Strategic Insurance Considerations for Corporate Policyholders

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INTRODUCTION

Large energy corporations are complex organizations engaged in a host of diverse operations. In-house counsel must be prepared to handle a broad variety of legal issues, sometimes in areas where they may have practical experience but not detailed subject matter expertise. How do these corporate policyholders go about addressing the sophisticated sorts of insurance problems arising from their corporate activities, and what can outside counsel learn to assist them most effectively?

I. IDENTIFYING WHETHER THERE IS AN INSURED LOSS OR CLAIM

Step One can be more difficult than it seems: identifying whether coverage may be available for a particular claim or loss. Unlike simpler businesses, large energy corporations usually possess a deep and wide portfolio of insurance covering a myriad of risks. On the other hand, these corporations often retain significant risk by carrying extremely high deductibles or self-retentions that must be exhausted before insurance comes into play, and claims-handling may be handled under an arrangement that simply passes through the total administrative and indemnity costs directly to the corporation.

The first challenge, then, is to review and understand the issues raised by a particular loss or claim, compare those issues to the inventory of insurance policies, and determine which if any coverage(s) may apply. At that early stage, counsel should also assess what law governs the policy interpretation, and in some instances whether less-than-obvious coverage might nonetheless apply.

A. Inventory potentially applicable policies / coverages to match-up with facts presented

Insurance typically is distinguished as “first party" and “third party" coverage. In first-party insurance coverage, the insured is covered for its own loss; in third party insurance coverage, the insured is covered for liability to another for their loss. *Warrilow v. Norrell*, 791 S.W.2d 515, 527, n.2 (Tex.App.- Corpus Christi 1989, writ denied)(opinion on rehearing).

The Texas Supreme Court has described the difference in first and third party coverage as follows:

> We distinguish first-party and third-party claims based on the claimant's relationship to the loss. '[A] first-party claim is stated when “an insured seeks recovery for the insured's own loss,” whereas a third-party claim is stated when “an insured seeks coverage for injuries to a third party.”
> *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660, 674 -675 (Tex. 2008), *citing Lamar Homes, Inc. v. Mid–Continent Cas. Co.*, 242 S.W.3d 1, 17 (Tex. 2007).

1. Standard insurance for third party liability claims

Complex corporations typically carry a host of general and more specialized policies covering a variety of potential liabilities to third parties. Depending on the nature and size of a claim, however, deductibles / self-retentions may minimize the utility of the coverage in a particular instance. The third-party liability policies often include:

Commercial General Liability

Excess / Umbrella policies, often in multiple layers or “towers” issued by different insurers and differing over sequential years

Employment Practices Liability Insurance (EPLI), sometimes including Sexual Misconduct

Directors & Officers (D&O)

Fiduciary / Employee Benefit Liability Policy (ERISA liabilities)

Errors & Omissions (E&O, professional liability / malpractice)

Workers Compensation

2. Direct loss to policyholder

First party property insurance for corporate policyholders typically requires extensive documentation of assets, usually accompanied with schedules listing properties and declared values. Corporations also may hold insurance to protect against loss of revenues when a loss results in a period of business decline of shutdown. Specific policies may also be issued to cover risks involved in particular projects, especially for construction. These first-party policies often include:

Policyholder-owned property loss (1st party property)

Business Interruption (BI) / Loss of Profits (LOPI)

Construction All-Risk / Builder's Risk

3. Specialized coverages

Worldwide and integrated operations require a host of coverages not often encountered by smaller corporations. Energy companies consequently may carry a number of policies with specialized coverage. Some of these may include:

Cyber loss or liability

New type of coverage, multiple forms, manuscripted (customized) rather than standard form, little precedent

Energy Package, typically comprising some or all of:

Onshore / Offshore property loss / property damage;
Operator's Extra Expense (OEE) providing well blowout, well control, redrilling & restoration, and associated pollution cleanup;
Excess liability;
Oil Spill Financial Responsibility; and
Loss of Profits

Hull (vessel loss) / Protection & Indemnity ("P&I", covering maritime liabilities, including Jones Act)

Cargo loss and liabilities
Warehouse / Bailee

Boiler & Machinery

Crime, Theft & Fraud coverage

Pollution cleanup and/or liability

B. Choice of Law

Counsel should make an initial determination what law applies to the particular policy(ies) that potentially apply to a loss or claim.

In the insurance context it is not particularly unusual for the insurer and policyholder to reside in different states or even different countries, and the accident or loss precipitating a claim for insurance coverage may have occurred in or be closely related to a third location. In those circumstances, what law should be applied to determine the intent of the parties in their insurance contract or to determine the standards for obligations and responsibilities of each?

Insurance law may differ significantly from state to state on particular issues, so the ultimate outcome may well depend on what law governs the insurance policy. The determination of applicable state law cannot be underestimated as a significant factor - - indeed, potentially the single most decisive factor - - in resolving the substantive question of insurance coverage. Even early issues like the policyholder's satisfaction of obligations to provide notification to the insurer may be determined by the law that applies.

Given the host of policies and widespread operations of the corporate energy policyholder, it may not be simple to determine governing law. And different policies may be governed by different law(s).

1. Most Significant Relationship Test & Restatement

Ever since the decision of the Texas Supreme Court in *Duncan v. Cessna Aircraft Co.*, 665 S.W.2d 414, 421 (Tex. 1984), contractual choice of law questions in this state have been governed by reference to the "most significant relationship" standard set forth in the Restatement (Second) of Conflicts of Laws (hereinafter "Restatement"). Likewise, federal courts in diversity jurisdiction also must apply this Texas choice of law rule where applicable to determine what law governs a contract. *Klaxon v. Stentor Electric Mfg. Co.*, 313 U.S. 487, 61 S.Ct. 1020, 85 L. Ed. 1477 (1941).

In practice, the project of applying these Restatement standards is extremely fact-intensive and each element must be weighed with reference to the specific dispute and contacts involved in the particular case. The relationship between the contacts and the policy factors must be determined on a case by case basis. *See Maxus Exploration Co. v. Moran Bros., Inc*., 817 S.W.2d 50, 53 (Tex. 1991); *Minnesota Min. and Mfg. Co. v. Nishika Ltd.*, 953 S.W.2d 733, 735-37 (Tex. 1997). Under this approach, the law governing an insurance policy will focus not on where the accident happened or where the loss occurred or where a lawsuit was filed against the insured; rather, the inquiry will focus on the indices of contract negotiation, formation, and issuance by the insurer to the policyholder.

But two predicates must be considered before applying the Restatement factors to determine Texas's "substantial relationship" to the issue presented in a choice-of-law question: (a) whether the parties have expressly chosen the law to be applied to their contract. *Duncan v. Cessna*, at 421 and (b) whether a statute of the forum state applies which resolves the issue. *Hefner v. Republic Indem.Co. of America*, 773 F.Supp. 11, 12 (S.D. Tex. 1991).

Texas generally will honor a contractual choice of law provision in an insurance policy, that bears a reasonable relationship to the parties or risk, and does not conflict with a fundamental public policy of Texas. *See DeSantis v. Wackenhut Corp.*, 793 S.W.2d 670 (Tex. 1990) cert. denied, 498 U.S. 1048, 111 S.Ct. 755, 112 L.Ed.2d 775 (1991); see also TEX. BUS. & COM. CODE ANN. § 1.105(a); and also Restatement at §187, Law of the State Chosen by the Parties.

TEX.INS.CODE, Art. 21.42, Texas Law Governs Policies, constitutes a "statutory directive" under Restatement § 6(1), thus trumping the significant relationship test where it is applicable. Article 21.42 has existed with essentially unchanged wording for almost a century, being enacted originally in 1903 as an antidote to the virtually automatic application of the then-prevailing "lex loci contractus" rule favoring out-of-state insurers to the detriment of Texas residents. The statute's application to a "citizen or inhabitant of Texas" has been interpreted, however, to refer only to corporations actually incorporated in Texas, even if the corporation also is headquartered or has substantial operations in Texas. *See Reddy Ice Corp. v. Travelers Lloyds Ins. Co.*, 145 S.W.3d 337, 340 (Tex.App.- Houston [14th Dist.] 2004, pet. denied).

Finally, it is not unusual for some policies - - particular for upper level or specialized risks - - to include not only choice of law but also arbitration or venue provisions. These can be especially challenging where multiple policies may apply (as with sequential layers of excess policies across a period of time), but each has its own unique requirements of applicable law, venue or arbitration.

C. Coverage not always obvious

Counsel may need to exercise a certain amount of creativity and diligence in determining whether insurance may apply to a particular claim or loss, and should resist what "everybody says" is a restricted scope of coverage. While insurers typically balk at paying beyond a traditional, established framework, Texas jurisprudence is replete with example where a persistent policyholder prevailed against conventional wisdom, where coverage was not necessarily obvious. For a few random examples:

1. In *Lamar Homes Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1 (Tex. 2007), the policyholder successfully persuaded the Court - - over a vigorous dissent by some Justices - - that the standard CGL insuring agreement is not limited to tort actions but can include contractual liability from deficiently performing a contract.
2. In *Don's Building Supply, Inc. v. OneBeacon Ins. Co.*, 267 S.W.3d 20 (Tex. 2008), the Court determined that CGL coverage is triggered by "injury in fact" and not by when the damage became evident, so that multiple policies might apply where multiple injuries occurred over a period of time.
3. The Court applied a similar approach in *Zurich Am. Ins. Co. v. Nokia, Inc*., 268 S.W.3d 487, 490 (Tex. 2008) in concluding that cellular level biological injuries from use of policyholder's cell phone product, as alleged in pleadings, potentially stated a claim for bodily injuries under the policies, much like the subclinical injuries alleged by plaintiffs who have been exposed to asbestos.
4. In *Excess Underwriters v. Frank's Casing Crew & Rental Tools, Inc*., 246 S.W.3d 42, 47 (Tex. 2008), the Court refused to allow an insurer to apply equitable subrogation against its insured by seeking reimbursement of settlement payments made to third party claimant.
5. The Court clarified its prior precedents in *In Re Deepwater Horizon*, 470 S.W.3d 452 (Tex. 2015), allowing consideration of contractual limits on additional insured status where the wording of the direct policyholder's insurance policy referenced the underlying contract obligations to establish the scope of coverage.
6. In *McGinnes Indus. Maint. Corp. v. Phoenix Ins. Co.*, 477 S.W.3d 786 (Tex. 2016) the Court determined that the insurer's obligation to defend a "suit" under standard CGL provision includes EPA enforcement proceedings issued to the policyholder.
7. Most recently, in *USAA Tex. Lloyds Co. v. Menchaca*, No. 14-0721, 2017 WL 1311752, __ S.W.3d __ (Tex. Apr. 7, 2017), the Court clarified the "substantial confusion" caused by its prior precedents, and held that damages consisting of policy benefits may result from and be recoverable under a statutory cause of action for bad faith without requirement for separate, independent damages.

II. PROVIDING PROPER NOTIFICATION OF OCCURRENCE-CLAIM-SUIT-LOSS

Once the claim or loss has been matched up with policies providing potential coverage, counsel should determine how, when and to whom notification must be given. This involves both internal administrative considerations, as well as requirements of policy wording and applicable law. The consequences of faulty notice can be severe in some instances, and can compromise coverage that might otherwise apply.

A. Internal considerations - Who is responsible?

Internal arrangements differ concerning responsibility for the initial handling of potentially insured losses and claims. Typically, early handling including notifications to insurers is handled by the risk Management Department, the Legal Department, or outsourced to the corporation's claims handling facility or insurance broker.

1. Risk Management

In some corporations the Risk Management Department receives and processes any notification or other processing that submits a loss or claim to relevant insurance carriers.

Risk management personnel often have frequent and close relations with the insurers, enjoy ready access to the actual policy wordings issued by insurers, and may even have ready-at-hand lists of notification particulars for each policy or insurer. Sometimes the risk management department is involved with handling standard or repetitive losses or claims that are simply part of operational business, or have responsibility to coordinate with claims handling functions within the company or as contracted for that purpose.

In this model, the Legal Department typically becomes involved only where a particular loss or claim is particularly large, presents complex problems, is disputed by the insurer, or otherwise requires special attention.

But a downside of Risk Management is that, for some corporations, the risk function has an essentially financial focus under the CFO, and personnel may have surprisingly little particular expertise in claims handling or in construing problematic policy wording to favor the corporate policyholder. As a Finance function, risk management often is more interested in contract and governmental requirements to carry certain insurances, and in the cost and tax consequences of coverage arrangements, than in actual collection of insurance proceeds to pay claims. Moreover, internal risk management personnel frequently come to the corporate environment from a background with a broker or other insurance related company, and so may have an affinity for the insurer's perspective that is not always consistent with the corporate policyholder's interests.

2. Legal Department

In other corporations, the Legal Department has initial responsibility for evaluating, handling or coordinating potentially insured losses and claims.

In-house lawyers often are attached formally or informally with specific subsidiaries or operational units within a large corporation, and therefore develop a good sense of the risks, types of losses or claims, related insurance coverage available and policy terms, and contractual arrangements with involved contractors that may provide additional coverage prospects. Sometimes individual in-house lawyers may develop particular expertise with insurance coverage issues, and act as a go-to resource either to handle especially large or complex claims, or to assist other lawyers within the department.

An advantage of in-house counsel is they are less likely to be deterred than risk management by overly friendly relations with insurers, so perhaps are more likely to take an aggressive posture in asserting coverage. A downside is that routine claims handling may be a poor use of comparatively expensive legal personnel. And in-house lawyers rarely develop significant specialized expertise with

insurance issues so as to navigate a broad scope of potential insurance coverages and specific policy wordings to grasp what is necessary to protect the corporation's interest.

3. Brokers or out-sourced claims handling

Large corporations usually place most or all of their insurance through mega-brokers who solicit a broad market to obtain the multiple types of coverages necessary to cover a wide variety of assets and risks. And given the typically high deductibles or self-retentions held by such corporations, smaller losses and claims may be outsourced for claims handling administration, perhaps as part of a fronting or retrospectively rated insurance arrangement with an insurer adjusting losses that are paid directly or indirectly by the corporation itself.

In these circumstances, the broker or claims handling facility may also provide services on the front end of any loss or claim, to provide notification to potentially involved insurance companies with whom they have placed coverage or for whom they are handling claims on a lower deductible / self-retention level subject to later potential involvement by insurers at higher layers.

This approach has the benefit that the broker has perhaps the best understanding of the breadth and scope of insurance available to the corporate policyholder, and is most familiar with the requirements of particular insurers / policies for providing notification of losses or claim. But brokers have little incentive to be particularly aggressive or creative in their assertion of coverage, and as a practical matter must retain good relationships with insurers as well as with their corporate customer. And one of the hazards of claims handling under fronting or retro premium claims is that the claims administrator often has little incentive to minimize costs where funding ultimately comes from the corporation itself, under which the corporation may have little say in how the funds are expended.

B. Who should receive notice, and how transmitted?

Notification should be given to any and all insurers who potentially might provide coverage for a particular claim or loss. That is a simple enough principle, but given the wide array of policies and coverages noted above, it is sometimes difficult to determine in practice.

It is virtually always better to err on the side of over-inclusion, than to inadvertently leave out notice to an insurer whose policy later proves to provide potential coverage. Inevitably, the determination of which insurers to notify involves a close review and evaluation of the nature of the loss or claim, and of the terms and scope of various insurance policies that could apply.

Likewise, how and to whom notification must be given is largely driven by policy wording. It is a rare policy that fails to include specifications for notice of a loss, occurrence, claim or suit, typically found in Declarations or Certificate provisions at the front of policy wording. These details may be best known to and accessible by the insurance broker, so even where Risk Management or the Legal Department has initial responsibility for handling, the broker often is called upon to physically implement notification to relevant insurers or their delegated representative.

C. Consequences of faulty notice

At best, faulty notice can create unnecessary issues in obtaining cooperation and coverage from the insurer; at worst, faulty notice may wholly defeat coverage that otherwise would have applied.

In all events, Texas courts normally will not require the insurer to pay pre-tender defense costs, so it is in the policyholder's interest to provide notice before incurring any such expenses. *See Coastal Ref. & Mktg., Inc. v. U.S. Fid. & Guar. Co.*, 218 S.W.3d 279, 294 (Tex.App.-Houston [14th Dist.] 2007, pet. denied)("Because an insurer's duty to defend is triggered by notice, the insurer has no duty to reimburse the insured for defense costs incurred before the insured gave the insurer notice of the lawsuit.") *citing E & L Chipping Co., Inc. v. Hanover Ins. Co.*, 962 S.W.2d 272, 278 (Tex.App.-Beaumont 1998, no pet.).

As a general rule, when the policyholder breaches a condition of the policy prescribing notice, the breach must be considered "material" before the insurer may avoid coverage. Typically, policy wording in an "occurrence" based policy requires notice somewhat flexibly "as soon as practicable" or similarly. Under that sort of policy and wording, the insurer must show that is was tangibly "prejudiced" by faulty notice, to prove materiality and avoid policy obligations. *See PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 630 (Tex. 2008); *Lennar Corp. v. Markel Am. Ins. Co.*, 413 S.W.3d 750 (Tex. 2013).

However, when a notification provision is part of the bargained-for coverage, as with claims-made policies, notice must be given with strict compliance regardless of any evidenced prejudice to the insurer. *See Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co.*, 174 F.3d 653, 658 (5th Cir. 1999)(requiring strict compliance with notification timetable of pollution buy-back endorsement); *Starr Indem. & Liability Co. v. SGS Petroleum Serv. Corp.*, 719 F.3d 700, 704 (5th Cir. 2013)(same); *see also Prodigy Communications Corp. v. Agricultural Excess & Surplus Ins. Co.*, 288 S.W.3d 374 (Tex. 2009)(noting with agreement the general rule that notice under claims-made policies is part of the bargained-for contract, but applying prejudice rule where policyholder complied with "as soon as practical" wording of particular policy); *Fin. Indus. Corp. v. XL Specialty Ins. Co.*, 285 S.W.3d 877 (Tex. 2009)(same observation and result where policyholder effected notice within policy's specified extension of time).

These principles were reviewed and confirmed recently by *Greene v. Farmers Insurance Exchange*, 446 S.W.3d 761 (Tex. 2014). But *Greene* also circumscribed the prejudice rule, holding that a vacancy clause in a homeowners policy was a core aspect of the bargained-for risk, that it did not act as a condition that a policyholder breaches, nor as an exclusion for purposes ot eh anti-technicality statute. And so the policy lapsed by its terms when the property was vacant beyond the specified time, nowithstanding that the insurer was not prejudiced because the particular loss was not caused by or related to the vacancy.

III. ENGAGING IN COVERAGE LITIGATION

While corporate policyholders obviously prefer to reach an amicable resolution with insurers, it is sometimes necessary to consider whether litigation is necessary to resolve disputed coverage. And part of that consideration is whether it is in the corporation's interest to file its own action, before the insurer.

A. Declaratory action / breach of contract

Depending on the nature of the dispute and on the type of policy involved, litigation options essentially include filing an action for declaratory relief, or for breach of contract.

1. Declaratory action

The Texas Declaratory Judgment Act comprises Chapter 37 of the Civil Practice & Remedies Code, Title 2, Subtitle C, §§37.001-37.011. Its remedial purpose is to settle and afford relief from uncertainty and insecurity with respect to rights, status, and other legal relations, and it is to be liberally construed and administered. §37.002. The DJA specifically applies to construction of contracts, either before or after there has been a breach. §37.004.

Since the basis of a declaratory judgment typically is interpretation of policy wording, those questions are issues of law to be decided by the court and not submitted to a jury. But where the declaratory proceeding involves the determination of an issue of fact, the issue may be tried and determined in the same manner as issues of fact are tried and determined in other civil actions in the court in which the proceeding is pending. §37.007.

However, a court is not empowered to issue purely advisory opinions, but must decide actual cases and controversies. For a controversy to be justiciable, there must be a real controversy between the parties that will actually be resolved by the judicial relief sought. *See State Bar of Tex. v. Gomez*, 891

S.W.2d 243, 245 (Tex. 1994). A declaratory judgment is appropriate where a justiciable controversy exists as to the rights and status of the parties and the declaration will resolve the controversy. *Brooks v. Northglen Ass'n*, 141 S.W.3d 158, 163–64 (Tex. 2004).

In the context of third-party liability policies, the duty to defend typically is justiciable prior to resolution of the underlying lawsuit, because it is determined solely on the allegations of the underlying pleading in comparison with the policy wording. *Firemen's Insurance Co. v. Burch*, 442 S.W.2d 331 (Tex.1968). By contrast, the duty to indemnify relies upon all evidence established at trial supporting a final judgment, whcih may differ from the allegations of the bare pleading, and so declaratory relief is not appropriate prior to conclusion of the underlying lawsuit by judgment or settlement. *D.R. Horton–Texas, Ltd. v. Markel Int'l Ins. Co.*, 300 S.W.3d 740 (Tex.2009). The sole exception to this rule is that a duty to indemnify may be justiciable before the insured's liability is determined in the liability lawsuit when the insurer has no duty to defend and the same reasons that negate the duty to defend will likewise negate any possibility the insurer will ever have a duty to indemnify. *Farmers Tex. County Mut. Ins. Co. v. Griffin*, 955 S.W.2d 81, 84 (Tex.1997)(holding that no facts could be developed in the underlying tort suit that can transform a drive-by shooting into a covered auto accident).

In the first-party insurance context, declaratory relief may be available to interpret disputed policy provisions, where resolution will resolve a coverage controversy between the policyholder and insurer.

Federal courts exercise further discretion in determining whether to decide a declaratory judgment action involving insurance coverage issues. Factors that warrant the federal court to decline jurisdiction includes:

* whether there is a pending state action in which all of the matters in controversy may be fully litigated;
* whether the plaintiff filed suit in anticipation of a lawsuit filed by the defendant;
* whether the plaintiff engaged in forum shopping in bringing the suit;
* whether possible inequities in allowing the declaratory plaintiff to gain precedence in time or to change forums exist;
* whether the federal court is a convenient forum for the parties and witnesses;
* whether retaining the lawsuit would serve the purposes of judicial economy; and
* whether the federal court is being called on to construe a state judicial decree involving the same parties and entered by the court before whom the parallel state suit between the same parties is pending.

See Sherwin–Williams Co. v. Holmes County, 343 F.3d 383 (5th Cir.2003).

Under the Texas DJA the court may award costs and reasonable and necessary attorney's fees as are equitable and just. §37.009. The award of attorney's fees in declaratory judgment actions is within the trial court's discretion and is not dependent on a finding that a party "substantially prevailed." *Barshop v. Medina*, 925 S.W.2d 618, 637–38 (Tex. 1996).

Federal courts do not recognize this provision of the DJA as "substantive law" and therefore do not award attorneys' fees to either party, even when sitting as an *Erie* court and handling a case removed from an initial state court filing. *See Camacho v. Tex. Workforce Comm'n*, 445 F.3d 407, 409–12 (5th Cir. 2006).

2. Breach of contract

Declaratory relief is more often sought by insurers than policyholders, because as a practical matter money damages typically are at issue if the policyholder believes the insurer has failed to comport with its policy obligations. So, for the policyholder, an action for breach of contract and damages may

make better sense.

However, the insurer must actually deny a defense, or fail to pay policy benefits, before a breach can occur; merely reserving rights seldom constitutes a breach of contract in an of itself. *See State Farm Lloyds Insurance Co. v. Maldonado,* 963 S.W.2d 38 (Tex.1998); *see also Motiva Enters., LLC v. St. Paul Fire and Marine Ins. Co.*, 445 F.3d 381, 386–87 (5th Cir. 2006)(reservation by insurer did not breach policy, so insurer entitled to assert contractual right to consent to settlement).

Should the policyholder prevail in a breach of contract action, its attorneys' fees are recoverable under Tex.Civ.Prac.&Rem.Code, §38.001. However, fees and costs only may be awarded when actual damages are found, and not when there is liability but no damages. *See Intercontinental Grp. P'ship v. KB Home Lone Star L.P.,* 295 S.W.3d 650 (Tex. 2009).

B. Should policyholder file first when question of coverage raised?

A conscientious policyholder faced with an impending and inevitable coverage dispute may well consider whether it is of benefit to file first to win the "race to the courthouse" for some particular advantage. This decision involves a keen balancing of whether the benefits of forum choice outweigh the cost and the loss of a less formal avenue for resolving the dispute. The factors to be considered depend on the particulars of the case.

Among those factors may be consideration of applicable law, where a particular forum may be more likely than another to utilize beneficial substantive law. Or a jury trial may be seen as beneficial in a particular matter, whereas early resolution through summary disposition of legal issues might be of more benefit in another; in the former instance a Texas state court forum is typically seen as advantageous, whereas in the latter instance federal courts may be a likely forum for dispositive rulings on complex legal issues.

A policyholder who files an action in state court that can provide "more complete" relief and resolution is likely to prevail in holding that forum against an insurer-filed suit in federal court where the district court exercises some discretion in whether to proceed or abate an action in favor of another proceeding. *See Wilton v. Seven Falls Co.*, 515 U.S. 277, 115 S.Ct. 2137, 132 L.Ed.2d 214 (1995); *Exxon Corp. v. St. Paul Fire and Marine Insurance Co.*, 129 F.3d 781 (5th Cir. 1997). A policyholder also may look to add as defendants parties who are Texas residents - - often adjusters or other intermediaries involved in the coverage who arguably have independent liability - - in order to prevent the insurer from successfully removing a state court case to federal court on the basis of diversity. *See e.g. Centaurus Inglewood, LP v. Lexington Ins. Co.*, 771 F.Supp.2d 667, 671–72 (S.D.Tex.2011);

The forum maneuvering of parties involved in hurricane and hail coverage cases in southeast Texas and the Rio Grande Valley in recent years, has resulted in a sharp focus in the current Texas legislative system. A bill is working its way through the process that would require 60-day advance notice by a policyholder to the insurer prior to filing suit, with detailed particulars of the loss claim, coverage demand and expenses incurred to date for attorneys' fees and costs. No suit could be filed by either party within 61 days of such notice; any suit filed without the requisite notice would be subject to abatement; and a policyholder could lose the right to recover attorneys' fee for failure to meet these requirements.

At the date of this paper a committee substitute bill has passed and it has been placed on the intent calendar, but is not known whether the bill or some form of it will be passed in the 85th Legislative Session. http://www.capitol.state.tx.us/BillLookup/History.aspx?LegSess=85R&Bill=SB10
It is clear, however, that the legislature is interested in the problem and is seriously considering statutory response in order to minimize the "forum shopping" options currently open to policyholders.

C. Pay attention to Policy particulars

In determining where and how to bring suit against the insurer, it is important to pay close

attention to the Policy wording. Most if not all of the sorts of policies issued to sophisticated corporations will include particulars of their consent to be sued, and details for service of suit.

Sometimes a policy provision may even require the insurer to consent to suit filed in state court, waiving their right to remove an action to federal court. In *Ensco Int'l Inc. v. Certain Underwriters at Lloyd's*, 579 F.3d 442, 448–49 (5th Cir. 2009), the Fifth Circuit concluded that a forum selection clause establishing "exclusive" venue "in the Courts of Dallas County, Texas" constituted a prima facie waiver of the right to remove. The court reasoned that permitting removal despite such a waiver provision would read the word "exclusive" out of the parties' agreement. *See also Grand View PV Solar Two, LLC v. Helix Elec., Inc.*, 847 F.3d 255 (5th Cir. 2017)(confirming same).

On the opposite side of the spectrum, some forms of policies issued to sophisticated corporations - - especially higher layers of liability excess or umbrella coverage - - may require arbitration to resolve any disputes. Under Texas law, a written agreement to arbitrate is valid and enforceable if an arbitration agreement exists and the claims asserted are within the scope of the agreement. Tex.Civ.Prac.&Rem. Code §§ 171.001, 171.021. Texas courts are should not deny a motion to compel arbitration unless the arbitration clause in the parties' agreement is not susceptible of an interpretation that is sufficiently broad so that it includes the matters at issue in a dispute. *See Prudential Sec. Inc. v. Marshall*, 909 S.W.2d 896, 899 (Tex. 1995) (orig. proceeding).

For example, the so-called "Bermuda Form" requires arbitration "seated" in London applying English procedural rules, but New York substantive law. See generally Richard Jacobs et al, LIABILITY INSURANCE IN INTERNATIONAL ARBITRATION: THE BERMUDA FORM (2nd ed. 2011)[ISBN-13: 978-1841138756; ISBN-10: 1841138754]. And even an additional insured who is a non-signatory in the policy issued to the direct insured, may nonetheless be bound by that policy's arbitration provisions. *Lexington Insurance Company v. Exxon Mobil Corporation*, No. 09-16-00357-CV, 2017 WL 1532271 (Tex. App.—Beaumont, Apr. 27, 2017)

IV. CHOICE OF COUNSEL

Sophisticated corporate policyholders typically retain a comparatively high level of uninsured risk compared with smaller companies. It is not unusual for these corporations to carry deductibles or self-retentions in the eight-figure or even low nine-figure range, depending on the nature of the risks and exposures.

As a result, absent contrary insurance policy requirements, large corporations frequently assign counsel of their own choosing to handle losses or claims within their retained risk, and insurers normally acquiesce to counsel's continued handling if and when the insurer's interests come into play. And it is not unusual for policies to name specific counsel agreeable to both the insurers and policyholder, for coverages where the insurance provides defense at a relatively low level of retention or where immediate response, specialized expertise, and/or remedial public relations may be needed.

Nonetheless, even the large corporate policyholder must be cognizant of its rights with respect to appointment of counsel, especially when the insurer disagrees and insists upon appointing counsel to act on the policyholder's behalf.

A. Defense counsel appointed by insurer to defend policyholder from third-party claim

The standard forms of primary insurance for third-party liability include a provision giving the insurer the "right and duty" to investigate, defend and settle claims against the policyholder. When an insured is sued and the petition contains factual allegations which, when fairly and reasonably construed, state a cause of action that is potentially covered by the policy, the insurer has a duty to defend the insured in the underlying lawsuit. *See e.g. Graper v. Mid–Continent Cas. Co.*, 756 F.3d 388 (5th Cir. 2014).

When the interests of insurer and policyholder are fully congruent, then the insurer may freely

exercise its contractual right and duty to defend with complete and exclusive control, is entitled to select counsel of its own choosing, and may even utilize directly employed staff counsel. *Unauthorized Practice of Law Committee v. American Home Assur. Co.*, 261 S.W.3d 24 (Tex. 2008) In that situation, defense counsel may accept reasonable direction and control from the insurer while discharging ethical duties owed to the policyholder, if the insurer's direction is not at odds with counsel's own professional legal judgment.

In many cases, this arrangement benefits both parties. The policyholder, often unfamiliar with litigation or disinterested in the distractions of handling the matter, may benefit from the insurer's expertise in handling lawsuits. The insurer benefits from controlling the amounts it incurs for defense and in settlements paid to a claimant, while still protecting the policyholder's interest.

But the insurer's contractual right to defend is not sacrosanct, and sometimes must give way to the policyholder's interests. In the fountainhead case *Employers Casualty Co. v. Tilley*, 496 S.W.2d 552 (Tex. 1973), the Texas Supreme Court squarely rejected the practice whereby counsel appointed by the insurer defended the policyholder while concurrently developing the insurer's defenses to coverage.

B. Limited right to independent counsel

When is a Policyholder entitled to appoint its own counsel to defend a suit, rather than accept the defense lawyer selected and controlled by its Insurer?

Not every disagreement about coverage or how the defense should be conducted amounts to a conflict of interest that justifies transferring control of the defense from the insurer to the policyholder. For example, no conflict existed where the insurer fully accepted coverage but disagreed with the policyholder over venue for the suit - mere disagreement over litigation tactics did not warrant independent counsel for the policyholder. *Northern County Mut. Ins. Co. v. Davalos*, 140 S.W.3d 685 (Tex. 2004).

Even though *Davalos* involved neither an actual conflict nor a reservation of rights, that opinion cited to a secondary source treatise listing a variety of situations in which independent counsel may be warranted. Picking up on this citation and upon arguable dicta or loose wording in *Davalos*, the Fifth Circuit has interpreted the rule so that independent counsel is warranted *only* when facts determining coverage actually will be adjudicated - - not simply developed - - in the underlying suit. *Downhole Navigator, L.L.C. v. Nautilus Ins. Co.*, 686 F.3d 325 (5th Cir. 2012).

In *Downhole Navigator*, the federal court isolated a single exemplar from *Davalos*, holding that independent counsel is required only "when the facts to be adjudicated in the liability lawsuit are the same facts upon which coverage depends" under the insurer's reservation. Confusingly, the court reasoned that the insurer was entitled to control defense even if its appointed defense attorney might develop facts relevant to aspects of the coverage exclusions - - but that actually engaging in such subterfuge would breach the policy and require independent counsel after the fact. Thus, the opinion effectively leaves the insurer as fox in charge of the henhouse, requiring the policyholder to keep close track of its chickens and defense counsel to act as faithful watchdog!

The court rejected Policyholder's argument that such a *Davalos* "rule" is superseded by *UPLC*, so that the critical question is whether facts affecting the coverage reservations are likely to be "developed" in the underlying lawsuit not whether they actually will be "adjudicated." Arguably, *UPLC* better conforms with *Tilley*, where insurer's counsel improperly developed a late notice coverage defense that never would have been addressed or adjudicated in the underlying suit.

Downhole Navigator recognizes but does not adequately address core ethical considerations the Texas Supreme Court found critical in *Tilley* and *UPLC*. For example, counsel is not permitted to take direction from an insurer when the lawyer reasonably believes the representation of her client, the policyholder, will be materially affected. Texas Ethics Opinion No. 533 (2008), citing *State Farm Mut. Auto. Ins. Co. v. Traver,* 980 S.W. 2d 625, 628 (Tex. 1998) ("Loyalty to the client/insured demands that

the lawyer must at all times protect the interests of the insured if those interests would be compromised by the insurer's instructions."). Yet, *Downhole Navigator* perversely precludes the policyholder from appointing independent counsel, even while acknowledging that an ethical defense lawyer cannot accept direction from the Insurer to develop facts in the underlying suit that might adversely affect the policyholder's coverage interests.

As might be expected, the holding in *Downhole Navigator* has been rigorously applied by all subsequent district courts and appellate panels within the fifth circuit. To date, only a Texas intermediate appellate court has adopted *Downhole's* "same facts that will be adjudicated" standard for determining when independent counsel is owed to a policyholder. *Allstate County Mutual Insurance Company v. Wootton*, 494 S.W.3d 825, Tex.App.-Hous. [14 Dist.], 2016, pet. denied)(conflict of interest exists preventing the insurer from insisting on contractual right to control the defense when the insurer has reserved its rights and the facts to be adjudicated in the liability lawsuit are the same facts upon which coverage depends; a potential conflict of interest is insufficient.

Notwithstanding the rule enunciated in *Davalos* as interpreted by *Downhole Navigator*, defense counsel cannot simply ignore a reservation of rights and concentrate solely on handling the defense. Counsel must ensure the Policyholder gives informed consent to direction by the Insurer, after full disclosure of the existence, nature, implications, and possible adverse consequences of following the Insurer's direction and the advantages involved, if any. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS §134 (2000). Yet, such informed consent is seemingly pointless, for if a policyholder refuses proffered representation because of a potential but not-yet actual conflict, under *Downhole Navigator* the policyholder apparently breaches the policy and must pay its own costs of independent counsel.

To discharge their ethical obligations, insurance defense lawyers must fully appreciate the issues raised by the insurer's reservation of rights. As usual, counsel are caught smack in the middle between interests of the insurer who hires the lawyer and the policyholder to whom fiduciary duty is owed. While the policyholder remains reliant upon the tender mercies of the insurer and faithful counsel.

Moreover, the policyholder is at risk of losing any right for reimbursement of fees if it insists on independent counsel without the necessary predicate. *Davalos* and *Downhole Navigator* both denied the policyholder's claim for reimbursement of independent counsel fees.

Given this substantial risk of uninsured expense, many corporate counsel are naturally reluctant to press the issue and insist on independent counsel without the insurer's full agreement. And where the insurer does not agree, then perhaps the safer course is for corporate counsel to closely monitor the handling and be prepared to assert claims for liability against either or both the insurer and defense counsel if they mishandle the suit and compromise the policyholder's interests in favor of their own.

C. Counsel for coverage action against insurer

When engaging in formal litigation against the insurer, corporate counsel must consider whether to hire counsel who normally handle their commercial matters or whether to hire specialized insurance coverage counsel. On the appellate level, a similar decision must be made whether to hire specialized appellate counsel or specialized coverage counsel, to the extent that lawyers who specialize in both may be rare.

Standard litigation counsel may have the advantage of superior familiarity with the personnel, processes, and operations of the client from prior experience. That familiarity may translate into increased efficiency of handling the coverage action, and minimize internal disruptions for the company. Standard counsel may also possess significant litigation and trial skills, and may offer resources designed to handle difficult discovery and procedural issues, contentious opposing counsel, and vagaries of the judicial system.

Specialized coverage counsel, on the other hand, may have an efficiency advantage in better

understanding the critical issues upon which the matter truly hinges. Coverage counsel also is more familiar with interpreting detailed and complex insurance policies, which can seem dense and almost indecipherable to a non-specialist. Coverage counsel may also be better attuned to discrete legal issues that can be asserted for early disposition, which may actually resolve the claim or provide increased clarity and/or leverage for settlement. Since many insurance coverage disputes involve issues of policy interpretation and not extensive fact problems, trial to a jury may not be necessary or appropriate in a particular matter.

Where a particularly large or complex case warrants the expense, both litigation and coverage counsel may be employed together effectively. In these circumstances, in-house counsel may need to assert a greater degree of involvement and control to ensure that respective counsel work together efficiently and without undue duplication. In-house counsel should be prepared to consider and affirmatively decide important strategic and tactical issue, and provide that guidance firmly.

Similar consideration affect the corporate policyholder's decision about counsel retained for handling an appeal; since insurance disputes often involve pure questions of law based on policy interpretation, appeal may be the true battlefield where the trial court is unwilling or unable to competently construe complicated insurance contract.

The trial lawyer or coverage specialist who has handled the underlying suit is one alternative. But trial skills seldom translate well to appellate practice, where the one skill relies on facts and jury persuasion; while the other skill is restricted to legal argument, not facts, and must persuade a small number of highly educated jurists rather than a jury of peers. And deep knowledge of all the underlying facts often has little utility for making the narrow legal arguments called for on appeal. As noted above, to some extent insurers relish the prospect of facing non-specialized trial counsel on the appellate level, and take advantage of those situations by countering with their own well-prepared coverage and appellate experts.

An appellate specialist is likely to be more experienced with the sort of persuasive briefing and convincing oral argument needed to pare down a case and address the issues upon which the appellate court should focus. But an appellate lawyer rarely also appreciates the particular issue within the full context of the insurance jurisprudence, and so may not even be aware of issues and avenues of argument that may bolster or even be foundational to the appellate project.

Specialized coverage counsel, on the other hand, may have a keen appreciation of the nuances of insurance jurisprudence that interplay with the particular issue on appeal, but may not have the briefing or argumentative skills necessary to convince an appellate court within the constrained and concise structure allowed by the appellate process.

As with the trial model, it is possible to hire both types of lawyer so that the appellate specialist has the benefit of the coverage lawyer's substantive expertise. But better, if a single lawyer combines both skills so that nothing is lost in the argument.

V. WHAT RELIEF TO SEEK

As discussed above, the policyholder may seek declaratory relief for the court to interpret rights and duties under the insurance contract. Or the policyholder may seek breach of contract damages, usually consisting of policy benefits.

With respect to third-party liability claims, relief typically is available only to determine the duty to defend, until the underlying lawsuit is concluded. This can be a critical battlefield for the policyholder, and worth the attention and resources devoted to winning it. Once coverage is found under the duty to defend, the insurer is at a significant disadvantage in attacking an eventual duty to indemnify based on trial evidence consonant with the allegations of the pleading.

A. Relief in addition to policy benefits

In addition to policy benefits, the policyholder may be entitled to extra-contractual damages in the proper circumstances. These may include excess-of-limits judgments under the *Stowers* doctrine; common law or statutory bad faith damages; and enhanced pre-judgment interest.

1. Stowers

A third-party claimant's judgment against the policyholder exceeding the policy limits may be recoverable against the insurer if the insurer unreasonably failed to settle within policy limits despite an appropriate demand.

In consideration of the insurer's exclusive right to defend and control third-party litigation on behalf of the policyholder, Texas courts and legislature have imposed a concomitant duty on the insurer to act reasonably and to protect the policyholder's interests in coverage during the handling of such claims. Under the so-called *Stowers* doctrine, one of those duties is that the insurer must act with "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. *Stowers Furniture Co. v. American Indem. Co.*, 15 S.W.2d 544, 547-48 (Tex. Comm'n App.1929, holding approved).

Ordinarily, upon a judgment against the insured, an insurer is liable for no more than the amount specified in the policy limit of their contract, the insurance policy. Violation of the Stowers duty, however, has the effect of shifting the risk of any judgment in excess of the policy limit onto the primary insurer in circumstances where the insurer was presented with a reasonable opportunity to prevent the excess judgment but failed to settle within the applicable policy limits. *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 849 (Tex. 1994).

Imposition of the Stowers duty is intended to protect the policyholder from an insurer abusing its control of defense and settlement and gambling at the policyholder's risk and expense. Otherwise, by failing to settle a claim that can and should be settled within the primary policy limits, the insurer could give priority to protecting its own limits by foregoing reasonable settlement opportunities, thus leaving the policyholder responsible for an uninsured loss beyond those primary limits.

As developed by Texas courts in more recent years, the *Stowers* duty is not simply a free-floating negligence standard. Rather, it has become a highly technical doctrine enshrouded with restrictive elements preventing its application except where a number of requirements are met. The insurer's duty is activated only when the claimant's demand meets certain prerequisites:

* the claim against the insured is within the scope of coverage;
* the demand is within the policy limits,
* 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; and
* the proposed settlement fully, completely, and unconditionally releases the insured from liability of all claims, including liens.

An insurer is not required under *Stowers* to affirmatively initiate any settlement offer nor to engage in any give-and-take settlement negotiations; the *Stowers* duty arises solely in relation to the actual settlement demand proposed by the claimant. *Id.*

But neither does a *Stowers* obligation depend upon the policyholder demanding that the offer be accepted; it is sufficient that the plaintiff makes a demand that meets the Stowers elements. *See Continental Cas. Co. v. St. Paul Fire & Marine Ins. Co.*, 2007 WL 2403656, *3, 6 (N.D.Tex. Aug 23, 2007) (NO. CIV A 304CV1866-D), relying upon *Highway Ins. Underwriters v. Lufkin-Beaumont Motor Coaches*, 215 S.W.2d 904, 929 (Tex.Civ.App.1948, writ ref'd n.r.e) ("It was not a defense to Insurer that Insured did not demand acceptance of [the settlement offers]. Insurer must perform the duty imposed upon it without being activated by Insured.")

Nor is it necessary that the insurer actually have a duty to defend; it is sufficient for *Stowers* that the insurer has taken actual control of settlement. See Rocor Int'l, Inc. v. Nat'l Union Fire Ins. Co., 77 S.W.3d 253, 263-64 (Tex. 2002) (excess insurer assumed exclusive control over settlement negotiations).

It is imperative, then, that the underlying plaintiff's trial lawyer include all elements necessary for a *Stowers* claim if a real threat of excess exposure is to be imposed on an insurer to encourage current settlement. Because these technical requirements are keenly applied by Texas courts, out of state precedents are virtually irrelevant. *See e.g. In re Enron Corporation*, 2006 WL 1663383, * 8-9 (S.D.Tex.2006) (rejecting consideration of non-Texas cases as irrelevant on issue governed by applicable Stowers principles concerning insurer's right to exhaust limits in partial settlements).

The policyholder is placed in a delicate position when the *Stowers* demand is faulty, balancing the duty to cooperate with the insurer in the defense of the case over against the inclination to advise the underlying plaintiff on the deficiencies in the demand so as to retain leverage for settlement against the insurer within policy limits. There is virtually no jurisprudence to guide the policyholder on the boundaries of its “cooperation” obligation to the insurer in this context.

2. Bad Faith

Texas law providing for bad faith differs between common-law concepts and statutory provisions, and between the relief available for insurer’s handling of third-party liabilities claims or first-party claims. The standard for proving a claim of bad faith is relatively high, and the corporate policyholder should be conscientious in asserting this extra-contractual remedy only in truly egregious circumstances.

a. Third-Party Insurance

Texas law recognizes only a single tort duty with respect to an insurer's practices concerning third-party claims handling, that being the duty stated in *Stowers*. *Maryland Ins. Co. v. Head Industr. Coatings & Servs., Inc.*, 938 S.W.2d 27, 28 (Tex. 1996). The Court maintained that "an insured is fully protected against his insurer's refusal to defend or mishandling of a third-party claim by his contractual and *Stowers* rights" and that "[i]mposing an additional duty on insurers in handling third-party claims is unnecessary and therefore inappropriate." *Id.* at 28-29.

Therefore, a *Stowers* claim is quintessentially a negligence claim, and does not provide a common law action or remedy for bad faith. *Id.*; *Mid-Continent Insurance Company v. Liberty Mutual Insurance Company*, 236 S.W.3d 765, 776 (Tex. 2007).

The Texas legislature has provided a statutory action for the unfair insurance practice of "[n]ot attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear." TEX. INS. CODE, Art. 21.21-2, § 2(b)(4), recodified as TEX. INS. CODE, §541.060 (a)(2).

However, the Texas Supreme Court has determined that this standard also is the functional equivalent of the *Stowers* duty and involves meeting the essential prerequisites noted above, together with an additional requirement that "the insured's liability has become reasonably clear." *Rocor Int'l, Inc. v. Nat. Union Fire Ins. Co. of Pittsburgh, Pa.*, 77 S.W.3d 253, 262 (Tex. 2002). As under *Stowers*, the statutory standard requires that the insurer respond properly to an actual settlement demand, but does not obligate the insurer to initiate, solicit, or engage in give-and-take settlement negotiations. *Id.* at 261-62. More recently, courts readily recite that the statutory duty of Sec. 541.060(a)(2) equates to the *Stowers* standard, without further inquiry. *See Mid-Continent Insurance Company v. Liberty Mutual Insurance Company*, 236 S.W.3d 765, 776 (Tex. 2007); *see also Pride Transportation v. Continental Cas. Co.*, 804 F. Supp.2d 520, 532 (N.D. Tex. 2011), aff'd, 511 F. App'x 347, 353-54 (5th Cir. 2013).

b. First-Party Insurance

A common-law tort action for bad faith actions of an insurer is recognized in Texas. An insurer breaches its duty of good faith and fair dealing when "the insurer had no reasonable basis for denying or delaying payment of [a] claim, and [the insurer] knew or should have known that fact." *Transportation Ins. Co. v. Moriel*, 879 S.W.2d 10, 18 (Tex.1994); *see also Aranda v. Insurance Co. of N. Am.*, 748 S.W.2d 210, 213 (Tex.1988). Evidence showing only a bona fide coverage dispute does not demonstrate that there was no reasonable basis for denying a claim. *Provident Am. Ins. Co. v. Castaneda*, 988 S.W.2d 189 (Tex. 1990)(citing *Aranda* and *Moriel)*.

This standard for the common-law tort was revised and expressed more clearly by reference to and adoption of the statutory bad faith standard: an insurer is liable for bad faith if the insurer knew or should have known that it was reasonably clear that the claim was covered. *Universe Life Ins. Co. v. Giles*, 950 S.W.2d 48 (Tex. 1997).

Punitive damages may be awarded for common-law bad faith, but only when an insurer was actually aware that its actions involved an extreme risk—that is, a high probability of serious harm, such as death, grievous physical injury, or financial ruin—to its insured and was nevertheless consciously indifferent to its insured's rights, safety, or welfare. *Id., citing Moriel*.

The Texas Insurance Code provides a "laundry list" of actions that comprise legislatively prohibited "Unfair Settlement Practices" as defined in §541.060:

> (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:
>
> (1) misrepresenting to a claimant a material fact or policy provision relating to coverage at issue;
>
> (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; or
> >
> > (B) a claim under one portion of a policy with respect to which the insurer's liability has become reasonably clear to influence the claimant to settle another claim under another portion of the coverage unless payment under one portion of the coverage constitutes evidence of liability under another portion;
>
> (3) failing to promptly provide to a policyholder a reasonable explanation of the basis in the policy, in relation to the facts or applicable law, for the insurer's denial of a claim or offer of a compromise settlement of a claim;
>
> (4) failing within a reasonable time to:
>
> (A) affirm or deny coverage of a claim to a policyholder; or
>
> (B) submit a reservation of rights to a policyholder;
>
> (5) refusing, failing, or unreasonably delaying a settlement offer under applicable first-party coverage on the basis that other coverage may be available or that third parties are responsible for the damages suffered, except as may be specifically provided in the policy;
>
> (6) undertaking to enforce a full and final release of a claim from a policyholder when only a

partial payment has been made, unless the payment is a compromise settlement of a doubtful or disputed claim;

(7) refusing to pay a claim without conducting a reasonable investigation with respect to the claim;

(8) with respect to a Texas personal automobile insurance policy, delaying or refusing settlement of a claim solely because there is other insurance of a different kind available to satisfy all or part of the loss forming the basis of that claim; or

(9) requiring a claimant as a condition of settling a claim to produce the claimant's federal income tax returns for examination or investigation by the person unless:

A) a court orders the claimant to produce those tax returns;

(B) the claim involves a fire loss; or

© the claim involves lost profits or income.

Even where the insurer violates the statute by acting in bad faith, however, liability ordinarily is limited to compensatory damages incurred by the policyholder as a result of the insurer's tort of bad faith, together with court costs and attorneys fees. *See* §541.152. Upon a determination by the trier of fact that the insurer "knowingly" committed the act complained of, the trier of fact may award an amount not to exceed three times the amount of actual damages. *Id.*

These damages do not duplicate the policy benefits owed and awarded for an Insurer's breach of contract, for which attorneys fees and costs for breach of contract that are available under TEX. CIV. PRAC.& REM. CODE § 38.001. Rather, the Policyholder ordinarily must prove that the Insurer's bad faith conduct in handling the claim caused injury independent of the contractual denial of policy benefits. *See, Provident American Ins. Co. v. Castaneda,* 988 S.W.2d 189, 199 (Tex. 1998). In an extensive review of its bad faith precedents, the Texas Supreme Court recently clarified that covered policy benefits may comprise recoverable damages when caused by the insurer's bad faith. *USAA Tex. Lloyds Co. v. Menchaca,* No. 14-0721, 2017 WL 1311752, __ S.W.3d __ (Tex. Apr. 7, 2017).

Policyholders should be aware, though, that the statute also provides for the insurer to recover court costs and reasonable and necessary attorney's fees if the court finds that the statutory bad faith action is groundless and brought in bad faith or brought for the purpose of harassment. §541.1523

3. Enhanced pre-judgment interest

Another critical tool providing leverage for a policyholder is the enhanced pre-judgment interest available against an insurer who fails to meet the detailed timetable of the Prompt Payment statute, TEX.INS.CODE §§542.051 - 542.061.

Section 542.060 imposes 18% interest upon Insurers as additional damages for failure to timely respond to a policyholders loss notification, investigate the claim, and pay covered claims within deadlines specified in sections §542.057 and §542.058 of the Prompt Payment statute. Attorneys' fees may also be recovered as costs for pursuing a claim for late payment under the statute. §542.060(b). A "claim" is defined as a "first-party claim" made by an Insured or Policyholder under an insurance policy or contract that must be paid by the insurer directly to the Insured or beneficiary. §542.051.

Violation of any deadline under Prompt Payment statute begins accrual of statutory interest; accrual was not limited to only when insurer did not pay claim within the requisite number of days after

receiving sufficient information upon which it could adjust the claim. *Cox Operating, L.L.C. v. St. Paul Surplus Lines Ins. Co.*, 795 F.3d 496 (5th Cir.2015); *see also GuideOne Lloyds Insurance Company v. First Baptist Church of Bedford*, 268 S.W.3d 822 (Tex.App.-Fort Worth 2008, no pet. 2008).

In addition to amounts owed under a normal first-party policy, a claim includes defense fees owed to the policyholder under a third-party liability policy, as determined in *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1, 16 ff. (Tex. 2007). But the statute does not apply to payments owed by an insurer to reimburse the policyholder for monies it paid to a third-party claimant in settlement of a claim, even when the insurer's wrongful denial of coverage required the policyholder to use its own funds for settlement, and even though reimbursement is therefore owed directly to the policyholder. *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660, 674 - 75 (Tex. 2008).

VI SETTLEMENT STRATEGY

When seeking coverage proceeds from an insurer, corporate policyholder should resist the temptation to view insurance proceeds as somehow more "morally owed" than other contract damages. As the Texas Supreme Court is fond of saying, an insurance policy is just a contract like any other contract. *See Forbau v. Aetna Life Insurance Co.*, 876 S.W.2d 132 (Tex.1994) While the policyholder may gain the benefit of any ambiguities in the policy, *see e.g. National Union Fire Ins. Co. v. Hudson Energy Co.*, 811 S.W.2d 552, 555 (Tex.1991), and while the insurer may be held to a higher degree of good faith, *see e.g. Stewart Title Guar. Co. v. Aiello*, 941 S.W.2d 68 (Tex.1997), at the end of the day the policy benefits are no more sacrosanct than other contract damages.

The reality is that the vast majority of cases settle without ever going to trial. As a practical matter, that means that most claims settle for less than the full amount that might be obtained in a wholly successful trial. So why should corporate policyholders insist on obtaining 100 cents on the dollar for insurance claims, while customarily settling other contract disputes for half that much?

This approach is bolstered when the corporate policyholder takes into account internal costs of pursuing insurance through vigorous litigation. These costs may include the time value of money or the loss of other business opportunities while awaiting a litigation outcome, and overhead costs of for internal personnel - - including in-house counsel and possibly management level executives - - needed to prepare for and respond to discovery and trial. Intangible considerations of aggravation and uncertainty are additional elements that a corporate policyholder may consider as more or less important depending on the nature of the insurance dispute.

Certainly, the corporate policyholder enjoys certain aspects of leverage in a insurance dispute that are not present in resolving other contract disputes, notably: the benefits of ambiguity interpreted in the policyholder's favor; enhanced pre-judgment interest, and; potential bad faith. But these tools may be better asserted in settlement negotiations to obtain a favorable resolution, rather than relied upon to seek maximum damages through final litigation.

VII NEVER BET AGAINST THE DEALER - DANGERS OF LITIGATING WITH INSURER

Corporate policyholders are well-served to remember that a core expertise offered by an insurance company is their access to skilled lawyers and their regular coordination of litigation matters. Litigation is an insurer's normal "business" in a way that seldom can be said about a large corporation that makes its profit pursuing other activities and operations.

Insurers also possess a superior knowledge of their own product - - the insurance policy wording, which they have crafted and which they issue to numerous policyholders as their normal business activity. Again, this intimate familiarity with the policy wording and configurations can seldom be duplicated by even the most sophisticated corporate policyholder.

And insurers are likely to have a detailed and nuanced understanding of problematic insurance provisions, that may be litigated to different interpretations or resolutions nationwide or even globally.

Insurers have heard and made most of the usual arguments for these disputed provisions, and start from a contextual appreciation of the issues that is difficult or impossible for the corporate policyholder to equal.

Finally, insurers seldom have to face the question of whether to utilize litigation or coverage counsel to handle a disputed coverage issue. Their own litigation *is* coverage litigation, so their normal trial lawyers also are specialized coverage experts. Similarly, insurers enjoy an advantage in developing overall insurance jurisprudence. Notwithstanding the principles of law favoring the policyholder in an individual case, insurers often are able to develop the overall law by choosing the particular matter they want to test up through appeal, utilize skilled coverage lawyers to make their case, and often engage against non-specialist policyholder counsel who handled the underlying claim but have little coverage or appellate expertise.

For all these reasons, the corporate policyholder should be cautious in going toe-to-toe or mano-a-mano with insurers over contested coverage. It is tough to beat insurers at their own game. Insurers are in the litigation business, most whereas policyholders are not.

VIII TO SEEK OR NOT TO SEEK SUMMARY JUDGMENT

Summary judgement may be of great benefit to a policyholder who is confident of a winning argument interpreting a dispositive policy provision or eliminating an issue of policy compliance. Sometimes, a case may hinge on interpreting the wording of a single exclusion or other policy wording. Or, the insurer may refuse to provide a defense or may reserve rights on a basis that is incompatible with the facts asserted by the underlying case. So in some instances, summary judgment may be available and useful to the policyholder in furthering its own interests.

On the other hand, if there is one thing that insurers fear, it is the general public antipathy for insurance companies. While this is not an insurmountable obstacle - - especially where the contest is between the insurer and a large corporation, not a mom-and-pop business or individual consumer - - it would be a rare insurer who did not take into account the added risk in the prospect of a jury trial in Southeast Texas or the Rio Grande Valley, for example. So from a policyholder's perspective, in the right case it might be better to avoid or resist summary disposition of coverage issues, in favor of putting facts before a jury that demonstrate the insurer's recalcitrance, uncooperativeness, or downright deception to good advantage. These factors particularly come into play if a credible case of bad faith accompanies the coverage issue.

A decision about prospects for and benefits of summary disposition should be considered at the outset and colors the forum in which policyholder may prefer to bring an affirmative action. Conventional wisdom considers federal courts to generally be more favorable if summary judgment is wanted or anticipated, whereas Texas state court generally is preferred if jury trial is anticipated on the critical issues.

As discussed above, summary judgment may be available to obtain a ruling as a matter of law as to whether the insurer owes a duty to defend, based on the "eight corners" rule whereby the duty is determined simply by comparing the factual allegations of the pleading against the policy wording to determine if potential liability within coverage is alleged. *GuideOne Elite Ins. Co. v. Fielder Road Baptist Church,* 197 S.W.3d 305 (Tex. 2006). But only rarely will summary judgment be available to determine the insurer's duty to indemnify under a third-party liability policy, prior to final resolution of the underlying lawsuit. *See D.R. Horton-Texas, Ltd. v. Markel Int'l Ins. Co.,* 300 S.W.3d 740 (Tex. 2009).

Where the policyholder is making a first party insurance claim, however, summary disposition of issues of law may be ripe and readily available where the insurer contests coverage. *See e.g. Balandran v. Safeco Insurance Company*, 972 S.W.2d 738 (Tex.1998)(foundation movement caused by underground plumbing leak not excluded); *RSUI Indem. Co. v. The Lynd Co.,* 466 S.W.3d 113, 118 (Tex. 2015)(policy

ambiguous as to whether blanket or scheduled value limit applied to pay for damaged property, so interpretation favoring policyholder prevailed); *Nassar v. Liberty Mut. Fire Ins. Co.*, 508 S.W.3d 254 (Tex. 2017)(fence attached to dwelling unambiguously covered under “dwelling” limit and not “other structures” limit).

IX ADDITIONAL INSUREDS AND CONTRACTUAL LIABILITY

Because of very high deductibles and self-retentions, much of the coverage litigation of large corporations involves their role under contractual indemnity or additional insured arrangements with their contractors or other parties. One of the major challenges for in-house counsel is to keep track of and strive to reconcile the contract obligations they provide to others or under which they are beneficiaries, to ensure that the insurance obtained actually covers the risks that are contractually assumed.

Sometimes the policy specifically identifies the third party(ies) by name as an additional insured in an endorsement or otherwise, in which case the third party may be known as an "additional named insured". This is a standard method by which companies related to the initial named insured are added onto a comprehensive insurance policy, or for identifying and adding companies with whom the named insured is engaged in a major project or joint venture.

More typically the policy adds as "additional insureds" those unnamed third parties for whom the direct named insured may agree to provide such coverage pursuant to a contractual undertaking. Adding additional insureds is often done by means of a "blanket" or "designated" additional insured endorsement. This is standard method by which companies unrelated to the direct named insured are added to the policy to fulfill a separate contractual requirement between the named insured and the additional insured.

Oftentimes, but not always, the coverage afforded to a third party as an additional insured, is limited to insurance for the direct policyholder's liabilities to the additional insured as established by the contract between the third party and direct policyholder, or for the additional insured's vicarious liability for the acts or omissions of the direct insured. But a contract or policy may provide coverage to an additional insured broader than that, potentially as broad as the coverage afforded to the direct insured.

The importance of this challenge is highlighted by the Texas Supreme Court’s opinion in *In Re Deepwater Horizon,* 470 S.W.3d 452 (Tex. 2015). Transocean’s insurance policies with up to $750M of liability limits provided for additional insured status to third parties such as BP as required by - - but only to the extent of - - liabilities Transocean assumed under contract. Concluding that there was only one reasonable construction of the policy wording and the underlying contractual additional-insured provision, the Court held that BP was an additional insured on Transocean’s policies only as to liabilities assumed by Transocean under the Drilling Contract and not otherwise. Because Transocean did not assume liability for subsurface pollution, Transocean was not contractually obligated to name BP as an additional insured as to that risk. Because there is no obligation to provide insurance for that risk, the insurance wording did not extend coverage to BP, and so BP lacked status as an additional insured under the policies.

This outcome depended on the comparatively restrictive wording of the insurance policies, limiting additional insured status to those liabilities assumed contractually by Transocean. Where an insurance policy fails to include that sort of restrictive wording, the insurance may provide greater coverage to a named insured unrestricted from any limitations in the underlying contract. That was the case in *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008), direct insured’s policy wording was interpreted to gratuitously secure more coverage for an additional insured than the direct insured was contractually required to provide.

Where a policy includes additional insureds, the policy typically states that the policy applies to each insured separately, as if the policy had been issued to each independently. *King v. Dallas Fire Ins. Co.*, 85 S.W.3d 185, 187 (Tex. 2002). Thus, depending on particular wordings, the breach of a policy

provision or the application of an exclusion to one insured, does not necessarily undermine the coverage afforded to other insureds.

Texas draws a sharp distinction between contractual indemnities, and contractual additional insured status. An indemnity provision makes the indemnitor liable for the indemnitee's own negligence. Additional insured provisions, on the other hand, make the insurance-purchaser's insurers liable for the loss caused by the negligence of the direct and/or additional insured (depending on the breadth of the additional insured insurance wording). Thus, indemnity and insurance clauses can impose separate and independent duties. Getty Oil Co. v. Insurance Co. of North America, 845 S.W.2d 794 (Tex. 1992). This distinction may have important implications given the restrictive construction given by courts to indemnity provisions, as contrasted with the liberal construction given in the insured's favor as an additional insured. *Id., and see Ethyl Corp. v. Daniel Construction Co.*, 725 S.W.2d 705, 708 (Tex. 1987).

This distinction is also important for coverage afforded under the Texas Oilfield anti-Indemnity Act, which large energy companies must deal with on a regular basis. TEX.PRAC.&REM.CODE §§127.001 - 127.007. While indemnities of operators by contractors are prohibited under that statute, indemnity undertakings may be enforceable if supported by insurance, and additional insured arrangements are not prohibited.

Finally, in-house corporate counsel must be sensitive to the company's operations where both indemnity and additional insured arrangements may be statutorily prohibited. Where a "construction contract" is involved, for example, Texas statute prohibits both indemnity provisions and additional insured provisions in favor of any other party, excepting comprehensive Owner Controlled Insurance Programs. *See* TEX. INS. CODE, Title 2, Subchapter C, Ch. 151. Likewise, the Louisiana Anti-Indemnity Act prohibits contractual indemnities and most additional insured arrangements where it applies. La.Rev.Stat.Ann. § 9:2780