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2017 Insurance Law Update

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I. New Texas Law Restricts Property Policyholder Rights

On May 26, 2017, Governor Greg Abbott signed into law House Bill 1774, a tort-reform bill that limits a policyholder's ability to sue its insurer for mishandling property claims arising from natural disasters. The new law took effect on September 1, 2017, just days after Hurricane Harvey made landfall along the Texas coast. Designed to curb the exploitation of storm victims and insurance companies, the new law undercuts penalties for late claim payments and will likely make it more difficult for policyholders to hold insurers accountable for improper delays and unpaid claims.

Although popularly referred to as the "hailstorm" bill, the law applies more broadly to any "first-party claim … made by an insured" under a property insurance policy that "arises from damage to or loss of covered property caused, wholly or partly, by forces of nature, including an earthquake or earth tremor, a wildfire, a flood, a tornado, lightning, a hurricane, hail, wind, a snowstorm, or a rainstorm." Tex. Ins. Code § 542A.001(2).

The law created a new section of the Texas Insurance Code—section 542A—that applies to actions alleging breach of contract, negligence, misrepresentation, fraud, or breach of a common law duty, or an action brought under Chapter 541 or 542 of the Texas Insurance Code or the Deceptive Trade Practices Act ("DTPA"). Tex. Ins. Code § 542A.002(a).

Although not as far-reaching as earlier drafts considered by the legislature, the new law restricts a policyholders' ability to sue its insurer in three ways. First, it requires pre-suit notice of any claim, with enhanced consequences for noncompliance. Second, it limits a policyholder's ability to bring suit against an insurer's agent by allowing the insurer to elect to take responsibility for its agent. Finally, the law limits a policyholder's ability to recover its attorney's fees for prosecuting such a claim and reduces the interest recoverable in connection with delayed payments.

The law impacts both claims made and lawsuits initiated after its September 1, 2017 effective date. New section 542A, including its pre-suit notice requirements, limitations on recovering attorney's fees, and provisions allowing an insurer to take responsibility for an agent, applies "only to an action filed on or after" September 1, 2017. The new law's provision reducing the penalty interest rate, on the other hand, applies to any claim "made on or after" September 1, 2017. Claims made before September 1, 2017 are governed by the penalty interest provisions in the old law.

A. Pre-Suit Notice and Inspection

Section 542A.003 requires a claimant to give written notice to its insurer "not later than the 61st day before the date a claimant files an action." This notice must include: "a statement of the acts or omissions giving rise to the claim; the specific amount alleged to be owed by the insurer on the claim for damage to or loss of covered property; and the amount of reasonable and necessary attorney's fees incurred by the claimant." Tex. Ins. Code § 542A.003(b). Such notice is not required if a claimant believes that the statute of limitations will run before notice can be given or for a claim asserted as a counterclaim. Tex. Ins. Code § 542A.003(d). This statutory notice does not relieve a claimant of any other obligation to provide notice. Tex. Ins. Code § 542A.003(f).

The new section also creates a statutory right for the insurer to "inspect, photograph, or evaluate" the property at issue. Tex. Ins. Code § 542A.004. The insurer's request must be made no later than 30 days after the insurer receives written notice. Tex. Ins. Code § 542.004.

The policyholder's failure to provide written notice as required by section 542A.003 or to allow a reasonable opportunity to inspect the property permits the insurer to file a plea in abatement after it files an answer in the action. Tex. Ins. Code § 542A.005. If abated, the court "may not compel participation in an alternative dispute

resolution proceeding until after the abatement period" has expired. Tex. Ins. Code § 542A.005(f).

Section 542A.003, which includes the requirement that a suit be abated for failure to provide notice, is similar to Texas Insurance Code section 541.0154, which requires pre-suit notice of claims under Chapter 541 of the Texas Insurance Code, and Texas Business and Commerce Code section 17.505, which requires pre-suit notice of claims pursuant to the Deceptive Trade Practices Act. Unlike the provisions in the DTPA and Chapter 541, however, failure to comply with section 542A.003 can limit the attorney's fees recoverable, as discussed below.

B. Agent Liability

Policyholders often sue both the insurer and a local agent, which may prevent an insurer from removing the lawsuit to federal court. Section 542A allows an insurer to "elect to accept whatever liability an agent might have to the claimant for the agent's acts or omissions related to the claim by providing written notice to the claimant." Tex. Ins. Code § 542A.006(a). If the insurer makes such an election before a policyholder files an action against the insurer and the agent, "no cause of action exists against the agent" and "the court shall dismiss that action with prejudice." Tex. Ins. Code § 542A.006(b).

If an election is made after the action is filed, "the court shall dismiss the action against the agent with prejudice." Tex. Ins. Code § 542A.006(c). As a practical matter, during the trial of an action in which the insurer makes such an election, "evidence of the agent's acts or omissions may be offered at trial and ... the trier of fact may be asked to resolve fact issues as if the agent were a defendant, and a judgment against the insurer must include any liability that would have been assessed against the agent." Tex. Ins. Code § 542A.006(g). Once made, the insurer may not revoke its election nor can the court nullify it. Tex. Ins. Code § 542A.006(f).

The law does provide some limitations on the insurer. If an insurer elects to assume liability for an agent but fails to make the agent available for deposition, in most cases, the law's restrictions on attorney's fees, described below, do not apply. Tex. Ins. Code § 542A.006(d). An insurer's election is ineffective if it "is conditioned in a way that will result in the insurer avoiding liability for any claim-related damage caused to the claimant by the agent's acts or omissions." Tex. Ins. Code 542A.006(e).

C. Attorney's Fees and Reduced Interest

Perhaps most notably, the new bill substantially limits the attorney's fees a policyholder can recover against its insurer, ties the recovery of attorney's fees to compliance with the pre-suit notice provisions and an accurate prediction of the damages that are ultimately awarded, and reduces the amount of statutory interest available for claims that fall within Section 542A.

First, the failure to provide the new required pre-suit notice may prevent the policyholder from recovering any attorney's fees. The court "may not award to the claimant any attorney's fees incurred after" the date on which the insurer files a pleading stating that it was entitled to, but did not receive, the pre-suit notice. Tex. Ins. Code § 542A.007(d).

Second, the court may reduce the attorney's fees awarded to a policyholder based upon the damages included in the pre-suit notice. A claimant is entitled to the "lesser of" its reasonable fees or the amount determined by a formula comparing the actual damages awarded to the amount alleged in the pre-suit notice. Tex. Ins. Code § 542A.007(a).

If a policyholder recovers at least 80% of the damages alleged in the pre-suit notice, it can recover its full attorney's fees. Tex. Ins. Code § 542A.007(b). If the amount recovered in the suit is 20% or less of the amount included in the pre-suit notice, a policyholder is precluded from any recovery of attorney's fees. Tex. Ins. Code § 542A.007(c). If the damages fall in between 20% and 80% of the damages included in the pre-suit demand, a policyholder may

recover only that percentage of attorney's fees—at least in connection with claims brought under the new law. Tex. Ins. Code § 542A.007(a)(3). This provision effectively conditions recovery of attorney's fees on an accurate prediction of the damages a jury will ultimately award following trial.

Finally, the new law amends Texas Insurance Code section 542.060, which allows a policyholder to recover 18% interest on a claim if the insurer has failed to comply with Chapter 542. Under the new bill, claims brought pursuant to Chapter 542A are limited to interest in the amount of the current interest rate plus 5%. Tex. Ins. Code 542.060(c). Under the current judgment interest rate, this would reduce the interest on covered claims from 18% to 10%.

D. Effects of HB 1774 Reach Far Beyond Hail Claims

While HB 1774 ostensibly was introduced to curtail abuse related to hailstorm litigation, its restrictions will apply more widely. Any property claim arising from a natural disaster and brought under the Texas Insurance Code will be governed by the new rules. Policyholders who fail to comply with the pre-suit written notice provision place their claims at risk. And the consequences faced by insurers for delays and improper or unfair claims handling are substantially diluted by the limitations on an aggrieved policyholder's ability to recover attorney's fees and interest.

II. SCOT *Menchaca* Ruling Benefits Policyholders, Clarifies Case Law

Resolving significant confusion regarding the remedies available for violations of the Texas Insurance Code, on April 7, 2017, the Texas Supreme Court issued its much-awaited decision in *USAA Texas Lloyds Co. v. Menchaca*. In an opinion welcomed by the policyholder bar, the Supreme Court set forth "five rules that address the relationship between contract claims under an insurance policy and tort claims under the Insurance Code." *USAA Texas Lloyds Co. v. Menchaca*, ___ S.W.3d ___, 2017 WL 1311752, at *1 (Tex. Apr. 7, 2017), reh'g granted (Dec. 15, 2017).

Insurance companies have long taken the position that an insured must prove an injury separate and apart from injury caused by a breach of an insurance contract in order to recover statutory damages under the Texas Insurance Code. Policyholders have argued, in response, that the independent injury requirement applies only where an insurer properly denied coverage. A case arising from the insurer's alleged failure to investigate and pay a claim for storm-related damage, *Menchaca*, placed this dispute squarely before the Texas Supreme Court.

A. Broader Remedies

In *Menchaca*, the Court considered "whether an insured can recover policy benefits as actual damages caused by an insurer's statutory violation absent a finding that the insured had a contractual right to the benefits under the insurance policy." Id. at *4. In answering this question, the Court set forth five "distinct but interrelated rules that govern the relationship between contractual and extra-contractual claims in the insurance context." *Id*. The first and fifth rules affirm propositions of law that were generally accepted prior to the Court's decision. Rules two, three and four confront key areas of confusion, seemingly making clear that the remedies available under the Texas Insurance Code are not as narrow in scope as insurance companies had argued.

The first general rule is that "an insured cannot recover policy benefits as damages for an insurer's statutory violation if the policy does not provide the insured a right to receive those benefits." *Id*. This rule is based on the Code's requirement that an insured's actual damages must be "caused by" the statutory violation. The Court noted that if "the insurer violates a statutory provision, that violation—at least generally—cannot cause damages in the form of policy benefits that the insured has no right to receive under the policy." *Id.* at *6.

B. No Conflict with *Vail*

The second rule provides that "an insured who establishes a right to receive benefits under the insurance policy can recover those benefits as actual damages under the Texas Insurance Code if the insurer's statutory violation causes the loss of benefits." *Id*. at *4. This rule reaffirms the Court's holding in *Vail v. Texas Farm Bureau Mutual Ins. Co.*, 754 S.W.2d 129 (Tex. 1988). In *Menchaca*, the Court underscored the principle that the Code's "statutory remedies are cumulative of other remedies," and therefore, insureds can "elect to recover the benefits under the statute even though they also could have asserted a breach-of-contract claim." The Court clarified that no conflict exists between its holdings in *Vail* and *Provident American Ins. Co. v. Castaneda*, 988 S.W.2d 189 (Tex. 1998) because in *Vail*, there was no dispute that the policyholder was entitled to policy benefits, but in *Castaneda*, the policyholder had not even alleged that she was entitled to policy benefits.

By characterizing policy benefits as "actual damages," the *Menchaca* opinion may have opened the door for insureds to seek trebling of those "actual damages" pursuant to section 541.152(b) of the Code where an insurer has "knowingly committed" the statutory violation. This conforms with the Code's provision, recognized in *Vail*, that the "statutory remedies are cumulative of other remedies."

C. Independent Injury

The third rule is "even if the insured cannot establish a present contractual right to policy benefits, the insured can recover benefits as actual damages under the Texas Insurance Code if the insurer's statutory violation caused the insured to lose that contractual right." *Id*. at *4. The Court noted that this rule has been recognized in several contexts, including claims alleging "that an insurer misrepresented a policy's coverage, waived its right to deny coverage or is estopped from doing so, or committed a violation that caused the insured to lose a contractual right to benefits that it otherwise would have had." *Id*. at *9. In some limited cases, therefore, a policyholder may be able to assert statutory claims to recover policy benefits as damages if the insurer "commits a statutory violation that eliminates or reduces its contractual obligations." *Id*. at *10.

Under the fourth rule, "if an insurer's statutory violation causes an injury independent of the loss of policy benefits, the insured may recover damages for that injury even if the policy does not grant the insured a right to benefits." *Id*. at *4. The Court noted that it had originally articulated this rule in *Republic Ins. Co. v. Stoker*, 903 S.W.2d 338 (Tex. 1995), but that no Texas court had ever found that a policyholder was entitled to recover for such an independent injury. *Id.* at *12. The Court stated again that while such a claim "could exist, we have no occasion to speculate what would constitute a recoverable independent injury." *Id.*

D. Good News to Policyholders

Finally, the fifth rule states that "an insured cannot recover any damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits." *Id*. at *4. This rule, like the first, has not been the subject of serious confusion and is, in the words of the Court, the "natural corollary" to the other four rules. *Id*. at *12.

While insurers are saying the *Menchaca* decision muddied the waters and more litigation will ensue in an attempt to limit the scope of the holding, the opinion's clarifications seem to be good news to policyholders.

Notably, USAA filed a motion for rehearing, arguing that the opinion caused significant confusion and asking the Court to clarify its ruling. That motion was granted on December 15, 2017.

III. Insured's Duty to Read Policy May be Undercut by Agent's Affirmative Misrepresentations

Insurance policyholders should read their policies, but the Fourteenth Court of Appeals' October 2017 in *Wyly v. Integrity Insurance Solutions*, No. 14-15-0042-CV, may provide some relief to policyholders who relied on an insurance agent for information regarding their policies.

Insureds may misunderstand the terms of an insurance policy or argue that they have been misled by an insurer's or an agent's statements regarding a policy's terms or coverage. In these disputes, defendants often argue in defense that the insured had a duty to read its policy. *Wyly* affirmed the rule under Texas law that this defense fails where an insured demonstrates that an insurance agent made a specific, affirmative misrepresentation about the policy.

In *Wyly*, the policyholder sought to recover damage to his aircraft sustained while it was in transit after the insurer denied coverage. The trial court granted summary judgment in favor of the defendant, the insured's agent who procured the motor truck cargo policy at issue. The court found that a policy exclusion for "improper packing, preparation for shipment or loading by you or the shipper" precluded his claim. On review, the appellate court reversed the summary judgment and held that the trial court erred in granting summary judgment in favor of the agent on the basis that there was no affirmative misrepresentation of insurance coverage and that the trial court could not have properly granted summary judgment on the basis that the plaintiff was deemed to know the contents of the policy.

A. "A to Z" Coverage

Before moving the aircraft, the plaintiff sought to insure the aircraft during transit. The policyholder alleged that he asked his agent for coverage from "A to Z" to cover the aircraft from loading to unloading, and he provided specific examples of the requested coverage. The plaintiff's agent contacted a broker, who obtained a policy from Essex Insurance Co. The agent asked the broker some questions about the policy but failed to read the policy himself. Nonetheless, the agent told the plaintiff that the policy "covers from loading through unloading," without disclosing that he had failed to read the policy or that the policy was subject to limiting terms and conditions.

Although the plaintiff received a copy of the exclusion for "improper packing, preparation for shipment or loading" before the aircraft was damaged, he asked his agent again if he was covered "from A to Z," and his agent said "yes." The agent also told him that the coverage was "full coverage" and "100 percent."

The plaintiff alleged that he relied upon his agent to provide the correct policy because the agent was an insurance professional, he was the plaintiff's longtime friend, and it appeared that he had read the policy. The plaintiff further believed that his agent had read the policy because the agent had affirmatively stated that the policy covered various examples of coverage in response to plaintiff's questions. The plaintiff further stated that he would have waited to transport the plane until he understood the terms of the policy if his agent had represented that he had not read the policy.

B. Specific, Affirmative Representations

Before the appellate court were the plaintiff's claims under the Texas Deceptive Trade Practices Act ("DTPA") and section 541.061 of the Texas Insurance Code that included two issues: (1) was there an actionable misrepresentation, and (2) did the plaintiff's failure to read the policy preclude his claims.

With respect to the first issue, the court noted that "general claims by the insurer about the adequacy or sufficiency of coverage, for instance, are not generally actionable under the DTPA." Moreover, "absent some specific

misrepresentation of its terms of coverage by the insurer that the insured's mistaken belief that he is obtaining coverage under certain contingencies which are not in fact covered under an insurance policy are not generally grounds for a DTPA claim against the insurer."

The court held that, in this case, the agent did make specific representations about the policy when he said that the policy provided "full coverage." The court noted that it was uncontested that the plaintiff did not read the policy because he relied upon his agent's assurances and that the agent's statements were more than "vague representations." Accordingly, the court determined that the agent's specific, affirmative misrepresentations were actionable.

The court then considered whether the plaintiff's failure to read the policy precluded his claims. It concluded that it did not, stating, "we decline to hold the defense of 'failure to read' is applicable to alleged violations of the DTPA or the Insurance Code for an affirmative misrepresentation of coverage."

IV. *AIG v. Tesoro* Ruling Reminds Policyholders that Insurance Devil is in the Details

A recent decision from the United States Court of Appeals for the Fifth Circuit underscores two important pieces of advice policyholders should follow to ensure that their insurance policies cover the entities that the policyholder intends to insure.

First, policyholders should read and review their insurance policies upon receipt because untimely discovery of a mistake may preclude a later claim for reformation of the policy.

Second, policyholders, especially those who operate through subsidiaries or affiliated entities, should ensure that their insurance policies include all such entities as named or additional insureds.

A. Who is Insured?

In *AIG Specialty Ins. Co. v. Tesoro Corporation*, No. 15-50953, the Fifth Circuit considered whether a transfer endorsement transferring an excess insurance policy was effective as to the named insured's subsidiary. 840 F.3d 205 (5th Cir.), reh'g denied, 844 F.3d 197 (5th Cir. 2016).

Tesoro Refining, a subsidiary of Tesoro Corporation, purchased a refinery, and the purchase and sale agreement specified that the seller was to secure an endorsement to a $100 million Chartis excess policy adding the buyer as an additional insured or assigning the policy directly. Chartis issued a transfer endorsement for the policy naming Tesoro Corporation, not Tesoro Refining, as the named insured. Tesoro Corporation's "corporate practice" was to name just the parent on insurance policies.

After the refinery transaction closed, Tesoro Refining sued the refinery's original owner for fraud alleging that it had concealed the severity of environmental liabilities at the refinery. This litigation lasted from 2003 until 2007, when Tesoro Refining sent a letter to Chartis regarding the progress of the litigation. In its reservation-of-rights letter, Chartis acknowledged the matter as a potential claim and identified Tesoro Corporation as the named insured.

B. Insured or Third Party?

In 2009, Tesoro Corporation sent a letter to Chartis demanding coverage for certain cleanup liabilities allegedly owed by Tesoro Refining. Ultimately, Chartis and the Tesoro parties litigated the issue of which Tesoro entity was insured under the Chartis policy. The Tesoro parties sought reformation of the Chartis policy to name Tesoro

Refining. They also argued that Chartis breached the parties' contract under California law on the theory that Tesoro Refining was a third-party beneficiary.

The Fifth Circuit rejected the third-party beneficiary argument and then considered whether, under Texas law, summary judgment was proper on the Tesoro parties' reformation claim. The court first noted the four-year statute of limitations for reformation claims under Texas law; the Tesoro parties argued that limitations did not run until they discovered a mistake in the policy, the failure to name Tesoro Refining in the transfer endorsement.

The court noted that Texas law provides that "receipt of a policy containing a mistake does not bar a later claim for reformation if the insured offers proof that when he received it he put it away without examination, or that he relied upon the knowledge of the insurer and supposedly he had correctly drawn it," and noted that "receipt of a policy without protest is not an absolute bar to a reformation claim."

C. Timing is Everything

Importantly, however, whether the Tesoro parties may have a meritorious reformation claim was "distinct from the statute of limitations inquiry." The court considered the merits and found that the Tesoro parties had provided no evidence that they had put the policy away without examination or that they had relied on Chartis to know that Tesoro Refining, not Tesoro Corporation, owned the refinery.

With respect to limitations, the court held that the Tesoro parties' claim for reformation was brought several years after the 2002 alleged mistake was made and rejected the Tesoro parties' argument that the discovery rule applied. Because the discovery rule applies where "the nature of the injury is inherently undiscoverable and the injury itself is objectively verifiable," the court found no basis to conclude that "the injury in this case—the alleged mistake over which entity was covered—is inherently undiscoverable" and affirmed summary judgment in favor of Chartis on the reformation claim.

D. Takeaways

The result might have been different if the Tesoro parties had recognized that the transfer endorsement did not name Tesoro Refining when the endorsement was issued or within four years of the mistake.

While reformation of an insurance policy is one potential remedy to extend coverage for an entity not otherwise named under that policy, it is far simpler and less expensive to try to work with an insurer or insurance broker to fix such mistakes at the outset.

Moreover, policyholders should ensure that all entities, including subsidiaries and affiliates, are covered by their insurance policies. Who is an insured under a policy can be defined in several ways, including naming entities on the declarations, including them as additional insureds, or including them through a policy's definitions or endorsements.

The simplest solution may be to ensure that every entity is specifically included as a named or additional insured. If there are questions, policyholders should work with their insurance brokers or coverage counsel to review their policies to ensure that their insurance program provides the coverage they have requested.

V. *Hamel* Ruling Leaves Policyholders in "Fully Adversarial" Conundrum

The Texas Supreme Court's June 2017 ruling in *Great American Insurance Co. et al. v. Hamel* creates a conundrum for policyholders if an insurer wrongly denies coverage for a claim and the policyholder is left to defend

itself at trial—the lack of a "fully adversarial trial" in which the insured bears financial risk may necessitate re-litigation of the liability issues in subsequent coverage litigation. *Great Am. Ins. Co. v. Hamel*, 525 S.W.3d 655 (Tex. 2017), reh'g denied (Sept. 22, 2017).

A. Background

Glen and Marsha Hamel sued Terry Mitchell Builders ("TMB") for construction defects in their home. Great American, TMB's insurer, denied coverage, claiming the alleged defect was excluded from the policy. Without the resources necessary to defend the lawsuit, TMB reached an agreement with the Hamels shortly before trial that, in the event of a judgment against TMB, the Hamels would not attempt to seek recovery against the company owner's personal assets, nor would they attempt to collect it through the sale of the company's truck or tools (the company's only assets). *Id*. at 660. TMB also stipulated that the company had a duty to the Hamels to inspect the work performed and ensure it was performed in a good and workmanlike manner, that defects were not noticed during inspection as a result of an "honest mistake," and that the defects could have been fixed if they had been noticed, avoiding the damages. *Id*.

At trial, Terry Mitchell testified consistently with the stipulations that TMB "agreed to make sure the house was finished in a good and workmanlike manner," including an obligation to inspect the work and ensure that it was completed properly. *Id.* Mitchell testified that "he did not notice the 'issues that the Hamels have had with their house,' including steel nails in the roofing system, a short roof deck, lack of a drip edge, inadequate securing of a fascia board to the framing, improper framing of the roof ridge and second-floor window opening, improper roof sloping and drainage, and shower leaks." *Id.* In his testimony, Mitchell admitted that his failure to discover these problems constituted a failure to complete the home in a good and workmanlike manner. *Id.*

TMB presented no witnesses and did not submit any findings of fact or conclusions of law to the judge. The court rendered judgment in favor of the Hamels, adopted their proposed findings without modification, and awarded them $365,000 in damages.

After trial, TMB assigned its rights against Great American to the Hamels, who then sued Great American. At trial in the insurance case, the court awarded the Hamels $355,000.

Great American appealed, claiming that the underlying judgment was unenforceable because "the pretrial agreement and stipulations entered into by the Hamels and [TMB] … ensured that [TMB] had no real stake in the trial's outcome." *Id*. at 663. As a result, the "sham trial" was "shaped entirely by the Hamels and designed to aid in the prosecution of the subsequent insurance litigation." *Id.* The Hamels argued in response that Great American sought to extend *Gandy* beyond its scope absent any evidence of fraud or collusion. *Id.*

B. Further Defining the "Adversarial Trial" Requirement

Recognizing key distinctions between *Gandy* and the case before it, the Texas Supreme Court noted that the assignment from TMB to the Hamels was valid:

> As Great American recognizes, the circumstances underlying our invalidation of the assignment in *Gandy* are lacking in this case. First, [TMB] assigned its claims following, not preceding, a trial and judgment. Second, unlike the insurer in *Gandy*, Great American breached its duty to defend. Third, Great American neither accepted coverage nor made a good-faith effort to adjudicate coverage before the Hamels' claims against [TMB] were resolved.

Id. at 664.

The Court agreed with Great American, however, that the judgment "rendered without a fully adversarial trial, in an action by the plaintiff as the insured's assignee" was not enforceable against the insurer based on *Gandy*.

> In holding that a plaintiff may not enforce an underlying judgment against the defendant's insurer absent a "fully adversarial trial," we shifted focus toward whether the underlying judgment accurately reflects the plaintiff's damages and thus the insured's covered loss.

Great Am. Ins. Co. v. Hamel, 525 S.W.3d 655, 665 (Tex. 2017), reh'g denied (Sept. 22, 2017). *See Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660, 673-74 (Tex. 2008) (binding the insurer to a judgment arising from a settlement agreement, rather than a trial, primarily because the defendant retained a stake in the litigation even upon settlement).

Recognizing that *ATOFINA* prevents an insurer, after wrongfully refusing to defend, from attacking a judgment or settlement between the insured and a plaintiff, the Court focused on whether the underlying judgment accurately reflects the plaintiff's true damages and the insured's covered losses.

> In *ATOFINA*, the insurer wrongfully refused to defend the underlying claims, and the insured settled without assigning his rights against the insurer to the plaintiff. More importantly, the insured retained the risk that he would be liable for the damages if the policy did not cover them. That incentive to contest the plaintiffs' alleged damages was sufficient to ensure that the settlements accurately reflected the insured's covered loss, even without a trial.

Id. at 666 (citations omitted).

Concluding that the underlying judgment was not binding on Great American, the Court explained the key attributes of an adversarial proceeding:

> When the parties reach an agreement before trial or settlement that deprives one of the parties of its incentive to oppose the other, the proceeding is no longer adversarial. Stated another way, proceedings lose their adversarial nature when, by agreement, one party has no stake in the outcome and thus no meaningful incentive to defend itself. When a plaintiff agrees to forgo execution of a judgment against a defendant's assets, whether in conjunction with a settlement or before trial, the defendant no longer has a financial stake in the outcome and thus likely has no interest in either avoiding liability altogether or minimizing the amount of damages. We believe adversity turns on the insured defendant's incentive to defend (or lack thereof), and an after-the-fact evaluation of the parties' trial strategies therefore has no place in the analysis.

Id. at 667.

C. Remand to Re-Litigate Damages

While declining to enforce the underlying judgment against Great American, the Court was nevertheless unwilling to render judgment in favor of Great American.

> [W]hile we will not hold an insurer to a judgment that was not the result of an adversarial proceeding, we will not preclude the parties from properly litigating the underlying liability issues in a subsequent coverage suit. Although in *Gandy* we identified the difficulties inherent in this undertaking, we also emphasized the importance of determining an insurer's obligations before its insured incurs liability. By declining to defend or litigate its duties early, an insurer plays a key

> role in making such a complicated endeavor necessary. Certainly, relitigation of underlying liability and damages issues is not a perfect solution, but it is necessitated by the circumstances. The insurer should not benefit from the problem that it helped create, as Great American's proposed solution—rendition of judgment in its favor—would allow. Rather, under the approach we adopt today, the insurer will have the opportunity to challenge its insured's underlying liability and the resulting damages, the abandoned insured is protected, and the burden on the plaintiff is fair.

Id. at 669. Accordingly, the Court remanded the case for a new trial on the damages issues.

4825-4219-0682, v. 1