was reasonable and thus did not demonstrate the requisite "good faith" for purposes of the motion for summary judgment.[26]

In *Mid-Continent Casualty Co. v. Eland Energy, Inc.*, the trial court rejected insurance code violations found by the jury and entered a judgment for the insurer, holding that *Stowers* was the only tort claim that that an insured has against his third-party liability insurer.[27] The court found that a third-party insurer owes no common law duty of good faith and fair dealing to its insured.[28] "An insured, however, has no claim for bad faith premised on the insurer's investigation or defense of a claim brought against it *by a third party*."[29] The trial court's interpretation of the statute in light of *Stowers* duty, however, followed the *Rocor* analysis requiring that the *Stowers* elements be read into the statutory requirements.[30] But whether the triggering factor for settlement under the statute was the liability of the *insurer* or the liability of the *insured*, or whether a proper *Stowers* demand should have been made,[31] were not fully analyzed as a comparison between *Stowers* and the statute.

Other relevant cases

In *Valentine v. Federal Insurance Co.*, the court held that, despite an order from the bankruptcy court authorizing such action, a third-party claimant could not assert a claim for violations of the Texas Insurance Code against a liability insurer of a bankrupt defendant because the statute defines "claim" as a "first-party claim that . . . is made by an insured or policyholder under an insurance policy or contract or by a beneficiary named in the policy or contract."[32] The duty to settle was not at issue in *Valentine*; however, the court refused to entertain any notion that a third-party claimant could assert a direct claim against a liability insurer under the statute.

In *AIG Specialty Insurance Co. v. Stoller Enterprises, Inc.*, the court denied the insurance company's motion for summary judgment as to the insured's Chapter 541 counterclaim, stating that the existence of insurance coverage is not a prerequisite "to every Chapter 541 Insurance Code claim" and suggesting that the third-party insurer is subject to the statutory duty to settle.[33] In that case, the court stated, "caselaw does not support AIG's broad contention that [the insureds] have only a *Stowers* claim" for settlement amounts as damages.[34] However, the court did not fully analyze the terms of the statute or the caselaw supporting its position that *Stowers* is

not the only duty a third-party insurer has to settle.

In *Urban Oaks Builders LLC v. Gemini Insurance Co.*, the court assumed that the statute requires proof of extracontractual damages for a claim against a third-party liability insurer.[35] "In addition to failing to satisfy Rule 9(b), Plaintiffs fail to state a claim for extracontractual damages as recognized by the Texas Supreme Court in *USAA Tex. Lloyds Co. v. Menchaca*, 545 S.W.3d 479, 489 (Tex. 2018)."[36] *Menchaca*, however, concerned a first-party policy, not a third-party liability policy.[37]

In *Pride Transportation v. Continental Casualty Co.*, the Fifth Circuit considered a *Stowers*/statutory duty to settle case.[38] There, the insured claimed that the insurer, in settling a claim, violated its duty to settle because the settlement was unreasonable.[39] The court analyzed *Stowers* as imposing liability on an insurer for rejecting a reasonable settlement demand, not imposing liability where a settlement was made in the absence of a demand.[40] As for the statutory violation claim, the court assumed that the settlement triggered duties under the statute, but held that the terms of the settlement were reasonable and made in good faith.[41]

Summary

Since *Rocor*, the issue concerning the source of a third-party liability insurer's duty to settle has been met with conflicting results. At this point, the tide seems to favor an imposition of the common-law *Stowers* elements onto the statutory duty to settle under the statute—a unique common law-statutory mix. However, the hybrid *Stowers*/statutory duty creates a confusing network of elements to the causes of action and results in the possibility of multiple damage awards arising from a single wrong. Furthermore, there is nothing in the statute that mentions *Stowers* or its elements. The *Stowers* doctrine, on the other hand, has been in place for nearly a hundred years, and it provides clear guidance and sufficient protection to insurance companies. Therefore, given the difficulty with interpreting a third-party insurer's duty to settle under the hybrid approach, a liability insurer's duty to settle should stem solely from *Stowers*.

1 *G.A. Stowers Furniture Co. v. Am. Indem. Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved).
2 *Rocor Int'l, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 77 S.W.3d 253 (Tex. 2002).
3 *See Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1, 17–18 (Tex. 2007).
4 *See id.*
5 *Mid-Continent Ins. Co. v. Liberty Mut. Ins.Co.*, 236 S.W.3d 765, 776 (Tex. 2007) (quoting *Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 849 (Tex. 1994) (citing *Stowers*, 15 S.W.2d at 547)).
6 *See* Tex. Ins. Code Art. 2.-21-2, § 2(b)(4).
7 *Id.* (emphasis added).
8 *See Rocor*, 77 S.W.3d at 261–62.
9 *Id.* at 255.
10 *Id.* at 262 (emphasis added).
11 *See id.*
12 *See Rocor*, 77 S.W.3d at 262 (analyzing the former statute and holding that liability may not be imposed under it unless, among other things, "the insured's liability is reasonably clear" (emphasis added)).
13 Tex. Ins. Code § 541.001.
14 Tex. Ins. Code §§ 541.060(a), 152(a)(1)-(3). In addition, if the trier of fact finds that the defendant committed the unfair settlement practice "knowingly," the trier of fact may award three times actual damages. *See id.* § 541.152(b).
15 *See* Act of June 21, 2003, 78th Leg., R.S., ch. 1274, § 2, 2003 Tex. Gen. Laws 1274.
16 Tex. Ins. Code § 541.060(a)(2)(A) (emphasis added).
17
18 Interestingly, the trial court's opinion in *Mid-Continent Casualty Co. v. Eland Energy, Inc.* noted that the insured there argued that the triggering event in the statute should be the insured's liability becoming reasonably clear. 795 F. Supp. 2d 493, 527 (N.D. Tex. 2011), *aff'd* 709 F.3d 515 (5th Cir. 2013) ("[The insured] responds that the jury found that [the insurer] did the opposite of what the Insurance Code requires: it attempted in bad faith to effectuate an unfair and excessive settlement of a claim for which [the insured's] liability was not clear.").
19 Tex. Ins. Code § 541.060(b).
20 *See* 841 F.3d 669, 672, 678–80 (5th Cir. 2016).
21 *Id.* at 674.
22 *Id.* at 675.
23 *See* 991 F. Supp. 2d 932, 939 (S.D. Tex. 2014).
24 *See* No. 1:19-CV-629-RP, 2020 WL 5820531, at *6 (W.D. Tex. Sept. 30, 2020) (quoting *Mid-Continent Cas. Co. v. Kipp Flores Architects, LLC*, No. 1:13-CV-60-JRN, 2014 WL 12479995 at *2 (W.D. Tex., Apr. 3, 2014) *adopted* by 2020 U.S. Dist. LEXIS 243241 (W.D. Tex. Nov. 3, 2020).
25 *See* No. 2:16-CV-01016-JRG-RSP, 2018 WL 3249708, at *4–5 (E.D. Tex. June 27, 2018).
26 *See id.*
27 *See* 795 F. Supp. 2d 493, 508–09 (N.D. Tex. 2011), *aff'd* 709 F.3d 515 (5th Cir. 2013).
28 *Id.* at 507.

29 *Id*.
30 *Id*. at 528 ("As a matter of law, Mid-Continent had no duty to attempt to settle with the [third party claimant] on behalf of Sundown absent presentment of a claim to Mid-Continent within policy limits.").
31 No demand was made. The insurer made an unprovoked settlement offer. *See id*. at 519.
32 *See* No. 14-18-00438-CV, 2020 WL 1467352, at *8 (Tex. App.—Houston [14th Dist.] Mar. 26, 2020, pet. denied).
33 *See* No. 4:16-CV-26, 2017 WL 541533, at *22 (S.D. Tex. Feb. 7, 2017).
34 *Id*. at 23.
35 *See* No. 4:19-CV-4211, 2020 WL 7064791, at *7 (S.D. Tex. Dec. 2, 2020).
36 *Id*.
37 *USAA Texas Lloyds Co. v. Menchaca*, 545 S.W.3d 479, 485 (Tex. 2018).
38 *See* 511 F. App'x 347, 350, 354 (5th Cir. 2013).
39 *Id*. at 351.
40 *Id*.
41 *Id*. at 354.

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ANATOMY OF AN INSURANCE POLICY

I. Introduction

Although insurance policies provide various types of coverage and the specific wording of provisions differ from one Coverage Part to the next, insurance policies are typically organized in the same manner. Understanding the basic structure of an insurance policy is essential to efficiently analyzing potential coverage. Many insurance practitioners develop a systematic method of dissecting insurance policies. This paper outlines one approach.

II. Determining the Applicable Coverage

- Selecting the Specimens

Before dissecting a policy, it is important to identify all the insurance policies containing a Coverage Part potentially affording coverage. There are multiple types of insurance policies (e.g., commercial general liability ("CGL"), professional liability, and commercial property)[1] and each policy generally contains multiple Coverage Parts. The particular facts or allegations of a claim may trigger one or more Coverage Parts in one or more policies. The timing of events will also dictate which policy years are potentially implicated. For example, CGL policies are usually triggered by the date of the occurrence, whereas professional liability policies are usually written on a claims-made basis. So, in a case filed in 2007 involving negligent hiring and supervision and malpractice occurring in 2005, the 2005 CGL and 2007 professional liability policies would be the most logical starting point for coverage analysis. Also, umbrella policies by definition are broader than underlying policies and should be evaluated. Consequently, to provide a comprehensive coverage evaluation, copies of all potentially applicable insurance policies and policy periods should be obtained, and review of each Coverage Part within each policy should be completed.

The insured may be unaware of the policies and specific types of coverage available to respond to a loss or other event. But, the insurer should have a good understanding of coverages that exist in the marketplace and also should have a specific listing of other coverages that the insured purchased for a given policy year. Also, if the policy was procured or issued through an agent, it is often helpful to communicate with the agent to obtain a schedule of all existing coverages. Sometimes, the insured may have coverage issued by different agents, and, in such event, each agent should be consulted. Finally, the insured may have coverage available through another entity's policy by virtue of an insured contract, indemnity agreement, or status as an additional insured.

After identifying the potentially applicable policies and Coverage Parts, the insurance policy analysis can begin.

*Definitions for bolded terms are located in Appendix 2 of this paper.

III. Basic Approach - Preparing the Specimen

The first step is to obtain a certified copy of each policy that is potentially triggered. With respect to each policy, be certain that all endorsements listed on the schedule are included and that the form number on the schedule matches the endorsement that is actually attached. The absence of an endorsement or the inclusion of an incorrect endorsement can change the entire analysis. Also make sure the pages are consecutively numbered. Policies are frequently printed as two-sided documents but copied as one-sided documents.

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Some insurance policies are issued as package policies, meaning they contain more than one base policy form (e.g., CGL and employee benefits liability). In such event, be sure all base policy forms and declarations pages are included. It is best to separate each base policy form, together with the applicable declarations and endorsements. An independent analysis of each potentially applicable Coverage Part contained within each base policy form should be completed. Finally, reviewing the entire policy is important. Coverage disputes frequently surround the meaning of a particular phrase. A slight difference in wording between otherwise parallel provisions can be outcome determinative. For example, even if pollution is not a direct coverage issue, the wording and structure of the absolute pollution exclusion can be helpful to distinguish a narrower exclusion.

IV. Analysis - Dissecting the Specimen

Once all potential base policy forms have been identified, the dissection of each Coverage Part may begin. Each policy will contain: (1) a declarations page; (2) a form that schedules all endorsements; and (3) a base coverage form. A review of each section constitutes dissection of the policy, which ultimately results in a determination of the potential for coverage.

A. Declarations

The declarations page is usually the first page in the policy and will contain specific and important information, including the name of the insurer, the policy number, the policy period, the named insured, the type(s) of coverage, and the schedule of limits. If applicable, the declarations page will also include a retained limit or deductible and a retroactive date.

In a Package Policy, each policy form will have a declarations page with applicable limits. The package should include a limits section that states how the limits interact in the event more than one policy form and/or Coverage Part are triggered. Limits are generally listed on a per claim or occurrence basis and in the aggregate.

B. Listing of Forms and Endorsements

Endorsements change the base policy—some add coverage, some exclude coverage, and some modify coverage. Additionally, some endorsements are broad and some are narrow. Basically, endorsements may impact any provision in the base policy form, including who is a named insured or additional insured and whether liability is limited to certain premises, vehicles, persons, or activities. Because an endorsement either adds to or replaces what is contained in the base policy form, review of the schedule of endorsements should be completed prior to review of the base policy form.

An endorsement list may be included on the declarations page or a separate endorsement list or schedule may be attached to the declarations page. Usually the schedule will include a form number as well as the title of the endorsement. The title may or may not be enough to determine whether it will impact coverage. When in doubt, review the endorsement. During this process, review the number of each endorsement and compare it with the number listed on the endorsement list to be certain that the correct endorsement was attached. Often, there are multiple forms with the same name and obtaining the correct one (determined by number) can be essential. In addition, if it appears that a listed endorsement is not included, obtaining the missing endorsement is necessary prior to making any final determination of whether coverage exists.

During review, if an endorsement replaces or modifies a provision in the base policy form, a notation in the base policy form should be made so that there is no reliance on the base policy form provision. Also, if coverage is added, a notation in the appropriate insuring agreement section, if applicable, should be made so that any accompanying exclusions can be analyzed in conjunction with the endorsed coverage.

Importantly, if the policy is a renewal, review of the prior policy is necessary. If endorsements that modify coverage are included in the renewal policy that were not included in the prior policy, review of applicable common, statutory, and regulatory laws is needed to determine whether the added endorsement will be permitted to modify the coverage.

C. Base Policy Form

The base policy form contains four key sections: (1) the definitions (2) the insuring agreement; (3) the exclusions; and (4) the conditions.

1. *Definitions*

While the definitions section is necessarily referred to throughout the review of the policy, it is rarely if ever near the front of the policy. It is a good idea to mark the page on which the definitions begin to ease the constant need for review of the defined terms.

*2. **The Insuring Agreement***

The **insuring agreement** is the heart of the insurance policy. It determines whether the claim is potentially within the initial scope of coverage.

There can be more than one insuring agreement in a base policy form and more than one base policy form that may apply to any given claim. A review of each insuring agreement within each policy form is essential. For example, a CGL policy typically has three separate Coverage Parts: (1) Coverage A – Bodily Injury and Property Damage; (2) Coverage B – Personal Injury and Advertising Injury; and (3) Coverage C – Medical Payments. Each Coverage Part has its own insuring agreement and affords a different scope for coverage.

Insuring agreement issues may include:

- whether the person or entity seeking coverage is insured;
- whether the damages or causes of action are covered;
- whether the acts or damages fall within the policy period (in a "claims made" policy, whether the claim was made during the policy period and the act or damages occurred after the retroactive date);
- whether the vehicle or other property involved is insured; or whether the event occurred in the coverage territory.

3. Exclusions.

After determining that one or more insuring agreements may afford coverage, review of all applicable **exclusions** is necessary. Exclusions apply only to the insuring agreement(s) that they modify and are tied into one section by reference to its Coverage Part. For example, in a typical CGL policy, the Coverage A Coverage Part for "bodily injury" and "property damage" will include an exclusion for acts that were expected or intended from the standpoint of the insured. However, the scope of coverage for "personal and advertising injury" contained within the Coverage B Coverage Part affords coverage for actions or omissions that are by their very nature intentional (e.g., invasion of privacy), so Coverage B does not include an expected or intended exclusion, although it does contain a knowledge of the falsity exclusion.

4. Conditions.

The next step after reviewing the insuring agreement and exclusions is to review the **conditions.** Some conditions must be met in order for coverage to exist at all, even if the claim is within the scope of an insuring agreement—these are referred to as true conditions precedent. In order for a true condition precedent to exist, the language within the condition must be reviewed, and it must state that coverage is dependent on satisfaction of the condition. If the condition is a true condition precedent (e.g., notice under a claims-made policy), prejudice is not required to be established for the insurer to avoid coverage. If the condition is not a true condition precedent (e.g., notice under an occurrence policy), prejudice must be established as a result of any alleged breach by the insured. Of course, statutory and case law trump policy language regarding the need to establish prejudice.

Some common conditions contained within CGL base policy forms include: (1) the notice provision; (2) the no action clause (i.e., insurer doesn't have to pay absent a settlement or judgment); (3) the voluntary payments provision (i.e., insurer must consent to settlement payments or attorneys' fees incurred prior to tender); (4) the cooperation clause; and (5) the other insurance clause.

D. Regulatory Notices.

The Texas Department of Insurance requires various provisions to be stated with respect to certain Coverage Parts. Although the requirements may vary, generally state specific provisions relate to cancellation and non-renewal and sometimes notice. Review of the Texas Department of Insurance website for requirements relative to a particular coverage and comparison to what is contained in the policy may be necessary. Sometimes the required provision will be read into the policy even if not stated within the policy. Different regulations are promulgated periodically, so be certain to review the requirements applicable to the policy period at issue.

E. Miscellaneous Items.

1. Policy Jacket.

Some policies include a **policy jacket.** A policy jacket is basically a covering around the policy—much like a paper or plastic protective book cover. If a jacket is included, all wording on it should be reviewed because it may contain some provisions that are incorporated into the policy.

In addition, the jacket may include representations or statements that may impact the analysis, although it may not directly involve the contractual provisions.

2. Application.

In addition, some coverage forms incorporate the **insured's application** for the policy. If so, a signed version of the application that was relied upon by the underwriter for the particular policy year in question must also be obtained.

3. Supplementary Payments.

When the policy affords coverage, the insured might also be entitled to additional benefits. These are frequently listed in a Supplementary Payments section. For example, most CGL policies include coverage for defense costs and expenses, prejudgment interest, various bonds, and reasonable costs to the insured for providing requested assistance to the insurer. These payments also typically do not erode the policy limits.

Appendix 1—Checklist

- ✓ **Determine Applicable Coverage.**
  - o **Type of Insurance Policies Issued.**
  - o **Consult with Insured's Risk Manager, Insurance Agent or Insurer's Underwriter.**
  - o **Review Coverage Parts.**
- ✓ **Prepare for Detailed Policy Review.**
  - ✓ **Obtain Certified Copy of Each Relevant Policy.**
  - ✓ **Scan into a document with searchable text (OCR).**
  - ✓ **Bates label a working copy and separate into forms.**
  - ✓ **Review Declarations Page for Coverage Parts.**
  - ✓ **Review schedule of endorsements for each Coverage Part and compare to attached endorsements (form number, etc.).**
  - ✓ **Tab Definitions.**
- ✓ **Dissect the Policy.**
  - ✓ **Declarations Page.**
    - **Name of Insurer.**
    - **Named Insured.**
    - **Policy Period.**
    - **Coverage Parts.**
    - **Limits.**
    - **Retained Limit or Deductible (if applicable).**
    - **Retroactive Date (if applicable).**
    - o **Schedule of Endorsements.**
      - **Add, Limit, or Modify? If so, note on base form.**
      - **Compare schedule of attached forms (whether all are included, form numbers, etc.)**
    - o **Coverage Parts.**
      - **Definitions.**
        - **In boldface or italic type.**
        - **Always review defined terms.**
        - **Does definition contain an exclusion or exception?**
      - **Insuring Agreement.**
        - **Review each Coverage Part (e.g., Coverage A. and Coverage B. in a CGL Policy)**
        - **Determine whether damages or causes of action are potentially covered.**
        - **Determine whether otherwise potentially inside the scope of coverage (policy period, coverage territory, etc.).**
      - **Exclusions.**
        - **Review all focusing on potentially applicable exclusions.**
        - **Different exclusions for different Coverage Parts.**
      - **Conditions.**
        - **Some common conditions include the notice provision and the cooperation clause.**
- ✓ **Miscellaneous.**
  - o **Policy Jacket.**
    - **Like a Book Cover.**
    - **Review all wording; may be incorporated.**
    - **Review for representations or statements.**
  - o **Application.**
    - **Review all wording; may be incorporated.**
    - **Be certain to obtain a signed, certified copy.**

If the application is incorporated into the policy, review

carefully for construction aids.

Appendix 2—Glossary

1. ***Typical Commercial Policies.***

a. CGL — Abbreviation for "Commercial General Liability" Policy Form. Provides limited liability coverage for commercial risks.

b. Property — Provides reimbursement or replacement cost for damage to buildings or structures or other property if caused by specified causes of loss.

c. E & 0 — Errors and omissions coverage for various professional exposures (i.e., real estate agents, architects).

d. WC — Abbreviation for "Workers' Compensation". This coverage is usually available as a stand-alone Coverage Part and provides general workers' compensation coverage for injury to employees.

e. EPLI— Abbreviation for "Employers' Practices Liability Insurance". This coverage is usually available as an endorsed coverage to the CGL. Notably, there is also an EPLI exclusion form.

f. EBL — Abbreviation for "Employers' Benefits Liability". Provides limited coverage for employee benefits.

2. ***Insuring Agreement*** — Provides the scope of what is covered. There may be more than one insuring agreement within a Coverage Part.

a. Duty to Defend —This provision is included in most liability insurance policies. In the event of a lawsuit against an insured, the insurance company may be obligated to pay for legal fees and expenses to defend the insureds. Some policies provide that this obligation is in addition to the indemnity limit; others contain a depleting limits provision.

b. Duty to Indemnify — This provision determines when the insurance company is obligated to pay the insured for the amount of the loss or claim.

3. ***Dec Page*** — Abbreviation for "Declarations Page"; usually the first page of a policy. Provides pertinent information including: (1) the first named insured; (2) the limits; (3) whether the policy written on an "occurrence" or "claims-made" basis; (4) the deductible or retained limit, if any; (5) list of endorsements; and (6) list of Coverage Parts, if it is a Package Policy.

a. Insureds.

i. First Named Insured — The individual or entity in the declarations page. Usually identified in the definitions section as "you".

ii. Additional Insured — A specified individual or entity, by name or group classification, specifically added within the base form or by endorsement. Importantly, additional insureds may be classified as additional named insureds, which qualifies them for "named insured" ("you") status.

iii. Omnibus Insured — Individual or entity that qualifies as an insured (although not a named insured) within the definition of "insured"; varies by Coverage Part.

b. Limits.

i. **Per Occurrence —** In a typical CGL policy, a single limit is provided for "bodily injury" or "property damage" on a "per occurrence" (per accident) basis; determined by the appropriate "trigger" of coverage.

(a). "Bodily Injury" — Defined term; usually means physical injury or physical manifestation of emotional distress; questionable —emotional distress with physical manifestation caused by economic loss (i.e. breach of contract). Not to be confused with "personal injury".

(b). "Property Damage"— Physical damage to or loss of use of tangible property.

(c). "Trigger" — Determines the date of the occurrence(s); various theories depending on the nature of the claim.

ii. **Per Offense —** In a typical CGL policy, a single limit is provided on a "per offense" basis for "personal and advertising injury" coverage. **"Personal and advertising injury"** is a CGL policy coverage for causes of action like false arrest, defamation, invasion of privacy, wrongful entry, false imprisonment, malicious prosecution and use of another's advertising idea.

iii. **Aggregate Limit —** The most an insurer will pay for all covered losses sustained during the specified policy period. There may be an aggregate limit for certain specified events in a liability policy or for certain covered causes of loss in a first party property policy.

c. Deductible/Retained Limit — An amount specified that the insured is required to pay prior to the insurer having an obligation to pay. May be specified on a "per

occurrence", "per offense" and/or aggregate basis in CGL policies. A self insured retention requires insured to bear defense costs within the retention.

d. Endorsements — Policy forms that are added to the base Coverage Parts. These forms may modify coverage or exclusions, add new coverage or add new exclusions. Each Coverage Part may have its own endorsements or endorsements may be applicable to only one or more Coverage Parts in a Package Policy.

e. Coverage Part; Package Policy — A Coverage Part is a base form that provides a certain type of insurance coverage. A Package Policy is a policy that contains multiple Coverage Parts.

4. Claims-Made Policy --Must be distinguished from an "occurrence" based policy. Generally, the incident giving rise to the claim must take place during the policy period and the claim must be first made during the policy period. However, a retroactive date is usually included, which provides a date earlier than the annual policy date within which the claim may take place. Furthermore, the policy may include an extended reporting period (ERP), which lengthens the time within which the claim may be made.

5. Dec Action — Short for declaratory judgment action. A dec action may be filed by an insured or an insurance company asking the court to determine certain obligations of the parties pursuant to the terms of the insurance policy.

Bad Faith Action -- A lawsuit filed by an insured against an insurance company or agent alleging certain actions or omissions that are extra-contractual in nature (i.e. independent of policy benefits).

1. Definitions for bolded terms are located in Appendix 2 of this paper.

By Catherine Hanna, Hanna & Plaut LLP

WHAT'S HAPPENING AT THE TEXAS LEGISLATURE

The late, great Molly Ivins once said that the Texas Legislature's practice is "putting little patches on our leaky raft of state, stopping up holes and tears here and there with gum and spit."[1] She also said that the Texas concept of what government is for is to "create a healthy bidness climate."[2] Ivins was talking about causes like funding for Head Start and indigent health care, but the sentiment rings true on current issues important to practitioners of insurance law and their clients on both sides of the "bidness" spectrum. Texas legislators, many of whom are practicing attorneys, and their constituents discover issues that need "fixin'," and every two years they travel to Austin to try to do so. Those that watched the 87th session of the Texas Legislature will find fewer than the usual amount of insurance-specific bills, but insurance lawyers should keep an eye on other bills that would affect insurance litigation.

The Texas Legislature can be a fast-moving beast once in session. The current legislative session ended on May 31, 2021, and the status of many these bills may have changed by the time you read this update. A good reference for keeping up is the Texas Legislature online, which can be found at https://capitol.texas.gov

Here are the bills worth noting from this term:

HB 359 – Recovery under Uninsured and Underinsured Motorist Insurance Coverage

This bill sought to amend the Texas Insurance Code to eliminate the requirement, imposed by the Texas Supreme Court in *Brainard v. Trinity Universal Insurance Company*, that a claimant seeking uninsured or underinsured motorist benefits from their own insurance policy first obtain a judgment establishing the liability of the tortfeasor and the amount of his or her damages.[3] The Supreme Court recently reaffirmed this holding in a unanimous opinion.[4] In addition to eliminating the *Brainard* requirement, the bill would also impose statutory extra-contractual liability for an insurer's failure to settle a claim when liability is reasonably clear.

Policyholders often complain that *Brainard* is a burdensome hurdle to overcome just to receive the benefits of an insured's own insurance policy. However, insurance carriers argue that the aim of UM/UIM coverage is to place insureds in the same place they would have been if the tortfeasor had adequate insurance. Because the UM/UIM carrier is simply stepping into the shoes of the underinsured tortfeasor, requiring a jury to establish liability and damages is no different that if the tortfeasor had adequate insurance.

HB 1682 - Disclosure by Liability Insurers and Policyholders to Third Party Claimants

This bill, introduced by Representative Matt Krause (R-Fort Worth), sought to amend the Insurance Code to require insurance carriers and policyholders to disclose coverage information to third-party claimants. An officer or claims manager of the insurer would have to submit a sworn statement with the following information: (1) the name of the insurer; (2) the name of each insured; (3) the limits of liability coverage; (4) any policy or coverage defense the insurer reasonably believes is available to the insurer at the time the sworn statement is made; and (5) a copy of each policy under which the insurer provides coverage. Failure to comply with the statute would result in an administrative penalty. This bill was left pending in committee.

SB 207 – Recovery of Medical or Healthcare Expenses in Civil Actions (Companion: HB 1617)

Another bill important to those who litigate UM/UIM cases involves proof of the reasonableness and necessity of medical expenses in civil actions. Sen. Charles Schwertner (R – Georgetown), Sen. Dawn Buckingham (R – Lakeway), and Sen. Donna Campbell (R – New Braunfels), sponsored the bill that would amend Texas Civil Practice and Remedies Code section 41.0105. Claimants seeking medical or health care expenses would be able to rely on additional types of evidence to establish the reasonableness of those damages. In addition to evidence of amounts actually paid or incurred, a party could introduce evidence of the following:

- the amount that would have been, or was likely to be, paid for the medical or health care services provided by a health benefit plan, workers' compensation insurance, an employer-provided plan, Medicaid, Medicare, or similar source available to the claimant at the time the services were provided or after the services were provided, as applicable;
- The average amount typically paid or allowed by

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benefit plans or governmental payers at or near the time the health services were provided to the claimant to medical or health care providers who: (1) are located in the same geographic area; and (2) offer the same type of services; or

- The average of the amounts actually accepted for payment in the previous 12 months by the health provider for the same services provided to patients other than the claimant.

The bill also operated to do away with the requirement that a party file a controverting affidavit to contest the reasonableness and necessity of medical charges, requiring instead merely a "notice." The changes in the law would have apply to an action commenced on or after the effective date of September 1, 2021.

In his statement of intent, Senator Schwertner noted that current law does not adequately provide for proof of medical damages given the "complex nature of medical billing and payment."[5] This statement echoes the reasoning of Justice Hecht in the Texas Supreme Court's 2011 opinion holding that the "actually paid and incurred" rule means that personal injury claimants are only entitled to recover medical expenses "that have been or will be paid, and excludes the difference between such amount and charges the service provider bills but has no right to be paid."[6] Justice Hecht reasoned that "it has become increasingly difficult to determine what expenses are reasonable. Health care providers set charges they maintain are reasonable while agreeing to reimbursement at much lower rates determined by insurers to be reasonable, resulting in great disparities between amounts billed and payments accepted."[7] The Court held that since a claimant is not entitled to recover medical charges that a provider is not entitled to be paid, evidence of such charges is irrelevant to the issue of damages and not admissible in evidence at trial.[8]

After *Haygood*, some personal injury plaintiffs chose not to submit their medical expenses to their health insurance carriers for payment. Claimants are treated under letters of protection and present evidence of the higher billed amount at trial. This bill would eliminate this practice, sometimes referred to as being "willfully uninsured." The bill was supported by a number of insurance carriers, as well as Texans for Lawsuit Reform, the Texas Civil Justice League, and the Texas Association of Defense Counsel. It is opposed by the Texas Trial Lawyers Association and a number of medical organizations. As of the date of this writing, the Senate bill had been passed out of committee, but the companion House bill had not.

HB 19 - Relating to civil liability of a commercial motor vehicle owner or operator

House Bill 19, otherwise known as the trucking litigation reform bill, is also being closely watched by personal injury lawyers, business interests, and the insurance industry. The bill, introduced by Rep. Jeff Leach (R-Plano), aims to protect the trucking industry from so-called "abusive commercial vehicle lawsuits." It would amend the Texas Civil Practice and Remedies Code to provide a separate framework for trial procedures, the use of evidence, and the determination of liability in certain civil trucking actions.

These changes would allow a defendant to demand a bifurcated trial. The jury would first determine liability and compensatory damages, and, if the defendant were liable, determine punitive damages in the second phase. The bill would also raise the bar for introduction of evidence that the defendant failed to comply with a governmental regulation or standard, requiring that the following conditions also be met:

- The evidence tends to prove that failure to comply with the regulation or standard was a proximate cause of the bodily injury or death for which damages are sought; and

- The regulation or standard is specific and governs, or is an element of a duty of care applicable to, the defendant, the defendant's employee, or the defendant's property or equipment when any of those is at issue.

The bill would also limit the liability of the driver's employer for damages caused by ordinary negligence to *respondeat superior* if the employer stipulates that at the time of the accident the driver was an employee and was acting within the scope of employment. Finally, a properly authenticated photograph or video of damage would be presumed admissible even if it supports or refutes an assertion regarding the severity of damages or injury to an object or person involved in the accident.

This bill is supported by the American Property Casualty Insurance Association, which says it is concerned about the increase in attorney involvement in automobile accidents in Texas.[9] It is opposed by the Texas Trial Lawyers Association and consumer advocacy organization Texas Watch, which argues that the bill gives "trucking corporations less incentive to follow safety measures" and "make it harder to punish trucking companies through our courts when they violate safety standards."[10] At the time of this writing, the bill had been reported favorably out of committee.[11]

SB 11 – Relating to the composition of the court of appeals districts.

There was a brief kerfuffle this session when word got out of a plan to reorganize the intermediate courts of appeals. Virtually every sitting appellate judge, as well as lawyer organizations and voting rights groups, opposed the bill,

which nevertheless got out of committee on a party line vote. The bill aimed to restructure the existing 14 district courts of appeals into seven districts. The new map establishes new districts with the following seats:

- District 1: Amarillo and Lubbock covering the Panhandle region;

- District 2: Combines El Paso and Midland in a huge district running east through the Hill Country;

- District 3: Combines San Antonio, Corpus Christi, and Edinburg;

- District 4: Combines Texarkana, Fort Worth, Eastland, and Waco;

- District 5: Combines Dallas and Austin;

- District 6: Keeps the two Houston courts, adds a Lake Jackson court, and expands the district to extend westward right up to Austin and San Antonio;

- District 7: Combines Tyler and Beaumont in a Deep East Texas district.

The sponsor of the bill, Sen. Joan Huffman (R-Houston), argued that consolidating the court districts would increase judicial efficiency and reduce the transfer of cases from one appellate district to another.[12] But opponents called it partisan gerrymandering. According to Rice University political scientist Mark Jones, "this wasn't really an effort to improve the functioning of our judicial system, but rather to bolster Republican chances of winning judicial seats in court of appeals elections across the state."[13] And former State Bar President and Midland attorney Harper Estes put it bluntly. "If it ain't broke, don't fix it."[14] The bill was ultimately withdrawn, but a counterpart bill, SB 1529, that would create a statewide court of appeals of five elected justices for civil cases brought by or against the state or a state agency, board, or commission, or an officer of one of those entities, remain pending.

SB 6 – Pandemic Liability Protection Bill

Last, though certainly not least, a bill providing heightened COVID-19 liability protections for physicians, healthcare providers, healthcare institutions, and first responders passed the Texas Senate by a vote of 29-1. The bill was subsequently passed in the House and signed by the Governor on June 14, 2021.

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6 *Haygood v. DeEscobedo*, 356 S.W.3d 390 (Tex. 2011).
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8 *Id.* at 398.
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14 Harper Estes, *Opinion: If the court system in Texas isn't broke, why fix it?* Midland Reporter Telegram, April 3, 2021. https://www.mrt.com/opinion/article/Opinion-If-the-court-system-in-Texas-isn-t-16074084.php

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