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The Court of Appeals for the Fifth Circuit: A Legal Analysis and Statistical Review of 2005-2006 Insurance Decisions

Willy E. Rice
St. Mary's University School of Law, wrice@stmarytx.edu

THE COURT OF APPEALS FOR THE FIFTH CIRCUIT: A LEGAL ANALYSIS AND STATISTICAL REVIEW OF 2005-2006 INSURANCE DECISIONS

*by Willy E. Rice**

* Professor of Law, St. Mary's University School of Law, San Antonio. M.A. 1972, Ph.D. 1975, University of North Carolina at Chapel Hill; Postdoctoral Fellow 1977, The Johns Hopkins University; J.D. 1982, The University of Texas at Austin; and an American Bar Foundation Scholar, 1987-88. The author acknowledges and appreciates the stellar assistance of student research assistant Allen Mahlon DeBard.

I. INTRODUCTION

The Fifth Circuit Court of Appeals decided and published twenty-four insurance-related appeals between June 2005 and May 2006 from cases originating in seven federal district courts.[1] Like petitioners in prior years, the overwhelming majority of the 2005-2006 appellants petitioned the court of appeals to reverse or vacate district courts' adverse summary judgments as well as the lower courts' allegedly questionable interpretations of various insurance contracts.[2] Again, most of the controversies involved familiar

1. The Fifth Circuit reported the following twenty-four insurance-related cases: Texaco Exploration & Prod., Inc. v. AmClyde Eng'rd Prod. Co., 448 F.3d 760 (5th Cir. May 2006); St. Paul Surplus Lines Ins. Co. v. Halliburton Energy Servs., Inc., 445 F.3d 820 (5th Cir. Apr. 2006); Wallace v. La. Citizens Prop. Ins. Corp., 444 F.3d 697 (5th Cir. Mar. 2006); Am. Reliable Ins. Co. v. Navratil, 445 F.3d 402 (5th Cir. Mar. 2006); Motiva Enters., LLC v. St. Paul Fire & Marine Ins. Co., 445 F.3d 381 (5th Cir. Mar. 2006); Dale v. Colagiovanni, 443 F.3d 425 (5th Cir. Mar. 2006); EMCASCO Ins. Co. v. Am. Int'l Specialty Lines Ins. Co., 438 F.3d 519 (5th Cir. Jan. 2006); Stewart v. W. Heritage Ins. Co., 438 F.3d 488 (5th Cir. Jan. 2006); Am. Bankers Ins. Co. of Fla. v. Inman, 436 F.3d 490 (5th Cir. Jan. 2006); Gallup v. Omaha Prop. & Cas. Ins. Co., 434 F.3d 341 (5th Cir. Dec. 2005); Fed. Ins. Co. v. Ace Prop. & Cas. Co., 429 F.3d 120 (5th Cir. Oct. 2005); Lamar Homes, Inc. v. Mid-Continent Cas. Co., 428 F.3d 193 (5th Cir. Oct. 2005); Int'l Ins. Co. v. RSR Corp., 426 F.3d 281 (5th Cir. Sept. 2005); Minter v. Great Am. Ins. Co. of N.Y., 423 F.3d 460 (5th Cir. Aug. 2005); Times-Picayune Publ'g Corp. v. Zurich Am. Ins. Co., 421 F.3d 328 (5th Cir. Aug. 2005); Thyssen, Inc. v. Nobility Mv, 421 F.3d 295 (5th Cir. Aug. 2005); Riverwood Int'l Corp. v. Employers Ins. of Wausau, 420 F.3d 378 (5th Cir. Aug. 2005); Coleman v. Sch. Bd. of Richland Parish, 418 F.3d 511 (5th Cir. July. 2005); Wentwood Woodside I, LP v. GMAC Commercial Mortgage Corp., 419 F.3d 310 (5th Cir. July 2005); Lifecare Hosps., Inc. v. Health Plus of La., Inc., 418 F.3d 436 (5th Cir. July 2005); Ridglea Estate Condo. Ass'n v. Lexington Ins. Co., 415 F.3d 474 (5th Cir. July 2005); Wright v. Allstate Ins. Co., 415 F.3d 384 (5th Cir. June 2005); United Teacher Assocs. Ins. Co. v. Union Labor Life Ins. Co., 414 F.3d 558 (5th Cir. June 2005); La. Patients' Comp. Fund Oversight Bd. v. St. Paul Fire & Marine Ins. Co., 411 F.3d 585 (5th Cir. June 2005).

2. *See Lifecare Hosps.*, 418 F.3d at 419.

procedural and substantive questions of law.[3] But the Fifth Circuit also decided many questions of fact. Furthermore, several preemption questions and disputes over subject matter jurisdiction appeared among the decisions.[4]

More significant, the Fifth Circuit decided numerous class action disputes during the 2004-2005 term.[5] This term, however, the appellate court resolved and published only one class action or class certification dispute.[6] To be sure, that was an unexpected result as Congress enacted the Class Action Fairness Act of 2005 that, by all objective measures, will generate a lot of substantive and procedural controversies and uncertainties.[7] On the other hand, given the severe after-effects of Tropical Storm Allison and Hurricane Katrina, the court of appeals resolved significantly more flood-related insurance disputes during this session.[8] Regardless of the ancillary procedural issues, the underlying

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3. *See id.*

4. *See Wallace*, 444 F.3d at 699.

5. *See* Willy E. Rice, *The Court of Appeals for the Fifth Circuit 2004-2005 Disposition of Insurance Decisions: A Survey and Statistical Review*, 38 TEX. TECH L. REV. 821, 903 (2006).

6. *See Wallace*, 444 F.3d at 697.

7. Class Action Fairness Act of 2005, 28 U.S.C.A. § 1332 (2006).

> In enacting the Class Action Fairness Act of 2005, Congress provided a fundamental redefinition of federal jurisdiction over state law class actions. The legislation arose from a congressional determination that state courts are not the best forum for deciding class cases with substantial out-of-state effects. The new Act broadens jurisdiction *per se*, but then retracts some of the breadth by providing for federal courts to "decline to exercise" jurisdiction under many circumstances.

Jerry Hartzell, *North Carolina Observations on Federal Jurisdiction Under the New Class Action Fairness Act*, THE N.C. STATE B. J., Fall 2005, at 12.

> Traditionally, rules governing federal jurisdiction have at least had the appearance of being relatively clear, and have been interpreted relatively consistently. . . . In contrast, the new class action federal jurisdiction statute is quite complex, and its structure and syntax seem to be modeled after the Internal Revenue Code. Class actions based on state law will (with some exceptions) be subject to federal jurisdiction so long as $5 million or more is in controversy, and so long as there is some minimal element of diversity. The diversity element will be far less meaningful than formerly, satisfied if any plaintiff is a citizen of a state different than any defendant. The Act creates exceptions to this grant of federal jurisdiction. . . . [T]he Act also creates another category of cases as to which federal judges are *required* to "decline to exercise" jurisdiction, and it creates yet another category of cases as to which federal judges *may* decline to exercise jurisdiction, prescribing multi-factor tests for each. These rules are too intricate to permit reasonable summary.

Id. at 14.

8. *See infra* Part II.B.

> The first tropical storm of the season was churning off the coast of Texas and Louisiana late Tuesday, packing heavy rain and wind gusts clocked at more than 60 mph. Tropical Storm Allison . . prompt[ed] forecasters to warn of flash floods. . . . A tropical storm is a cyclone with sustained winds of 39 to 73 mph and is capable of becoming a full-fledged hurricane. Allison formed over a large swath of the Gulf of Mexico.

John Tedesco, *Tropical Storm Makes Waves*, SAN ANTONIO EXPRESS-NEWS, June 6, 2001, at 1A.

> A weak Hurricane Katrina drenched densely populated South Florida . . . Flooding was a major worry . . . Sam Miller, executive vice president of the Florida Insurance Council, an industry trade group, said insurers are expecting a 'two-punch hit' from Katrina, with the more-severe blow coming if the storm comes ashore again in the state's Panhandle region. Four hurricanes last year caused about $23 billion in insured losses, and Hurricane Dennis inflicted additional

substantive conflicts in those cases concerned whether insurers breached some alleged duties under flood insurance contracts.[9]

The specific procedural questions before the Fifth Circuit were the following: (1) whether the National Insurance Flood Act preempts insured flood victims from commencing state law actions against property insurers, (2) whether an "Other Assured" clause in a builder's risk property insurance contract allowed the insurer—an alleged subrogee—to collect damages under the contract's subrogation clause, (3) whether the McCarran-Ferguson Act reverse preempts the Federal Arbitration Act and prevents the forced arbitration of a coverage dispute under an underinsured motorist clause, (4) whether the Foreign Sovereign Immunity Act prevents various state insurance commissioners from suing the Vatican for allegedly violating the Racketeer Influenced and Corrupt Organizations Act and other common law rules, (5) whether state regulators may initiate a direct action against a medical malpractice insurer who allegedly fraudulently adjusted and settled medical malpractice claims, (6) whether the federal district court properly stayed an action in which the sole, bankrupt shareholder of an insured corporation sued the liability insurer for refusing to defend or indemnify the corporation after a patron filed a wrongful-death action against the corporation, and (7) whether a professional liability insurer may commence a legal malpractice action against an insurance defense law firm after the insurer settles an underlying lawsuit but before an appeal of an adverse jury verdict in the underlying suit.[10]

Petitioners asked the Fifth Circuit to decide three less litigated substantive questions: (1) whether a health insurer has a contractual duty to reimburse a healthcare provider for the costs of treating a terminated employee, a participant under an Employee Retirement Income Security Act (ERISA) group medical plan, (2) whether an insurer engages in fraudulent conduct by failing to disclose all material information before selling Medicare Supplement and Select Insurance contracts to another insurer, and (3) whether, under a service agreement, a subcontractor has a duty to indemnify the contractor's liability insurer after the insurer settles the contractor and subcontractor's employee's personal injury claim.[11]

For sure, the court of appeals spent the overwhelming majority of its time and resources answering the familiar and frequently litigated substantive questions of whether insurers were liable for refusing to pay first party

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losses of nearly $1 billion last month, according to Insurance Services Office Inc., an insurance-consulting firm. In response, several small insurers left Florida this year, and some of the largest carriers are dropping policyholders or no longer issuing new policies. Floridians also are facing double-digit percentage increases on homeowners' policies, and some mobile-home owners have been unable to find coverage in the private market.

Chad Terhune, *Katrina Begins March, Florida Braces*, WALL ST. J., Aug. 26, 2005, at A2.

9. *See infra* Part II.B.

10. *See infra* Parts II.B-C, IV.A.3-4, IV.C.2.

11. *See infra* Parts II.A.1-2, IV.A.8.

coverage and indemnification claims in a timely manner and whether insurers were liable for a "bad-faith" or negligent refusal to defend insureds against third party claims.[12]

Parts I through III present a more comprehensive analysis of relevant facts and questions appearing in the twenty-four published insurance decisions.[13] Furthermore, following the practice appearing in previous reviews, the author conducted a content analysis of the decisions, generated some percentages, and performed a limited empirical analysis of the findings.[14]

Therefore, in Part V, several tables appear illustrating the types of legal questions, theories of recovery, types of plaintiffs and defendants, types of first and third party victims, and types of insurance contracts appearing in the various controversies.[15]

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12. *See, e.g.*, DeLeon v. Lloyd's London, Certain Underwriters, 259 F.3d 344, 354 (5th Cir. 2001); *see infra* Parts II.B.3, II.C.2-3, IV.A-C.

> Article 21.55 of the Texas Insurance Code requires the prompt payment or resolution of claims according to a defined timetable. This timetable is only triggered by the filing of a "claim," defined as "a first party claim made by an insured or a policyholder under an insurance policy or contract or by a beneficiary named in the policy or contract that must be paid by the insurer directly to the insured or beneficiary."

DeLeon, 259 F.3d at 354; *see* Parts III.A-C and accompanying text; *see also* Gen. Star Indem. Co. v. Vesta Fire Ins. Corp., 173 F.3d 946, 949-50 (5th Cir. 1999).

> Texas law recognizes only one tort duty in the context of third party claims against an insured, that being the duty owed by a primary insurer to its insured, as set forth . . . in the landmark case of *G.A. Stowers Furniture Co. v. American Indemnity Co.* 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved). In *Stowers*, the Texas Commission of Appeals held that an insurer which, under the terms of its policy, assumes control of a claim, becomes the agent of the insured and is held to the degree of care and diligence that an 'ordinarily prudent person would exercise in the management of his own business.' Although *Stowers* focused specifically on an insurer's obligation to settle within the limits of its policy, the duty owed by an insurer to its insured has because been broadly interpreted by the Texas Supreme Court to include the full range of obligations arising out of an agency relationship. A breach of the *Stowers* duty . . . gives rise to a cause of action in negligence against that insurer.

General Star Indem. Co., 173 F.3d at 949-50.

13. *See infra* Parts I-III.

14. *See infra* Part IV.

15. *See infra* Part V.

II. FIRST PARTY INSURANCE CONTRACTS—STATE COMMON LAW CLAIMS AND DECISIONS

A. Health Insurance

1. Whether Under Louisiana Law a Health Insurer Has a Duty to Reimburse a Healthcare Provider for the Costs of Treating a Terminated Employee Who Was Still a Member of an ERISA Group Medical Plan

In 1994, an article appeared in the *Wall Street Journal* and the title asked: "Who Pays the Doctor if You're Too Sick to Work?"[16] Here are the relevant points that appeared in the article:

> Susan Marchand, like a lot of Americans, thought the most valuable thing about having health coverage from her employer was that she'd be protected if she suffered a catastrophic illness or injury.
>
> But . . . the 47-year-old . . . bank employee became too disabled to work because of a back injury and multiple sclerosis . . . .[Six months later Susan's] employer terminated her health coverage.
>
> Chances are, your employer would do the same.
>
> Most small- and medium-size employer health plans cut off coverage soon after an employee becomes too disabled to work. And in a major shift, even large employers that have traditionally provided medical benefits to disabled employees until they reach age 65are also dropping coverage.
>
> . . . .
>
> For those whose employers don't provide medical coverage after they become disabled and who aren't yet eligible for Medicare, one stopgap option is "COBRA" coverage. Under federal law, people who work at companies with more than 20 employees have the right to continue coverage under their employer's health plan for 18 months after they terminate employment (29 months for disabled employees), provided they pay the premiums themselves, plus a surcharge for disabled people that brings the total cost to 150% of the group plan cost.[17]

Like Susan's employer, the employer in *Lifecare Hospitals, Inc. v. Health Plus of Louisiana, Inc.* also terminated a seriously ill employee.[18] The employee did not pay the necessary premiums immediately after his termination to justify his continued medical coverage under the employees' benefit plan.[19] Yet, the Fifth Circuit ordered the insurer to reimburse the

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16. Ellen E. Schultz, *Who Pays the Doctor if You're Too Sick to Work*, WALL ST. J., Dec. 9, 1994, at C1.

17. *Id.*

18. Lifecare Hosps., Inc. v. Health Plus of La., Inc., 418 F.3d 436, 437 (5th Cir. July 2005).

19. *Id.* at 437-38.

healthcare provider who treated the terminated and allegedly uninsured employee.[20] How did the Court of Appeals for the Fifth Circuit reach that bewildering conclusion?

First, consider the pertinent facts in *Lifecare Hospitals*. Custom-Bilt Cabinet & Supply, Inc. employed James Sloan.[21] Health Plus of Louisiana, Inc. is a private health insurer that sells health plans or "employees' benefit plans" to employers.[22] In April 2000, Custom-Bilt and Health Plus entered into a Group Service Agreement (Custom Plan), under which Health Plus agreed to provide medical services for Custom-Bilt employees.[23] "Health Plus, through its contracted physicians and hospitals, arranged for medical services to be provided to Custom-Bilt's employees in accordance with terms outlined in the plan."[24] James Sloan participated in the plan.[25]

ERISA regulates the Custom Plan and similar employees' benefit plans.[26] In particular, ERISA outlines various rights and obligations of parties —employees, beneficiaries, employers and administrators—associated with an employee benefit plan.[27] More significant, Congress amended ERISA by

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20. *Id.* at 443.

21. *Id.* at 437.

22. *Id.* at 438.

23. *Id.*

24. *Id.*

25. *Id.*

26. Employment Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001, 1132(a) (2000). Congress enacted ERISA to protect the rights of employees and their beneficiaries in employee benefit plans. Importantly, ERISA preempts the application of state law remedies when an employee seeks redress under an employee benefit plan. *See* § 1144.

> § 1144. Other laws
>
> (a) Supersedure; effective date
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.
>
> (b) Construction and application.
>
> . . .
>
> (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> [(2)](B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Id.

27. *See* § 1001. ERISA complainants may commence a number of contract- and tort-based actions in a court of law to secure various remedies. For an excellent review of various actions sounding in contract law, *see* Professor George Flint's analysis and general discussion in *ERISA: Reformulating the Federal Common Law for Plan Interpretation*, 32 SAN DIEGO L. REV. 955, 956-57 (1995).

Under state contract law, litigants developed four recovery theories. Under contract law's

enacting the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).[28] COBRA was a congressional response to "'"reports of the growing number of Americans without any health insurance coverage and the decreasing willingness of . . . hospitals to provide care to those who cannot afford to pay."'"[29] Thus, COBRA attempts "to preserve employees' medical insurance as they move from job to job" and prevent the loss of insurance coverage that could accompany any changes in employment.[30]

On July 16, 2001, Sloan became seriously ill.[31] Later that month, healthcare personnel transferred Sloan to Lifecare Hospital—a long term acute care hospital.[32] Sloan stayed there until December 12, 2001.[33] Also, in July 2001, Sloan's wife, Beatrice, went to Custom-Bilt's office to ask about her husband's insurance benefits.[34] She met with Francis Caldwell, presumably someone in the personnel or human resources office.[35] At that time, Caldwell stressed the importance of her husband exercising his right and purchasing COBRA health insurance coverage.[36] Before ending the meeting, Caldwell secured a COBRA enrollment form, along with instructions, and gave it to Mrs. Sloan.[37]

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gratuity theory, courts treated the employer's promise to pay benefits as a future gift . . . .

Second, under the bilateral contract theory, the participant's continued employment constituted consideration for the employer's promise to pay the benefit. . . .

Third, under the unilateral contract theory, the participant's benefit constituted deferred compensation, retention of which would result in unjust enrichment of the employer. . . .

Fourth, under the estoppel theory, the court held that the participant's right to a plan benefit arose because of his reliance on the promise of benefits in continuing his work with that employer.

George Flint, *ERISA: Reformulating the Federal Common Law for Plan Interpretation*, 32 SAN DIEGO L. REV. 955, 956-57 (1995).

28. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (1986).

29. *Lifecare*, 418 F.3d at 441 (citing Brock v. Primedica, Inc., 904 F.2d 295, 296 (5th Cir.1990)).

30. Teweleit Hosps. v. Hartford Life and Accident Ins. Co., 43 F.3d 1005, 1006, 1008-09 (5th Cir.1995); *see also* McGee v. Funderburg, 17 F.3d 1122, 1124 (8th Cir.1994) ("ERISA, as amended by COBRA, is remedial legislation which should be liberally construed to effectuate Congressional intent to protect employee participants in employee benefit plans."); *accord* Smith v. CMTA-IAM Pension Trust, 746 F.2d 587, 589 (9th Cir.1984); Rettig v. Pension Benefit Guar. Corp., 744 F.2d 133, 155 n.54 (D.C. Cir. 1984).

31. *Lifecare Hosps.*, 418 F.3d at 438.

He was . . . diagnosed with Guillain-Barré Syndrome, a life-threatening disorder, considered a medical-emergency, in which the body's immune system attacks part of the peripheral nervous system. The syndrome is characterized by a rapid onset of paralysis sometimes leading to virtual total paralysis. As was the case in Sloan's situation, the breathing muscles often become so weakened that a machine is required to keep the patient alive. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.*

During James Sloan's tenure at Lifecare Hospital, Custom-Bilt officially terminated Sloan's employment on August 13, 2001.[38] After learning about Sloan's termination of employment, Health Plus, the insurer, terminated Sloan's healthcare coverage effective August 31, 2001.[39] Once more, in late November 2001, Custom-Bilt gave additional written information to the Sloans regarding James Sloan's rights under COBRA.[40] The employer also gave James a second COBRA election form.[41]

On December 17, 2001, nearly four months after losing his employment, Sloan mailed his completed COBRA election form to Health Plus, along with a payment for premiums for September through December.[42] Lifecare, rather than Sloan, paid the premiums of $180 per month, and the record indicates that the insurer accepted the premiums.[43]

About a week later, on December 21, 2001, Lifecare submitted claims to Health Plus.[44] Those claims were for medical services that Health Plus delivered to Sloan between September 1, 2001 and December 12, 2001.[45] Health Plus denied the claims.[46] The insurer alleged that Sloan was no longer a Health Plus member because Sloan did not make a timely election of continued coverage under COBRA.[47]

Unsatisfied, Lifecare Hospital filed a suit in equity against Health Plus in the District Court for the Western District of Louisiana.[48] In the indemnification action, Lifecare alleged that Sloan made a timely election and that Health Plus was obligated to pay $252,154.56 for Sloan's unpaid medical expenses.[49] The district court found that, as a matter of law, Custom-Bilt's attempt to inform Sloan of his right to continued medical coverage under COBRA in July 2001 was insufficient.[50] Granting Lifecare's motion for summary judgment, the court found that Sloan did not receive valid notice until November 2001.[51] Consequently, Sloan's COBRA election in December 2001 was timely and Health Plus had to pay $252,154.56.[52] The insurer appealed.[53]

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38. *Id.*
39. *Id.*
40. *Id.*
41. *Id.*
42. *Id.*
43. *Id.*
44. *Id.*
45. *Id.*
46. *Id.*
47. *Id.* at 439.
48. *Id.*
49. *Id.*
50. *Id.*
51. *Id.*
52. *Id.*
53. *Id.*

Before the Fifth Circuit, Health Plus argued that employers are required only to make a good faith effort to provide employees adequate notification of their COBRA rights.[54] Certainly, the insurer acknowledged that the Custom Plan was silent regarding the exact deadline for a member to select continued coverage under COBRA.[55] But, Health Plus stressed that the COBRA statute provides a sixty day default election period.[56] Health Plus argued that Mrs. Sloan received notice to exercise her husband's COBRA rights in July 2001.[57] The Sloans, however, did not purchase COBRA coverage in a timely manner —within sixty days of Sloan's termination.[58] Therefore, from the insurer's perspective, James Sloan was not a Custom Plan member after August 31, 2001, and Health Plus should not be accountable for his medical expenses.[59]

Contrarily, Lifecare insisted that Custom-Bilt did not give Sloan any timely or adequate notice regarding his COBRA rights and the employer did not make a good faith attempt to do so.[60] Lifecare asserted that Sloan did not receive adequate notice until December 2001 and that his right to purchase COBRA coverage began on that date.[61] Thus, from Lifecare's perspective, Sloan's election was timely because he elected to continue COBRA coverage within sixty days of being notified in December.[62]

The Fifth Circuit began its analysis by examining the plain language of COBRA's "election period" provision—section 1165(1), which reads as follows:

> The term "election period" means the period which—
> (A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,
> (B) is of at least 60 days' duration, and
> (C) ends not earlier than 60 days after the later of—
> (i) the date described in subparagraph (A), or

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54. *Id.* at 440.

> Lifecare and Health Plus focus[ed] their arguments primarily on whether Mrs. Sloan's July meeting with Caldwell, a Custom-Bilt representative, met the minimum statutory requirements for notification of COBRA rights. Health Plus assert[ed] that because the July notice was adequate, Sloan had until October 31, 2001 to elect COBRA continuation coverage, thus, his December election was untimely.

Id.

55. *See id.*
56. *Id.*
57. *Id.*
58. *Id.* at 439.
59. *Id.* at 440.
60. *Id.*
61. *Id.*
62. *Id.*

(ii) in the case of any qualified beneficiary who receives notice under section 1166(4) of this title, the date of such notice.[63]

The Fifth Circuit concluded that the statute's plain language requires at least a sixty day COBRA election period, to be measured from the later of either the qualifying event date or the date when the beneficiary receives notice of his COBRA options.[64] But the court found that "the statute does not mandate any outer boundary for the election period."[65] Stated a bit differently, a COBRA employee "must have a minimum election period of at least 60 days but the statute is silent with respect to the maximum length of an election period."[66] Among other things, this means that participants in an ERISA plan may "choose to have an election period of any length, so long as it is at least 60 days long."[67]

The Fifth Circuit declared that the Custom Plan "did not limit the election period in any way."[68] The court of appeals found no maximum election period and no immediate deadline for James Sloan to elect COBRA coverage.[69] The statute left it to the contracting parties to limit the election period, and the Custom Plan stated that "Health Plus [was] only responsible for a terminated employee's health care expenses for eighteen months after termination, subject to certain limiting conditions."[70] And, Sloan could choose COBRA coverage at any time within the eighteen-month period allowed for continuation coverage.[71]

Furthermore, assuming that Mrs. Sloan's meeting in July 2001 with Caldwell was an adequate notification of COBRA rights, Sloan's election in December 2001 was still timely because no sixty-day deadline existed.[72] Therefore, the court concluded that Health Plus had to reimburse Lifecare for the cost of medical services delivered to Sloan.[73] The Fifth Circuit also found that Custom-Bilt did not have to indemnify the insurer, Health Plus, for Sloan's medical expenses.[74] The court concluded: "Even assuming Custom-Bilt failed in its July attempt to fulfill its contractual and statutory duty to notify, its failure did not harm Health Plus."[75]

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63. *Id*; 29 U.S.C. § 1165 (2000).
64. *Lifecare Hosps.*, 418 F.3d at 441.
65. *Id.*
66. *Id.* (citing 26 C.F.R. § 54.4980B-6).
67. *Id.*
68. *Id.*
69. *Id.*
70. *Id.*
71. *Id.*
72. *Id.*
73. *Id.* at 443.
74. *Id.*
75. *Id.*

Without doubt, the court of appeals reached the correct conclusions. But note: Lifecare's complaint was an action in equity for indemnification; consequently, both the lower and appellate courts' tasks could have been considerably easier. Lifecare only wanted a declaration of Health Plus's contractual obligations under a contract.[76] Yet, the district court entertained the parties' various motions for summary judgment—a needless and, arguably, harmful practice that occurs all too often in equitable actions. This writer has criticized the widespread and careless use of summary judgments in equitable trials in which litigants only want a declaration of rights and obligations.[77] Why? Like the federal district and appellate courts in the present case, federal and state courts spend an inordinate amount of precious and limited judicial resources deciding whether to award summary judgments, an exercise that focuses primarily on questions of fact rather than questions of law.[78]

Whether an insurer has a duty to indemnify or make reimbursements under a contract is generally viewed as a question of law.[79] But in the present case, both courts spent valuable resources on a relatively inconsequential question of fact: Whether James Sloan satisfied the requirements under

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76. *Id.* at 438 ("Health Plus, through its contracted physicians and hospitals, arranged for medical services to be provided to Custom-Bilt's employees in accordance with terms outlined in the plan.").

77. *See* Willy E. Rice, *Questionable Summary Judgments, Appearances of Judicial Bias, and Insurance Defense in Texas Declaratory-Judgment Trials: A Proposal and Arguments for Revising Texas Rules of Civil Procedure 166a(a), 166a(b), and 166a(l)*, 36 ST. MARY'S L.J. 535, 638-39 (2005).

> Texas's trial judges participate in another unsettling practice. Instead of conducting full-blown declaratory-judgment trials, trial judges regularly grant or deny summary-judgment motions without giving intelligible, meticulous, or studious explanations of their rulings. As a consequence, Texas's appellate courts must spend an enormous amount of time and limited judicial resources exploring various plausible theories to determine whether an unexplained summary-judgment ruling was sound or erroneous.
>
> Texas's courts of appeals must engage in such costly, wasteful, and unnecessary conduct whenever a party challenges any unfavorable summary-judgment ruling because the Texas Supreme Court has been consistently clear regarding one particular summary-judgment issue: When a trial court does not specify the ground for a summary judgment, the appealing party may proffer multiple theories to establish that the judgment was erroneous. In other words, to generate more costs and ensure that appellate courts consume even more judicial resources, an appellant may present an assortment of reasons to explain why a summary judgment was unwarranted.

Id.

78. *Lifecare Hosps.*, 418 F.3d at 439-40.

79. *See, e.g.*, Liberty Mut. Ins. Co. v. Pine Bluff Sand & Gravel Co., 89 F.3d 243, 245-46 (5th Cir. 1996) ("Newberg filed this diversity action in federal district court, seeking recovery, pursuant to the indemnification provision of the Subcontract Agreement . . . . [Q]uestions of law are reviewed de novo.").

> "[Q]uestions of law are reviewed de novo." American Economy avers that the district court applied an incorrect standard when it determined that it had a duty to indemnify the Church. American Economy contends that this error stemmed from the district court's incorrect assumption that the duty to indemnify is inexorably linked to the duty to defend. American Economy asserts that the district court assumed that it had the duty to indemnify the Church because of its duty to defend the Church.

Am. States Ins. Co. v. Synod of the Russian Orthodox Church Outside of Russ., 335 F.3d 493, 495 & n.2 (5th Cir. 2003).

COBRA's election period.[80] The Fifth Circuit overlooked the important points.[81] Louisiana's equitable estoppel and waiver-of-rights rules are clear: When applicants for insurance pay their premiums and the insurer accepts those premiums, the insurer may be estopped from asserting that the applicants are not covered under an insurance contract.[82]

In fact, the doctrine of equitable estoppel applies and prevents an insurer from denying coverage, even if an insured pays his premiums late.[83] Furthermore, if an insurer accepts the applicant's premiums, the applicant may argue waiver.[84] Thus, a court may conclude that the insurer waived its right to demand a timely submission of a completed and signed application.[85] The Fifth Circuit, in particular, should have considered and applied these doctrines. In the process, the appellate court would have saved valuable time and resources.

2. *Whether Under Texas Law an Insurer Commits Fraud by Failing to Disclose all Material Information Before Selling Medicare Supplement and Select Insurance Contracts to Another Insurer*

The litigants in *United Teacher Associates Insurance Co. v. Union Labor Life Insurance Co.*, are insurers who were allegedly parties to a sales contract.[86] United Teacher Associates Insurance Company (United Teacher)

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80. *Lifecare Hosps.*, 418 F.3d at 439-43.

81. *Id.*

82. *See, e.g.*, Harding v. Metro. Life Ins. Co., 188 So. 177, 182 (La. Ct. App. 1939).

> [R]etention of the premium and failure to reject within a reasonable time may imply an acceptance. . . . Even though it be true that technically no contract has been made because the offer tendered has never been accepted, it is evident that there may be situations in which substantial harm may come to the applicant by reason of the failure of the insurer to act with reasonable promptness upon the tendered application.

Id.

83. *See, e.g.*, Maddox v. Keen, 756 So.2d 1279, 1283 (La. Ct. App. 2000).

> In Louisiana, the doctrine of equitable estoppel applies to situations [when] an insurer's custom of accepting overdue premiums reasonably leads an insured to believe his policy will remain in effect even though he has not paid the premiums when due. . . . The doctrine of equitable estoppel is designed to prevent a miscarriage of justice by preventing one from taking a position contrary to his prior acts, admissions, representations, or silences when another has changed his position in detrimental reliance thereon.

Id. The following conditions must be present to establish equitable estoppel: "(1) there must be a habit or custom of accepting overdue premiums; and (2) the insured must reasonably believe that by reason of this custom the insurer will maintain the policy in effect without prompt payment of the premiums." Ledent v. Guar. Nat'l Ins. Co., 723 So.2d 531, 536 (La. Ct. App. 1998).

84. *Maddox*, 756 So. 2d at 1284-85.

85. *Cf.* Bush v. Liberty Indus. Ins. Co., 130 So. 839, 840 (La. Ct. App. 1930) (holding that acceptance of premiums which were in arrears for approximately sixteen weeks and without requiring compliance with other provisions of the policy operated as an insurer's waiver of rights).

86. United Teacher Assocs. Ins. Co. v. Union Labor Life Ins. Co., 414 F.3d 558 (5th Cir. June 2005).

is the alleged purchaser, with its principal place of business in Texas.[87] Union Labor Life Insurance Company and its subsidiary, Union Standard of America Life Insurance Company (collectively UnionUnion-USAUSA), are the alleged sellers.[88] Union-USA's principal place of business is in Florida.[89] The alleged buyer commenced a common law fraud action against the seller, and the latter filed an action in equity against the alleged buyer seeking declaratory relief and specific performance.[90]

Union-USA sold individual Medicare Supplement[91] and Medicare Select insurance contracts (collectively Medicare Block), to senior citizens in Florida.[92] But the insurer wanted to sell its business to a willing buyer.[93] Before selling the Medicare Block business, however, the Florida Department of Insurance (FDI) issued two consent orders that restricted Union-USA's

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87. *Id.* at 561.

88. *Id.*

89. *Id.*

90. *Id.* at 562-63.

91. *See* U.S. Department of Health & Human Services, Medigap (Supplemental Insurance) Policies, http://www.medicare.gov/medigap/default.asp (last visited Apr. 10, 2007). The following information appears on the website of the Department of Health and Human Services:

> A Medigap policy is health insurance sold by private insurance companies to fill in the "gaps" in the Original Medicare Plan coverage. Medigap policies help pay some of the health care costs that the Original Medicare Plan doesn't cover. If [an individual participates in an] Original Medicare Plan and [has] a Medigap policy, then Medicare and [the] Medigap policy will pay [their respective] shares of covered health care costs.
>
> . . .
>
> Medigap policies must follow [f]ederal and [s]tate laws. . . . [They] must be clearly identified . . . as "Medicare Supplement Insurance."
>
> . . .
>
> Generally, when [an individual buys] a Medigap policy [that person must have already purchased] Medicare Part A and Part B. . . . In addition, [the individual] will have to pay a premium to [a] Medigap insurance company.

Id.

92. *United Teacher Assocs.*, 414 F.3d at 561-62; *see* State of New York, Information for Medicare Beneficiaries, http://www.ins.state.ny.us/caremain.htm#sub_sel (last visited Mar. 14, 2007). At the website, the following description of Medicare Select insurance contracts appears:

> Medicare Select is a type of Medigap policy that requires insureds to use specific hospitals and in some cases specific doctors (except in an emergency) in order to be eligible for full benefits. Other than the limitation on hospitals and providers, Medicare Select policies must meet all the requirements that apply to a Medigap policy. Medicare Select policies may have lower premiums because of this requirement.
>
> When [one uses] the Medicare Select network hospitals and providers, Medicare pays its share of approved charges and the insurance company is responsible for all supplemental benefits in the Medicare Select policy. In general, Medicare Select policies are not required to pay any benefits if [one does] not use a network provider for non-emergency services. However, Medicare will still pay its share of approved charges no matter what provider [one uses].
>
> The availability of Medicare Select coverage is limited to the geographic areas of the state serviced by the particular policy's network of hospitals and doctors.

New York State, Information for Medicare Beneficiaries, http://www.ins.state.ny.us/caremain.htm#sub_sel (last visited Mar. 14, 2007).

93. *United Teacher Assocs.*, 414 F.3d at 562.

ability to increase the rate of premiums for the Medicare Block.[94] On May 27, 1997, Union-USA accepted the consent order restricting premium increases for two years on Medicare Select policies in Florida.[95] On June 18, 1999, Union-USA embraced the FDI's second order that allowed a 12% premium rate increase on the Medicare Supplement policies in force before the effective date of the consent order, but restricting future rate increases unless Union Labor could satisfy certain conditions.[96]

About five months after accepting the consent orders, Union-USA decided to sell its business—all Medicare Block insurance policies.[97] Union-USA assembled a team of representatives to respond to prospective purchasers' requests for information and inquiries.[98] Jennifer Lazio, Union-USA's associate actuary, headed the team.[99] Larry Doze, President of United Teacher, requested information about the proposed sale.[100] Lazio responded and sent Union-USA's rate-filing information regarding the 1998 Medicare Supplement policies and an actuarial memorandum about the Medicare Select policies.[101]

During that initial interaction, however, Lazio did not mention the consent orders.[102] As part of his "due diligence investigation," Doze subsequently requested other documents and information to assess Medicare Block's profitability.[103] But Larry Doze never requested any information about the consent orders or about impediments to future rate increases.[104] Consequently, the president of United Teacher never received any information about FDI's intervention and oversight.[105] On the other hand, during the negotiations between Doze and Lazio, the latter disclosed that FDI had recently approved a 12% and an 8% increase in premiums for Medicare-Supplement and Medicare-Select insurance, respectively.[106] But again, Union-USA's associate actuary never disclosed to United Teacher's president that consent orders governed those rate increases.[107]

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94. *Id.*

95. *Id.* at 561 & n.1 ("'Trend' increases are increases based solely on the growth in claims from year to year because of medical inflation, the increased utilization of medical services, and general inflation. They do not take into account the actual experience of a line of business.").

96. *Id.* at 561 n.2 ("In Florida, an insurer must issue at least 500 new policies to get 'partial credibility,' and at least 2,000 new policies to get 'full credibility,' in order to obtain future rate increases based on the actual experience of a line of business.").

97. *Id.* at 561.

98. *Id.*

99. *Id.*

100. *Id.* at 562.

101. *Id.*

102. *Id.*

103. *Id.* at 561-62.

104. *Id.* at 562.

105. *Id.*

106. *Id.*

107. *Id.*

United Teacher decided to purchase the Medicare Block in November 1999, using a letter of agreement and promising to consummate a formal written agreement.[108] In August 2000, however, United Teacher reversed its decision.[109] Nine months passed before the alleged buyer rejected the offer.[110] Therefore, on December 6, 2000, Union-USA commenced a breach-of-contract action against United Teacher in the U.S. District Court for the District of Columbia (D.C. Lawsuit).[111]

On October 4, 2001, the parties settled the D.C. Lawsuit with Union-USA agreeing to pay United Teacher $2.5 million.[112] In return, United Teacher agreed to acquire the Medicare Block insurance policies.[113] The parties signed the Medicare Block Agreements (Agreements) on October 4, 2001, but the closing date was October 15, 2001.[114] Still, during the settlement negotiations, Union-USA did not reveal the FDI's consent orders.[115] On October 22, 2001, Lazio participated in a conference call to United Teacher, and during that session, she disclosed information about the 1999 consent order for the first time without prodding.[116]

After learning of both consent orders, United Teacher understood the full impact and significance of the consent orders from a business perspective.[117] Therefore, on December 18, 2001, United Teacher contacted Union-USA.[118] During that exchange, the alleged buyer announced that it would rescind the Agreements.[119] And on that very day, United Teacher filed a lawsuit against Union-USA in a Texas state court alleging common law fraud against the seller.[120] In the complaint, the alleged buyer-insurer petitioned the state court to rescind the Agreements.[121]

In state court, United Teacher argued that Union-USA failed to disclose material facts about its Medicare Block business before the sale.[122] Claiming a diversity of citizenship, Union-USA removed the lawsuit to the U.S. District Court for the Western District of Texas.[123] Subsequently, United Teacher

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108. *Id.*
109. *Id.*
110. *Id.*
111. *Id.*
112. *Id.*
113. *Id.*
114. *Id.*
115. *Id.*
116. *Id.*
117. *Id.* at 561-63. "On October 22, 2002, nearly a year after it learned about the 1999 consent order, United Teacher, which was investigating a discrepancy in the Medicare Select line's lifetime loss ratios, learned for the first time of the 1997 consent order." *Id.* at 562.
118. *Id.* at 563.
119. *Id.*
120. *Id.* at 562.
121. *Id.*
122. *Id.*
123. *Id.*

amended its complaint and requested damages.[124] Countering, Union-USA filed a declaratory judgment action, petitioning the district court to declare that the Agreements were valid.[125] The latter insurer also asked the court to compel United Teacher's specific performance under the Agreements.[126]

Following a bench trial, the district court found that United Teacher did prove a prima facie case of fraud.[127] To reach that conclusion, the lower federal court found the following: (1) Under Texas law, a duty to disclose only arises if "a confidential or fiduciary relationship between the parties" exists; and (2) "no confidential or fiduciary relationship existed between United Teacher and Union-USA."[128] In its amended findings, the district court addressed Union-USA's declaratory judgment action and request for specific performance.[129] The District Court for the Western District of Texas declared that "the Agreements 'are valid and binding, and that [United Teacher] must perform its obligations thereunder.'"[130] United Teacher appealed the district court's amended and final judgment.[131]

Also, United Teacher allegedly failed to pay the assessed damages and failed to perform all necessary tasks to effectuate the district court's order.[132] Therefore, citing 28 U.S.C. § 2202, Union-USA filed a motion to reopen and for further declaratory relief.[133] Again, Union-USA encouraged the district court to force United Teacher to pay its debts and obligations under the agreements.[134] The court summarily denied the motion.[135] Union-USA appealed the denial to the Fifth Circuit, where the court of appeals consolidated both insurers' appeals.[136]

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124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.* at 563.

128. *Id.*; *see also* Engstrom v. First Nat'l Bank of Eagle Lake, 936 S.W.2d 438, 444-45 (Tex. App.—Houston [14th Dist.] 1996, writ denied) (requiring proof of a confidential or fiduciary relationship); Travel Music of San Antonio, Inc. v. Douglas, No. 04-00-00757-CV, 2002 WL 1058527, at *4 (Tex. App.—San Antonio, 2002) (requiring proof of a confidential or fiduciary relationship).

129. *United Teacher Assocs.*, 414 F.3d at 563.

130. *Id.*

131. *Id.*

132. *Id.*

> On May 7, 2004, Union-USA demanded that United Teacher immediately pay all amounts due and owing to Union-USA under the Agreements and take steps to consummate the transfer of the Medicare Block. According to Union-USA, the amount due and owing at that time was $8,393,660 (for insurance losses and expenses associated with the policies that United Teacher had agreed to assume.

Id.

133. *Id.*; 28 U.S.C. § 2202 (2000). Section 2202 allows a petitioner to secure additional declaratory relief, by request the relief in a motion. § 2202. The statute states: "Further necessary or proper relief based on a declaratory judgment or decree may be granted, after reasonable notice and hearing, against any adverse party whose rights have been determined by such judgment." *Id.*

134. *United Teacher Assocs.*, 414 F.3d at 567.

135. *Id.*

136. *Id.*

On appeal, United Teacher cited the Fifth Circuit's holding in *Union Pacific Resources Group, Inc. v. Rhone-Poulenc, Inc.* and argued that a duty to disclose can exist in Texas absent a fiduciary or confidential relationship between the parties.[137] Therefore, from United Teacher's perspective, Union-USA had a duty to disclose the consent orders, because the district court made an "*Erie* guess" and incorrectly concluded that the holding in *Rhone-Poulenc* conflicted with settled Texas law.[138]

To counter, Union-USA cited the ruling in *Bradford v. Vento*, which the Texas Supreme Court decided three weeks after the Fifth Circuit's ruling in *Rhone-Poulenc*.[139] Put simply, in *Bradford*, the Supreme Court of Texas conclusively established that a duty to disclose does not exist in Texas absent a confidential or fiduciary relationship.[140] Union-USA also presented other Fifth Circuit and Texas intermediate appellate courts' rulings, before and after *Bradford*, stating that no duty to disclose exists absent a fiduciary or confidential relationship.[141]

To resolve United Teacher's fraud claim, the Fifth Circuit concluded that the case did not turn on whether a fiduciary or confidential relationship existed between the two insurers.[142] Instead, the court of appeals found that United Teacher did not meet its burden and prove a prima facie case of fraud.[143] To prevail in Texas, a plaintiff must prove that (1) the defendant "misrepresented

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137. *Id.* at 564 (citing Union Pac. Res. Group, Inc. v. Rhone-Poulenc, Inc., 247 F.3d 574, 586 (5th Cir. 2001).

> A duty to speak arises by operation of law when (1) a confidential or fiduciary duty relationship exists between the parties; or (2) one party learns later that his previous affirmative statement was false or misleading; or (3) one party knows that the other party is relying on a concealed fact . . . and does not have an equal opportunity to discover the truth; or (4) one party voluntarily discloses some but less than all material facts, so that he must disclose the whole truth, i.e., all material facts, lest his partial disclosure convey a false impression.

Rhone-Poulenc, Inc., 247 F.3d at 586.

138. *United Teacher Assocs.*, 414 F.3d at 56-64 (citing Erie R.R. Co. v. Tompkins, 304 U.S. 64 (1938)) ("In order to determine questions of state law, federal courts look to final decisions of the state's highest court.").

139. *Id.* (citing Bradford v. Vento, 48 S.W.3d 749, 760 (Tex. 2001)).

140. *Id.* at 555-56.

> [I]n support of [their] claim, Union-USA cites the following language from *Bradford*: Several courts of appeals have held that a general duty to disclose information may arise in an arm's-length business transaction when a party makes a partial disclosure that, although true, conveys a false impression. The Restatement (Second) of Torts section 551 also recognizes a general duty to disclose facts in a commercial setting. In such cases, a party does not make an affirmative misrepresentation, but what is said is misleading because other facts are not disclosed. *We have never adopted section 551.*

Id. (quoting *Bradford*, 48 S.W.3d at 760) (citations omitted).

141. *Id.* at 565; *see* Coburn Supply Co. v. Kohler Co., 342 F.3d 372, 377 (5th Cir. 2003); Imperial Premium Fin., Inc. v. Khoury, 129 F.3d 347, 352-53 (5th Cir.1997); Bay Colony Ltd. v. Trendmaker, Inc., 121 F.3d 998, 1004 (5th Cir. 1997); Travel Music of San Antonio, Inc. v. Douglas, 2002 WL 1058527, at *4 (Tex. App.—San Antonio 2002, writ denied); Engstrom v. First Nat'l Bank of Eagle Lake, 936 S.W.2d 438, 444-45 (Tex. App.—Houston [14th Dist.] 1996, writ denied).

142. *United Teacher Assocs.*, 414 F.3d at 567.

143. *Id.*

a material fact," (2) the defendant knew the material representation was false or made it recklessly without any knowledge of its truth, (3) the defendant made the false material representation with the intent that it should be acted upon by the plaintiff, and (4) the "plaintiff justifiably relied on the representation and thereby suffered injury."[144]

In particular, United Teacher failed to prove the third element—fraudulent intent.[145] And the appellate court declared that whether the complaining insurer styled the cause of action as fraud by nondisclosure or fraud by affirmative misrepresentation was irrelevant:

> Courts in Texas have consistently held that fraud by nondisclosure or concealment requires proof of all of the elements of fraud by affirmative misrepresentation, including fraudulent intent, with the exception that the misrepresentation element can be proven by the nondisclosure or concealment of a material fact in light of a duty to disclose.[146]

Addressing Union-USA's concerns, the Fifth Circuit found that the district court abused its discretion when that court denied Union-USA's section 2202 motion for further declaratory relief.[147] Union-USA had a right to file a section 2202 motion for further relief, to effectuate the district court's

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144. *United Teacher Assocs.*, 414 F.3d at 566 (citing Ernst & Young, L.L.P. v. Pacific Mut. Life Ins. Co., 51 S.W.3d 573, 577 (Tex. 2001)).

145. *Id.* at 567.

> United Teacher alleges that Union Labor knew the consent orders were material and intentionally concealed them from United Teacher during negotiations. . . . United Teacher points to Union Labor's insistence on performing the 2001 Florida rate filing, which, if performed by United Teacher, would have led to its discovery of the consent orders. United Teacher argues that Union Labor's failure to send the 2001 filing information to Doze promptly after he requested it is further evidence of Union Labor's intent to conceal the consent orders. However, Union Labor explained that it performed the 2001 Florida rate filing because it had access to the necessary information and that when Doze later requested the filing information, it was not readily available because an outside consultant had actually prepared the filing. . . . United Teacher has presented evidence that Union Labor may have intended to conceal the consent orders, but Union Labor's explanations for its allegedly suspicious behavior are plausible. United Teacher has failed in its burden of proof and persuasion.

Id.

146. *Id.* at 567-68. United Teacher contended that the court's "finding is not dispositive of its claim of fraud by nondisclosure because the district court's analysis regarding intent only applied *to* fraud by affirmative misrepresentation." *Id.* In support of this claim, United Teacher argued "that it need not prove intent in order to establish fraud by nondisclosure, because intent is irrelevant when an affirmative duty to disclose exists and was violated." *Id.* The court disagreed: "Because the intent prong is the same in Texas for fraud by affirmative misrepresentation as it is for fraud by nondisclosure or concealment, the district court's finding of a lack of fraudulent intent would apply equally if the district court had found that a common law duty to disclose the consent orders existed." *Id.* at 568. The Fifth Circuit pointed out that United Teachers fraud by nondisclosure claim stood little chance of success because United Teacher failed to challenge the district court's finding of a lack of fraudulent intent in not disclosing the consent orders. *Id.* In light of that fact, the court did not find it necessary to consider the "question of whether a duty to disclose can exist in Texas absent a confidential or fiduciary relationship." *Id.*

147. *Id.* at 574.

prior declaratory judgment and secure damages.[148] The court of appeals also found that the district court's prior declaratory judgment "conclusively established the validity of the Agreements and the fact that they should be specifically performed."[149]

B. Flood Insurance

1. Whether the Class Action Fairness Act of 2005 Preempts an Insured Flood Victim's Filing a Class Action Suit Against Property Insurers in a Louisiana Court

The procedural conflict appearing in *Wallace v. Louisiana Citizens Property Insurance Corp.* is an excellent example of class action controversies that will flood federal courts in the near future, given Congress's recent enactment of the Class Action Fairness Act of 2005 (CAFA).[150] Although Congress enacted the new legislation ostensibly to "assure fair and prompt recoveries for class members" and to ensure that federal courts exercise diversity jurisdiction and consider interstate cases of national importance, the litigation in *Wallace* strongly suggests that CAFA will undermine or slow prompt recoveries for class members.[151]

In *Wallace* Several insurers doing business in Louisiana—Louisiana Farm Bureau Mutual Insurance Company, Louisiana Farm Bureau Casualty Insurance Company, Louisiana Citizens Property Insurance Corporation (LCPIC), and ANPAC Louisiana Insurance Company (collectively, Insurers) —sold flood insurance to various property owners.[152] When Hurricane Katrina devastated parts of Louisiana and caused flood damage, however, the Insurers refused to pay claims.[153] Therefore, one class of property owners sued the Insurers in a then-pending class action suit in the U.S. District Court for the Middle District of Louisiana—the *Chehardy* action.[154] Another class of disgruntled insureds filed a class action suit against the Insurers in a Louisiana

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148. *Id.* at 571.

149. *Id.* at 574.

150. 28 U.S.C.A. § 1332 (West 2006); Wallace v. La. Citizens Prop. Ins. Corp., 444 F.3d 697, 698 (5th Cir. Mar. 2006).

151. Class Action Fairness Act of 2005, Pub. L. No. 109-2, 119 Stat 4, 5; *Wallace*, 444 F.3d at 700. Sec. 2 (b) of CAFA states:

> The purposes of this Act are to—
>
> (1) assure fair and prompt recoveries for class members with legitimate claims;
>
> (2) restore the intent of the framers of the United States Constitution by providing for Federal court consideration of interstate cases of national importance under diversity jurisdiction; and
>
> (3) benefit society by encouraging innovation and lowering consumer prices.

119 Stat 5.

152. *Wallace*, 444 F.3d at 698.

153. *Id.* 698-99.

154. *Id.* at 699.

state court—the *Wallace* action.[155] The Insurers removed the *Wallace* action to the District Court for the Eastern District of Louisiana, asserting that the latter district court had subject matter jurisdiction over the controversy.[156]

The Insurers argued that they met the requirements of section 1441(1)(B) of the Multiparty, Multiforum Trial Jurisdiction Act (MMJTA) because they were also parties to the *Chehardy* action, a separate class action based on section 1369 that arose from the same peril—Hurricane Katrina.[157] To support that assertion, the Insurers cited section 1441(e)(1)(B), which reads in pertinent part:

> [A] defendant in a civil action in a State court may remove the action to the district court . . . if . . . the defendant is a party to an action which is or could have been brought . . . under section 1369 in a United States district court and arises from the same accident as the action in State court, even if the action to be removed could not have been brought in a district court as an original matter.[158]

Two relevant subsections are under section 1369.[159] The first section, 1369(a), provides:

> The district courts shall have original jurisdiction of any civil action involving minimal diversity between adverse parties that arises from a single accident, where at least 75 natural persons have died in the accident at a discrete location, if:
>
> (1) a defendant resides in a State and a substantial part of the accident took place in another State or other location, regardless of whether that defendant is also a resident of the State where a substantial part of the accident took place;
>
> (2) any two defendants reside in different States, regardless of whether such defendants are also residents of the same State or States; or
>
> (3) substantial parts of the accident took place in different States.[160]

The other section, 1369(b), places limitations on district courts' jurisdictions and reads:

> The district court shall abstain from hearing any civil action described in subsection (a) in which:

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155. *Id.* 698-99.
156. *Id.*
157. *Id.*; 28 U.S.C. §§ 1369, 1441(e)(1)(B) (Supp. 2003).
158. *Id.* § 1441(e)(1)(B).
159. *Wallace*, 414 F.3d at 698-99.
160. § 1369(a).

> (1) the substantial majority of all plaintiffs are citizens of a single State of which the primary defendants are also citizens; and
> (2) the claims asserted with be governed primarily by the laws of that State.[161]

The Insurers observed that both the *Wallace* and *Chehardy* actions involved insurance claims and damages associated with Hurricane Katrina.[162] Therefore the Insurers claimed that because section 1369(a) allowed the district court to exercise subject matter jurisdiction over those claims, section 1441(e)(1)(B) allowed the other district court to exercise supplemental jurisdiction over the *Wallace* action.[163]

After entertaining the Insurers' argument, the District Court for the Eastern District of Louisiana remanded the *Wallace* action to the Louisiana state court.[164] To justify the remand, the district court concluded that section 1369(b)'s mandatory abstention provisions prevented a federal court from hearing the *Wallace* action.[165] The Insurers appealed to the Fifth Circuit, arguing that the district court erred when the court read § 1369(b)'s "mandatory abstention provisions" into section 1441(e)(1)(B)—the MMTJA's removal statute.[166]

At the outset, the Fifth Circuit considered the language appearing in section 1447(d):

> An order remanding a case to the State court from which it was removed is not reviewable on appeal or otherwise, except that an order remanding a case to the State court from which it was removed pursuant to section 1443 of this title shall be reviewable by appeal or otherwise.[167]

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161. § 1369(b).
162. *Wallace*, 444 F.3d at 699.
163. *Id.*
164. *Id.*
165. *Id.*
166. *Id.*
167. *Id.* Section 1447 outlines the applicable procedures after a case has been removed to federal court. 28 U.S.C. § 1447 (2000). In its entirety, the statute states:

> (a) In any case removed from a State court, the district court may issue all necessary orders and process to bring before it all proper parties whether served by process issued by the State court or otherwise.
> (b) It may require the removing party to file with its clerk copies of all records and proceedings in such State court or may cause the same to be brought before it by writ of certiorari issued to such State court.
> (c) A motion to remand the case on the basis of any defect other than lack of subject matter jurisdiction must be made within 30 days after the filing of the notice of removal under section 1446(a). If at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded. An order remanding the case may require payment of just costs and any actual expenses, including attorney fees, incurred as a result of the removal. A certified copy of the order of remand shall be mailed by the clerk to the clerk of the State court. The State court may thereupon

The court of appeals also examined the Supreme Court's decision in *Things Remembered, Inc. v. Petrarca* and stressed that federal courts' powers to review a remand order are limited under section 1447(d).[168] But, the Insurers argued that a recently enacted provision of CAFA gave the court of appeals authority to hear the appeal.[169] Of course, the Insurers were referring to 28 U.S.C.A. § 1453(c)(1) of CAFA, which reads:

> [Section 1447] shall apply to any removal of a case under this section, except that notwithstanding [28 U.S.C. § 1447(d)], a court of appeals may accept an appeal from an order of a district court granting or denying a motion to remand a class action to the State court from which it was removed if application is made to the court of appeals not less than 7 days after entry of the order."[170]

The court of appeals, however, refused to embrace the Insurers' argument.[171] The court of appeals correctly observed: The legislative history of CAFA indicates that Congress "enacted 28 U.S.C. § 1453(c)(1) to ensure expeditious review of remand decisions in class action suits brought under the new legislation."[172] Applying the plain meaning test and carefully reviewing the phrase "'any removal of a case under this section,'" the Fifth Circuit declared that 28 U.S.C.A. § 1453(c)(1) only permits the removal of class actions under CAFA.[173]

But the Court of Appeals for the Fifth Circuit did not end its analysis at that point.[174] The appellate declared that it still could exercise jurisdiction over the present case under section 1291, which reads in pertinent part:

> proceed with such case.
> (d) An order remanding a case to the State court from which it was removed is not reviewable on appeal or otherwise, except that an order remanding a case to the State court from which it was removed pursuant to section 1443 of this title shall be reviewable by appeal or otherwise.
> (e) If after removal the plaintiff seeks to join additional defendants whose joinder would destroy subject matter jurisdiction, the court may deny joinder, or permit joinder and remand the action to the State court.

Id.

168. *Wallace*, 444 F.3d at 699 (citing Things Remembered, Inc. v. Petrarca, 516 U.S. 124, 127 (1995)).

169. *Id.*

170. 28 U.S.C.A. § 1453(c)(1) (West 2006).

171. *Wallace*, 444 F.3d at 700 ("We disagree that § 1453(c)(1) confers appellate jurisdiction over the instant appeal.").

172. *Id.*

173. *Id.* at 700 (quoting CAFA §1435(c)(1)). "The application of § 1453(c)(1) is therefore limited to the context of CAFA. [T]hus no nexus with CAFA [exists] that would justify the exercise of appellate jurisdiction under § 1453(c)(1). Accordingly, we lack appellate jurisdiction under § 1453(c)(1)." *Id*; *cf.* Transp. Ins. Co. v. Standard Oil Co. of Tex., 337 S.W.2d 284, 288 (Tex. 1960) (reiterating that courts must give words appearing in insurance contracts their plain meaning when no ambiguity exists).

174. *Wallace*, 444 F.3d at 700.

> The courts of appeals (other than the United States Court of Appeals for the Federal Circuit) shall have jurisdiction of appeals from all final decisions of the district courts of the United States, the United States District Court for the District of the Canal Zone, the District Court of Guam, and the District Court of the Virgin Islands, except [when] a direct review may be had in the Supreme Court.[175]

Citing *Quackenbush v. Allstate Insurance Co.*, the Fifth Circuit noted that "the Supreme Court has recognized a narrow class of collateral orders which do not meet [the] definition of finality, but which are nevertheless immediately appealable under 28 U.S.C. § 1291."[176] More relevant, the court of appeals observed that the Insurers "expressly disavowed any reliance on CAFA" and based their notice of removal solely on 28 § 1441(e)(1)(B)—the mandatory abstention provision of the Multiparty Multiform Trial Jurisdiction Act.[177] Also, abstention suggests that "subject matter jurisdiction [exists,] but for some other policy reason, a court refrains from exercising that power to hear the merits of a case."[178]

Furthermore, an "abstention-based remand order does not fall into either category of remand order described in [28 U.S.C.] § 1447(c), as it is not based on lack of subject matter jurisdiction or defects in removal procedure."[179] Therefore, in light of the Supreme Court's ruling in *Quackenbush*, the Fifth Circuit declared that it had jurisdiction to review the remand order given that abstention was involved.[180]

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175. 28 U.S.C. § 1291 (2000).

176. *Wallace*, 444 F.3d at 701 (quoting Quackenbush v. Allstate Ins. Co., 517 U.S. 706, 712). "Though ordinarily, 28 U.S.C. § 1447(d) bars consideration of a remand order, the Supreme Court has instructed us that the § 1447(d) limitation on appellate review of remands 'must be read *in pari materia* with 28 U.S.C § 1447(c).'" *Id.* (quoting *Quackenbush*, 517 U.S. at 712).

177. *Id.* ("Section 1369(b) is an abstention provision. It assumes subject matter jurisdiction under § 1369(a), but abstains [when] the 'substantial majority' of the plaintiffs and the 'primary defendants' are citizens of the same state and the claims at issue are "governed primarily by the laws of that State.").

178. *Id.* at 701 (citing Eng. v. La. State Bd. of Med. Exam'rs, 375 U.S. 411, 415-16 (1964)). "Abstention 'accord[s] appropriate deference to the respective competence of the state and federal court systems' while 'recogniz[ing] that abstention does not, of course, involve the abdication of federal jurisdiction.' *Id.* (quoting *Eng.*, 375 U.S. at 415-16).

179. *Id.* at 700 (quoting *Quackenbush*, 517 U.S. at 712).

180. *Id.* at 701-02.

> Because the district court based its remand on abstention principles, we have appellate jurisdiction to hear this appeal from the district court's remand order under [28 U.S.C. §] 1291.
>
> On the merits of their appeal, Petitioners argue that the district court erred by applying [28 U.S.C §] 1369(b) to a case removed under 28 U.S.C. § 1441(e)(1)(B). Although the district court recognized that Farm Bureau removed under § 1441(e)(1)(B), the court did not determine whether the defendants met the requirements of § 1441(e)(1)(B), instead stating that even if the defendants could meet those requirements, the abstention provisions of 1369(b) prevented the case from being heard in the federal courts.
>
> The district court misapplied mandatory [28 U.S.C. §] 1369(b) abstention to the exercise of supplemental jurisdiction established by section 1441(e)(1)(B). Section 1369(b) applies only to original jurisdiction under section 1369(a).

2. *Whether the National Insurance Flood Act Preempts Insured Flood Victims' Commencing State Law Actions Against Property Insurers in Texas and Louisiana Courts*

Two of the Fifth Circuit's more poorly reasoned and unclear decisions appear in *Wright v. Allstate Insurance Co.* and in *Gallup v. Omaha Property & Casualty Insurance Co.*[181] In each case, a controversy involved flood insurance.[182] And, in both cases, the central procedural question is whether flood victims may commence state law actions against flood insurers in federal courts.[183] More important, because the Fifth Circuit cited *Wright*'s less than stellar decision to craft and justify an even worse and unintelligible conclusion in *Gallup*, the two decisions are discussed together.

Although some insurers sell flood insurance in the United States' private markets, the price of that product is nearly prohibitive for the average homeowner.[184] Therefore, among other reasons, Congress enacted the National Flood Insurance Act of 1968 (NFIA).[185] The Act established the National Flood Insurance Program (NFIP) and FEMA, an agency of the Department of Homeland Security, administers the program.[186] The NFIP has two components: a flood insurance program and a unified national plan for flood management.[187]

In 1977, the Secretary of the Department of Housing and Urban Development (HUD) gave the primary responsibility for operating the NFIP to FEMA.[188] To achieve the intended goals, FEMA enacted regulations and created the Standard Flood Insurance Policy (SFIP).[189] The agency also encouraged private insurers—so-called "Write Your Own" (WYO) insurers—to market and sell the flood insurance contracts.[190] More significant, WYO insurers sell the SFIP contracts in their own names.[191]

Id.

181. Gallup v. Omaha Prop. & Cas. Ins. Co., 434 F.3d 341 (5th Cir. Dec. 2005); Wright v. Allstate Ins. Co., 415 F.3d 384 (5th Cir. June 2005).

182. *Wright*, 415 F.3d at 385; *Gallup*, 434 F.3d at 342.

183. *Wright*, 415 F.3d at 385; *Gallup*, 434 F.3d at 342.

184. *See* National Flood Insurance Act of 1968, 42 U.S.C. §§ 4001-4129 (2000).

185. *Id.*

186. *Id.*

187. § 4001(b), (c).

188. § 4071.

189. 44 C.F.R. §§ 61.4(b), 61.13(d) (2006).

190. 42 U.S.C. §§ 4071(a)(1), 4081(a).

191. *See* United Policy Holders, Insurance Advice - Flood Insurance, http://www.unitedpolicyholders.org/claimtips/tip_flood.html (last visited Mar. 14, 2006). FEMA reimburses the benefits that the private insurers pay under flood insurance policies using funds from the U.S. Treasury. *See id.*

> Many insurers subcontract all policy administration and claims handling to outside companies. It is not uncommon for the private insurer whose name appears on the policy, and from whom the insured purchased the insurance to have nothing whatsoever to do with the policy or the claim handling. As such, tremendous authority for the administration of the

In addition, WYO insurers are responsible for adjusting, settling, paying, and defending all claims arising under SFIP contracts.[192] FEMA's regulations, however, establish the rates and premiums for SFIP contracts.[193] Also, given that the NFIP is a federally-administered program, funds from the federal treasury support the program.[194] But again, FEMA developed the SFIP contracts and WYO insurers cannot waive or modify those terms.[195] Today, consumers purchase nearly all residential flood insurance under the NFIP.[196]

Against that background, consider the brief reported facts in *Wright*.[197] Dr. Thomas Wright lived in Houston, Texas.[198] To insure his residential property, Wright purchased a SFIP insurance contract from Allstate Insurance Company—a WYO flood insurer.[199] After Tropical Storm Allison struck Houston in 2001, a flood damaged Wright's home; therefore, he filed a SFIP claim.[200] Allstate's claims adjuster, Jack Gardner of Pilot Catastrophe Services, visited Wright and inspected his flood-damaged home.[201] Gardner determined that Wright lost $125,840.23.[202] Wright, however, hired his own certified public insurance adjuster and received a different estimate, $233,497.59.[203] Although Wright and Allstate's representatives continued to squabble about the "true" value of the property loss, they were unable to settle the dispute amicably.[204]

Under FEMA regulations, insureds must file a proof-of-loss form (POL) with a WYO insurer before receiving proceeds under a SFIP insurance contract.[205] Wright, however, refused to sign a proper POL outlining Gardner's estimate.[206] Instead, Wright submitted a POL form, in which the phrase "to be determined" appeared where the cost of repairs, cash value, depreciation, and net amount claimed should have appeared.[207] Ultimately, Allstate rejected Wright's claim, citing the insured's failure to cooperate under

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policies and the handling of claims has been delegated to obscure companies, some of whom are merely data processing businesses.

Id.

192. *See* Gallup v. Omaha Prop. & Cas. Ins. Co., 434 F.3d 341, 342 (5th Cir. Dec. 2005).

193. 42 U.S.C. § 4015.

194. § 4011.

195. *See* 44 C.F.R. §§ 61.4(b), 61.13(d) (2006).

196. United Policy Holders, Insurance Advice - Flood Insurance, http://www.unitedpolicyholders.org/claimtips/tip_flood.html (last visited Mar. 14, 2006).

197. Wright v. Allstate Ins. Co., 415 F.3d 384, 385-87 (5th Cir. June. 2005).

198. *Id.* at 385.

199. *Id.*

200. *Id.*

201. *Id.*

202. *Id.*

203. *Id.*

204. *Id.*

205. *Id.*

206. *Id.*

207. *Id.*

the terms of the flood-insurance contract and failure to file a proper and timely POL.[208]

Wright commenced a lawsuit against Allstate in the District Court for the Southern District of Texas.[209] The disgruntled insured raised several Texas common law actions, sounding in contract and in tort: breach of contract, fraud, and negligent misrepresentation.[210] Wright also filed a statutory action, under the Texas Insurance Code and the Deceptive Trade Practices Act.[211] In addition, the law in Texas is clear: Every insurance contract has an implied covenant of good faith and fair dealing.[212] Therefore, Wright claimed that Allstate breached that common law duty of good faith and fair dealing.[213] But, in Wright's complaint, this claim or allegation appeared as if it were a cause of action—one containing specific elements and requiring proof of a prima facie case.[214] As discussed more fully below, however, neither the district court nor the Fifth Circuit appreciated this important point; and consequently, their analyses were less than ideal.[215]

The District Court for the Southern District of Texas dismissed every cause of action and claim, except the cause of action for breach of contract.[216] The district court found that federal law preempts the tort-related state law actions.[217] To defend itself against Wright's breach-of-contract action, Allstate argued that Wright failed to file a proper and timely POL claim.[218] But the district court held that Allstate was equitably estopped from asserting that defense.[219] The district court awarded only $24,029, plus court costs and

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208. *Id.*

209. *Id.*

210. *Id.*

211. *Id.*; *see* TEX. BUS. & COM. CODE ANN. §§ 17.46 and 17.50 (Vernon 2002) (listing deceptive acts and consumer's remedies, respectively); *see also* Vail v. Tex. Farm Bureau Mut. Ins. Co., 754 S.W.2d 129, 135 (Tex. 1988) (stating that in order to establish statutory violations under the DTPA and under Art. 541.060(a) and Art. 542.003 of the Texas Insurance Code, an insured needs to prove the same elements necessary to establish that the insurer's common law duty of good faith and fair dealing and breach of that duty).

212. *See* Natividad v. Alexsis, Inc., 875 S.W.2d 695, 697 & n.5 (Tex. 1994).

> Because its inception, the duty of good faith and fair dealing has only been applied to protect parties who have a special relationship based on trust or unequal bargaining power. . . . In the insurance context, this special relationship arises out of "the parties' unequal bargaining power and the nature of insurance contracts which would allow unscrupulous insurers to take advantage of their insureds. . . . This Court in *Arnold* stated: "While this court has declined to impose an implied covenant of good faith and fair dealing in every contract, we have recognized that a duty of good faith and fair dealing may arise as a result of a special relationship between the parties governed or created by a contract.'"

Id. (quoting Arnold v. Nat'l County Mut. Fire Ins. Co., 725 S.W.2d 165, 167 (Tex. 1987)).

213. *Wright*, 415 F.3d at 386.

214. *See generally id.*

215. *See id*; *see also infra* pp. 117-27.

216. *Wright*, 415 F.3d at 386.

217. *Id.*

218. *Id.*

219. *Id*; *see also* Johnson & Higgins of Tex., Inc. v. Kenneco Energy, Inc., 962 S.W.2d 507, 515-16

attorneys' fees, after Wright failed to prove that the flood caused all of his damages.[220] Both parties appealed.[221]

Allstate raised two arguments before the Fifth Circuit.[222] The insurer asserted that federal district courts may not apply the doctrine of equitable estoppel against a WYO insurer in light of the present facts and that Wright did not prove the elements of equitable estoppel.[223] Citing similar facts and its decision in *Gowland v. Aetna*, the Fifth Circuit embraced Allstate's arguments.[224] The appellate court stated: "Here, as in *Gowland*, we find the doctrine of equitable estoppel inapplicable. The Supreme Court has made clear that 'judicial use of the equitable doctrine of estoppel cannot grant respondent a money remedy that Congress has not authorized.'"[225]

Therefore, in reversing the district court's finding in favor of Dr. Wright, the Fifth Circuit concluded:

> [When] federal funds are implicated, the person seeking those funds is obligated to familiarize himself with the legal requirements for receipt of such funds.... Under these circumstances, and in light of our previous case law, we hold that the district court erred in estopping Allstate from asserting Wright's failure to file an adequate POL as a basis for denying his claim.[226]

(Tex. 1998) (concluding that the doctrine of equitable estoppel requires the defendant to prove the following elements: "(1) a false representation or concealment of material facts, (2) made with knowledge, actual or constructive, of those facts, (3) with the intention that it should be acted on, (4) to a party without knowledge or means of obtaining knowledge of the facts and (5) who detrimentally relies on the representations"); *Rendon v. Roman Catholic Diocese of Amarillo*, 60 S.W.3d 389, 391 (Tex. App.—Amarillo 2001, pet. denied) (noting that estoppel may be invoked in two ways—when a defendant conceals necessary facts or when the defendant engages in conduct that induces the plaintiff to rely to his detriment).

220. *Wright*, 415 F.3d at 386-87.

221. *Id.* at 387.

222. *Id.*

223. *Id.*

224. *Id.*

> We previously considered the application of equitable estoppel against a WYO in *Gowland*. There, the insureds, like Wright, argued that their WYO should be equitably estopped from asserting their failure to file a POL as a basis for denying their claim. We declined to so hold, stating that: "Although the Gowland policy was written by Aetna, a private insurance company, payments made to that policy are a 'direct charge on the public treasury.' When federal funds are involved, the judiciary is powerless to uphold a claim of estoppel because such a holding would encroach upon the appropriation power granted exclusively to Congress by the Constitution."

Id. (quoting Gowland v. Aetna, 143 F.3d 951, 954-55 (5th Cir. 1998)).

225. *Id.* at 387 (citing Office of Pers. Mgmt. v. Richmond, 496 U.S. 414, 426 (1990)).

226. *Id.* at 388. "'Protection of the public fisc requires that those who seek public funds act with scrupulous regard for the requirements of law .... [T]hose who deal with the Government are expected to know the law and may not rely on the conduct of Government agents contrary to law.'" *Id.* (quoting Heckler v. Cmty. Health Servs. of Crawford County, Inc., 467 U.S. 51, 63 (1984)). The Fifth Circuit declined to hear the arguments regarding the damage award after deciding the district court erred in not allowing Allstate to assert Wright's failure to file a POL as a basis for denying the claim. *Id.* at 391.

On appeal, Wright argued that federal law did not preempt his state law tort actions and that the allegation that Allstate breached the implied covenant of good faith and fair dealing.[227] Thus, the insured asserted that the district court's ruling was erroneous and that the district judge reached that allegedly incorrect conclusion by citing the Fifth Circuit's decisions in *West v. Harris* and *Spence v. Omaha Indemnity Insurance Co.*[228]

In *West*, the court of appeals declared that federal rather than state law governed a flood insurance dispute in which attorneys' fees were the focus of interest.[229] In *Spence*, the Fifth Circuit held that state law statute of limitations were determinative for an insured's state law tort actions against a WYO insurer.[230] So, in the present case, the district court interpreted the *West* and *Spence* decisions to mean that federal law did not preempt Wright's state law actions and claims.[231] But, the Fifth Circuit stated that the district court's reading of *Spence* was incorrect.[232] Instead, the rule in *Spence* is this one: The NFIA preempts the filing of state law tort claims in federal courts.[233]

As mentioned at the outset, the Fifth Circuit cited its decision in *Wright* to decide a similar procedural controversy in *Gallup*.[234] Bo and Susan Gallup

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227. *Id.*

228. *Id.* at 389 (citing Spence v. Omaha Indem. Ins. Co., 996 F.2d 793, 796 (5th Cir. 1993); West v. Harris, 573 F.2d 873, 883 (5th Cir. 1978)).

229. *West*, 573 F.2d at 881. To justify that conclusion, the Fifth Circuit stated that "the flood insurance program was a 'child of Congress, conceived to achieve policies which are national in scope, and the federal government participates extensively in the program both in a supervisory capacity and financially.'" *Id.* (citation omitted).

230. *Id.*

> The issue in *Spence* was a narrow one: whether federal or state law determined the statute of limitations for bringing state law claims against a WYO. While we held that state law would govern the statute of limitations for state law tort claims, we did not foreclose the possibility of field or conflict preemption. Rather, our holding was premised on the fact that '[t]he NFIA contains no express preemption provision' and '[n]either [the insurer] nor the federal government as amicus suggests preemption of the state law fraud claim.'"

Id. (citing *Spence*, 996 F.2d at 797 n.20); *see also Wright*, 415 F.3d at 389 n.3.

> We endorsed the latter view in an unpublished decision, *Richmond Printing LLC v. Dir. Fed. Emergency Mgmt. Agency*, 72 Fed. Appx. 92 (5th Cir. 2003). There, we reconciled *West* and *Spence* as distinguishing between state law claims tied to the contract itself, which are preempted, and extracontractual tort claims, which are not. We went on to hold that, while the insured's state law claims against the WYO in that case were not preempted by federal law, they were impossible of success.

Wright, 415 F.3d at 389 n.3.

231. *Id.*

232. *Id.*

233. *Id.* To reinforce its position, the Fifth Circuit cited decisions from other federal circuits and stated: "We join these circuits in holding that state law tort claims arising from claims handling by a WYO are preempted by federal law." *Wright*, 415 F.3d at 390. *See* C.E.R. 1988, Inc. v. The Aetna Cas. & Sur. Co., 386 F.3d 263, 265-66 (3rd Cir. 2004) (granting summary judgment on the ground that federal law preempted state law claims); Gibson v. Am. Bankers Ins. Co., 289 F.3d 943, 948-50 (6th Cir. 2002) (concluding that the NFIA preempted a state statutory action).

234. Gallup v. Omaha Prop. & Cas. Ins. Co., 434 F.3d 341, 342 (5th Cir. Dec. 2005).

(the Gallups) are the insured plaintiffs in the latter case.[235] The Gallups reside in Covington, Louisiana, and purchased insurance from Omaha Property & Casualty Insurance Company (Omaha).[236] Like Allstate, Omaha is a WYO insurer under the NFIP.[237]

In 2002 and 2003, the Gallups purchased a SFIP contract from Omaha to cover their house and its contents.[238] On December 24, 2002 the plaintiffs' property flooded (Flood I).[239] The Gallups filed a POL with Omaha claiming $210,000 in damages (Insurance Claim I).[240] Omaha, however, only paid $9,000, which covered the cost of replacing the soil beneath the Gallups' home.[241]

In June 2003, the Gallups suffered another flood (Flood II).[242] This flood severely damaged the Gallups' house and caused part of the house to sag, thereby undermining the piers that elevated the house.[243] The homeowners filed a second POL and asked Omaha to pay approximately $209,000, the total replacement value of the house less the deductible (Insurance Claim II).[244] Omaha denied the second claim after attempting unsuccessfully to settle Insurance Claim II for a nominal sum.[245]

In December 2003, the Gallups filed a lawsuit against Omaha in the District Court for the Eastern District of Louisiana.[246] The complaint contained several mixed causes of action and allegations.[247] First, citing the insurer's failure to pay proceeds to satisfy Insurance Claim I, the Gallups filed the following causes of action against Omaha: a federal common law breach of contract and a statutory bad faith breach of contract under Louisiana Civil Code Article 1997.[248] And citing Omaha's denial of Insurance Claim II, the disgruntled homeowners filed the following causes of action against the WYO insurer: (1) a federal, common law breach of contract (2) a statutory bad faith breach of contract under Louisiana Civil Code article 1997 and (3) a statutory bad faith adjustment action under Louisiana Revised Statute Section 22:1220.[249]

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235. *Id.*
236. *Id.*
237. *Id.*
238. *Id.* at 343.
239. *Id.*
240. *Id.*
241. *Id.*
242. *Id.*
243. *Id.*
244. *Id.*
245. *Id.*
246. *Id.*
247. *Id.*
248. *Id.* (citing LA. CIV. CODE ANN. art. 1997 (1985)) ("An obligor in bad faith is liable for all the damages, foreseeable or not, that are a direct consequence of his failure to perform.").
249. *Id.* (citing LA. CIV. CODE ANN. art. 1997 and LA. REV. STAT. ANN. § 22:1220 (2006)). The statute reads in pertinent part:

More important, citing both Insurance Claims I and II, the Gallups also alleged that Omaha breached the implied covenant of good faith and fair dealing under federal common law.[250] But to repeat, this is only an allegation and not a cause of action.[251] So, we ask: To collect damages for this alleged breach of covenant, which cause(s) of action did the Gallups advance? And did that cause(s) of action sound in tort or in contract? Did the district court and Fifth Circuit address this latter issue? Put simply, the answer is no.[252]

Omaha filed a motion to dismiss in the federal district court, arguing that an express preemption provision in the SFIP insurance contracts preempted the Gallups' state law claims.[253] The district court, however, found that Congress did not authorize FEMA "to preempt the application of state laws to extra-contractual claims."[254] Therefore, finding that preemption was inconsistent with the purposes of the NFIA, the district court denied Omaha's motion to dismiss the Gallups' statutory bad faith breach of contract claim under Louisiana Civil Code article 1997.[255]

A. An insurer, including but not limited to a foreign line and surplus line insurer, owes to his insured a duty of good faith and fair dealing. The insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach.

B. Any one of the following acts, if knowingly committed or performed by an insurer, constitutes a breach of the insurer's duties imposed in Subsection A:

. . . .

(5) Failing to pay the amount of any claim due any person insured by the contract within sixty days after receipt of satisfactory proof of loss from the claimant when such failure is arbitrary, capricious, or without probable cause.

(6) Failing to pay claims pursuant to R.S. 22:658.2 when such failure is arbitrary, capricious, or without probable cause.

C. In addition to any general or special damages to which a claimant is entitled for breach of the imposed duty, the claimant may be awarded penalties assessed against the insurer in an amount not to exceed two times the damages sustained or five thousand dollars, whichever is greater. Such penalties, if awarded, shall not be used by the insurer in computing either past or prospective loss experience for the purpose of setting rates or making rate filings.

LA. REV. STAT. ANN. § 22:1220 (2006).

250. *Gallup*, 434 F.3d at 343.

251. *Id.*

252. *Id.* at 344.

253. *Id.* at 343.

254. *Id.* at 343-44; *see also*, 44 C.F.R. pt. 61, App. A(1), Art. IX (2001). Effective December 31, 2000, FEMA proposed an amendment to the SFIP, which added the following language to Article IX of the standard flood insurance policy:

IX. What Law Governs?

This policy and all disputes arising from the handling of any claim under the policy are governed exclusively by the flood insurance regulations issued by FEMA, the National Flood Insurance Act of 1968, as amended (42 U.S.C. § 4001, et seq.), and Federal common law.

44 C.F.R. pt. 61, App. A(1), Art. IX.

255. *Gallup*, 434 F.3d at 343-44.

On the other hand, the district court granted Omaha's motion to dismiss the homeowners' statutory bad faith adjustment action under Louisiana Revised Statute Section 22:1220.[256] To justify that ruling, the district court found that 42 U.S.C. § 4072 governs all causes of action premised on a violation of a flood insurance contract.[257] In addition, the district court granted the insurer's motion to dismiss the Gallups' "federal common law claims for breach of good faith and fair dealing . . . because [those] claims could be asserted under Civil Code article 1997."[258] The parties appealed their respective adverse rulings.[259]

As mentioned earlier, the Fifth Circuit cited its decision in *Wright* to resolve the procedural conflict in *Gallup*.[260] Again, in *Wright*, the court of appeals declared that federal law preempts state law tort claims arising from a WYO insurer's alleged misconduct under the NFIA.[261] Therefore, in light of *Wright*, the Fifth Circuit concluded that the *Gallup* district court erred when it denied Omaha's motion to dismiss the Gallups' statutory bad faith breach of contract under Louisiana Civil Code article 1997.[262] Contrary to the lower court's ruling, the NFIA preempted all of the Gallups' tort-based and contract-based causes of action.[263] Furthermore, the NFIA preempted the homeowners' claims or allegations premised on Omaha's alleged breach of the implied covenant of good faith and fair dealing.[264]

Once more, the Fifth Circuit's rulings in *Wright* and *Gallup* are problematic for two important reasons. First, they conflict. The *Wright* panel did not permit the insured to commence tort-based state law actions against Allstate, a WYO insurer; but the Wright panel certainly allowed the insured to file a breach-of-contract action against Allstate.[265] In fact, in *Wright*, the

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256. *Id.*

257. *Id.* at 344. Section 4072 of the NFIA allows suits against FEMA for claims on flood policies: Adjustment and payment of claims; judicial review; limitations; jurisdiction

> In the event the program is carried out as provided in section 1340 [42 U.S.C. § 4071], the Director shall be authorized to adjust and make payment of any claims for proved and approved losses covered by flood insurance, and upon the disallowance by the Director of any such claim, or upon the refusal of the claimant to accept the amount allowed upon any such claim, the claimant, within one year after the date of mailing of notice of disallowance or partial disallowance by the Director, may institute an action against the Director on such claim in the United States district court for the district in which the insured property or the major part thereof shall have been situated, and original exclusive jurisdiction is hereby conferred upon such court to hear and determine such action without regard to the amount in controversy.

42 U.S.C. § 4072.

258. *Gallup*, 434 F.3d at 344.

259. *Id.* at 343-44.

260. *See supra* note 236 and accompanying text.

261. Wright v. Allstate Ins. Co, 415 F.3d 384, 390 (5th Cir. June 2005).

262. *Gallup*, 434 F.3d at 345.

263. *Id.* To reiterate, the statute permits an insured to commence a bad faith breach-of-contract cause of action, unlike § 22:1220, which allows a tort-based and arguably a contract-based cause of action. *Id.*

264. *Id.* at 344.

265. *Wright*, 415 F.3d at 385. The following justices comprised the Fifth Circuit *Wright* panel:

Fifth Circuit panel even allowed Allstate to raise the doctrine of equitable estoppel, which is a defense to a breach-of-contract action and a source of major contention in *Wright*.[266]

However, in *Gallup*, a different Fifth Circuit panel declared that the NFIA preempts all of the insureds' state law actions—both tort-based and contract-based actions.[267] In light of the conflict between the *Wright* and *Gallup* panels, what is the current law of the Fifth Circuit? Which case controls? And even assuming that *Wright* presents the superior holding, a second problem exists: in both *Wright* and *Gallup*, the insureds accused the WYO insurers of breaching an implied covenant of good faith and fair dealing.[268]

The latter is only an allegation rather than a cause of action. Consequently, to collect damages, plaintiffs must cite a viable cause of action and prove the breach-of-an-implied-covenant claim along with other elements.[269] The important question is which cause of action is the more appropriate theory of recovery to secure damages—actions sounding in tort, actions sounding in contract, or actions sounding in both.

A clear majority of jurisdictions have embraced this common law rule: Every contract—including insurance contracts—contains an implied covenant of good faith and fair dealing.[270] And when there is an alleged breach of that covenant, the insured or insurer may commence a lawsuit that sounds either in tort, contract, or both.[271] To be sure, Louisiana courts have embraced and applied this rule.[272] For example, in *Hogan v. State Farm Automobile Insurance Co.*, a Louisiana court of appeals stated:

Circuit Justices Garwood, Garza and Benavides. *Id.* The case originated in Texas. *Id.*

266. *Id.*

267. *Gallup*, 434 F.3d at 344-45. The following justices comprised the Fifth Circuit *Gallup* panel: Circuit Justices Davis, Smith and Dennis. *Id.* The case originated in Louisiana. *Id.*

268. *Id.*; *Wright*, 415 F.3d at 385-86.

269. *See supra* text accompanying notes 213-19.

270. *Cf.* RESTATEMENT (SECOND) OF CONTRACTS § 205 (1981). This section states:

> Every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement.
>
> . . . .
>
> *Good faith performance.* Subterfuges and evasions violate the obligation of good faith in performance even though the actor believes his conduct to be justified. . . . A complete catalogue of types of bad faith is impossible, but the following types are among those which have been recognized in judicial decisions: evasion of the spirit of the bargain, lack of diligence and slacking off, willful rendering of imperfect performance, abuse of a power to specify terms, and interference with or failure to cooperate in the other party's performance.

Id. at § 205 & Comment d.

271. *Cf.* Gruenberg v. Aetna Ins. Co., 510 P.2d 1032, 1036-37 (Cal. 1973) (reaffirming that an insurer has a duty of fairness and good faith to its insured and that courts impose this duty, the breach of which sounds in both contract and tort, because "[t]here is an implied covenant of good faith and fair dealing in every contract [including insurance policies] that neither party will do anything which will injure the right of the other to receive the benefits of the agreement") (citing Comunale v. Traders & Gen. Ins. Co., 328 P.2d 198, 200 (Cal. 1958)).

272. *See* Hogan v. State Farm Auto. Ins. Co., 649 So. 2d 45, 52 (La. Ct. App. 1994).

> It is well-settled under California law that, if an insurer fails to deal fairly and in good faith with [its] insured by refusing, without proper cause, to compensate its insured for a loss covered by the policy . . . , this conduct may give rise to a cause of action in tort for breach of an implied covenant of good faith and fair dealing.[273]

Also, on several occasions, the Texas Supreme Court ruled and reaffirmed its ruling that an insurer's breach of the implied covenant of good faith and fair dealing allows the insured to commence a cause of action that sounds in tort.[274] On other occasions, the Supreme Court of Texas has allowed insureds to commence a contract-based cause of action against insurers when the latter allegedly breached the implied covenant of good faith and fair dealing.[275] In *Union National Life Insurance Co. v. Crosby*, the Mississippi Supreme Court also held that "a breach of a duty of good faith and fair dealing arises from the existence of a contract between parties," but a suit for breaching the covenant sounds either in tort or contract, or in both.[276]

Therefore, whether a breach arises from a duty of good faith and fair dealing or from a breach of an implied covenant of good faith and fair dealing, the states in the Fifth Circuit allow complaining parties to commence a cause of action sounding in contract.[277] In *Wright* and *Gallup*, the court of appeals

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273. *Id.* An insured may also commence a contract base action in Louisiana, because *Hogan* cited *Brandt v. Superior Court*, 693 P.2d 796, 798 (Cal. 1985), which cited *Gruenberg v. Aetna Ins. Co.* 510 P.2d 1032, 1036 (Cal. 1973) which declared that the breach of an implied covenant of good faith and fair dealing sounds in both contract and tort. *See id.*

274. *See* Twin City Fire Ins. Co. v. Davis, 904 S.W.2d 663, 666 (Tex. 1995) (reaffirming that an "insurer's failure to deal fairly and in good faith with its insured [allows the insured to commence] a cause of action that sounds in tort, [which] is distinct from the contract cause of action for the breach of the terms of an underlying insurance policy." (citing Arnold v. Nat'l County Mut. Fire Ins. Co., 725 S.W.2d 165, 167 (Tex. 1987); Aranda v. Ins. Co. of N. Am., 748 S.W.2d 210, 212-13 (Tex. 1988); Viles v. Sec. Nat'l Ins. Co., 788 S.W.2d 566, 567 (Tex. 1990)).

275. Atl. Lloyds Ins. Co. v. Butler, 137 S.W.3d 199, 222-23 (Tex. App.—Houston [1st Dist.] 2004, pet. denied). Regarding a first party lawsuit filed by an insured against an insurer based on an agreed judgment, "the insurer's contractual duty of good faith and fair dealing only extends to signing of the agreed judgment; consequently, any cause of action that the insured may have against the insurer based on the agreed judgment sound in contract, not in tort." *Id.* (citing Mid-Century Ins. Co. of Tex. v. Boyte, 80 S.W.3d 546, 548-49 (Tex. 2002); Stewart Title Guar. Co. v. Aiello, 941 S.W.2d 68, 71 (Tex. 1997)); *see also* United Servs. Auto. Ass'n v. Pennington, 810 S.W.2d 777, 783 (Tex. App.—San Antonio 1991, writ denied).

> In order for a tort duty to arise out of a contractual duty . . . , the liability must arise "independent of the fact that a contract exists between the parties": the defendant must breach a duty imposed by law rather than by the contract. If the defendant's conduct would impose liability on him only because it breaches the parties' agreement, the claim is contractual. The [Texas Supreme Court] also looked to the nature of the plaintiff's loss in determining whether the claim sounded in contract or tort. "When the only loss or damage is to the subject matter of the contract, the plaintiff's action is ordinarily on the contract." Economic loss to the subject matter of the contract does not give rise to tort liability."

Pennington, 810 S.W.2d at 783 (citing Sw. Bell Tel. Co. v. Delanney, 809 S.W.2d 493, 494 (Texas 1991)).

276. United Nat'l Life Ins. Co. v. Crosby, 870 So. 2d 1175, 1182 (Miss. 2004).

277. *See id.*

did not address this critical issue.[278] Consequently, the Fifth Circuit's procedural rulings against the homeowners were arguably unfair. But more important, a failure to thoroughly review this issue and the accompanying rules seriously undermined the quality of the analyses in both cases.

3. Whether Under Texas Law an Excess Flood Insurer Has a Duty to Indemnify an Insured for Flood-Related Damages Assuming that the Insured Mistakenly Insured Against the Wrong Peril

The Fifth Circuit's final flood-insurance decision appears in *Wentwood Woodside I, LP v. GMAC Commercial Mortgage Corp.*[279] Wentwood Woodside I, L.P. (Wentwood) is a single-asset limited partnership organized under the laws of Texas.[280] Although the precise organizational structure is unclear, Wentwood is affiliated with and under the common control of several other single-asset partnerships.[281] These entities own more than fifty apartment buildings across the country.[282] Seven single-asset partnerships are located in Houston, Texas, and each one owns an apartment complex in Houston.[283]

More specifically, Wentwood Hartford D Partners (Wentwood Hartford) owns the Wentwood Hartford apartments (Hartford Complex) and Wentwood St. James, L.P. (Wentwood St. James) owns the Wentwood St. James apartments (St. James Complex).[284] Wentwood purchased Woodside Village Apartments (Woodside Village) in Houston.[285] Pinnacle Realty Management Company (Pinnacle) is a management company with its principal place of business located in Tacoma, Washington.[286] At all relevant times, Pinnacle managed Woodside Village and the other seven Houston properties.[287]

Column Financial and an unidentified New York common law trust—a real estate mortgage investment conduit (REMIC)—are commercial lenders.[288]

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278. *See* discussion *supra* Part II.C.

279. Wentwood Woodside I, LP v. GMAC Commercial Mortg. Corp., 419 F.3d 310, 311 (5th Cir. July 2005).

280. *Id.* at 312.

281. *Id.*

282. *Id.*

283. *Id.*

284. *Id.*

285. *Id.*

286. *Id.*

287. *Id.*

288. *See* Column Financial, http://www.columnfinancial.com/MyColumn/info/view.aspx (last visited Mar. 14, 2007). Since its founding in August 1993, Column has been in the commercial real estate loan origination business:

> Our primary business is to originate, underwrite and close commercial mortgage loans. Loans are funded directly by Column. The closed mortgage loans are then aggregated into pools and securitized. Credit Suisse provides underwriting, rating agency, structuring and distribution expertise for Commercial Mortgage Backed Securities. . . . Column provides a local presence to enable borrowers and mortgage bankers to originate individual loans. We have 16 production

Without knowing more, the two financial service companies are affiliated.[289] More significant, neither the REMIC nor Column Financial is a federally regulated lending institution.[290] As sole grantor, Wentwood executed a deed of trust with Column Financial, the deed of trust beneficiary.[291] On December 30, 1996, the partnership secured a $5,950,000 commercial loan from the lender to finance the purchase of Woodside Village.[292]

GMAC Commercial Mortgage Corporation (GMAC) (presently doing business as Capmark) manages one of the world's largest servicing portfolios thereby allowing its clients to outsource all of their commercial loan servicing needs or select specific services to be performed either in the client's or GMAC's name.[293] Therefore, the partnership selected GMAC to service Wentwood's deed-of-trust mortgage on the Woodside Village apartments.[294] Under the deed of trust, Wentwood had an express contractual duty to purchase adequate flood insurance to cover the Woodside Village apartments.[295] And given that GMAC serviced the loan, GMAC had a contractual duty to ensure that Wentwood insured the property against a specific peril—floods.[296]

As discussed above, Congress enacted the NFIA and established the NFIP.[297] FEMA, an agency of the Department of Homeland Security, administers the program.[298] Among other responsibilities, FEMA categorizes geographical areas from high to low risk, based on an area's likelihood of flooding.[299] On April 20, 2000, FEMA determined that Houston, Texas was located in a special flood hazard area (SFHA)—Flood Zone A.[300]

Partially adhering to its contractual obligations, GMAC sent separate letters to Wentwood Hartford and Wentwood St. James on September 19,

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> offices throughout North America to provide local services to borrowers.... Column has closed in excess of 6,400 commercial mortgage loans, with an aggregate principal balance of over $79 billion.

Id. "The trustee for the REMIC is LaSalle Bank of Chicago. LaSalle merely holds the REMIC's assets in trust[, but LaSalle] is not the lender and is not at risk in the event of default by any of the REMIC's debtors, including Wentwood." *Wentwood*, 419 F.3d at 312.

289. *Id.*

290. *Id.*

291. *Id.*

292. *Id.* The record is unclear, but the New York common law trust likely initially acquired the debt and continued to carry the commercial loan. *Id.*

293. *See* Capmark, http://www.capmark.com/capmark/ (last visited Mar. 14, 2007).

294. *Wentwood*, 419 F.3d at 312 n.1. "The mortgage documents of the seven other Houston properties are not in the record. An affidavit of Wentwood's attorney states, 'on information and belief,' that each of the eight separate loans on the eight separate Houston properties is included in the same REMIC and that all loans in the REMIC are serviced by GMAC." *Id.*

295. *Id.* at 312.

296. *Id.*

297. National Flood Insurance Act of 1968, 42 U.S.C. §§ 4001-4129 (2000).

298. *Wentwood*, 419 F.3d at 312.

299. *Id.*

300. *Id.*

2000.[301] GMAC reported that FEMA rezoned its properties—Woodside Village and Wentwood St. James—and that its complexes were currently located in a SFHA.[302] GMAC also told Wentwood Hartford and Wentwood St. James to purchase flood insurance to cover its SFHA properties.[303] GMAC did not send a notification letter to Wentwood even though Woodside Village was located in the same SFHA.[304]

Although GMAC addressed the letters to Wentwood Hartford and Wentwood St. James, the management company, Pinnacle, received the letters at its headquarters in Tacoma, Washington.[305] Later, Pinnacle forwarded the two letters to Boreal Properties, L.L.C. (Boreal), Pinnacle's independent contractor that co-managed the eight apartment complexes in Houston.[306] Ultimately, Boreal's risk manager, Janet Barnes, received the letters as she was responsible for insuring the Houston properties.[307] But, no evidence that Barnes purchased specified risk insurance to cover the properties located in the SFHA existed.[308] Additionally, in the letters, GMAC promised that it would purchase, at the partnerships' expense, the specified-risk insurance to cover the SFHA properties, however, GMAC did not.[309]

Later in 2000, the consortium of partnerships, including Wentwood, contacted another agent, Graoch Associates (Graoch).[310] Assuming that primary insurance covered the apartment complexes, the partnerships instructed Graoch to secure excess insurance for the properties.[311] Graoch retained the services of Lockton Companies, Inc. (Lockton), an insurance brokerage firm, and instructed Lockton to purchase a single excess property insurance policy that would cover every apartment complex, including the

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301. *Id.*
302. *Id.*
303. *Id.* at 312-13.
304. *Id.* at 313.
305. *Id.*
306. *Id.*
307. *Id.*
308. *Id.*
309. *Id.* at 312, 314; *see, e.g.*, Poulton v. State Farm Fire and Cas. Cos., 675 N.W.2d 665, 670 (Neb. 2004) (observing that a property insurance contract can insure against "specific perils" or "named perils").

> A specific perils policy "exclude[s] all risks not specifically included in the contract" . . . and is the converse of an all-risks or open perils policy, which provides coverage for all direct losses not otherwise excluded. . . . Consequently, in order for there to be coverage for damage to personal property under the [insurance contract], the damage to the personal property must arise out of [the] listed perils.

Poulton, 675 N.W.2d at 670. "[U]nder all-risks policies, 'all risks are included in the coverage unless specifically excluded in the terms of the contract.'" *Id.* (quoting 7 Lee R. Russ & Thomas F. Segalla, COUCH ON INSURANCE 3D § 101:7, 101-17 to 101-18 (1997). "All-risks insurance is a special type of insurance extending to risks not usually contemplated, and generally allows recovery for all fortuitous losses, unless the policy contains a specific exclusion expressly excluding the loss from coverage." *Id.* (quoting Jane Massey Draper, Annotation, *Coverage Under All-Risk Insurance*, 30 A.L.R. 5th 170 (1995)).

310. *Wentwood*, 419 F.3d at 313.
311. *Id.* at 314.

Woodside Village.[312] Lockton contacted Royal Specialty Underwriting (Royal) and purchased excess insurance from the insurer.[313] Royal's standard excess property insurance contract covered flood damage generally.[314] On the other hand, the excess policy excluded property located in an SFHA.[315] To circumvent that exclusion, however, a property owner could purchase "an exception to the exclusion for an additional premium."[316]

A Lockton representative and Richard McAdam, a property underwriter for Royal, negotiated the terms of the excess insurance contract.[317] During the negotiations, McAdam asked specifically whether any of the partnerships' properties were located in an SFHA.[318] Lockton's representative only identified three SFHA properties—one each in Ohio, North Carolina, and Texas.[319] Among the eight apartment complexes in Texas, Lockton's agent only identified the Wentwood St. James complex in Houston.[320] Lockton's agent did not identify Wentwood's property, the Woodside Village.[321]

After reviewing Lockton's efforts and suggestions, Graoch decided to purchase a one-year, excess insurance policy from Royal.[322] The effective date of coverage was November 27, 2000, but Woodside Village was not covered under the excess policy for floods because "the premium . . . did not incorporate the risk of insuring the Woodside Village against flood damage."[323] In its entirety, the "covered perils" provision in Royal's excess insurance contract stated:

> Perils Covered: All Risk including Flood and Earthquake except excluding California Earthquake and excluding Flood in Zone A or V except at: 1) 2400 West Shore Blvd. Columbus, OH, 2) 215 Rippling Stream Rd., Durham, NC, 3) 9109 Fondron [sic] Road, Houston, TX.[324]

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312. *See generally* Lockton: The Company, http://www.lockton.com/default.asp (last visited Mar. 14, 2007).

> Lockton Companies is one of the largest, most respected and experienced insurance brokerage firms in the country. We provide our clients with insurance, surety and risk management services while maintaining a superior level of customer service. We also offer our clients technologically advanced resources and global capabilities. We work to anticipate needs of our clients and offer proactive recommendations. These distinct characteristics put Lockton in a class by itself.

Id.

313. *Wentwood*, 419 F.3d at 313.

314. *Id.*

315. *Id.*

316. *Id.*

317. *Id.*

318. *Id.*

319. *Id.*

320. *Id.*

321. *Id.*

322. *Id.*

323. *Id.*

324. *Id.* The Woodside Village Apartments are located at 2400 Hackett, Houston, TX 77008.

A few months after purchasing the excess insurance, Graoch decided to switch primary carriers.[325] Therefore, representing the consortium of partnerships, Graoch purchased a one-year, primary insurance contract from Lexington Insurance Company (Lexington).[326] The effective date for the primary coverage was April 28, 2001.[327] The policy limit was $1,000,000.[328] More relevant, the primary insurance contract fully insured the eight SFHA properties, without exclusions, against floods.[329] Thus, when the hurricane season began in 2001, Woodside Village had primary flood insurance, but it did not have any coverage under an excess insurance contract.[330]

On June 9, 2001, Tropical Storm Allison struck Houston, bringing extensive flooding to the area, with Woodside Village Apartments sustaining more than $4,000,000 in losses.[331] A few days after the storm, Wentwood filed a notice-of-loss claim with Lexington, the primary insurer.[332] Immediately, Lexington paid the policy limit—$1,000,000.[333] Shortly thereafter, Wentwood filed a second notice-of-loss claim with Royal, its allegedly excess insurer.[334] Royal refused to pay, insisting that Woodside Village was located in an SFHA and that Graoch did not purchase excess coverage for Woodside Village.[335]

About one year later, Wentwood filed a complaint in a Texas court alleging that Royal breached an excess insurance contract and violated the Texas Insurance Code.[336] Wentwood also sued GMAC, listing multiple causes of action.[337] First, Wentwood filed a common law negligence action against GMAC, arguing that GMAC breached an affirmative duty to notify Wentwood if FEMA rezoned the Woodside Village property and listed it as an SFHA property.[338] Second, Wentwood filed a common law negligence action against GMAC, claiming that GMAC was negligent per se for breaching a statutory duty under 42 U.S.C. § 4012a of the NFIA.[339] Finally, Wentwood also sued

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Pinnacle Realty, http://www.pinnaclerealty.com/Main/property_listings/property_detail.aspx?state=TX&city=Houston (last visited Apr. 1, 2007).

325. *Wentwood*, 419 F.3d at 313-14.

326. *Id.*

327. *Id.* at 313.

328. *Id.*

329. *Id.*

330. *Id.* at 314.

331. *Id.*

332. *Id.*

333. *Id.*

334. *Id.*

335. *Id.*

336. *Id.* The decision does not identify the exact statute under the Texas Insurance Code. *See id.* A fair reading of the decision suggests that Wentwood cited statutory violations under the Deceptive Trade Practices Act and the Texas Insurance Code. *See id.*; TEX. BUS. & COM. CODE ANN. §§ 17.46, 17.50 (Vernon 2002) (listing deceptive acts and consumer's remedies); TEX INS. CODE ANN. §§ 541.060(a), 542.003 (Vernon 2002) (formerly TEX INS. CODE ANN. art. 21.21 § 4(10), art. 21.21).

337. *Wentwood*, 419 F.3d at 314.

338. *Id.*

339. *Id.* 42 U.S.C. § 4012a outlines the amount and type of flood insurance purchase and compliance

GMAC for allegedly breaching its statutory duty under 42 U.S.C. § 4012a to obtain adequate flood insurance coverage for properties located in SFHAs.[340]

Royal removed the case to the District Court for the Southern District of Texas.[341] The district court granted Royal and GMAC's motions for summary judgment.[342] The district court refused to embrace Wentwood's argument: Wentwood's failure to purchase the appropriate type of excess insurance for Woodside Village was a mistake; but an "errors and omissions" clause in the Lexington primary insurance policy excused Wentwood's mistake.[343] Wentwood appealed the case.[344]

To determine whether Royal breached various contractual, tort-based, and statutory duties, the Fifth Circuit examined the errors and omissions clause in Lexington's primary insurance contract.[345] That provision reads: "Any unintentional error or omission made by the Insured shall not void or impair the insurance hereunder provided the Insured reports such error or omission as soon as reasonably possible after discovery."[346]

Before the court of appeals, Wentwood argued that Royal incorporated Lexington's errors and omissions clause into Royal's excess insurance contract.[347] To support that assertion, Wentwood cited the "maintenance of

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requirements, and it states:

> (a) Amount and term of coverage
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> After the expiration of sixty days following December 31, 1973, no Federal officer or agency shall approve any financial assistance for acquisition or construction purposes for use in any area that has been identified by the Director as an area having special flood hazards and in which the sale of flood insurance has been made available under the National Flood Insurance Act of 1968 [42 U.S.C.A. § 4001 et seq.], unless the building or mobile home and any personal property to which such financial assistance relates is covered by flood insurance in an amount at least equal to its development or project cost (less estimated land cost) or to the maximum limit of coverage made available with respect to the particular type of property under the National Flood Insurance Act of 1968 [42 U.S.C.A. § 4001 et seq.], whichever is less: Provided, That if the financial assistance provided is in the form of a loan or an insurance or guaranty of a loan, the amount of flood insurance required need not exceed the outstanding principal balance of the loan and need not be required beyond the term of the loan. The requirement of maintaining flood insurance shall apply during the life of the property, regardless of transfer of ownership of such property.

42 U.S.C. § 4012a (2000).

340. *Wentwood*, 419 F.3d at 314.

341. *Id.*

342. *Id.*

343. *Id.* at 314-15.

> Wentwood concedes . . . that the Royal policy . . . did not identify the Woodside Village as a property [that was exempted] from Royal's blanket exclusion from flood coverage of any property in an SFHA . . . . Graoch never asked for SFHA coverage for the Woodside Village and never paid for such coverage. . . . Wentwood contends, however, that this failure to insure the Woodside Village was an oversight that is nullified by the Errors and Omissions clause of Lexington's primary policy.

Id.

344. *Id.* at 315.

345. *Id.*

346. *Id.*

347. *Id.*

primary insurance" provision in the excess insurance contract, which reads in pertinent part:

> In respect of the perils hereby insured against, this Policy is subject to the same warranties, terms and conditions . . . as are contained in or as may be added to the policy/ies of the primary insurer(s) prior to the happening of a loss for which claim is made hereunder, and should any alteration be made in the premium for the policy/ies of the primary insurer(s), then the premium hereon shall be adjusted accordingly.[348]

After carefully reviewing both provisions, the Fifth Circuit panel delivered an intelligible analysis and a correct decision regarding Royal's alleged liability. First, the court of appeals observed that Wentwood's agents, Graoch and Lockton, were not the named insureds under the primary insurance contract.[349] They negotiated and purchased the Royal excess insurance contract on behalf of Wentwood.[350] Therefore, assuming that an error or an omission had been committed, the Fifth Circuit found that someone other than the insured made the mistake.[351] But note: The appellate court found no error or omission because Lockton knew Woodside Village was in an SFHA.[352]

The court of appeals also stressed that even assuming that Wentwood committed an unintentional error or omission by failing to purchase a Royal excess flood insurance policy to cover Woodside Village, the "maintenance of primary insurance" clause in Royal's excess coverage policy incorporated Lexington's error and omission clause only if Wentwood had insured against flooding in an SFHA under Lexington's primary insurance contract.[353] Furthermore, the "Excess Physical Damages Schedule" in Royal's excess policy clearly listed the covered perils, and the schedule did not include "flooding of Woodside Village in a SFHA" as an insured peril.[354]

Applying Texas's plain meaning rule, the Fifth Circuit affirmed the district court's ruling, stating: "[The] undisputed facts of this case establish that Graoch simply never purchased excess flood insurance for . . . Woodside

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348. *Id.*

349. *Id.*

350. *Id.*

351. *Id.*

352. *Id.* Evidence existed that "Barnes did not know the Woodside Village was in an SFHA when Graoch bought the policy, but there [was] no basis in the record for treating Barnes' knowledge, or lack thereof, as equivalent to Graoch's or Lockton's knowledge." *Id.*

353. *Id.*

354. *Id.* at 315-16.

> Nevertheless, even if we were to assume that the Errors and Omissions clause was incorporated into the Royal policy with respect to the Woodside Village, it still would not apply. The Errors and Omissions clause states that an unintentional error will not "void or impair the insurance hereunder[.]" The errors and omissions clause, in other words, applies only to insured risks.

Id.

Village."[355] Therefore, because Wentwood did not purchase "an exception to the exclusion for an additional premium" and Royal's excess policy did not incorporate Lexington's errors and omissions clause, the Fifth Circuit declared that Royal had no duty to reimburse Wentwood for flood-related property losses in a SFHA.[356]

Again, the district court granted GMAC's summary judgment motion, but on appeal, Wentwood argued that the lower court's adverse ruling was unwarranted.[357] Wentwood argued that GMAC had assumed a common law duty to notify Wentwood of changes to FEMA's flood maps.[358] Second, Wentwood argued that GMAC's failure to discharge an alleged statutory duty under the NFIA gave rise to a cause of action under Texas law for negligence per se.[359]

To support its first argument that GMAC breached a common law duty, Wentwood cited § 323 of the Restatement (Second) of Torts, which provides:

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if (a) his failure to exercise such care increases the risk of such harm, or (b) the harm is suffered because of the other's reliance upon the undertaking.[360]

Wentwood maintained that GMAC assumed a duty to notify the single-asset partnership in September 2000, when GMAC sent separate letters of notification to the other single-asset partnerships, Wentwood Hartford and Wentwood St. James.[361] Once more, those letters informed the latter two partnerships that FEMA had rezoned the geographical location of their respective properties.[362]

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355. *See* Transp. Ins. Co. v. Standard Oil Co. of Texas, 337 S.W.2d 284, 288 (Tex. 1960) (reiterating that courts must give words appearing in insurance contracts their plain meaning when no ambiguity exists); *see also* Sulzer Carbomedics, Inc. v. Or. Cardio-Devices, Inc., 257 F.3d 449, 457 (5th Cir. 2001) (stating that an unambiguous contract "must be enforced as written, looking at the objective intent as manifested by the language used, rather than interpreting it by attempting to divine the subjective intent of the parties." (citing Sun Oil Co. v. Madeley, 626 S.W.2d 726, 731 (Tex. 1981))).

356. *Wentwood*, 419 F.3d at 316 ("In light of the conclusion that Wentwood never insured the Woodside Village against flood damage, Wentwood's lawsuit is in effect an attempt to retroactively purchase excess insurance for a loss that has already been realized.").

357. *Id.* at 317.

358. *Id.*

359. *Id.*

360. RESTATEMENT (SECOND) OF TORTS § 323 (1965); *see, e.g.*, Torrington Co. v. Stutzman, 46 S.W.3d 829, 838 (Tex. 2000); Colonial Sav. Ass'n v. Taylor, 544 S.W.2d 116, 120 (Tex. 1976) (affirming Texas' adoption of section 323).

361. *Wentwood*, 419 F.3d at 319.

362. *Id.*

The Fifth Circuit, however, disagreed, stating that Wentwood's assertion was inconsistent with the plain language in § 323.[363] The court of appeals found that GMAC did not assume a duty to render or undertake any notification services for Wentwood's benefit.[364] In addition, GMAC indisputably gave notice to Wentwood Hartford and Wentwood St. James about matters affecting their respective properties.[365] From the Fifth Circuit's perspective, those notices did not establish that GMAC created an affirmative duty to notify Wentwood about matters that could affect Wentwood's Woodside Village apartments.[366]

Finally, the court of appeals considered Wentwood's negligence per se and statutory actions under the National Flood Insurance Program.[367] At the outset, the Fifth Circuit examined Texas's negligence per se rule.[368] In *Perry v. S.N.*, the Texas Supreme Court declared: "The threshold questions in every negligence *per se* case are whether the plaintiff belongs to the class that the statute was intended to protect and whether the plaintiff's injury is of a type that the statute was designed to prevent."[369] But taken alone, those rules were not helpful because the Texas Supreme Court and lower courts in Texas have never addressed the question of whether 42 U.S.C. § 4012a protects a class of persons like Wentwood and gives them the right to commence a private right of action.[370]

To determine how the Texas Supreme Court would answer the question, the Fifth Circuit decided to make an *Erie* guess.[371] The court of appeals began

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363. *Id.*

364. *Id.* (citing *Torrington*, 46 S.W.3d at 837 ("Texas['s] law generally imposes no duty to take action to prevent harm to others absent special relationships or circumstances."); Fort Bend County Drainage Dist. v. Sbrusch, 818 S.W.2d 392, 396 (Tex.1991)).

365. *Id.*

366. *Id.* at 319-20. The Fifth Circuit found the following:

> GMAC only notified the affiliated but nevertheless legally separate and distinct independent partnerships, Wentwood Hartford and Wentwood St. James. Indeed, the letters GMAC sent were addressed specifically to these two partnerships. The only grantor and the only debtor in the deed of trust is Wentwood Woodside I, L.P. The only property covered by the deed of trust is Woodside Village. The only indebtedness secured thereby is the $5,950,000 debt for the Woodside Village acquisition. The deed of trust does not mention any other indebtedness, nor any property other than Woodside Village, nor does it mention Wentwood Hartford or Wentwood St. James or give any indication that Wentwood Woodside I, L.P., is a party of any affiliated group of entities; neither Wentwood Hartford nor Wentwood St. James has any interest in Woodside Village (so far as this record shows) or any liability on the indebtedness secured by the deed of trust thereon; nor (so far as this record shows) does Wentwood Westside have any interest in any of the properties owned by Wentwood Hartford or by Wentwood St. James or any liability on any indebtedness secured by any such property.

Id.

367. *Id.* at 321.

368. *Id.*

369. Perry v. S.N., 973 S.W.2d 301, 305 (Tex. 1998).

370. *Id.* at 323.

371. *See, e.g.*, Primrose Operating Co. v. Nat'l Am. Ins. Co., 382 F.3d 546, 564-65 (5th Cir. 2004). This court must predict how the Texas Supreme Court would decide this issue. In making an

its analysis by examining federal courts' decisions generally and Fifth Circuit decisions in particular.[372] Among the federal courts considering this question, the present Fifth Circuit panel found that Congress enacted section 4012a to protect the federal treasury rather than a class of individual mortgagors like Wentwood.[373] Therefore, the court of appeals guessed that "the Texas Supreme Court would construe 42 U.S.C. § 4012a in a manner consistent with the unanimous conclusion of the federal judiciary" and that the Texas Supreme Court would not treat mortgagors as a protected class.[374] Consequently, the Fifth Circuit concluded that section 4012a of the NFIA did create a private right of action, one that would allow Wentwood to sue GMAC for negligence per se under Texas law.[375]

C. Property Insurance

1. Whether Under Louisiana Law a Subcontractor Was an "Other Assured" Under a Builder's Risk Property Insurance Contract Thereby Preventing the Insurer—the Alleged Subrogee—from Citing the Subrogation Clause and Collecting Reimbursements from the Subcontractor

Although multiple procedural questions were raised in *Texaco Exploration and Production, Inc. v. AmClyde Engineered Products Co., Inc.*, they are not complicated or novel.[376] The central insurance-related question was whether an insurer has a contractual right to commence a subrogation action against a subcontractor who was allegedly responsible for damaging an insured's property.[377] The facts in *Texaco*, however, are lengthy and complicated; they explain in part the Fifth Circuit's poorly reasoned analysis and arguably incorrect conclusions.[378]

> "*Erie* guess" in a diversity case, this court will "seek guidance by looking to the precedents established by intermediate state appellate courts only when the state supreme court has not spoken on an issue." However, if "convinced by other persuasive data that the highest court of the state would decide otherwise," this court will not defer to the decisions of the intermediate state appellate courts.

Id. (quoting Webb v. City of Dallas, 314 F.3d 787, 795 (5th Cir. 2002); Herrmann Holdings Ltd. v. Lucent Techs. Inc., 302 F.3d 552, 558 (5th Cir. 2002)).

372. *Wentwood*, 419 F.3d at 323.

373. *See, e.g.*, Till v. Unifirst Fed. Sav. & Loan Ass'n, 653 F.2d 152, 159-61 (5th Cir. 1981); Hofbauer v. Nw. Nat'l Bank, 700 F.2d 1197, 1201 (8th Cir.1983); Arvai v. First Fed. Sav. & Loan Ass'n, 698 F.2d 683, 684 (4th Cir.1983); Mid-America Nat'l Bank of Chicago v. First Sav. & Loan Ass'n of South Holland, 737 F.2d 638, 642 (7th Cir. 1984).

374. *Wentwood*, 419 F.3d at 323.

375. *Id.* ("No error [was] shown in the district court's grant of summary judgment in favor of GMAC.").

376. Texaco Exploration & Prod., Inc. v. AmClyde Eng'rd Prods. Co., 448 F. 3d 760, 765 (5th Cir. May, 2006).

377. *Id.*

378. *See id.* at 765-66.

Texaco Exploration and Production, Inc. and Marathon Oil Company (Texaco) develop oil and gas fields.[379] During the late 1990s, Texaco secured an offshore federal lease on the Outer Continental Shelf (OCS).[380] The lease block is located in approximately 1750 feet of water off the coast of Alabama and Louisiana.[381] The development project is called Petronius.[382] Texaco hired J. Ray McDermott, Inc. (McDermott) to develop the site.[383] In the construction of the Petronius compliant tower, McDermott mounted a crane, manufactured by the defendant's predecessor, onto a barge.[384] The crane was to lift a section of the platform, the South Deck Module, onto the support frame.[385] During this process, the platform section fell to the ocean floor.[386] The module was never recovered and the construction of the Petronius compliant tower was delayed fifteen months.[387]

Certain Underwriters at Lloyd's of London (Underwriters) insured the Petronius project as well as the lost South Deck Module under a builder's risk property insurance contract.[388] Several relevant sections appeared in the insurance contract: a general conditions clause, a section that covers third party legal and contractual liabilities, and a provision that covers physical damage.[389] Texaco was a principal assured under the policy, and consequently, Underwriters reimbursed to Texaco more than $72 million for the covered losses, including the loss of the South Deck Module.[390]

Shortly thereafter, Texaco filed multiple negligence and products liability actions against Clyde's successors, AmClyde and Halter, in the District Court for the Eastern District of Louisiana.[391] Texaco argued that both were responsible for causing the losses.[392] Underwriters also commenced a subrogation-of-rights action against AmClyde and J. Ray McDermott

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379. *Id.*

380. *Id.* at 766.

381. *Id.*

382. *Id.* at 765.

> The contract charged McDermott with the engineering design, drafting, fabrication, installation, and construction of the Petronius compliant tower platform and its components, including the foundation piles, tower, support frame, two deck modules (the North Deck Module and the South Deck Module), and attendant drilling rigs at Viosca Knoll Block 786.

Id.

383. *Id.* at 765-66 ("The Petronius project was a $400 million deepwater drilling and production project for the development of 80 to 100 million barrels of oil equivalent.").

384. *Id.*

385. *Id.*

386. *Id.*

387. *Id.*

388. *Id.* at 766.

389. *Id.*

390. *Id.*

391. *Id.*

392. *Id.* Although not relevant in this presentation, this suit proceeded under the Outer Continental Shelf Lands Act and admiralty law. *Id.* Consequently subject matter jurisdiction and admiralty questions arose. *Id.* at 766-67.

International Vessels, Ltd (JRMIV), seeking indemni-fication for the reimbursement that Underwriters paid Texaco under the terms of the builder's risk policy.[393] Underwriters did not sue McDermott because McDermott was an additional named assured under the builder's risk policy.[394]

But JRMIV claimed that it was an other assured or an additional assured under the insurance contract because it was McDermott's affiliate or subcontractor.[395] Consequently, JRMIV argued that the waiver of subrogation clause in the insurance policy barred Underwriters' suit against JRMIV.[396]

Regarding Underwriters' subrogation claim, the district court granted AmClyde's motion for summary judgment.[397] The district found that AmClyde was indeed an additional assured under the builder's risk policy; therefore, the company was entitled to a waiver of subrogation.[398] JRMIV also moved to dismiss Underwriters' subrogation action, citing language in the insurance contract.[399] The district court granted JRMIV's summary judgment motion finding that JRMIV was also an additional assured.[400] Consequently, JRMIV was able to defend itself by asserting a waiver of subrogation.[401]

Underwriters separately appealed the district court's summary judgment to the Court of Appeals for the Fifth Circuit.[402] On appeal, Underwriters argued: To qualify as an "other assured party" under the builder's risk policy, AmClyde and JRMIV had to establish the presence of a written contract between them and Texaco—the principal assured under the insurance contract.[403] To determine whether Underwriters' argument was sound, the Fifth Circuit examined the principal assured clause in the insurance contract.[404] That provision reads in relevant part:

The principal assureds are defined as

(1) Texaco Exploration and Production, Inc. and/or Marathon Oil Company Inc. and/or associated partners in the Petronius Project and/or as may be agreed hereon.
(2) Parent and/or subsidiary and/or affiliated and/or associated and/or inter-related companies of the above as they now exist or may hereafter be constituted and their Directors, Officers and/or employees and/or other participants as may be agreed.

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393. *Id.*
394. *Id.* at 767.
395. *Id.*
396. *Id.*
397. *Id.*
398. *Id.*
399. *Id.*
400. *Id.*
401. *Id.*
402. *Id.* at 776.
403. *Id.* at 776-77.
404. *Id.* at 777 n.14.

(3) Project managers, if applicable.[405]

Then the Fifth Circuit compared the language in the principal assured clause with that appearing in the other assured provision in the builder's risk insurance contract.[406] The latter clause states:

> J. Ray McDermott, Inc. and/or Gulf Island Fabrication, Inc. and/or W.H. Linder & Associates, Inc. and/or Waldemar S. Nelson and Company, Inc. and/or Project Consulting Services, Inc. and/or other contractors and/or sub-contractors and/or suppliers and any other company, firm, person or party with whom the Assured(s) in (1), (2) or (3) of this Clause have, or in the past had, entered into written agreement(s) in connection with the subject matters of insurance, and/or any works, activities, preparations etc. connected therewith.[407]

A fair reading of the principal assured clause would allow an objective reader to conclude that Texaco was the named assured and that AmClyde and JRMIV were not conclusively Texaco's subsidiaries, associates or affiliates.[408] At best, based on the reported facts, AmClyde and JRMIV were Texaco's subcontractors or suppliers.[409] Therefore, under the principal assured clause, AmClyde and JRMIV were not assureds, and they did not claim to be assureds under that clause.[410]

AmClyde and JRMIV, however, asserted that they were assureds under the other assured clause.[411] But an objective observer would note that property insurance only protects the named assured's interest from covered risks, and the builder's risk policy covered Texaco's property, not AmClyde's or JRMIV's property.[412] To qualify as an additional assured under a personal property insurance contract, a contractor, subcontractor, or suppliers must have an insurable interest in the property.[413] Louisiana's property insurance statute is clear:

> A. No contract of insurance on property or of any interest therein or arising therefrom shall be enforceable except for the benefit of persons having an insurable interest in the things insured.

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405. *Id.*
406. *Id.* at 777.
407. *See id.*
408. *Id.*
409. *See id.*
410. *Id.*
411. *Id.*
412. *See* Miller v. Hartford Fire Ins. Co., 412 So.2d 662, 669 (La. Ct. App. 1982) (embracing the principle that one's securing property insurance to protect one's own interest, and one's interest alone, does not inure to the benefit of another).
413. *See* LA. REV. STAT. ANN. § 22:614 (2004).

> B. "Insurable interest" as used in this section means any lawful and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage.[414]

Of course, with an insurer's consent, subcontractors—like AmClyde and JRMIV—may secure an insurable interest in another person's property if evidence exists to prove that the subcontractors have a substantial pecuniary or economic interest in the safety or preservation of another's property.[415] A written contract between the contractors and subcontractors can provide evidence of an insurable interest.[416] Thus, in the present case from Underwriters' perspective, the builder's risk policy required a written agreement before AmClyde or JRMIV could become an other assured.

The Fifth Circuit, however, did not cite or consider Louisiana's insurable interest rules.[417] Instead, the court concluded:

> The clear construction of the [other assured] provision provides a list of categories of assureds, separating each category by the conjunction 'and/or'.... Under the unambiguous language of the Builder's Risk Policy, a contractor or subcontractor may be an other assured, irrespective of the written agreement qualification.[418]

Ultimately, the Fifth Circuit affirmed the district court's rulings, finding that AmClyde and JRMIV were assureds, thereby barring Underwriters' equitable subrogation suit against the two alleged tortfeasors.[419]

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414. *Id.*

> "Insurable interest" as thus defined by our state legislature is consistent with the universally recognized rule to the effect that a policy of insurance on property is predominately a contract of indemnity the purpose of which is to protect the assured against any loss he may sustain by virtue of its loss, damage or destruction. The great weight of authority further recognizes and holds that an interest in the property protected is essential to the existence of a valid insuring agreement and additionally serves to differentiate an enforceable indemnity agreement from a wagering pact which latter transaction is invalid and unenforceable for reasons obviously prompted by public policy and good morals. It is also generally recognized and held the interest of the insured sought to be protected must have for its object the obviation of pecuniary or financial loss to or liability of the assured which would otherwise result from damage to or destruction of the insured property. If the loss or damage to the insured property does not expose the insured to either direct, immediate or potential loss or liability, the insured is without insurable interest therein.

Rube v. Pac. Ins. Co. of N.Y., 131 So.2d 240, 243 (La. Ct. App. 1961).

415. *See supra* notes 282-83 and accompanying text.

416. *Texaco Exploration*, 448 F.3d at 776-78.

417. *See id.*

418. *Id.* at 777-78.

419. *Id.* at 779.

> Underwriters next argue . . . that AmClyde is not a subcontractor and therefore cannot qualify as an other assured. . . . The record reflects that AmClyde is a subcontractor to Texaco's

To be sure, the Fifth Circuit could have reached the same conclusion more convincingly and intelligibly simply by (1) citing, applying, and discussing Louisiana's doctrine of ambiguity more carefully; (2) declaring that the other assured clause was ambiguous, rather than unambiguous; (3) construing the unclear language in the other assured provision against Underwriters; and (4) ruling in favor of AmClyde and JRMIV.[420] Instead, the courts of appeals focused on whether AmClyde and JRMIV were contractors rather than on whether they had an insurable interest in Texaco's property under the law of Louisiana.[421] As a consequence, the Fifth Circuit delivered two highly questionable rulings in *Texaco*.

Petronius tower construction project. AmClyde and McDermott entered a written agreement requiring AmClyde's provision of work to McDermott and covering the work provided by AmClyde to the Petronius tower construction project. The record also reveals that subject to its contract with McDermott, AmClyde provided . . . services to the Petronius construction project . . . . In light of the contractual agreement between AmClyde and McDermott, in combination with AmClyde's provision of work to the Petronius project itself subject to that contract, including the very lift of the deck module most closely tied to the property loss at the heart of this case, AmClyde is a subcontractor to the Petronius tower construction project. . . . Also, the allegations in Underwriters' own complaint support in part that Underwriters understood AmClyde's status as a subcontractor. . . . [W]e affirm the district court's conclusion that AmClyde is an "other assured" under the Policy on the basis that AmClyde was a subcontractor. The record reflects AmClyde's subcontractor status in form of a written agreement to provide work to McDermott and AmClyde's actual provision of work, under contract with McDermott, related to the Petronius tower construction project. As subcontractor, under the Policy's unambiguous language, AmClyde is an other assured. The policy provides for waiver of subrogation against any assured and any entity or person "whose interests are covered by this Policy." Thus, AmClyde is entitled to the waiver of subrogation.

. . . .

[W]e similarly affirm the district court's conclusion that JRMIV was an other assured entitled to waiver of subrogation. JRMIV argued before the district court that Underwriters could not proceed in subrogation against it because of express waivers of subrogation in the Builder's Risk Policy and because JRMIV is an other assured against whom subrogation is waived. . . . The court held that Underwriters expressly waived rights of subrogation against it as an insured in the Builder's Risk Policy because JRMIV qualified as an insured subcontractor. The court also concluded that JRMIV is an affiliate or contractor/subcontractor under the waiver of subrogation provision for affiliate entities and is also therefore entitled to waiver of subrogation.

. . . .

The district court correctly dismissed Underwriters' subrogation claim against JRMIV.

. . . .

We affirm the district court's dismissal of Underwriters' suit seeking subrogation against AmClyde and JRMIV. Each entity is an other assured entitle to waiver of subrogation.

Id. at 781-83.

420. *Id.* at 777 ("[T]he district court applied Louisiana law, and the parties [did] not contest the choice of law."); *see also* Succession of Fannaly v. Lafayette Ins. Co., 805 So.2d 1134,1138 (La. 2002) (repeating that an "ambiguous contractual provision is construed against the insurer who furnished the contract's text and in favor of the insured").

421. *Texaco Exploration*, 448 F.3d at 777.

2. *Whether Under Texas Law a Property Insurer Has a Duty to Indemnify an Insured Condominium Association for Expenses Associated with Hail-Related Losses and Damages*

Ridglea Estate Condominium Ass'n v. Lexington Insurance. Co. (*Ridglea I*) was among the cases reported and reviewed during the Fifth Circuit's 2004-2005 session.[422] The broad question in *Ridglea I* was whether a property insurer had a contractual duty to indemnify an insured condominium association after the association filed a notice-of-loss claim and asked the insurer to pay.[423] Four specific substantive issues were raised in *Ridglea I*.[424] The Fifth Circuit decided three satisfactorily and remanded the case to the U.S. District Court for the Northern District of Texas with instructions.[425]

Recently, after reviewing its analysis of the fourth sub-issue in *Ridglea I*, the Fifth Circuit decided that its *Erie* guess of how the Texas Supreme Court would decide the issue was less than sound.[426] Therefore, during the 2005-2006 term, the Fifth Circuit withdrew its opinion in *Ridglea I* and substituted a slightly revised opinion in *Ridglea Estate Condominium Ass'n v. Lexington Insurance Co.* (*Ridglea II*).[427] The analyses and holdings in the original and substituted opinions are identical, except for the court's analysis surrounding the fourth sub-issue.[428] This survey briefly reviews the salient facts in the case and discusses only the fourth issue that the appellate court remanded to the district court in *Ridglea I*.

Ridglea Estate Condominium Association (Ridglea) manages and represents the interests of condominium owners in Fort Worth, Texas.[429] In July 2001, an inspector examined the roofs on the condominiums and discovered much destruction.[430] At that time, Chubb Custom Insurance (Chubb) insured the property.[431] Ridglea submitted a claim to Chubb four months later—in November of 2001.[432] Chubb inspected the roofs and concluded that a hail storm probably caused the damage.[433]

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422. *See* Rice, *supra* note 5, at 858-64.

423. Ridglea Estate Condo. Ass'n v. Lexington Ins. Co. (*Ridglea I*), 398 F.3d 332, 332 (5th Cir. 2005).

424. *Id.*

425. *Id.* at 339.

426. *Id.* at 337.

427. *See* Ridglea Estate Condo. Ass'n v. Lexington Ins. Co. (*Ridglea II*), 415 F.3d 474, 475 (5th Cir. July 2005).

428. *Id.*

429. *Ridglea I*, 398 F.3d at 333.

430. *Id.*

431. *Id.*

432. *Id.*

433. *Id.*

Problematically, the only hail storm in greater Fort Worth had occurred six years earlier—on May 5, 1995.[434] Chubb told Ridglea to file a notice-of-loss claim to Lexington Insurance Company because Lexington insured the property from February 1995 to February 1996.[435] Ridglea submitted a claim to Lexington immediately, and Lexington's claims adjuster inspected the damaged roofs.[436] Ultimately, Lexington concluded that the financial loss did not exceed Ridglea's deductible under Lexington's property insurance contract.[437] In addition, Lexington could not uncover any evidence proving conclusively that the losses occurred during the policy period.[438] As a result, Lexington denied Ridglea's claim on December 19, 2001—six years, seven months, and fourteen days from the purported loss on May 5, 1995.[439]

Following a year of negotiations and Ridglea's demand for $449,198.63 and attorneys' fees, Lexington denied the claim again.[440] Shortly thereafter, Lexington commenced a declaratory judgment action in U.S. District Court for the Northern District of Texas.[441] The property insurer asked the federal district court to declare that Lexington had no contractual duty to indemnify Ridglea for hail-related losses.[442] The district court dismissed the declaratory judgment suit, realigned the litigants, and made Ridglea the plaintiff in a direct-action suit against Lexington.[443]

Although the opinion did not state precisely Ridglea's theory of recovery in the underlying lawsuit, a fair guess suggests that Ridglea sued Lexington for a breach of contract.[444] Both parties filed motions for summary judgment.[445] Granting Lexington's motion, the district court held that Ridglea's failure to comply with the policy's notice-of-loss requirement barred the direct-action suit.[446] The district court found that Ridglea had a contractual obligation to give "'prompt notice of the loss or damage'" before filing the lawsuit.[447] The lower court also concluded that Ridglea did not satisfy another condition precedent before filing the underlying lawsuit in that the aggrieved insured had a duty to contact Lexington and "provide, as soon as possible[,] a description of how, when and where the loss or damage occurred."[448]

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434. *Id.*
435. *Id.*
436. *Id.*
437. *Id.*
438. *Id.*
439. Ridglea Estate Condo. Ass'n v. Lexington Ins. Co. (*Ridglea II*), 415 F.3d 474, 475-76 (5th Cir. July 2005).
440. *Id.* at 476.
441. *Id.*
442. *Id.*
443. *Id.*
444. *See id.* (explaining that Ridglea sued Lexington for damages on the insurance policy).
445. *Id.*
446. *Id.*
447. *Id.* (quoting Ridglea's insurance policy).
448. *Id.*

To repeat, the property destruction occurred in May 1995.[449] But Ridglea did not send a notice-of-loss to Lexington until November 2001.[450] Therefore, the district court found that those six-plus years prejudiced Lexington because the hail damage and financial loss were not reported "within a reasonable time."[451] Ridglea appealed the district court's adverse summary judgment ruling.[452]

Before the Fifth Circuit, Ridglea argued that the District Court for the Northern District of Texas committed four reversible errors: (1) declaring that Lexington did not waive its right to raise the breach of notice affirmative defense; (2) concluding that the notice requirement was void as a matter of public policy; (3) failing to find ambiguity in the notice provision, which would have allowed the court to construe the notice clause against Lexington and in favor of Ridglea; and (4) holding that Lexington did not have to show prejudice, thereby allowing the insurer to proffer breach of notice as an affirmative defense.[453]

The Fifth Circuit addressed and quickly decided the waiver, public-policy, and ambiguity issues.[454] A thorough discussion of those issues and holdings appear in the 2004-2005 review of the Fifth Circuit's insurance decisions.[455] The *Ridglea I* court of appeals decided the three questions in favor of Lexington.[456] More specifically, in *Ridglea I*, the Fifth Circuit declared that (1) Lexington did not waive the notice-of-loss requirement, (2) the notice-of-loss provision was not void and unenforceable as a matter of public policy, and (3) the notice-of-loss provision was not ambiguous in light of Texas's doctrine of ambiguity.[457] Put simply, in *Ridglea I*, the Fifth Circuit embraced the district court's conclusion that Ridglea's giving notice of a loss

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449. *Id.*

450. Ridglea Estate Condo. Ass'n v. Lexington Ins. Co. (*Ridglea I*), 398 F.3d 332, 333 (5th Cir. 2005).

451. *Id.* at 334.

452. *Id.*

453. *Id.*

454. *Id.* at 334-38.

455. *See* Rice, *supra* note 5, at 821.

456. *Ridglea I*, 398 F.3d at 334-38.

457. *Id.* at 335-36.

> In sum, because Ridglea gave its notice of damage after the period for prompt notice had expired, Lexington's subsequent general denial of liability likewise came "after the time limited for giving notice' and thus did not constitute a waiver of the defense of late notice. . . . Ridglea contends that 'interpreting the notice provision as requiring notice *once the insured discovers a loss* . . . would certainly be reasonable."

Id. at 335-37. The Fifth Circuit dismissed this argument, citing a prevailing rule under Texas common law: When an insurance contract does not define "prompt," courts must construe the term to mean that "notice must be given within a reasonable time after [an] occurrence." *Id.* (citing Stonewall Ins. Co. v. Modern Exp., Inc., 757 S.W.2d 432, 435 (Tex. App.—Dallas 1988, no writ); *see* St. Paul Mercury Ins. Co. v. Tri-State Cattle Feeders, Inc., 628 S.W.2d 844, 846 (Tex. App.—Amarillo 1982, writ ref'd) (stating, in dicta, that "[a]n ambiguous clause in an insurance policy [must] be strictly construed in favor of the insured").

six-plus years after the hail damaged the condominium roofs was simply unreasonable.[458]

But as reported in the 2004-2005 review, the *Ridglea I* court of appeals refused to dismiss Ridglea's fourth argument as quickly.[459] Ridglea argued that the district court's finding that Lexington had no duty to show prejudice when Ridglea breached the notice-of-loss provision was reversible error.[460] The district court adopted Lexington's argument that proof of prejudice applies only if the dispute involves liability insurance contracts.[461] Contrarily, Ridglea stressed that Texas law requires an insurer to show prejudice, regardless of the type of policy, if an insurer intends to use breach-of-notice as an affirmative defense.[462] In *Ridglea I*, the Fifth Circuit endorsed Ridglea's argument.[463] Of course, the appellate court made a questionable *Erie* guess about how the Texas Supreme Court would address the issue.[464] Furthermore, the panel reached that conclusion after relying in part on its dubious opinion in *Hanson Production Company v. American Insurance Company* and citing *Hernandez v. Gulf Group Lloyds.*[465]

In *Hanson*, a different Fifth Circuit panel cited the Texas State Board of Insurance's order and concluded that Texas law requires an insurer to show prejudice if that insurer intends to raise breach-of-notice as a defense against paying proceeds under certain types of insurance policies.[466] The orders, however, only required mandatory endorsements in general liability and automobile insurance contracts.[467] The endorsement stated that if an "insured's failure to comply with the requirement [does not prejudice the insurer,] any provision of this policy requiring the insured to give notice of . . . occurrence or loss . . . shall not bar liability under this policy."[468]

In *Hernandez*, the Texas Supreme Court held that a violation of a condition precedent in an insurance contract cannot bar an insured's right to recover insurance proceeds, unless the insurer establishes that the violation materially prejudiced the insurer's rights under the contract.[469] Therefore,

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458. *Ridglea I*, 398 F.3d at 335.

459. *See* Rice, *supra* note 5, at 862.

460. *Ridglea I*, 398 F.3d at 333.

461. *Id.* at 337; *see* Hanson Prod. Co. v. Am. Ins. Co., 108 F.3d 627, 629 (5th Cir.1997).

462. *Ridglea I*, 398 F.3d at 337.

463. *Id.*

464. *Id.* ("When deciding questions of state law, [the Fifth Circuit] is bound by *Erie* to rule as it believes the state's supreme court would." (citing Browning Seed Inc. v. Bayles, 812 F.2d 999, 1002 (5th Cir.1987))); *see* Erie R.R. Co. v. Tompkins, 304 U.S. 64, 64 (1938).

465. Hernandez v. Gulf Group Lloyds, 875 S.W.2d 691, 691 (Tex.1994); *Hanson*, 108 F.3d at 627.

466. *Hanson*, 108 F.3d at 629.

467. *Id.*

468. *Id.* at 629 (quoting Texas State Board of Insurance, Order No. 23080).

469. *Hernandez*, 875 S.W.2d at 693.

> In determining the materiality of a breach, courts will consider, among other things, the extent to which the non-breaching party will be deprived of the benefit that it could have reasonably anticipated from full performance. The less the non-breaching party is deprived of expected

embracing *Hanson*, with its heavy reliance on the Texas State Board of Insurance's order, and the decision in *Hernandez*, the *Ridglea I* appellate panel guessed wildly and crafted an exceedingly broad rule to govern Texas cases.[470] The panel stated:

> Given . . . the Texas Supreme Court's reasoning, and the general principle underlying that reasoning, we conclude that the prejudice requirement applies equally to all insurance policies issued in Texas, including the property insurance policy at issue here. As such, we hold that the district court erred in holding that Lexington was not required to show prejudice in order to raise breach of the policy's prompt notice provision as a defense.[471]

In *Ridglea II*, the Fifth Circuit panel withdrew *Ridglea I*'s broad ruling and substituted the following:

> In *Hernandez*, the Texas Supreme Court held that an insured's violation of a settlement-without-consent provision was not a bar to recovery under an uninsured motorist policy, unless the insurer could show that it was prejudiced by the violation. The court made no reference to the orders by the Board of Insurance; instead, the court based its holding on general principles of contract interpretation. . . . Given the method of the Texas Supreme Court's reasoning, and the general principle underlying that reasoning, we conclude that the prejudice requirement applies to the property insurance policy at issue here. As such, we hold that the district court erred in holding that Lexington was not required to show prejudice in order to raise breach of the policy's prompt notice provision as a defense. . . We emphasize that our holding is a narrow one. We do not read *Hernandez* as necessarily creating a prejudice requirement for all insurance policies issued in Texas."[472]

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benefit, the less material the breach [and prejudice].

. . .

We conclude, therefore, that an insurer who is not prejudiced . . . may not deny coverage . . . .

Id. (citing RESTATEMENT (SECOND) OF CONTRACTS § 241(a) (1981)) (citations omitted); *see* Jack v. State, 694 S.W.2d 391, 398-99 (Tex. App.—San Antonio 1985, writ ref'd n.r.e.) (embracing a fundamental principle of contract law that states that when one party to a contract commits a material breach of that contract, the other party has no contractual obligations to perform); *see also Hanson*, 108 F.3d at 630-31. The Fifth Circuit later declared in Ridglea that the Texas Supreme Court's reasoning in *Hernandez* was straightforward: "(1) all insurance policies are contracts; (2) all contracts require material breach to excuse non-performance; and, (3) for a breach to be material, it must prejudice the non-breaching party in some way. Ridglea Estate Condo. Ass'n v. Lexington Ins. Co. (*Ridglea I*), 398 F.3d 332, 338 (5th Cir. 2005) (citing *Hanson*, 108 F.3d at 630-31 (citing *Hernandez*, 875 S.W.2d at 692)).

470. *See id.* at 334-38.

471. *Id.* at 338. "This is, of course, consistent with our decision in *Hanson*, [in which] we held that surplus lines insurers, who are not subject to the mandatory endorsements required by the Texas Department of Insurance, are nonetheless required to show prejudice in order to raise late notice as a defense." *Id.* (citing *Hanson*, 108 F.3d at 629).

472. Ridglea Estate Condo. Ass'n v. Lexington Ins. Co. (*Ridglea II*), 415 F.3d 474, 480 & n.4 (5th Cir. July 2005) ("We have previously held, for example, that an insurer may deny coverage under a claims

For the reasons appearing above, the panel in *Ridglea II* vacated the district court's summary judgment motion in favor of Lexington and remanded the case, ordering the lower court to determine whether Ridglea's breach of the prompt notice provision allowed Lexington to raise prejudice as an affirmative defense and whether a trial on the merits was required, if questions of fact exist.[473]

3. Whether Under Texas Law an Excess Insurer Has a Duty to Indemnify an Insured Corporation for Financial Losses After an Employee Embezzled Corporate Funds

Previously in this survey, a discussion of the conflict and legal issues in *Wentwood* appears.[474] In that case, one of the issues concerned the extent of the insured's rights under the primary and excess insurance contracts.[475] In particular, the insured partnership in *Wentwood* argued that the excess insurer incorporated the primary insurer's errors and omissions clause into the excess insurer's property insurance contract.[476] Similarly, in *Times-Picayune Publication Corp. v. Zurich American Insurance Co.*, a secondary question also concerns whether an excess insurance contract incorporates language that appears in a primary insurance policy.[477]

Differences exist between the two cases.[478] In *Zurich*, the excess insurer rather than the insured argued for incorporation.[479] And, a "prior loss clause" in the primary insurance contract, rather than an errors and omissions clause, was the focus of attention in *Zurich*.[480] Also like *Wentwood*, the central substantive question in *Zurich* is was fairly familiar: whether an excess insurer has a duty to indemnify an insured.[481] But in the latter case, the facts are much more tedious, extensive, and complex.[482]

First, the dispute in *Zurich* involves several corporate entities.[483] The Times-Picayune Publishing Corporation (Times-Picayune) is a Louisiana corporation with its principal place of business in New Orleans.[484] Times-

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made liability policy without a showing of prejudice. Whether other types of policies likewise fall outside the scope of *Hernandez* is a question we need not reach." (citing Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co., 174 F.3d 653, 659 (5th Cir.1999) (other citations omitted))).

473. *Id.* at 480.

474. *See supra* text accompanying notes 195-263.

475. *See supra* text accompanying notes 195-263.

476. *See supra* text accompanying notes 195-263.

477. Times-Picayune Publ'g Corp. v. Zurich Am. Ins. Co., 421 F.3d 328, 331 (5th Cir. Aug. 2005).

478. *See id.*; *see also supra* text accompanying notes 195-263.

479. *Times-Picayune*, 421 F.3d at 331.

480. *Id.*

481. *Id.* at 330.

482. *See id.* at 329-30.

483. *Id.*

484. *See* The Times-Picayune, http://www.times-picayune.com/moreinfo.htm (last visited Jan. 31, 2007).

Picayune's primary business activities are gathering news and publishing newspapers.[485] Federal Insurance Company (Federal), a property and casualty insurer, is an affiliate of the Chubb Group.[486] Federal is an Indiana corporation with its principal place of business in Indianapolis.[487] Zurich American Insurance Company (Zurich-American)—Zurich North America Commercial —is a subsidiary of the Swiss insurance giant, Zurich Financial Services.[488] Zurich-American is a leading provider of commercial property and casualty insurance and offers a range of insurance coverage for businesses of all sizes.[489] Zurich-American is a New York corporation.[490] In this dispute, Federal and Zurich-American are the primary and excess insurers, respectively.[491]

Times-Picayune purchased six primary insurance contracts from Federal which insured against various perils, including acts of employee dishonesty.[492] Under each contract, Federal agreed to compensate Times-Picayune for losses identified within one year after the policy ended—the discovery period—and losses that occurred before the policy period if Times-Picayune satisfied certain conditions.[493] In addition, each primary contract insured against losses that occurred during the policy period and required Times-Picayune to file a notice-of-loss or POL within 120 days of discovering the loss.[494] Those contracts covered a six-year interval from January 1, 1995 to July 1, 2001.[495] The policy limit in each primary policy was $1,000,000.[496]

On July 1, 1996, Times-Picayune also purchased a one-year, excess property insurance contract from Federal along with the second primary insurance policy.[497] The excess contract insured against losses exceeding the $1,000,000 policy limit in the primary contract.[498] Among other perils, the excess contract insured against acts of employee dishonesty and resulting

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485. *Id.*

486. *See* Chubb Grove, Subsidiaries, http://www.chubb.com/corporate/chubb2403.html (last visited Mar. 14, 2007).

487. *See* Chubb Group, Federal Insurance, http://www.chubb.com/international/hk/terms.html (last visited Mar. 14, 2007).

488. *See* Zurich in North America, http://www.zurichna.com/zus/aboutus.nsf/ (last visited Mar. 14, 2007).

489. *Id.*

490. *Times-Picayune Publ'g Corp. v. Zurich Am. Ins. Co.*, 421 F.3d 328, 329 (5th Cir. Aug. 2005).

491. *Id.* at 329-30.

492. *Id.* at 329.

493. *Id.* at 329 & n.1. Each primary policy provided: "DISCOVERY PERIOD. This insurance does not cover any loss, sustained by any insured, discovered later than one year following termination of this insurance in its entirety." *Id.*

494. *Id.* at 329.

495. *Id.* "The first of these primary policies ran from January 1, 1995, to July 1, 1996, and each subsequent policy was for a one year term beginning July 1, with the sixth and final primary policy running from July 1, 2000, to July 1, 2001." *Id.*

496. *Id.*

497. *Id.* at 330.

498. *Id.*

economic losses.[499] The policy limit of Federal's excess insurance contract was $1,500,000.[500] On July 1, 1997, Times-Picayune renewed the one-year excess contract with Federal.[501] On July 1, 1998, however, the Times-Picayune switched excess carriers and purchased a three-year, $1,500,000 policy from Zurich-American.[502] The contract began on July 1, 1998 and terminated on July 1, 2001.[503]

From January 1995 to December 2000, a Times-Picayune employee, Arthur Anzalone, embezzled $2,205,879 from the Times-Picayune.[504] The illegal activities occurred over six years, during the interval that Federal insured the Times-Picayune under the six primary contracts against acts of employee dishonesty and other perils.[505] After discovering the employee's theft, the Times-Picayune contacted Federal, filing a notice-of-loss and presenting proof of the loss.[506] Asserting that the consecutive primary insurance contracts covered the loss, the newspaper asked Federal to pay.[507]

Without admitting any liability, Federal settled the Times-Picayune's claim in December 2000.[508] The primary insurer paid the full policy limit—$1,000,000.[509] After the settlement, however, the Times-Picayune still had an outstanding loss of $1,205,879.[510] Therefore, the newspaper contacted Zurich-American, asking the excess insurer to pay the remainder.[511] The Times-Picayune filed a timely notice and POL, but Zurich-American refused to reimburse the newspaper.[512]

On September 19, 2002, the Times-Picayune sued the excess insurer in a Louisiana state court, advancing several theories of recovery sounding in tort and in contract: (1) a common law breach of the excess insurance contract; (2) a bad faith breach-of-contract; (3) a statutory violation of good faith for the insurer's failure to adjust an insurance claim promptly;[513] (4) a statutory

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499. *Id.*
500. *Id.*
501. *Id.*
502. *Id.*
503. *Id.*
504. *Id.*
505. *Id.*

Over the course of his crime, Anzalone stole: $536,428 during the term of Federal's first primary policy (1/1/95-7/1/96); $268,871 during the second policy (7/1/96-7/1/97); $234,707 during the third policy (7/1/97-7/1/98); $330,647 during the fourth policy (7/1/98-7/1/99); $562,859 during the fifth policy (7/1/99-7/1/00); and $272,367 during the sixth (and last) primary policy (7/1/00-7/1/01).

Id.

506. *Id.*
507. *Id.*
508. *Id.*
509. *Id.* at 330.
510. *Id.*
511. *Id.*
512. *Id.*
513. *See* LA. REV. STAT. ANN. § 22:1220(A) (2004).

violation for the insurer's failure to pay a claim promptly—within thirty days after receiving a satisfactory POL;[514] and (5) a breach-of-contract action for breaching an implied covenant of good faith and fair dealing.[515]

The Times-Picayune also filed a declaratory judgment action, petitioning the state court for equitable relief.[516] Zurich-American removed the case to the U.S. District Court for the Eastern District of Louisiana claiming diversity of jurisdiction.[517] The district court partially granted Zurich-American's motion for summary relief, citing language in both contracts.[518]

More specifically, Zurich-American's excess insurance contract did contain a "prior loss" provision; therefore, the excess contract was silent regarding excluding losses discovered within one year after the policy expired, or to losses occurring before the policy period.[519] But in its motion for summary relief, Zurich-American cited the prior loss clause in Federal's primary insurance contract.[520] The excess insurer also cited the coverage clause in the excess insurance contract, which stated: "'[C]overage under this policy shall apply [after the required primary coverage has been exhausted] in conformance with and subject to the warranties, limitations, conditions, provisions, and other terms of the [p]rimary [p]olicy.'"[521]

Again, partially embracing the excess insurer's position, the federal district court found, as a matter of law, that the excess insurance contract was unambiguous.[522] Therefore, it held Zurich-American liable only for losses that the newspaper incurred during the three-year period when both the primary and excess insurance contracts ran concurrently.[523] Ultimately, the district

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An insurer, including but not limited to a foreign line and surplus line insurer, owes to his insured a duty of good faith and fair dealing. The insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach.

Id.

514. *See* LA. REV. STAT. ANN. § 22:658(A)(1) (2004).

All insurers issuing any type of contract . . . shall pay the amount of any claim due any insured within thirty days after receipt of satisfactory proofs of loss from the insured or any party in interest.

Id.

515. *Times-Picayune*, 421 F.3d at 331.

516. *Id.*

517. *Id.*

518. *Id.*

519. *Id.* at 330.

520. *Id.*

521. *Id.*

522. *Id.*

523. *Id.* at 331.

The first . . . primary polic[y] ran from January 1, 1995, to July 1, 1996, and each subsequent policy was for a one year term beginning July 1. [The] sixth . . . primary policy [covered the period] from July 1, 2000, to July 1, 2001. . . . [O]n July 1, 1998, the Times-Picayune switched excess carriers and bought a three-year, $1,500,000 policy from Zurich that was effective from July 1, 1998 until July 1, 2001.

court entered a final judgment under FED. R. CIV. P. 54(b),[524] citing just one of Times-Picayune's theories of recovery, the breach-of-contract action.[525] The district court concluded that Zurich-American had to pay just $60,000 rather than $1,205,879.[526] The Times-Picayune appealed.[527]

The only question before the Fifth Circuit had two prongs: (1) whether Zurich-American had a duty to indemnify the Times-Picayune for all or a part of the remaining uncompensated losses ($1,205,879) and (2) whether the excess insurer had a duty to pay the newspaper $165,873—fourteen percent (14.2%) of the $1,165,873 that the employee embezzled while the primary and excess insurance contracts ran concurrently during a three-year period.[528]

Again, citing the prior loss clause in Federal's primary insurance contract, Zurich strongly asserted that it was liable only for losses exceeding $1,000,000 during the three-year life of its excess policy—July 1, 1998 to July 1, 2001.[529] Alternatively, the excess insurer argued that it was not responsible for any losses occurring before July 1, 1998 and that Anzalone never embezzled more than $1,000,000—the policy limit in Federal's primary contracts—during the years when the Times-Picayune also purchased excess insurance coverage from Federal.[530]

To begin its analysis, the Fifth Circuit reviewed several provisions in Zurich-American's excess contract.[531] First, the coverage clause stated:

> The Underwriter shall provide the Insureds with insurance coverage during the Policy Period [in] excess of the Underlying Insurance. Coverage under this policy shall attach only after all of the Limit(s) of Liability of the Underlying Insurance has been exhausted by the actual payment of loss(es). Except as otherwise provided herein, coverage under this policy shall then

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Id. During those three years, Federal insured the newspaper company under successive one-year primary polices. *Id.*

524. *Id.* at 331. FED. R. CIV. P. 54(b) gives a court the authority to enter a final judgment when multiple causes of action or parties are part of a lawsuit:

> When more than one claim for relief is presented in an action . . . or when multiple parties are involved, the court may direct the entry of a final judgment as to one or more but fewer than all of the claims or parties only upon an express determination that there is no just reason for delay and upon an express direction for the entry of judgment.

FED. R. CIV. P. 54(b).

525. *Times-Picayune*, 421 F.3d at 331.

526. *Id.*

527. *Id.*

528. *Id.*

529. *Id.* at 330-31 & n.3. Anzalone embezzled $1,165,873 during this three-year period. *Id.* at 330. Zurich-American argued that after subtracting Federal's $1,000,000, its remaining exposure under the $1,500,000 excess policy was only $165,873 out of the total in embezzlement losses—$1,205,879. *Id.* The excess insurer actually offered to settle for roughly $165,873 and paid $93,064 to the Times-Picayune. *Id.* The excess policy had a $1,500 deductible. *Id.*

530. *Id.* at 330 n.2 (noting that the Times-Picayune did not carry excess insurance from January 1, 1995 to July 1, 1996).

531. *Id.* at 332.

> apply in conformance with and subject to the warranties, limitations, conditions, provisions, and other terms of the Primary Policy as in effect the first day of the Policy Period, together with the warranties and limitations of any other Underlying Insurance. In no event shall coverage under this policy be broader than coverage under any Underlying Insurance.[532]

The Zurich-American excess insurance contract also had a "drop-down" clause.[533] It outlined the factors that trigger the excess insurer's duty to indemnify after the underlying primary insurance contract's policy limit had been exhausted or reduced.[534] The drop-down clause stated in relevant part:

> In the event . . . of the reduction or exhaustion of the Limit(s) of Liability of the Underlying Insurance solely as the result of actual payment of [a covered loss] thereunder, this policy shall: I) in the event of reduction, pay excess of the reduced Limit(s) of Liability of the Underlying Insurance, and ii) in the event of exhaustion, continue in force as primary insurance excess of the retention applicable in the Primary Policy, which retention shall be applied to any subsequent loss as specified in the Primary Policy.
>
> Notwithstanding any of the terms of this policy which might be construed otherwise, this policy shall drop down only in the event of reduction of exhaustion of the Underlying Insurance by the actual payment of loss and shall not drop down for any other reason including, but not limited to, uncollectibility (in whole or in part) of any Underlying Insurance.[535]

As previously mentioned, a prior loss clause appeared in Federal's primary insurance contract.[536] It removed or reduced the primary insurer's liability for losses occurring before the primary contract's effective date.[537] The prior loss clause read in pertinent part:

> If you were continuously insured by a policy prior to this insurance providing the same insurance as this policy, but cannot recover on a loss because that policy was terminated and its discovery period has run out, we will cover your loss provided:
>
> 1. this insurance would have covered your loss had it been in effect at the time the acts that caused the loss occurred; and
> 2. you discovered the loss within one year after this insurance is terminated.
>
> We will not pay more than the Limit of Insurance for the loss under the prior policy or under this insurance when it became effective, whichever is less.

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532. *Id.* at 332.
533. *Id.*
534. *Id.*
535. *Id.*
536. *Id.* at 329.
537. *Id.*

The amount we pay will be a part of this insurance, not in addition to it.[538]

Again, in the present case, the district court ruled that Zurich-American's excess policy, with a $1,500,000 policy limit, covered only $165,873 of the Times-Picayune's $1,205,879 losses.[539] And the district court ruled that the fact that prior losses had exhausted the $1,000,000 limit in Federal's July 1, 2000 to July 1, 2001 primary insurance policy was irrelevant.[540] To reach that finding, the district court largely ignored the drop down clause in Zurich-American's excess contract, focused on the prior loss clause in Federal's primary policy, and relied on an earlier Fifth Circuit ruling in *First National Bank of Amarillo v. Continental Casualty Co.*[541]

In *Amarillo*, an employee embezzled a bank's funds, thus creating a dispute over whether an excess insurer had a duty to indemnify the insured bank under the excess insurance contract.[542] But the current Fifth Circuit panel declared that *Amarillo* was not the controlling authority for two important reasons.[543] First, the court of appeals decided *Amarillo* in 1934, four years prior to the Supreme Court issuing its landmark decision *Erie R.R. Co. v. Tompkins*.[544] The *Erie* Court held that federal courts sitting in diversity should apply substantive state law and federal procedural law.[545] Second, the appeal in *Amarillo* originated from the Northern District of Texas, rather than from a federal district court in Louisiana.[546] Therefore, from the court of appeal's perspective, using "a pre-*Erie* Texas case . . . as controlling authority respecting an insurance contract dispute under Louisiana law" is inappropriate.[547]

To determine whether the district court correctly ordered Zurich-American to pay $165,873, the Fifth Circuit first examined Louisiana's doctrines for interpreting insurance contracts: (1) traditional rules of contract construction,[548] (2) the plain meaning rule,[549] (3) the doctrine of ambiguity,[550]

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538. *Id.* at 329-30.

539. *Id.* at 331.

540. *Id.* at 334.

541. *Id.* at 335 (citing First Nat'l Bank of Amarillo v. Cont'l Cas. Co., 71 F.2d 838 (5th Cir. 1934)).

542. *First Nat'l Bank of Amarillo*, 71 F.2d at 838-39.

543. *Times-Picayune*, 421 F.3d at 334.

544. *Id.* (citing Erie R.R. Co. v. Tompkins, 304 U.S. 64 (1938)).

545. *Erie*, 304 U.S. at 78; *Times-Picayune*, 421 F.3d at 334 (noting that the *Amarillo* panel did not cite any court decision, treatise, or other authority to support its conclusions, suggesting that the panel "was simply elucidating a federal common law of insurance contracts, a law that has long because ceased to apply to cases of this kind").

546. *Times-Picayune*, 421 F.3d at 334.

547. *Id.* at 334 & n.6. Until the district court resurrected it, *Amarillo* had only been cited by one other case. Nat'l Sur. Co. v. First Nat'l Bank, 61 P.2d 1122, 1123 (1936).

548. *See* Ledbetter v. Concord Gen. Corp., 665 So.2d 1166, 1169 (La. 1996) (holding that "[a]n insurance policy is an agreement between the parties and should be interpreted by using ordinary contract principles").

549. *See* La. Ins. Guar. Ass'n v. Interstate Fire & Cas. Co., 630 So.2d 759, 763 (La. 1994) (holding

(4) the doctrine of reasonable expectation,[551] and (5) the adhesion doctrine.[552] Then the Fifth Circuit carefully examined the pertinent language appearing in the coverage cause, which stated: "The Underwriter shall provide the Insureds with insurance coverage during the Policy Period excess of the Underlying Insurance. Coverage under this policy shall attach only after all of the Limit(s) of Liability of the Underlying Insurance has been exhausted by the actual payment of loss(es)."[553]

Put simply, Louisiana's plain meaning doctrine states: When interpreting an insurance contract, courts must determine the parties' intent according to "the general, ordinary, plain and popular meaning of the words" appearing in the contract.[554] Therefore, after examining the clause, the Fifth Circuit determined that only a single condition would trigger Zurich-American's duty to pay—the exhaustion of the policy limit in the underlying primary insurance contract.[555] And the Fifth Circuit found that unambiguous language in the drop down clause substantially reinforced that interpretation.[556] Briefly put, the latter clause stated that Zurich-American must keep the excess insurance in force after the policy limit has been exhausted in the underlying primary insurance contract.[557]

Between July 1, 1998 and the discovery of Anzalone's embezzlement in December of 2000, the Times-Picayune undisputedly lost $1,165,873.[558] At that time, Federal paid $1,000,000 and thereby exhausted the policy limit under its primary insurance policy.[559] Therefore, citing the plain and unambiguous language of the insuring and drop down clauses in Zurich-

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that the parties' intent must be determined in accordance with the general, ordinary, plain, and popular meaning of the words used in the policy).

550. *See* Succession of Fannaly v. Lafayette Ins. Co., 805 So.2d 1134, 1138 (La. 2002) (repeating that an "ambiguous contractual provision is construed against the insurer who furnished the contract's text and in favor of the insured").

551. *See La. Ins. Guar. Ass'n*, 630 So.2d at 764 (holding that a court should construe an insurance contract "to fulfill the reasonable expectations of the parties in the light of the customs and usages of the industry").

552. Duncan v. Kan. City S. Ry. Co., 747 So.2d 656, 674 (La. Ct. App. 1999). "It is well settled that . . . insurance policies are generally contracts of adhesion . . . ." *Id.*

553. *Times-Picayune Publ'g Corp. v. Zurich Am. Ins. Co.*, 421 F.3d 328, 335 (5th Cir. Aug. 2005).

554. Ledbetter v. Concord Gen. Corp., 665 So.2d 1166, 1169 (La. 1996).

555. *Times-Picayune*, 421 F.3d at 335 ("The most straightforward construction of this clause is that Zurich will pay for covered losses that the primary policy will not cover because it has been exhausted by the actual payment of benefits.").

556. *Id.*

557. *Id.* at 335 n.7.

> Zurich contends that the drop down clause has no application to this case because, by virtue of its sub-clause (ii), the provision of the drop down clause stating that the Zurich policy will drop down as primary coverage insurance in the event of exhaustion applies only to subsequent losses. The plain language of the sub-clause (ii), however, is clear that what applies in the event of subsequent losses is simply the retention applicable to the exhausted primary policy.

Id.

558. *Id.* at 336.

559. *Id.*

American excess insurance contract, the Fifth Circuit decided that Zurich-American, now in the role of a primary insurer, was liable for the entire amount of $1,165,873 that Anzalone embezzled between July 1, 1998, and July 1, 2001.[560] The final question, therefore, became whether Zurich-American was also liable for the outstanding $40,006.[561]

To answer that question, the Fifth Circuit examined the prior loss clause in Federal's primary contract because the employee embezzled the $40,006 before Zurich-American's excess policy began on July 1, 1998.[562] The court of appeals found two relevant conditions in that clause: (1) "the insured must have been 'continuously insured' by a substantively identical policy which the district court read to mean . . . a substantively identical *excess* policy," and (2) insurance coverage only if the loss had "been in effect at the time the acts that caused the loss occurred."[563]

But the Fifth Circuit concluded that the "district court did not opt for the simplest and most straightforward reading of Zurich's policy."[564] The appellate court found ambiguity in the prior loss clause and construed it against the excess insurer.[565] For that reason, the Fifth Circuit declared that the

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560. *Id.*

561. *Id.*

> We turn to a final detail. The $1,000,000 payment by Federal under its primary policy compensated the Times-Picayune for the first $1,000,000 of its total $2,205,879 embezzlement losses incurred from 1995 through 2000. Anzalone, however, stole $1,040,006 thereof between the beginning of . . . 1995 and the inception date of the Zurich excess policy on July 1, 1998. Because [the employee embezzled an additional $40,006 over the $1,000,000 policy limit under the primary contract before the inception date of Zurich-American's policy] on July 1, 1998, it was not included in the preceding analysis.

Id.

562. *Id.*

563. *Id.*

564. *Id.* at 337.

> It is undisputed that all of the Times-Picayune's $805,299 in embezzlement losses from January 1, 1995 until July 1, 1997 were within the coverage of the Federal primary policy. It is also undisputed that the Federal primary policy covered $194,701 of the Times-Picayune's losses from July 1, 1997, to July 1, 1998, when the Zurich policy began.

Id.

565. *Id.* at 337-38.

> [C]onsidering the Zurich policy as a whole, we cannot accept the district court's reading of the third sentence of its insuring clause. The sentence in question plainly intends to of itself exclude from the excess policy coverage of any loss *excluded* from (or not covered by or otherwise not recoverable under) the primary policy, whether or not *otherwise* excluded by the *excess* policy itself. But we cannot read that sentence as unambiguously *of itself independently* imposing a limitation on coverage under the excess policy so as to exclude from the excess policy coverage of losses that *are* within the coverage of and are *not* excluded by or otherwise not recoverable under the underlying primary policy. The excess policy has no Prior Loss clause, and it contains no provision excluding prior losses or limiting coverage to losses incurred after the effective date of the policy. The underlying primary policies each do have a Prior Loss clause, and it *does provide* coverage under those policies (subject to certain conditions, which are indisputably satisfied respecting the Federal primary policy in effect from July 1, 2000, to July 1, 2001, as to the entire $2,205,879 loss).

prior loss clause in Federal's primary insurance contract did not support the district court's partial summary judgment in favor of the insured.[566] As a result, the court of appeals reversed the district court's ruling and remanded the case to the district court for additional proceedings.[567]

III. FIRST PARTY INSURANCE CONTRACTS—FEDERAL STATUTORY CLAIMS AND DECISIONS

A. Automobile Insurance—Whether the McCarran-Ferguson Act Reverse Preempts the Federal Arbitration Act and Prevents the Forced Arbitration of a Coverage Dispute in Mississippi Under an Underinsured Motorist Clause

The Federal Arbitration Act (FAA) permits an aggrieved party to file a motion to compel arbitration when another party fails, neglects, or refuses to comply with an arbitration agreement.[568] For centuries, however, English common law was hostile to arbitration agreements and American courts embraced such hostility when they adopted English rules.[569] Therefore, Congress enacted the FAA and reversed longstanding judicial bias against arbitration agreements.[570] Presently, courts give arbitration agreements the same protection as other valid and enforceable contracts.[571]

On the other hand, one might ask: Because arbitration contracts are enforceable, are arbitration *clauses* also enforceable if state statutes outlaw such clauses in insurance contracts or in endorsements? And if the answer is yes, do state statutes preempt or reverse preempt federal laws, even though the

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Id.

566. *Id.* at 338.

567. *Id.*

568. Federal Arbitration Act, 9 U.S.C. § 4 (2000).

> A party aggrieved by the alleged failure, neglect, or refusal of another to arbitrate under a written agreement for arbitration may petition any United States district court which, save for such agreement, would have jurisdiction under Title 28, in a civil action . . . for an order directing that such arbitration proceed in the manner provided for in such agreement. Five days' notice in writing of such application shall be served upon the party in default. Service thereof shall be made in the manner provided by the Federal Rules of Civil Procedure. The court shall hear the parties, and upon being satisfied that the making of the agreement for arbitration or the failure to comply therewith is not in issue, the court shall make an order directing the parties to proceed to arbitration in accordance with the terms of the agreement. The hearing and proceedings, under such agreement, shall be within the district in which the petition for an order directing such arbitration is filed. If the making of the arbitration agreement or the failure, neglect, or refusal to perform the same be in issue, the court shall proceed summarily to the trial thereof. If no jury trial be demanded by the party alleged to be in default . . . , the court shall hear and determine such issue.

Id.

569. *See* Gilmer v. Interstate/Johnson Lane Corp., 500 U.S. 20, 24 (1991).

570. *Id.*

571. *Id.*

latter are overwhelmingly superior to conflicting state statutes?[572] In *American Bankers Insurance Co. of Florida v. Inman*, the Fifth Circuit answered these questions.[573]

The facts in *Inman* are few and uncomplicated.[574] American Bankers Insurance Company of Florida (American Bankers) sold an automobile policy to Jack Inman, a resident of Mississippi.[575] The policy limit for underinsured motorist coverage was $100,000.[576] During the policy period, the driver in another vehicle struck Inman's motorcycle from the rear, and Inman was severely injured.[577] The other driver's liability insurer gave its policy limit of $10,000 to cover Inman's injuries.[578]

Inman's injuries were quite extensive, requiring more money than the $10,000.[579] Thus, he sent a demand letter to American Bankers, demanding the entire $100,000 under the underinsured motorist provision.[580] American Bankers denied the insurance claim and insisted that the motorcycle was not insured when the accident occurred.[581] More relevant, Inman's insurance contract contained an arbitration provision that required the insurer and insured to arbitrate all disputes.[582] Perhaps believing that Inman would file a lawsuit rather than enter arbitration, American Bankers filed a motion to compel arbitration in the District Court for the Southern District of Mississippi.[583] The insurer cited its rights under the FAA to justify its motion.[584]

Before this controversy, the Mississippi's legislature enacted section 83-11-109, which states:

> No such endorsement or provisions shall contain a provision requiring arbitration of any claim arising under any such endorsement or provisions. The insured shall not be restricted or prevented in any manner from employing legal counsel or instituting or prosecuting to judgment legal proceedings, but the insured may be required to establish legal liability of the uninsured owner or operator.[585]

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572. *See* Munich Am. Reinsurance Co. v. Crawford, 141 F.3d 585, 590 (5th Cir.1998) (observing that "federal law [ordinarily] preempts conflicting state law").

573. Am. Bankers Ins. Co. of Fla. v. Inman, 436 F.3d 490, 492-94 (5th Cir. Jan. 2006).

574. *See id.*

575. *Id.*

576. *Id.*

577. *Id.*

578. *Id.*

579. *Id.*

580. *Id.*

581. *Id.*

582. *Id.*

583. *Id.*

584. *Id.*

585. MISS. CODE ANN. § 83-11-109 (1999).

In light of the language appearing in section 83-11-109, the district court denied American Bankers' motion to compel arbitration.[586] The district court found that the Mississippi statute reverse preempts the FAA.[587] On the other hand, the district court granted Inman's motion to dismiss, citing Federal Rule of Civil Procedure 12(b)(6), because American Bankers failed to state a cognizable claim upon which relief could be granted.[588] The insurer appealed.[589]

Before the Fifth Circuit, the central question was whether and how section 83-11-109 reverse preempts the FAA.[590] The insured cited the McCarran-Ferguson Act (MFA) and asserted that the MFA gives the State of Mississippi authority to enact section 83-11-109 and to reverse preempt the force and effect of the FAA.[591] Stated another way, Inman maintained that the MFA gives states the authority to regulate the business of insurance and forces insurers and insureds to arbitrate issues involving the business of insurance.[592] Contrarily, American Bankers asserted that compelling insurers and insureds to perform under an arbitration clause—under an insurance contract—was not the business of insurance.[593] Therefore, from the insurer's perspective, the FAA supersedes and is superior to section 83-11-109.[594]

First, the Fifth Circuit reviewed section 1012(b) of the MFA to find an answer for the central question and resolve the dispute.[595] That provision provides in pertinent part: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance . . . ."[596] Stated more precisely, the reverse preemption doctrine allows a state law to reverse preempt a federal statute only if the following apply: (1) the federal statute does not expressly concern the

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586. *Inman*, 436 F.3d at 493.

587. *Id.*

588. *Id.*; FED. R. CIV. P. 12(b)(6) states:

> Every defense, in law or fact, to a claim for relief in any pleading, whether a claim, counterclaim, cross-claim, or third party claim, shall be asserted in the responsive pleading thereto if one is required, except that the following defenses may at the option of the pleader be made by motion: . . . (6) failure to state a claim upon which relief can be granted . . . . If, on a motion asserting the defense numbered (6) to dismiss for failure of the pleading to state a claim upon which relief can be granted, matters outside the pleading are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided . . . .

FED. R. CIV. P. 12(b)(6).

589. *Inman*, 436 F.3d at 493.

590. *Id.* at 492.

591. *Id.* (citing the McCarran-Ferguson Act, 15 U.S.C. § 1101-15 (2000)).

592. *Id.*

593. *Id.* at 493. "American Bankers specifically challenge[d] the district court's conclusion that the state law was enacted to 'regulate the business of insurance,' the second requirement of the McCarran-Ferguson Act." *Id.*

594. *Id.*

595. *Id.* at 493.

596. 15 U.S.C. § 1012(b) (2000).

business of insurance; (2) the state enacted a statute to purposefully regulate the business of insurance; and (3) the federal statute "invalidate[s], impair[s], or supercede[s]" the state statute.[597]

What is the "business of insurance"? The Supreme Court answered that question in *Union Labor Life Insurance Co. v. Pireno*.[598] The Court outlined three factors and encouraged lower courts to consider each to determine whether states' statutes and regulations involve the business of insurance.[599] These elements are: (1) "whether the practice in question has the effect of transferring or spreading a policyholder's risk," (2) "whether the practice is an integral part of the policy relationship between the insurer and the insured," and (3) "whether the practice is limited to entities within the insurance industry."[600] Of course, the Court stressed that no single factor, examined alone, is determinative."[601]

On appeal, American Bankers argued that section 83-11-109 does not satisfy the test in *Pireno*, and therefore, it did not reverse preempt the FAA.[602] The district court concluded otherwise, finding that Mississippi enacted section 83-11-109 specifically to regulate the business of insurance.[603] The lower court found that the statute transfers or spreads risk, thereby satisfying the first prong of the *Pireno* test, and that section 83-11-109 is an integral part of the relationship between the insurer and insured, which satisfies the second element.[604]

The Fifth Circuit embraced the District Court for the Southern District of Mississippi's findings and conclusions.[605] Focusing on the first prong of the *Pireno* test, the court of appeals found that the Mississippi legislature enacted the anti-arbitration statute to control the risks and harms—those that uninsured and underinsured motorists might produce.[606] Therefore, the Fifth Circuit concluded that section 83-11-109 "has the effect of transferring or spreading a policyholder's risk . . . ."[607] The appellate court also found that section "is an integral part of the insurer-insured relationship," thereby satisfying the second *Pireno* factor.[608] The Fifth Circuit observed that the statute "controls how disputes regarding uninsured/underinsured motorist coverage will be resolved" and helps insureds recover "'all sums which [they are] legally

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597. *Inman*, 429 F.3d at 493 (quoting Munich Am. Reinsurance Co. v. Crawford, 141 F.3d 585, 590 (5th Cir. 1998)).

598. Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 120 (1982).

599. *Id.* at 129.

600. *Id.*

601. *Id.*

602. *Inman*, 436 F.3d at 493.

603. *Id.*

604. *Id.* at 494.

605. *Id.*

606. *Id.*

607. *Id.*

608. *Id.*

entitled to recover as damages for bodily injury or death from the owner or operator of an uninsured motor vehicle.'"[609]

Again, federal law ordinarily preempts conflicting state law, but the McCarran-Ferguson Act allows a narrow exception for states that regulate the business of insurance.[610] In *Inman*, the Fifth Circuit correctly concluded that Mississippi statute section 83-11-109 regulates the business of insurance.[611] As a consequence, the statute reverse preempts the FAA.[612]

B. Life Insurance—Whether the Foreign Sovereign Immunity Act Prevents Various State Insurance Commissioners from Suing the Vatican for Allegedly Violating the Racketeer Influenced and Corrupt Organizations Act and Other Common Law Rules in Mississippi

To be sure, the procedural conflict in *Dale v. Colagiovanni* is neither novel nor complicated.[613] But without a doubt, the underlying substantive controversy in *Colagiovanni* is highly atypical for several reasons: (1) the Vatican City State (Vatican) and its alleged agents are defendants; (2) several state insurance commissioners are plaintiffs; and (3) as plaintiffs, the insurance commissioners alleged that the Vatican looted various insurance companies and forced those companies into receiverships.[614]

Assuming the reported facts and allegations are true, they are somewhat unexpected, incomprehensible, and unsettling as one of the allegedly offending parties was a jurist.[615] When this controversy arose, Emilio Colagiovanni was a Roman Catholic "monsignor."[616] More precisely, Colagiovanni was an *emeritus* judge.[617] He sat on the *Tribunale della Rota Romana* (*Rota*)—one of the Vatican's three courts of appeals.[618] In addition, Colagiovanni was a

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609. *Id.* (quoting Standard Sec. Life Ins. Co. of N.Y. v. West, 267 F.3d 821, 823 (8th Cir. 2001)).

610. *Id.* at 493 (citing Munich Am. Reinsurance Co. v. Crawford, 141 F.3d 585, 590 (5th Cir.1998)) "Ordinarily, federal law pre-empts conflicting state law by virtue of the Supremacy Clause—U.S. CONST. art. VI, cl. 2. The McCarran-Ferguson Act reverses that effect in the narrow range of cases involving state regulation of the insurance industry." *Id.*

611. *Id.*

612. *Id.*

613. Dale v. Colgiovanni, 443 F.3d 425, 426 (5th Cir. Mar. 2006).

614. *See id.*

615. *Id.*

616. *Id.*

617. *Id.*

618. *See id.*

> [The Tribunal of the Roman Rota] is a court of appeal from local Tribunals, and a court of first instance where there is no competency with local Tribunals. For example, any matter concerning a bishop would have to be dealt with by the Roman Rota rather than the Bishop's own tribunal. In addition, certain matrimonial matters must come to the Roman Rota rather than the local tribunal (e.g., those involving Royalty! The annulment of the marriage of Caroline of Monaco had to be dealt with by the Vatican, not by the marriage tribunal of the Archdiocese of Monaco).

Catholic-pages.com, The Roman Curia, http://www.catholic-pages.com/vatican/curia.asp (last visited Mar. 15, 2007).

professor in the *Studio Rotale*, the graduate program connected to the *Rota*, a senior member of the *Curia*, the Vatican's government, and President of the Monitor Ecclesiasticus Foundation (MEF), an autonomous organization that published a journal of canon law.[619]

Martin Frankel was a financier.[620] For nearly ten years, Frankel "engaged in a massive insurance fraud scheme, using various alter egos and front organizations to acquire and loot several insurance companies."[621] In 1998, Frankel decided to include the Roman Catholic Church in his scheme.[622] Frankel wanted to form a charitable foundation with an initial $55 million in capital—$50 million to acquire insurance companies and $5 million for charitable purposes.[623] Thus, pretending to be a philanthropist who only wanted a charitable foundation, Frankel found a way to contact and befriend Colagiovanni, who later introduced Frankel to Vatican officials.[624]

Ultimately, Frankel formed the Saint Francis of Assisi Foundation to Serve and Help the Poor and Alleviate Suffering (SFAF).[625] "He told associates that the foundation would use the profits from the acquired insurance companies for charitable purposes."[626] Colagiovanni agreed to MEF's serving as "SFAF's settlor of record."[627] More important, Frankel transferred funds to the MEF, which the MEF then transferred to SFAF.[628] Even more important, "Colagiovanni admitted he had falsely told insurance companies and government regulators that [SFAF's] funds . . . came from his own foundation," the MEF.[629]

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619. *Colagiovanni*, 443 F.3d at 426-27; *see also* Ellen Joan Pollock, *Italian Prelate Pleads Guilty in Case Tied to Frankel Scheme*, WALL ST. J., Sept. 6, 2002, at C10.

> A priest with ties to the Vatican pleaded guilty to one felony count in connection with efforts by financier Martin Frankel to purchase insurance companies as part of his plan to defraud them. . . . Colagiovanni admitted he had falsely told insurance companies and government regulators that the funds used by Saint Francis came from his own foundation, the Monitor Ecclesiasticus Foundation, which published a journal of canon law.

Pollock, *supra*, at C10.

620. *See* Ellen Joan Pollock, *Priest's Arrest Is New Avenue In Financier Frankel's Case*, WALL ST. J., Aug. 31, 2001, at C1.

621. *Colagiovanni*, 443 F.3d at 426.

622. *Id.* at 427.

623. *Id.*

624. *See* Pollock, *supra* note 621, at C1.

> Mr. Frankel's associates contacted Msgr. Colagiovanni, a former judge of the Roman Rota—a Vatican appeals court—who allegedly agreed to help and introduced a representative of Mr. Frankel to Vatican officials. According to the sworn statement by Charles Cooney, a special agent with the IRS Criminal Investigation Division, Msgr. Colagiovanni received at least $40,000 from Mr. Frankel and believed Mr. Frankel would transfer $5 million to Monitor Ecclesiasticus.

Id.

625. *Id.*

626. *See id.*

627. *Colagiovanni*, 443 F.3d at 427.

628. *Id.*

629. *See* Pollock, *supra* note 620, at C10.

Eventually, federal authorities arrested and prosecuted both Frankel and 81-year-old Colagiovanni.[630] The authorities prosecuted Frankel for securities fraud and racketeering, and they prosecuted Colagiovanni for wire fraud and conspiring to launder money.[631]

Significantly, during the criminal prosecution, a special agent in the Internal Revenue Service's Criminal Investigation Division presented even more damaging information about Colagiovanni's criminal activity:

> [T]hat Msgr. Colagiovanni helped Mr. Frankel . . . to secretly acquire Capitol Life Insurance Co. and Western United Life Assurance Co. Neither deal was consummated. As Mr. Frankel was attempting to acquire Western United Life, Msgr. Colagiovanni allegedly signed an affidavit . . . stating that [MEF] "has contributed approximately $1,000,000,000 (one billion dollars) to [SFAF]."
>
> . . . .
>
> Msgr. Colagiovanni later told federal agents that he signed the affidavit and admitted that it was false.[632]

After learning about Colagiovanni's involvement, the insurance commissioners in five states, as receivers of the targeted insurance companies, sued the Vatican and Colagiovanni in the District Court for the Southern District of Mississippi.[633] The suit alleged that Colagiovanni violated the civil Racketeer Influenced and Corrupt Organizations Act (RICO).[634] The complaint also alleged that the Vatican was vicariously liable because Colagiovanni was the Vatican's agent.[635]

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630. *See id.*

631. *See id.*

632. *See* Pollock, *supra* note 621, at C1; *see also Colagiovanni*, 443 F.3d at 427.

> By March of 1999, Frankel was being investigated by the Mississippi Department of Insurance regarding his acquisitions, and received a letter from the Department asking specific questions about Frankel's investment practices. Frankel responded by causing SFAF to purchase the trust that had been involved in the acquisitions, which in turn caused the Department to set an emergency hearing. Colagiovanni appeared at the hearing and represented that Vatican-related entities had contributed over $1 billion to SFAF.

Colagiovanni, 429 F.3d at 427.

633. *Colagiovanni*, 443 F.3d at 427. The commissioners-receivers were George Dale, Commissioner of Insurance for the State of Mississippi; W. Dale Finke, Director of the Department of Insurance for the State of Missouri; Kim Holland, Insurance Commissioner for the State of Oklahoma; Julie Benafield Bowman, Insurance Commissioner for the State of Arkansas; and Paula A. Flowers, Commissioner of Commerce and Insurance for the State of Tennessee. *Id.*

634. *Id.*; 18 U.S.C. § 1962(c) (2000).

> It shall be unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity or collection of unlawful debt.

§ 1962(c).

635. *Colagiovanni*, 443 F.3d at 426.

The Vatican filed its first motion to dismiss under FED. R. CIV. P. 12(b)(1), arguing that the district court did not have subject matter jurisdiction.[636] To support its position, the Vatican asserted that it was a foreign state and that it was immune from the RICO lawsuit under the Foreign Sovereign Immunities Act (FSIA).[637] The Vatican also advanced other theories to defend itself, but the district court rejected those theories.[638]

On the other hand, the insurance commissioners argued that the district court had subject matter jurisdiction to hear the case because Colagiovanni's conduct involved a certain type of "commercial activity" for which the FSIA did not grant immunity, and the Vatican ratified Colagiovanni's conduct or he secured the actual or apparent authority to engage in such illegality from the Vatican.[639]

The district court expressly declined to decide whether Colagiovanni received actual authority from the Vatican or whether the Vatican ratified Colagiovanni's errant conduct.[640] Instead, the district court denied the Vatican's motion in part, finding that the Vatican was not immune from the lawsuit.[641] The lower tribunal found that Colagiovanni had the Vatican's apparent authority to engage in various activities on behalf of the Vatican.[642] Therefore, the Vatican was not immune under the FSIA.[643] Dissatisfied with that conclusion, the Vatican appealed.[644]

The FSIA provides the sole source of subject matter jurisdiction in suits against a foreign state.[645] Thus, at the outset, the Court of Appeals for the Fifth Circuit reviewed the FSIA's "general immunity" clause, which states:

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636. *Id.*; FED R. CIV. P. 12(b)(1) states in pertinent part:

> Every defense, in law or fact, to a claim for relief in any pleading, whether a claim, counterclaim, cross-claim, or third party claim, shall be asserted in the responsive pleading thereto if one is required, except that the following defenses may at the option of the pleader be made by motion: (1) lack of jurisdiction over the subject matter . . . .

FED R. CIV. P. 12(b)(1).

637. *Colagiovanni*, 443 F.3d at 427; 28 U.S.C. § 1604 (2000).

638. *Colagiovanni*, 443 F.3d at 427.

> The Vatican urges several additional theories arguing that it is not subject to jurisdiction under the FSIA: (1) the creation of a charitable foundation is not a commercial activity; (2) Colagiovanni's criminal activity was not a commercial activity; (3) the alleged claims were tort-based, and therefore not within the commercial activity exception; and (4) the Vatican could not form the requisite intent necessary for [the insurance commissioners'] fraud-based claims. The district court considered and rejected each of these arguments, and we affirm the district court's judgment on these issues on the basis of its well-reasoned opinion.

Id.

639. *Id.* at 428 n.1. The commissioners argued that the Vatican was liable "because its agent, Colagiovanni, engaged in commercial activity while possessing apparent authority." *Id.* They also argued that Colagiovanni possessed actual authority and that the Vatican ratified his commercial acts. *Id.*

640. *Id.* at 427.

641. *Id.*

642. *Id.*

643. *Id.*

644. *Id.*

645. *See* Argentine Republic v. Amerada Hess Shipping Corp., 488 U.S. 428, 434-39 (1989).

> Subject to existing international agreements to which the United States is a party at the time of enactment of this Act a foreign state shall be immune from the jurisdiction of the courts of the United States and of the States except as provided in sections 1605 to 1607 of this chapter.[646]

A district court, however, may exercise subject matter jurisdiction over a foreign state if one of several exceptions under the statute applies.[647] For example, FSIA's "commercial activity" exception states:

> A foreign state shall not be immune from the jurisdiction of courts of the United States or of the States in any case—
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> . . . .
>
> [I]n which the action is based upon a commercial activity carried on in the United States by the foreign state; or upon an act performed in the United States in connection with a commercial activity of the foreign state elsewhere; or upon an act outside the territory of the United States in connection with a commercial activity of the foreign state elsewhere and that act causes a direct effect in the United States . . . .[648]

Once more, citing the commercial activity exception, the insurance commissioners argued that they could sue the Vatican because Colagiovanni, the Vatican's agent, engaged in commercial activity with apparent authority.[649] Contrarily, the Vatican argued that merely establishing that an agent performed with apparent authority was insufficient to trigger the commercial activity exception.[650]

Certainly, whether actual authority, apparent authority, or ratification would trigger the commercial activity exception was an issue of first impression for the Fifth Circuit.[651] Both the Fourth and Ninth Circuits, however, have addressed the question squarely and concluded that proof of an agent's apparent authority is insufficient.[652] On the other hand, under the

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646. Foreign Sovereign Immunity Act, 28 U.S.C. § 1604 (2000); *see also* Byrd v. Corporacion Forestal y Industrial de Olancho S.A., 182 F.3d 380, 388 (5th Cir. 1999). "The general rule under the FSIA is that foreign states are immune from the jurisdiction of the United States Courts." *Byrd*, 182 F.3d at 388.

647. *Id.*

648. 28 U.S.C. § 1605(a)(2).

649. *Colagiovanni*, 443 F.3d at 428.

650. *Id.*

651. *Id.*

652. *See* Velasco v. Gov't of Indon., 370 F.3d 392, 399-400 (4th Cir. 2004) (citing Byrd v. Corporacion Forestal y Industrial de Olancho S.A., 182 F.3d 380, 388 (5th Cir. 1999) (holding that the plaintiff must demonstrate that the agent acted with the actual authority of the state to trigger the commercial activity exception); El-Fadl v. Cent. Bank of Jordan, 75 F.3d 668, 671 (D.C. Cir. 1996) (holding that a government bank was immune from suit under the FSIA for the acts of agents); Chuidian v. Philippine Nat'l Bank, 912 F.2d 1095, 1101-03 (9th Cir. 1990) (interpreting section 1603(b) to include individuals sued in their official capacities)); Phaneuf v. Republic of Indon., 106 F.3d 302, 307-08 (9th Cir. 1997) (concluding that the commercial activity exception may be invoked only if one presents evidence of the foreign state's agent's actual authority).

FSIA, a federal court has subject matter jurisdiction and a foreign state has no immunity from a legal action if an aggrieved party establishes that the foreign state's agent engaged in commercial activity with actual authority.[653]

Also, the commercial activity must be the activity "of the foreign state."[654] The Ninth Circuit explained the rule this way:

> When an agent acts beyond the scope of his authority, however, that agent "is not doing business which the sovereign has empowered him to do." If the foreign state has not empowered its agent to act, the agent's unauthorized act cannot be attributed to the foreign state; there is no "activity of the foreign state."[655]

Still, the insurance commissioners in *Colagiovanni* insisted that proof of apparent authority was sufficient to trigger the commercial activity exception.[656] And to reinforce that assertion, they cited relatively recent Fifth Circuit decisions in *Arriba Ltd. v. Petroleos Mexicanos* and *Hester International Corp. v. Federal Republic of Nigeria*.[657] The current Fifth Circuit panel ruled, however, that neither opinion was relevant because the questions in *Arriba* and *Hester* were different from the present question.[658]

Embracing the Fourth and Ninth Circuits' rules and explanations, the Fifth Circuit vacated the district court's ruling and concluded that the Vatican was immune under the FSIA.[659] To trigger the commercial activity exception under the FSIA and subject a foreign state to a federal court's jurisdiction, a complaining party must prove that an agent had actual authority to act on behalf of a foreign state.[660]

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653. *Velasco*, 370 F.3d at 399-400; *Phaneuf*, 106 F.3d at 307.

654. *Phaneuf*, 106 F.3d at 307-08. "'[C]ommercial activity of the foreign state' clearly entails commercial activity in which the foreign state engaged. Because a foreign state acts through its agents, an agent's deed which is based on the actual authority of the foreign state constitutes activity 'of the foreign state.'" *Id.* (quoting Chuidan v. Phil. Nat'l Bank, 912 F.2d 1095, 1101-03 (9th Cir. 1990)).

655. *Id.*

656. *Dale v. Colgiovanni*, 443 F.3d 425, 428 (5th Cir. Mar. 2006).

657. *Id.* at 429 (citing Arriba Ltd. v. Peroleos Mexicanos, 962 F.2d 528, 530 (5th Cir. 1992); Hester Int'l Corp. v. Fed. Republic of Nig., 879 F.2d 170, 172 (5th Cir. 1989)).

> Both opinions address the presumption of separate juridical status of government instrumentalities under the test articulated by the Supreme Court in *First Nat'l City Bank v. Banco Para El Comercio Exterior de Cuba*, 462 U.S. 611 (1983). Neither case directly addresses the apparent authority of an individual agent in the context of the commercial activity exception."

Id.

658. *Id.*

659. *Id.*

660. *Id.* at 428-29.

IV. THIRD PARTY INSURANCE CONTRACTS STATE COMMON LAW CLAIMS AND DECISIONS

A. Third Party Liability Claims Injury to Persons

1. Whether Under Louisiana Law an Educator's Liability Insurer Has a Duty to Defend Its Insured School Board in an Underlying Race-Discrimination Lawsuit

In 2000, the author conducted an empirical investigation to determine how state and federal courts resolve duty-to-defend controversies—those in which third party victims accuse insureds of practicing racial, gender-based, and employment discrimination.[661] The author published multiple statistically significant findings, and in that article, the following observation appears:

> Mixed-claims or multiple-allegation controversies generate an exorbitant amount of litigation and cause much division among state and federal courts. Nonetheless, the excessive litigation and interjurisdictional divisions that mixed-claims cases generate could be avoided, especially [when] the controversy concerns insurers' duty to defend alleged civil rights violators. This can be achieved if courts would simply stop trying to apply a Title VII analysis in duty-to-defend . . . discrimination cases, because the subsequent declaratory judgments are poorly reasoned and provide little direction for future litigants.[662]

During the 2005-2006 session, the Fifth Circuit decided *Coleman v. School Board of Richland Parish*.[663] *Coleman* is a duty-to-defend and mixed-claims case.[664] In the underlying lawsuit, the third party victim alleged that the insured violated federal anti-discrimination and various state laws.[665] But more significantly, the Fifth Circuit resolved the conflict in *Coleman* by avoiding the errors that this author highlighted and criticized in 2000.[666] Put simply, *Coleman* is a superbly reasoned opinion—one in which the court of appeals correctly used Louisiana's traditional doctrines of contract interpretation rather than federal substantive law to determine whether the insurer had a duty to defend and indemnify.[667] Without doubt, the opinion is a model of how federal courts should decide similar insurance law conflicts.

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661. *See* Willy E. Rice, *Insurance Contracts and Judicial Decisions Over Whether Insurers Must Defend Insureds that Violate Constitutional and Civil Rights: An Historical and Empirical Review of Federal and State Court Declaratory Judgments 1900-2000*, 35 TORT & INS. L.J. 995, 1032 (2000).

662. *Id.*

663. Coleman v. School Bd. of Richmond Parish, 418 F.3d 511, 514 (5th Cir. July 2005).

664. *Id.*

665. *Id.*

666. *Id.*

667. *See id.*

Rayville Elementary School (Rayville) is located in Rayville, Louisiana.[668] The Richland Parish School Board (School Board) regulates the elementary school's curriculum and other activities.[669] In 2000, the School Board created an associate principal position for the elementary school.[670] Katie Coleman, an African-American, applied for the position.[671] The School Board awarded the position to Coleman.[672] The contract of employment spanned two years, but after serving as associate principal for about a month, the School Board's superintendent asked Coleman to submit her involuntary resignation.[673] She refused.[674]

Shortly thereafter, the School Board conducted a hearing to consider nine separate insubordination charges that had been levied against Coleman.[675] Finding that she was guilty of four, the School Board voted to terminate Coleman's employment.[676] In response, Coleman filed a mixed-claims lawsuit against the School Board.[677] Citing her race, she alleged that the School Board violated Title VII of the Civil Rights Act,[678] 42 U.S.C. §§ 1981[679] and 1983.[680]

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668. *Id.*

669. *Id.* at 513-14.

670. *Id.*

671. *Id.* at 514.

672. *Id.*

673. *Id.*

674. *Id.* Coleman alleged that the School Board's white member created the associate principal position only after a proposed school bond on the October 2000 ballot received support from the African-American members, who agreed to campaign within the African-American community on behalf of the bond. *Id.* She claimed that she did not know of the "political under-currents." *Id.* She alleged that the School Board asked her to resign the next business day after the bond passed. *Id.* Coleman stated that the superintendent "explained the political reality of her appointment and told her that she risked ruining her career if she did not resign." *Id.* She alleged that the superintendent threatened her with continuous "write-ups" and termination if she did not comply with his demands and accept his offer to compensate her for one year of her two-year contract. *Id.*

675. *Id.* at 514 n.1. The School Board raised the following charges or allegations against Coleman: "Coleman's failure to perform 'bus duty,'" Coleman's addressing "the Rayville Elementary principal in an unprofessional and insubordinate manner," and Coleman's improperly using "a federally-funded copier for a non-designated use." *Id.*

676. *Id.* at 514.

677. *Id.* "She claimed that . . . she was subjected to disparate enforcement of the [School] Board's rules and regulations, and was continuously written-up for infractions that she did not commit. These events ultimately culminated in her termination by the [School] Board without the consent and approval of several African-American members." *Id.*

678. 42 U.S.C. § 2000e-2 (2000). Title VII reads in pertinent part:

> It shall be an unlawful employment practice for an employer—(1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin; or (2) to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's race, color, religion, sex, or national origin.

Id.

679. § 1981(a).

> All persons within the jurisdiction of the United States shall have the same right in every State

She also filed a common law breach-of-contract cause of action and an action in equity, citing Louisiana's abuse of rights doctrine.[681]

From October 11, 2000 to October 11, 2001, Mid-Continent Casualty Insurance Company (Mid-Continent) insured the School Board under an educators' legal liability insurance contract.[682] Therefore, because the School Board terminated Coleman and she filed her mixed-claims lawsuit during the policy period, the School Board asked Mid-Continent to provide a legal defense.[683] Mid-Continent refused.[684] Later, the School Board presumably filed a breach-of-contract action against Mid-Continent in the District Court for the Western District of Louisiana.[685]

Mid-Continent responded and filed a motion for summary judgment, arguing that it had no duty to defend or indemnify the School Board.[686] The insurance contract contained an exclusion clause that excluded coverage for an insured's knowingly wrongful or intentional acts.[687] Citing the causes of action in Coleman's mixed-claims complaint, Mid-Continent argued that the School Board terminated Coleman and intentionally discriminated against her because of Coleman's race.[688] To rebut, the School Board filed a cross-motion for summary judgment, arguing that the insurer had a contractual duty to defend and indemnify because the liability insurance contract explicitly

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and Territory to make and enforce contracts, to sue, be parties, give evidence, and to the full and equal benefit of all laws and proceedings for the security of persons and property as is enjoyed by white citizens, and shall be subject to like punishment, pains, penalties, taxes, licenses, and exactions of every kind, and to no other.

Id.

680. § 1983.

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or any other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered a statute of the District of Columbia."

Id. Section 1983 does not create federal, substantive rights. *Id.* Instead, the statute creates a private right of action and provides a possible remedy whenever anyone, acting under color of state law, deprives a person of federal rights, privileges, or immunities; violation of state law, by itself, does not allow for relief under section 1983. *See* Crocker v. Hakes, 616 F.2d 237, 239-40 (5th Cir. 1980).

681. *Coleman*, 418 F.3d at 514; *see also* G.I.'s Club of Slidell, Inc. v. Am. Legion Post No. 374, 504 So.2d 967, 969 (La. Ct. App. 1987) ("Abuse of rights is an equitable doctrine that has been used sparingly in Louisiana.").

682. *Coleman*, 418 F.3d at 514.

683. *Id.*

684. *Id.*

685. *Id.* at 515.

686. *Id.*

687. *Id.*

688. *Id.*

covered injuries emanating from actual or alleged racial discrimination and racial harassment.[689]

While the district court considered summary judgment motions, the School Board defended itself against Coleman's lawsuit.[690] The School Board used its financial resources, and ultimately, the School Board and Coleman settled the suit.[691] Shortly after the settlement, the district court granted Mid-Continent's motion for summary relief, finding that the "intentional acts" exclusion clause in the contract precluded coverage for all of Coleman's federal and state causes of action.[692] On the other hand, the lower court denied the School Board's motion for summary judgment.[693] The School Board appealed the adverse ruling.[694]

Before the Fifth Circuit, the School Board argued that the district court committed reversible error by ruling summarily that Mid-Continent did not have a duty to defend and indemnify the School Board against Coleman's intentional racial discrimination claims.[695] In addition, the School Board stressed that a breach-of-contract action and the action in equity, the abuse of rights allegation, appeared in Coleman's complaint.[696] The School Board argued that Mid-Continent still had a duty to defend against Coleman's nonexcluded claims, even though the insurance contract excluded coverage for intentional discrimination.[697]

To determine if the School Board's assertions were sound, the court of appeals examined the contract's "insuring-agreement clause."[698] It stated that "Mid-Continent [would] defend and indemnify the School Board, its directors, trustees, officers, and employees against loss resulting from any 'claim' made during the policy period . . . ."[699] That same provision "defined 'claim' as any written notice received by an insured, or any judicial or administrative proceeding initiated against an insured, seeking to hold the insured responsible or liable for a 'wrongful act.'"[700]

The contract defined a wrongful act as follows:

> [A]ny actual or alleged act, error, omission, misstatement, misleading statement, neglect or breach of duty in the discharge of [the insured's] duties,

689. *Id.*
690. *Id.*
691. *Id.*
692. *Id.*
693. *Id.*
694. *Id.*
695. *Id.* at 516.
696. *Id.*
697. *Id.*
698. *Id.* at 518-19.
699. *Id.* at 514.
700. *Id.*

including:

(1) actual or alleged discrimination, whether based upon race, sex, age, national origin, religion, disability or sexual orientation;
(2) actual or alleged sexual or racial harassment;
(3) actual or alleged libel, slander or other defamation;
(4) actual or alleged invasion of privacy; or
(5) actual or alleged interference with or breach of any employment contract, whether oral, written, express or implied.[701]

The controversial exclusion clause excluded "coverage for loss resulting from any claim 'brought about or contributed to in fact by any dishonest, fraudulent or criminal Wrongful Act or by any Wrongful Act committed with actual knowledge of its wrongful nature or with intent to cause damage.'"[702]

The court of appeals then examined three of Louisiana's doctrines of contract construction and interpretation to determine which one was more applicable in light of the facts appearing in the present case.[703] First, Louisiana law is clear: "When the language of an insurance policy is clear, [Louisiana] courts lack the authority to change or alter its terms under the guise of interpretation."[704] The state's doctrine of ambiguity states, however, that courts must construe ambiguous coverage and exclusion clauses in insurance contracts against the insurer and in favor of the insured.[705]

Also, Louisiana's reasonable expectations doctrine requires a court to construe an ambiguous insurance policy "to fulfill the reasonable expectations of the parties in the light of the customs and usages of the industry."[706] Stated differently, Louisiana courts must interpret ambiguous insurance contract

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701. *Id.* at 514.

702. *Id.* at 515.

703. *Id.* at 516-17.

704. La. Ins. Guar. Ass'n v. Interstate Fire & Cas. Co., 630 So.2d 759, 764 (La. 1994).

705. *See* LA. CIV. CODE ANN. art. 2056 (1987) ("In case of doubt that cannot be otherwise resolved, a provision in a contract must be interpreted against the party who furnished the text."); Mayo v. State Farm Mut. Auto Ins. Co., 869 So.2d 96, 100 (La. 2004) ("Ambiguous policy provisions are generally construed against the insurer and in favor of coverage."); Reynolds v. Select Props., Ltd., 634 So.2d 1180, 1183 (La. 1994) ("[A] provision which seeks to narrow the insurer's obligation is strictly construed against the insurer, and, if the language of the exclusion is subject to two or more reasonable interpretations, the interpretation which favors coverage must be applied."); *Louisiana Ins. Guar. Ass'n*, 630 So.2d at 764 ("If after applying the other general rules of construction an ambiguity remains, the ambiguous contractual provision is to be construed against the drafter, or, as originating in the insurance context, in favor of the insured."); RPM Pizza, Inc. v. Auto. Cas. Ins. Co., 601 So.2d 1366, 1369 (La. 1992) ("[I]f [an] exclusion is . . . ambiguous, insurance policies must be liberally construed in favor of coverage, and provisions susceptible of different meanings must be interpreted with a meaning that renders coverage effective and not with one that renders it ineffective.") (citing LA. CIV. CODE ANN. art. 2049 (1987); Breland v. Schilling, 550 So.2d 609, 610 (La. 1989); Capital Bank & Trust Co. v. Equitable Life Assurance Soc'y, 542 So.2d 494, 496 (La.1989)).

706. *La. Ins. Guar. Ass'n*, 630 So.2d at 764 (citing Trinity Indus., Inc. v. Ins. Co. of N. Am., 916 F.2d 267, 269 (5th Cir.1990)).

provision "by ascertaining how a reasonable insurance policy purchaser would construe the clause at the time the insurance contract was [formed]."[707] Generally, Louisiana courts may employ this rule to extend coverage to meet the reasonable expectations of the insured, even though a close examination of the policy reveals that such expectations conflict with the expressed intent of the insurer.[708]

Directing the Fifth Circuit to a large body of Louisiana[709] and federal law,[710] the School Board strongly asserted that a conflict existed between the coverage and exclusion clauses.[711] The insured argued that the contract excluded knowing and intentional racial discrimination and harassment, in particular.[712] On the other hand, the contract also covered unintentional acts

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707. *Breland*, 550 So.2d at 610-11.

708. *La. Ins. Guar. Ass'n*, 630 So.2d at 764 n.9 (citing Robert E. Keeton & Alan I. Widiss, INSURANCE LAW § 6.13 (1988)).

709. *See* McIntosh v. McElveen, 893 So.2d 986, 991-92 (La. Ct. App. 2005); Cugini Ltd. v. Argonaut Great Cent. Ins. Co., 889 So.2d 1104, 1113 (La. Ct App. 2004) (declaring that a conflict between coverage provisions and exclusions gives rise to ambiguity which must be resolved in favor of coverage); Gottsegen v. Hart Prop. Mgmt. Inc., 820 So.2d 1138, 1142 (La. Ct. App. 2002) (finding that when "a conflict exists between the declared coverage that was negotiated and paid for and the exclusion that states that same hazard is not covered," an ambiguity exists that must be interpreted in favor of coverage); Domingue v. Rodrigue, 686 So.2d 132, 137 (La. Ct. App. 1996) ("[A]n insurance policy cannot in one clause declare that there is coverage . . . and in another clause declare that there is no coverage . . . ."); Korossy v. Sunrise Homes, Inc., 653 So.2d 1215, 1229 (La. Ct. App. 1995) (holding that a conflict between an exclusion provision and a narrowed coverage provision which eliminated coverage created an ambiguity that must be construed against the drafter in favor of coverage).

710. *See* N. Bank v. Cincinnati Ins. Cos., 125 F.3d 983, 986 (6th Cir. 1997) (finding ambiguity when an insurance policy provided coverage for acts of discrimination, yet excluded coverage for acts which did not occur unexpectedly or unintentionally); Fed. Ins. Co. v. Stroh Brewing Co., 127 F.3d 563, 571 (7th Cir. 1997) (refusing to interpret a policy so that covered acts of discrimination were completely excluded by a later provision when the meaning of provision was genuinely ambiguous); Hurst-Rosche Eng'rs, Inc. v. Commercial Union Ins. Co., 51 F.3d 1336 (7th Cir. 1995) (finding ambiguity in a policy concerning intentional torts such as libel, slander, defamation, false arrest, malicious prosecution, and humiliation while simultaneously limiting coverage to unintentional acts); Liberty Life Ins. Co. v. Commercial Union Ins. Co., 857 F.2d 945, 950-51 (4th Cir. 1988) (vacating summary judgment in favor of insurer on grounds that potential ambiguity was raised by an apparent conflict between the policy's coverage of libel, slander, defamation, and unfair competition and limitation of coverage to unintentional or unexpected injuries); Tews Funeral Home, Inc. v. Ohio Cas. Ins. Co., 832 F.2d 1037, 1045 (7th Cir. 1987) (finding ambiguity in a policy that covered advertising injury yet excluded coverage for intentional acts); Titan Indem. Co. v. Newton, 39 F. Supp. 2d 1336, 1344 (N.D. Ala. 1999) (finding a policy ambiguous when it provided coverage for false arrest, unlawful prosecution, and civil rights violations and then excluded coverage for intentional acts); Transamerica Ins. Group v. Rubens, No. 97 Civ. 8911, 1999 WL 673338 (S.D.N.Y. Aug.27, 1999) (approving of the reasoning in *N. Bank*, 125 F.3d 983); Lineberry v. State Farm Fire & Cas. Co., 885 F. Supp. 1095, 1099 (M.D. Tenn. 1995) (finding ambiguity regarding invasion of privacy); Lincoln Nat'l Health & Cas. Ins. Co. v. Brown, 782 F. Supp. 110, 113 (M.D. Ga. 1992) (finding ambiguity with respect to false arrest, malicious prosecution, and assault and battery); Purrelli v. State Farm Fire & Cas. Co., 698 So.2d 618, 619-20 (Fla. Dist. Ct. App. 1997) (finding ambiguity with respect to invasion of privacy).

711. Coleman v. Sch. Bd. Of Richland Parish, 418 F.3d 511, 521 (5th Cir. July 2005) ("[T]he School Board argues that a conflict cannot be averted between the policy's exclusion for intentional acts and its provision of coverage for racial harassment.").

712. *Id.* at 518.

generally.[713] From the School Board's perspective, the liability contract offered coverage that was "illusory and meaningless."[714] Therefore, the School Board maintained that the contract was ambiguous, requiring the court to resolve the confusion in its favor.[715] The School Board also asserted that the conflict undermined its reasonable expectation that the coverage provision would cover all of Coleman's claims.[716]

The Fifth Circuit, however, found "no intractable or irreconcilable conflict... between the policy's coverage of racial discrimination and harassment and its exclusion[] of intentional conduct."[717] To reach that conclusion, the court of appeals observed that allegations of racial discrimination may involve an alleged tortfeasor's intentional or unintentional acts.[718] For example, a complainant who accuses an alleged tortfeasor of violating Title VII may prove that either racially motivated disparate treatment occurred or a disparate impact based on one ethnicity formed the basis of the

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713. *Id.*

714. *Id.*

715. *Id.*

716. *Id.* at 522 ("The School Board also argues that regardless of whether the policy is ambiguous, it must be interpreted in a manner consistent with the reasonable expectations of a typical purchaser of insurance.").

717. *Id.* at 520-21 n.44 ("We are persuaded that the exclusion for intentional acts in the School Board's policy does not conflict with the policy's coverage for racial discrimination and racial harassment."). The court further expanded on its holding, stating:

> Our interpretation of the policy is buttressed by the apparent existence in Louisiana law of a public policy prohibiting a person from insuring against his own intentional acts."), citing First Mercury Syndicate, Inc. v. New Orleans Private Patrol Serv., Inc., 600 So.2d 898, 902 (La. Ct. App. 1992) (finding that allowing "indemnification for such wrongdoing on the part of the insured" would violate public policy when insured corporate officers paid themselves excessive compensation for no work, placed family members on the corporate payroll when such members were not working, raided corporate funds for personal use, and enacted a resolution indemnifying themselves against their own wrongful acts); Williams v. Diggs, 593 So.2d 385, 387 (La. Ct. App. 1991) (concluding that "when considering an intentional injury exclusion in an automobile liability policy, another well-established public policy must also be given consideration. This is the policy against allowing a person to insure himself against his own intentional acts causing injury to others"); Leon Lowe & Sons, Inc. v. Great Am. Surplus Lines Ins. Co., 572 So.2d 206, 210 (La. Ct. App. 1990) (concluding that "[p]ublic policy forbids a person from insuring against his own intentional acts, but does not forbid him from insuring against the intentional acts of another for which he may be vicariously liable."); Vallier v. Oilfield Constr. Co., 483 So.2d 212, 218 (La. Ct. App. 1986) (stating that "a longstanding principle of public policy that no person can insure against his own intentional acts" exists); Swindle v. Haughton Wood Co., 458 So.2d 992, 995 (La. Ct. App. 1984) ("No person can insure against his own intentional acts. Public policy forbids it. But public policy does not forbid one to insure against the intentional acts of another for which he may be vicariously liable.") (quoting McBride v. Lyles, 303 So.2d 795, 799 (La. Ct. App. 1974) (citations omitted)); and, Creech v. Aetna Cas. & Sur. Co., 516 So.2d 1168, 1172 (La. Ct. App. 1988) (noting that "[t]he provisions of the insurance policy should be given effect except to the extent they conflict with law or public policy," and holding that public policy does not preclude coverage of exemplary damage awards).

Id.

718. *Id.* at 520.

impermissible discrimination.[719] The former requires proof of intentional conduct and the latter does not.[720] Thus, the Fifth Circuit found that the insurance contract covered disparate impact claims and excluded coverage for disparate treatment claims.[721]

"Under Louisiana law, the scope of the duty to defend under an insurance agreement is broader than the scope of the duty to provide coverage."[722] Furthermore, "an insurer's duty to defend is determined solely from a reading of a third party victim's pleadings and the language in the insurance contract, without considering extraneous evidence.[723] And if the complaint contains facts which support coverage for a claim that is not excluded, the insurer must defend the insured.[724] "'[O]nce a complaint states one claim within the policy's coverage, the insurer has a duty to [defend against] the entire lawsuit, even though other claims in the complaint fall outside of the policy's coverage.'"[725] Furthermore, courts will liberally interpret a complaint's allegations to determine if the allegations establish the insurer's duty to defend.[726] Applying these rules, the appellate court declared that Mid-Continent had no duty to defend or indemnify the School Board against Coleman's Title VII claim.[727] The appellate court found no evidence that would have supported a claim for disparate impact discrimination.[728]

But the appellate court also applied the plain meaning rule and declared: The present insurance contract's clear and explicit language covers acts of racial discrimination or harassment if an insured commits those acts unintentionally and without actually knowing the acts are wrongful.[729] Thus,

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719. *Id.* at 520 n.37 (citing *Munoz v. Orr*, 200 F.3d 291, 299 (5th Cir. 2000). "Disparate treatment refers to *deliberate* discrimination in the terms or conditions of employment," whereas disparate impact claims "do not require proof of intent to discriminate." *Id.*

720. *See* E.E.O.C. v. J.M. Huber Corp., 927 F.2d 1322, 1328 n.24 (5th Cir. 1991) (citing Griggs v. Duke Power Co., 401 U.S. 424, 430 n.6 (1971)). "[U]nder an impact theory, the employee need not prove intentional discrimination, but need only show that a certain employment policy has a disparate impact on a protected group." *Id.*

721. *Coleman*, 418 F.3d at 520-21.

722. *Id.* at 523; *see* Lamar Adver. Co. v. Continental Cas. Co., 396 F.3d 654, 660 (5th Cir. 2005); Selective Ins. Co. of S.E. v. J.B. Mouton & Sons, Inc., 954 F.2d 1075, 1077 (5th Cir. 1992); Suire v. Lafayette City-Parish Consol. Gov't, 907 So.2d 37, 51-52 (La. 2005).

723. *Selective Ins. Co. of S.E.*, 954 F.2d at 1078.

724. *Lamar*, 396 F.3d at 660 (quoting Complaint of Stone Petroleum Corp., 961 F.2d 90, 91 (5th Cir. 1992)); Jensen v. Snellings, 841 F.2d 600, 612 (5th Cir. 1988) ("[When] the pleadings, taken as true, allege both coverage under the policy and liability of the insured, the insurer is obligated to defend, regardless of the outcome of the suit or the eventual determination of actual coverage."); *Suire*, 907 So.2d at 52 ("Unless unambiguous exclusion of all the plaintiff's claims is shown, the duty to defend arises.").

725. *Coleman*, 418 F.3d at 523 n.49; *see* Montgomery Elevator Co. v. Bldg. Eng'g Servs. Co., 730 F.2d 377, 382 (5th Cir. 1984).

726. *Coleman*, 418 F.3d at 523 n.50; *see Lamar*, 396 F.3d at 660 ("In making [the duty to defend] determination, this Court must liberally interpret the complaint.").

727. *Coleman*, 418 F.3d at 523.

728. *Id.* at 522-23.

729. *Id.* at 518.

comparing the factual allegation in the underlying third party complaint with the clear and plain meaning of the language in the exclusion clause, the Fifth Circuit also concluded Mid-Continent had no duty to defend or indemnify the School Board against Coleman's 42 U.S.C. §§ 1981 and 1983 claims.[730] The reason is not complicated: Under sections 1981 and 1983, a complainant must prove intentional racial discrimination.[731]

After examining Coleman's Title VII and 42 U.S.C. §§ 1981 and 1983 claims, concluding that Mid-Continent had no duty to defend or indemnify, and affirming the district court's rulings regarding these issues, the Fifth Circuit addressed the School Board's final argument.[732] In her underlying third party complaint, Coleman asserted that (1) the School Board did not have a serious and legitimate interest requiring judicial protection to justify Coleman's termination; (2) the School Board's unwarranted conduct was a deviation from sound moral rules, good faith, and elementary fairness; and (3) the School Board exercised one of its legal rights—the power to terminate —for a nonauthorized purpose.[733] Therefore, Coleman sought an equitable remedy under Louisiana's abuse of rights doctrine.[734]

Originally, courts recognized the abuse of rights doctrine to "prevent . . . holder[s] of [legal] rights or powers from exercising those rights exclusively for the purpose of harming another . . . ."[735] To prove that a tortfeasor abused a legal right, however, a complaining party must prove that the holder of the right used it for either of the following reasons: (1) exclusively or predominantly to harm another or to cause harm; (2) when "no serious and legitimate interest . . . worthy of judicial protection" exists; (3) to deviate from "moral rules, good faith or elementary fairness"; or (4) "for a purpose other than that for which the right was granted."[736]

Again, Coleman alleged that the School Board abused its otherwise legitimate rights when it voted to terminate Coleman's employment.[737] The

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730. *Id.* at 522.

731. *See id.*; 42 U.S.C. §§ 1981, 1983 (2000).

732. *Coleman*, 418 F.3d at 522.

> In essence, the [School] Board asks that we re-write the terms of the insurance policy to conform with the reasonable expectations of a typical purchaser of insurance. This step is foreclosed by Louisiana law, which precludes use of the reasonable expectations doctrine to recast policy language when such language is clear and unambiguous. Because the language of the policy at issue here is unambiguous, we cannot impose an alternative meaning on the policy by way of interpretation.

Id.

733. *Id.* at 523-24.

734. *Id.* at 523.

735. Ill. Cent. Gulf R.R. Co. v. Int'l Harvester Co., 368 So. 2d 1009, 1014 (La. 1979).

736. *Id.*

737. *Coleman*, 418 F.3d at 525.

> Coleman explicitly alleged that, following her meeting with the [School] Board Superintendent at which he asked her to resign, she was subjected to disparate enforcement of the [School] Board's rules and written-up for infractions that she did not commit. Implicit in this allegation

liability insurance contract covered losses resulting from claims based on wrongful acts.[738] And the policy defined a wrongful act as "'any actual or alleged act, error, omission, misstatement, misleading statement, neglect or breach of duty . . . including but not limited to' a variety of specifically enumerated acts."[739] Therefore, the Fifth Circuit declared that the wrongful act clause was sufficiently expansive enough to cover Coleman's abuse of right allegation.[740]

The Fifth Circuit also found that "Coleman's factual allegations could . . . support a garden-variety breach-of-contract claim."[741] Coleman alleged that the School Board terminated her after disciplining her for violations that she did not commit.[742] From the court of appeal's perspective, a jury could still find that the School Board breached Coleman's employment contract and terminated her without cause.[743] And a jury could reach that conclusion, "[e]ven if a jury were to disbelieve Coleman's claims of intentional racial discrimination."[744] The Fifth Circuit also found that "the policy explicitly provide[d] coverage for 'actual or alleged interference with or breach of any employment contract whether oral, written, express or implied.'"[745]

Ultimately, the court of appeals declared that Mid-Continent had a duty to defend the School Board against Coleman's breach of contract and abuse of rights actions.[746] The Fifth Circuit remanded the case to the district court, instructing the lower court to determine whether the insurer had to indemnify or reimburse the School Board for the funds it spent to defend itself and settle some of Coleman's third party claims.[747]

> is the assertion that Coleman did not commit an infraction for which she could be rightfully terminated under her contract of employment. Based on this assertion, a jury could hold the School Board liable for abusing Coleman's rights under her employment contract by firing her without cause, while simultaneously holding that the [School] Board's actions were not actuated by intentional racial discrimination.

Id.

738. *Id.* at 514.

739. *Id.* at 524.

740. *Id.* at 524-25 ("Interpreting Coleman's complaint liberally, we find that she alleged facts which, if true, would support a finding of liability under an abuse of rights theory without requiring proof of intent to cause harm.").

741. *Id.* at 525.

742. *Id.*

743. *Id.*

744. *Id.*

745. *Id.*

746. *Id.*

747. *Id.* at 526 n.58.

> It is premature for us to decide whether Louisiana law permits an insured to recover the *entire* balance of a settlement amount when coverage is potentially available for only a fraction of the claims alleged in the plaintiff's complaint. We note, however that when applying Texas law we have held that coverage 'cannot be created *ex nihilo* by estoppel.'

Id. (citing Enserch Corp. v. Shand Morahan & Co., Inc., 952 F.2d 1485, 1493 (5th Cir. 1992)).

2. *Whether Under Louisiana Law an Employer's Liability Insurer Has a Duty to Reimburse the Employer for Expenses Associated with a Terminated Employee's Asbestos-Related Injuries*

Asbestos is a mineral that has been linked to lung diseases.[748] For years, manufacturers used asbestos to make flame-resistant insulation, and, the automotive, construction and defense industries, in particular, used the insulation extensively.[749] For decades, asbestos-related claims and lawsuits have plagued asbestos manufacturers as well as companies that used the toxic substance.[750] As of this writing, "[a]n estimated 400,000 asbestos claims are pending and still more are likely over the next decades."[751]

Asbestos-related litigation can span ten years or more and the lawsuits are extremely costly.[752] For example, ABB Ltd. (ABB) is a Swiss electrical-engineering company, and ABB's U.S.-based subsidiary, Combustion Engineering, Inc., produced asbestos-insulated boilers until the 1970s.[753] Over several decades, complainants' presenting asbestos-related injuries filed 100,000 lawsuits against ABB.[754] Recently, ABB agreed to pay $1.43 billion to settle those suits.[755] To add to ABB's misery, "the crippling legal fights . . . cost Europe's largest engineering firm around $1 billion in legal fees—even before the settlement—and put [ABB] on the brink of bankruptcy . . . ."[756]

"Many companies have sought refuge from asbestos claims by filing for bankruptcy, leaving insurance companies to settle with plaintiffs while protecting the defendants' assets."[757] But fairly often, insurance companies refuse to settle claims.[758] Liability insurers also refuse to defend insured

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748. John Godfrey, *Asbestos Fund Narrowly Approved By Senate Panel*, WALL ST. J., May 27, 2005, at B3.

749. *Id.*

750. *Id.* ("The bill would provide a substantial break from potential legal liabilities to former U.S. asbestos manufacturers. Many of those companies and their successor businesses have been driven to seek bankruptcy protection due to asbestos-related claims, some dating back decades.").

751. *Id.*

752. *See id.*

753. Goran Mijuk, *ABB Nears Pact On Settlement Of Asbestos Suits*, WALL ST. J., Feb. 23, 2006, at A8.

754. *Id.* ("ABB Ltd. is likely to settle its U.S. asbestos litigation in early spring, concluding 10 years of restructuring and stanching a $1 billion stream of losses . . . . ABB's wrangle with asbestos litigation distracted the company for a decade as it closed down production and cleaned up asbestos sites.").

755. *Id.*

756. *Id.*

757. Nathan Koppel, *Asbestos Ruling, $13 Million Fine Buffet Law Firm*, WALL ST. J., Apr. 24, 2006, at B1.

758. Godfrey, *supra* note 751, at B3.

> Legislation creating a $140 billion trust fund to handle asbestos-related injury claims narrowly passed the Senate Judiciary Committee and faces further challenges on the Senate floor.
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> . . . .
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> The trust would be funded by defendant employers and their insurers. The trust would also seize the assets of other asbestos trusts previously set up by state and bankruptcy courts. Those

corporations against third parties' asbestos-related lawsuits.[759] This term, the Fifth Circuit decided *Riverwood International Corp. v. Employers Insurance of Wausau*, a duty-to-indemnify case in which an insured corporation sued an insurer for refusing to pay for asbestos-related settlement costs.[760] Like most similarly situated insurers, the insurer in *Riverwood* refused to pay, citing a complex and nearly indecipherable affirmative defense.[761]

Graphic Packaging International, Inc., formerly known as Riverwood International Corp. (Riverwood), owns and operates a paperboard manufacturing facility in West Monroe, Louisiana.[762] In early 2000, numerous present and former employees began to sue Riverwood, claiming that they were exposed to asbestos while working at the West Monroe facility.[763] The employees sought damages for an assortment of injuries, including asbestosis and other asbestos-related diseases.[764] Riverwood paid $1.513 million to settle the multiple lawsuits with 260 employees.[765]

Before 2000, Riverwood purchased several excess workers' compensation and employers' liability insurance contracts (Policies) from

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funding the trust would be relieved of legal responsibility for further asbestos-injury claims.

. . . .

Insurers said the bill is 'wholly unacceptable.

Id.

759. *See* Amy Stevens and Arthur S. Hayes, *Legal Beat—Insurers Must Pay Asbestos Litigation Costs of Policy Holders, Court Says*, WALL ST. J., May 23, 1991, at B6.

The Illinois Supreme Court ruled that the terms of comprehensive general liability policies require insurance companies to reimburse asbestos manufacturers and insulation contractors for the costs of defending asbestos property damage cases. Whether insurers have a duty to reimburse policyholders for asbestos litigation is an issue in courts in nearly every state. . . . In the Illinois suit, the USF&G Corp. of Baltimore contended that it only has a duty to pay legal costs in cases [in which] its policy holders were being sued for property damage which involves tangible injury to buildings. . . . The Illinois high court ruled that 'an insurer has a duty to defend its insured if any theory of recovery alleges potential coverage.

Id.

760. Riverwood Int'l Corp. v. Employers Ins. of Wausau, 420 F.3d 378, 379-80 (5th Cir. Aug. 2005).

761. *Id.*; *see* Stevens & Hayes, *supra* note 762, at B6.

In the Illinois suit, the USF&G Corp. of Baltimore contended that it only has a duty to pay legal costs in cases [in which] its policy holders were being sued for property damage which involves tangible injury to buildings. Asbestos contamination results only in economic loss due to the diminished value of buildings, it argued. Five other former insurers of policy holder Wilkin Insulation Co., of Mt. Prospect, Illinois, joined the suit. They are Commercial Union Insurance Co., Argonaut Insurance Co., Argonaut Midwest Insurance Co., Aetna Casualty & Surety Co. and Zurich Insurance Co. Wilkin Insulation is defending itself in numerous asbestos removal actions[.] . . . The company claimed that contamination is the same as damage. The Illinois high court ruled that 'an insurer has a duty to defend its insured if any theory of recovery alleges potential coverage.

Id.

762. *Riverwood*, 420 F.3d at 380.

763. *Id.*

764. *Id.*

765. *Id.*

Employers Insurance of Wausau (Wausau).[766] Collectively, those contracts insured Riverwood from May 1974 to January 1984.[767] Thus, when the employees filed the asbestos-related lawsuits, Riverwood sent letters of notification to Wausau.[768] More relevant, neither the reported facts nor letters identified the underlying third party victims' theories of recovery.[769] The letters simply stated that the employees' claims concerned "bodily injury by disease."[770]

Citing the respective thirty-six month exclusion clauses in the Policies, Wausau refused to contribute to the $1.513 million settlement.[771] Wausau also refused to pay for another reason: the insurer claimed that Riverwood breached several conditions precedent in the Policies.[772] In response, Riverwood filed an action against Wausau in the District Court for the Western District of Louisiana.[773] The company asserted that the insurer breached a contractual duty to reimburse Riverwood for the cost of settling the underlying asbestos-related actions.[774]

Initially, Wausau filed a partial motion for summary judgment, asserting that the Policies' thirty-six month exclusion provision excluded the asbestos claims.[775] The district court found, however, that a question of fact existed regarding "whether the claimant's asbestos-related disease qualified as a 'bodily injury by disease' or a 'bodily injury by accident,'" because both phrases appeared in the Policies.[776] Put briefly, the district court denied Wausau's partial summary judgment motion, finding that the two phrases were ambiguous.[777]

Still, the insurer was undeterred, and more than a year and a half later, Wausau again filed another motion for summary judgment, arguing that: (1) the injured employees' asbestos-related claims were bodily injury by

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766. *Id.*
767. *Id.*
768. *Id.*
769. *Id.*
770. *Id.*
771. *Id.*
772. *Id.*
773. *Id.*
774. *Id.* at 380 n.4.

Riverwood also filed suit seeking indemnity under various standard workers' compensation and employers' liability policies and blanket liability policies it had purchased. The claims regarding the blanket liability policies were voluntarily dismissed. Furthermore, the court granted summary judgment against Riverwood on the standard policies because they did not cover any of the employees' claims at issue. Riverwood does not appeal as to that determination. Initially, Riverwood had also sought coverage for claims asserted by non-employees, but those claims were also voluntarily dismissed.

Id.

775. *Id.* at 380.
776. *Id.*
777. *Id.* at 381.

disease, (2) the thirty-six month exclusion provision barred those claims, and (3) Riverwood breached a condition precedent that would trigger coverage under the Policies—regardless of whether the claims were bodily injury by disease or bodily injury by accident.[778] After the second try, the district court granted Wausau's motion for summary judgment and Riverwood appealed.[779]

The Policies contained multiple allegedly inharmonious provisions, and the parties proffered different interpretations of various key phrases.[780] So, the Fifth Circuit examined those to determine whether they were ambiguous and stated Riverwood and Wausau's intent.[781] First, the Policies' coverage section was multi-pronged, containing several subsections.[782] Subsection I-B stated: "This policy applies to loss sustained by the insured on account of . . . [] sums which the insured shall become legally obligated to pay as damages because of bodily injury by accident or disease . . . ."[783]

Subsection II, "Application of Policy," outlined the types of injuries that would trigger coverage and stated: "This policy applies only to injury (1) by accident occurring during the policy period, or (2) by disease caused or aggravated by exposure of which the last day of the last exposure, in the employment of the insured, to conditions causing the disease occur[red] during the policy period . . . ."[784] The definitions clause, Subsection V-C, defined bodily injury by accident and bodily injury by disease.[785] The entire section read:

> The contraction of disease is not an accident within the meaning of the word "accident" in the term "bodily injury by accident" and only such disease as results directly from a bodily injury by accident is included within the term "bodily injury by accident." The term "bodily injury by disease" includes only such disease as is not included within the term "bodily injury by accident."[786]

The Policies also contained a conditions-precedent clause.[787] Outlining a series of self-insured retention (SIR) conditions, the clause read in pertinent part:

> RETENTION AND INDEMNITY. The insured shall retain as its own net retention loss . . . the amount of the retention stated in the declarations and the

778. *Id.*
779. *Id.*
780. *Id.*
781. *Id.* at 381-82.
782. *Id.*
783. *Id.* at 382.
784. *Id.*
785. *Id.*
786. *Id.* at 382-83.
787. *Id.* at 380 n.3.

> company . . . agrees to indemnify the insured against loss in excess of such retention . . . [up] to the limit of indemnity stated in the declarations; provided, that the retention and limit of indemnity apply . . . [to]:
>
> (a) bodily injury by accident, including death resulting therefrom, sustained by one or more employees in each accident, or
>
> (b) bodily injury by disease, including death resulting therefrom, sustained by each employee.[788]

Finally, the exclusions clause stated somewhat inelegantly: "This policy does not apply . . . to bodily injury by disease unless prior to thirty-six months after the end of the policy period[,] [a] written claim is made or suit is brought against the insured for damages because of . . . injury or death resulting therefrom . . . ."[789]

On appeal, Riverwood argued generally that the words and phrases in the various clauses were ambiguous.[790] First, the company asserted correctly that the Policies did not define the word accident.[791] Therefore, Riverwood insisted that the common understanding of an undefined term must control.[792] And because popular dictionaries define an accident as "an unforeseen and unplanned event or circumstance," the company argued that the causes of the asbestos-related injuries in the present case could be described reasonably as unforeseen and unplanned events or circumstances.[793]

The Fifth Circuit disagreed, concluding that an insurance contract's failure to define a term does not make the term ambiguous, without knowing more.[794] More significant, the court of appeals observed that the Louisiana Legislature defined an accident in a workers' compensation statute: An accident is "an unexpected or unforeseen actual, identifiable, precipitous event happening suddenly or violently, with or without human fault, and directly producing at the time objective findings of an injury which is more than simply a gradual deterioration or progressive degeneration."[795]

Because the duty-to-indemnify issue involved the workers' compensation policies, the court of appeals decided that the term accident must be given its plain meaning.[796] After applying the rule, the Fifth Circuit found that "an asbestos-related disease has a long latency period and normally manifests itself after continued exposure."[797] The appellate court also concluded that "an

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788. *Id.* at 380 n.3.
789. *Id.* at 380 n.2.
790. *Id.* at 383.
791. *Id.*
792. *Id.*
793. *Id.*
794. *Id.*
795. LA. REV. STAT. ANN. § 23:1021(1) (1998).
796. *Riverwood*, 420 F.3d at 383.
797. *Id.* (citing Hamilton v. Anco Insulation, Inc., 844 So.2d 893, 897 (La. Ct. App. 2003) (observing

asbestos-related disease cannot be considered an 'accident,' because one's exposure to asbestos is 'normally not violent' and does not, at the time of exposure, 'produce objective findings of an injury.'"[798]

Regarding the thirty-six month exclusion provision, the district court concluded that the underlying claims in the present lawsuit involved bodily injury by disease.[799] Therefore, the thirty-six month exclusion applied and should be enforced as written.[800] Regarding the SIR issue, the district court decided that a separate SIR had to be met for each claim because each claim was a bodily injury by disease claim.[801] But evidence established that no individual claim exceeded the smallest per-employee $100,000 SIR limit or the $500,000 SIR limit under later policies.[802]

Still, the Fifth Circuit stated:

> We . . . hold that the district court properly concluded that . . . an asbestos-related disease is not a "bodily injury by accident" but is rather a "bodily injury by disease." Accordingly, the thirty-six month exclusion provision applies. [Because] Riverwood is not entitled to coverage under the thirty-six month exclusion provision, we need not address its arguments [regarding] the SIR issue.[803]

The Fifth Circuit's analysis is a bit problematic for two reasons.[804] First, the court of appeals adopted without questioning the district court's decision to view the workers' compensation contract and the employers' liability insurance contract as if they were identical.[805] Little evidence existed in the record to support that conclusion.[806] Second and more important, "[t]he Policies [did] not state affirmatively that workers' compensation law [would] govern the terms" under both the workers' compensation contract and the employers' liability contract.[807] Yet, the Fifth Circuit used workers'

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that the "vast majority of courts considering the issue have also treated asbestos-related claims as injury by disease under excess [w]orker's [c]ompensation/[e]mployer [l]iability policies with the same or nearly the same policy definitions")).

798. *Id.*

799. *Id.* at 385.

800. *Id.* at 385.

801. *Id.* at 381.

802. *Id.* at 381 n.5.

> The SIR amount for the years covered [under] the Policies were: (1) $100,000 per year for 1974-1977; (2) $250,000 per year for 1977-1980; and (3) $500,000 per year for 1980-1984. The court noted that for the settled claims, only Walter Graves's $400,000 claim could possibly satisfy the SIR, but Graves's last exposure was in 1986, a date not within the policy period.

Id.

803. *Id.* at 385.

804. *Id.*

805. *Id.* at 379.

806. *Id.* at 379, 383.

807. *See id.* at 379, 383 n.6.

compensation rules to define a controversial concept—an accident—to decide the case.[808] The appellate court used workers' compensation rules to decide that Wausau had no duty to indemnify Riverwood, simply because "workers' compensation law is referenced throughout the Policies."[809]

From this commentator's perspective, that is arguably an unfair and a less-than stellar decision for two reasons. First, a fair reading of the reported facts reveals that Riverwood filed a breach-of-contract suit against Wausau.[810] The company claimed that the insurer breached a contractual duty to indemnify or to reimburse funds after the company settled a third party suit.[811] Without doubt, employers' liability insurance contracts typically outline an insurer's duty to defend an employer against a third party employee's personal injury suit. Liability insurance contracts also specify when an insurer will reimburse an employer after the latter settles a third party lawsuit.[812]

Second, barring intentional acts, courts use workers' compensation rules typically to decide whether employees should be compensated for work-related injuries and illnesses.[813] Stated differently, workers' compensation rules and policies generally do not disclose whether a liability insurer has a contractual duty to indemnify an employer after the employer has settled a third party lawsuit.[814]

More significantly, the facts in *Riverwood* show conclusively that Riverwood purchased a series of excess workers' compensation and employers' liability contracts from Wausau over a ten-year period—from May 1974 to January 1984.[815] Arguably, Wausau could have been liable under the employers' liability contract even if it was not liable under the workers' compensation contract. Even though Wausau was the only "obligor," a liberal reading of Louisiana's "solidary obligors" doctrine[816] suggests that Wausau's

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808. *Id.* at 383.

809. *Id.*

810. *See id.* at 381-83.

811. *Id.*

812. *See generally* discussion *supra* Part III.A.

813. *See* LA. REV. STAT. ANN. § 23:1032(A)(1)(a) (1998) (outlining employees' rights and remedies and employers' liabilities to workers under other laws).

> Except for intentional acts[,] . . . the rights and remedies herein granted to an employee or his dependent on account of an injury, or compensable sickness or disease for which he is entitled to compensation under this Chapter, shall be exclusive of all other rights, remedies, and claims for damages, including but not limited to punitive or exemplary damages, unless such rights, remedies, and damages are created by a statute, whether now existing or created in the future, expressly establishing same as available to such employee, his personal representatives, dependents, or relations, as against his employer, or any principal or any officer, director, stockholder, partner, or employee of such employer or principal, for said injury, or compensable sickness or disease."

Id.

814. *See generally id.*

815. *Riverwood*, 420 F.3d at 380.

816. *See* LA. CIV. CODE ANN. art. 1787 (1987). The statute defines "solidary obligors" as follows: When several persons obligate themselves to the oblige by the terms in solido, or use any other

obligations under the obviously dissimilar insurance contracts were not identical as the district and appellate courts assumed.[817]

The Fifth Circuit's opinion, therefore, would have been significantly more enlightening if the appellate court had separately discussed coverage, exclusions, and the definition of an accident under those distinct insurance polices. Instead, the Fifth Circuit concluded: "Applying the rules of contract interpretation, we conclude that the district court properly determined that the Policies are subject to only one reasonable interpretation—that an asbestos-related injury is not a 'bodily injury by accident' under *the policies* in question."[818]

3. Whether Under Louisiana's Medical Malpractice Act State Regulators May Initiate a Direct Action Against a Medical Malpractice Insurer Who Allegedly Adjusted and Settled Medical Malpractice Claims Fraudulently

Yearly, the overwhelming majority of insurers and their insureds ask the Fifth Circuit to interpret various rights and obligations under a variety of insurance contracts. And, as discussed elsewhere, the three state supreme courts within the Fifth Circuit have adopted identical doctrines to interpret insurance contracts' words and phrases.[819] On the other hand, insurance litigants rarely ask the Fifth Circuit to interpret a state's insurance statute, as insurance contracts typically outline the insureds and insurers' substantive rights and duties.

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expressions, which clearly show that they intend that each one shall be separately bound to perform the whole of the obligation, it is called an obligation in solido on the part of the obligors.

Id.

817. *Cf.* Viada v. A & A Machine Works, Inc., 914 So.2d 1113, 1116-17 (La. Ct. App. 2005).

> Appellants . . . assign as error the workers' compensation judge's finding that the workers' compensation carrier and the uninsured motorist carrier are not solidary obligors. [A]ppellants aver that the relationship between the workers' compensation obligor and . . . insurers is solidary to the extent of the overlapping obligations.
>
> . . . .
>
> [A]n insurer bound to repair the damage caused by a tortfeasor is solidarily liable with the tortfeasor because both are obligated to the same thing, repair of the tort damage.
>
> . . . .
>
> On the other hand, medical insurers are not obligated to repair tort damages. A medical insurer contracts to pay stipulated medical expenses, regardless of whether there is a tortfeasor and tort liability. The medical insurer thus pays its own debt, not that of the tortfeasor, and the two are not obligated to "the same thing."

Id.

818. *Riverwood*, 420 F.3d at 382-83.

819. *See* Willy E. Rice, *The Court of Appeals for the Fifth Circuit 2003-2004 Insurance Decisions: A Survey and an Empirical Analysis*, 37 TEX. TECH L. REV. 871, 874, 1029-30 nn.1474-78 (2005). "Louisiana, Mississippi, and Texas have embraced five recognized doctrines to interpret insurance contracts—the traditional rules of contract construction and interpretation, the doctrine of plain meaning, the adhesion doctrine, the doctrine of ambiguity, and the doctrine of reasonable expectations." *Id.*

During the 2005-2006 term, however, the court of appeals agreed to decide the procedural conflict in *Louisiana Patients' Compensation Fund Oversight Bd. v. St. Paul Fire & Marine Insurance Co.*[820] A state appointed board asked the court of appeals to rule that a state statute allowed the board to sue an insurer under one of several enumerated conditions.[821] Of course, the Fifth Circuit interpreted the statute and issued its ruling.[822] But unfortunately, the ruling was strained, highly unintelligible, and arguably incorrect because the court of appeals did not cite nor apply any of the rules that Louisiana has developed to interpret state statutes.

First, a careful review of the reported facts and laws is warranted before critiquing the Fifth Circuit's analysis and determining whether this commentator's criticisms are reasonable. First, "the purpose of the Louisiana Medical Malpractice Act [(LMMA)] is to prevent the uncontrollable escalation of medical malpractice insurance rates."[823] To help achieve that end, the Louisiana Legislature created the Patients' Compensation Fund (Fund).[824] Among other activities, the Fund collects and holds monies in trust for the "use, benefit, and protection of medical malpractice claimants and . . . private health care provider members . . . ."[825] In addition, the Fund pays "excess judgments against [qualified] health care providers under the [LMMA] . . . ."[826]

Even more significant, the legislature created the Fund and placed it under the financial control of the Louisiana State Treasury.[827] That department manages and monitors the Fund's assets as well as other special and general funds in Louisiana.[828] On the other hand, the Louisiana Legislature created the Patients' Compensation Fund Oversight Board (Board) and placed it in the Office of the Governor.[829] Furthermore, the Board's duties and responsibilities are exceedingly broad: The Board has "full authority under law, for the management, administration, operation and defense" of the Fund.[830] The Board and Fund are not identical entities under the LMMA.

St. Paul Fire & Marine Insurance Company (St. Paul) is a Minnesota corporation which sells medical malpractice insurance to healthcare providers

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820. La. Patients' Comp. Fund. Oversight Bd. v. St. Paul Fire & Marine Ins. Co.411 F.3d 585, 586 (5th Cir. June 2005).

821. *Id.* at 586.

822. *Id.* at 591.

823. LA. REV. STAT. ANN. § 40:1299.41 (2006); *see* William P. Wynne, *In Re Medical Review Panel for the Claim of Maria Moses: The Supreme Court Parts a Red Sea of Questions—The Doctrine of Continued Tort Applied to Medical Malpractice Claims*, 47 LOY. L. REV. 1605, 1612-13 (2001).

824. § 40:1299.44A(1).

825. *Id.*

826. United Med. Corp. of La. v. Johns, 798 So.2d 1161, 1165 (La. Ct. App. 2001).

827. § 40:1299.44A(1).

828. *Id.*

829. *Id.* § 40:1299.44D(1)(a).

830. *Id.* § 40:1299.44D(2)(a).

in Louisiana.[831] Before August 2000, the Board discovered that St. Paul was engaging in some highly questionable insurance-related practices.[832] Although the reported facts are sparse, allegedly disgruntled and injured patients filed medical malpractice suits against healthcare providers—those that St. Paul had agreed to defend and indemnify under St. Paul's medical malpractice liability contracts.[833]

With St. Paul's prodding or assistance, some patients decided to settle their suits rather than proceed to a trial by jury.[834] Thereafter, St. Paul convinced the medical malpractice plaintiffs to enter into an allegedly secret agreement with St. Paul.[835] Under the agreement, St. Paul promised to help the third party victims to secure monies from the Fund, if the patients accepted a reduced settlement from St. Paul.[836] The scheme worked and the Board responded by suing St. Paul in the District Court for the Western District of Louisiana.[837]

From the Board's point of view, reducing the medical malpractice patients' settlement amounts, securing the secret agreements, and concealing those agreements were St. Paul's fraudulent activities, and the Fund was the victim.[838] Therefore, the Board filed a declaratory judgment action.[839] The Board asked the lower court to declare that St. Paul's allegedly fraudulent conduct breached St. Paul's statutory duty to exercise good faith and reasonable care under Section 40:1299.44(C)(7) of the LMMA for the benefit of both the insured healthcare providers and the patients' compensation fund.[840] The Board also asked the district court to declare that St. Paul had a duty to indemnify the malpractice claimants as well as the Fund for all monies that the insurer had secured fraudulently.[841]

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831. *See* St. Paul Travelers Insurance, About Us, http://www.stpaultravelers.com/about/at_a_glance.html (last visited Mar. 16, 2007).

832. La. Patients' Comp. Fund. Oversight Bd. v. St. Paul Fire & Marine Ins. Co.411 F.3d 585, 586 (5th Cir. June 2005).

833. *Id.* at 587.

834. *Id.*

835. *Id.*

836. *Id.* The complaint was based on "known underlying malpractice cases, as well as underlying cases unidentified prior to discovery." *Id.*

837. *Id.*

838. *Id.*

839. *Id.*

840. *Id.*; LA. REV. STAT. ANN. § 40:1299.44(C)(7) (2006). Section 40:1299.44(C)(7) states:

> For the benefit of both the insured and the patient's compensation fund, the insurer of the health provider shall exercise good faith and reasonable care both in evaluating the plaintiff's claim and in considering and acting upon settlement thereof. A self-insured health care provider shall, for the benefit of the patient's compensation fund, also exercise good faith and reasonable care both in evaluating the plaintiff's claim and in considering and acting upon settlement thereof.

§ 40:1299.44C(7).

841. *Oversight Board*, 411 F.3d at 587 ("[T]he Board requested monetary damages, including loss of credits for providers involved in the malpractice and loss of funds resulting from adverse judgments and settlements due to [St. Paul's] fraud and ill practices . . . .").

St. Paul filed a motion for summary judgment, advancing two arguments: (1) although it had a contractual duty to protect its insureds' interests, it had no statutory or regulatory authority to protect or preserve the Fund's interests; and (2) the Board had no legal right to challenge collaterally valid settlement agreements that injured patients, insured healthcare providers, St. Paul, and the Fund had approved.[842]

The district court denied St. Paul's summary judgment motion.[843] First, the lower court concluded that St. Paul breached its regulatory duty under Louisiana's administrative code by failing to give the Fund ten days' written notice of proposed settlements or compromises.[844] The district court also found that St. Paul breached its statutory duty under the LMMA.[845] More specifically, St. Paul did not exercise good faith and reasonable care to protect the Fund's interest when the insurer evaluated underlying malpractice victims' claims and settled the claims for a reduced amount.[846]

St. Paul appealed, and the procedural issue before the Fifth Circuit was whether the district court's adverse summary judgment was erroneous.[847] More specifically, St. Paul argued that LMMA Section 40:1299.44(C)(7) did not permit the Board to commence a cause of action against an insurer on behalf of the Fund, asserting that the insurer breached a duty of good faith and reasonable care.[848]

The Fifth Circuit, however, began its puzzling analysis by stating: "The Medical Malpractice Act . . . contemplates that the issue of liability is generally to be determined between the malpractice victim and the healthcare provider, either by settlement or by trial, and that the Fund is primarily concerned with the issue of the amount of damages."[849] To further the confusion, the Fifth Circuit stated: "Payment by one health care provider of the maximum amount of his liability statutorily establishes that the plaintiff is a victim of that health care provider's malpractice. Once payment by one health care provider has triggered the statutory admission of liability, the Fund cannot contest that admission."[850] In both instances, however, the court of appeals did not cite a reference, either in the statute or in case law.[851]

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842. *Id.*
843. *Id.*
844. *Id.*
845. *Id.*
846. *Id.*
847. *Id.*
848. *Id.* at 588. St. Paul also raised two additional arguments: (1) Even if the LMMA created a cause of action for damages, St. Paul did not breach a duty to protect the Fund's interest because St. Paul had a superior fiduciary duty to protect its insureds' interests; and (2) the district court failed to dismiss two underlying lawsuits from its deliberation. *Id.* Given the Fifth Circuit's limited appellate jurisdiction under § 1292(b), however, the appellate court only addressed St. Paul's first argument. *Id.*
849. *Id.*
850. *Id.* at 588-89.
851. *Id.*

Furthering the confusion even more, the Fifth Circuit also stated: "We agree with St. Paul. . . . [T]he Fund attempts to collaterally challenge the complete and effected settlements in underlying malpractice actions by claiming against one of the health care provider insurers, as opposed to the health care provider."[852] Then the court of appeals declared:

> The Louisiana legislature did not provide the Fund with the cause of action it seeks to create here. Nowhere in the LMMA is the Fund, or the Board on the Fund's behalf, given the authority to challenge prior malpractice settlements by instituting fraud claims against the insurer of a health care provider.[853]

In Louisiana, "[l]egislation is a solemn expression of legislative will; therefore, interpretation of a law is primarily the search for the Legislature's intent."[854] To achieve that end, the Louisiana Supreme Court encourages lower courts to use the following methodology to interpret litigants' rights and obligations under Louisiana's civil statutes.[855] First, "[t]he starting point for interpreting a statute is the language of the statute itself."[856] When a statute "is clear and unambiguous and its application does not lead to absurd consequences," courts must apply the statute as written; therefore, courts may not deliberate further "in search of [a] legislative intent."[857]

On the other hand, when a statute is "susceptible to different meanings," courts must interpret the statute in a manner that conforms best to its stated purpose.[858] Courts must interpret ambiguous words by "examining the context in which they occur and the text of the law as a whole."[859] In addition, if two or more statutes concern the same subject matter, courts must review each

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852. *Id.* at 590. (citing Stuka v. Fleming, 561 So. 2d 1371, 1373 (La. 1990)). The court observed that under the LMMA, a qualified healthcare provider is not liable for an amount in excess of one hundred thousand dollars plus interest for all malpractice claims because of injuries to or death of any one patient. *Stuka*, 561 So. 2d at 1373. All "damages in excess of the total liability of *all* liable health care providers, up to $500,000, are to be paid by the Fund." *Id.* (citing LA. REV. STAT. ANN. § 40:1299.42B(2)); *see also* Turner v. Sw. La. Hosp. Ass'n, 856 So.2d 1237, 1240-41 (La. Ct. App. 2003) (approving *Stuka*).

853. *Oversight Board*, 411 F.3d at 590-91.

> Rather, the LMMA provides a regulatory structure through which the Board manages the Fund and administers the system created in Louisiana within which both insurers and health care providers work. . . . The cause of action alleged by the Board is not expressly granted by the governing statute, and, to the extent the Board seeks additional enforcement powers on behalf of the Fund under the LMMA, its pleas must be addressed to the Louisiana legislature.

Id.

854. *See* O'Regan v. Preferred Enters., Inc., 758 So. 2d 124, 128 (La. 2000); LA. CIV. CODE ANN. art. 2.

855. *See Oversight Board*, 411 F.3d at 590-91.

856. Deshotel v. Guichard Operating Co., 916 So. 2d 72, 78 (La. 2004).

857. *O'Regan*, 758 So.2d 128; *see also* LA. CIV. CODE art. 9 (1987).

858. *Deshotel*, 916 So. 2d at 76; *see also* LA. CIV. CODE ANN. art. 10.

859. *Deshotel*, 916 So. 2d at 76.

statute and give an interpretation after harmonizing the conflict or differences among the statutes.[860]

Section 40:1299.44(C)(2) of the LMMA states in relevant part:

> If the insurer of a health care provider . . . has agreed to settle its liability on a claim against its insured and claimant is *demanding an amount in excess* thereof from the patient's compensation fund for a complete and final release, then the following procedure must be followed:
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> . . . .
>
> A copy of the [third party claimant's] petition shall be served on the board, the health care provider and his insurer, at least ten days before filing and shall contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.[861]

Once more, the Board asserted that St. Paul entered into secret agreements with third party victims on behalf of insured healthcare providers.[862] The insurer reduced the settlement amount by a certain percentage and encouraged victims to sue the Fund to secure the remainder.[863] The Board argued that St. Paul concealed that allegedly fraudulent conduct, which is arguably a violation under LMMA Section 40:1299.44(C)(2).[864] The Board also maintained that the allegedly fraudulent concealment violated St. Paul's statutory duty to exercise good faith and reasonable care under LMMA Section 40:1299.44(C)(7).[865]

Furthermore, LMMA Section 40:1299.44(D)(2)(a) states that "[t]he board shall be responsible, and have full authority under law, for the management, administration, operation and *defense of the fund* in accordance with the provisions of this Part."[866] And finally, LMMA Section 40:1299.44(D)(2)(b)(xi) states:

> In addition to such other powers and authority elsewhere expressly or impliedly conferred on the board by this Part, the board shall have the authority, to the extent not inconsistent with the provisions of this Part, to
>
> . . . .
>
> [d]efend the fund from all claims arising under R.S. 40:1299.44(D)(2)(b)(x), and obtain indemnity and reimbursement to the fund of all amounts for which [anyone other than a qualified healthcare provider]

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860. *Id.*; *see also* LA. CIV. CODE ANN. art. 13.

861. LA. REV. STAT. ANN. § 40:1299.44(C)(2) (2006).

862. La. Patients' Comp. Fund Oversight Bd. v. St. Paul Fire & Marine Ins. Co., 411 F.3d 585, 587 (5th Cir. June 2005).

863. *Id.*

864. *Id.*

865. *Id.*

866. § 40:1299.44(D)(2)(a).

may be held liable.[867]

So, we raise the question again: Do these sections of the LMMA allow the Board to commence a fraud action against St. Paul on behalf of the Fund? The district court said yes.[868] Moreover, a fair application of Louisiana's rules for interpreting statutes, which the Fifth Circuit did not cite or embrace, also suggests that the Board could bring a fraud action. But the Fifth Circuit concluded: "In the absence of the Louisiana legislature's express language so providing, and in light of the Louisiana Supreme Court's interpretation of the LMMA in *Stuka* and *Mumphrey*, we decline to do so."[869] Unfortunately, the questions and holdings in *Stuka* and *Mumphrey* had absolutely nothing to do with the procedural question before the Fifth Circuit in *Oversight Board*.[870]

4. Whether the Federal District Court Properly Stayed a Lawsuit in Which an Insured Corporation's Sole Bankrupt Shareholder Sued the Liability Insurer for Refusing to Defend or Indemnify the Insured After a Patron Filed a Wrongful Death Action Against the Corporation in a Mississippi State Court

Stewart v. Western Heritage Insurance Co. is an ideal case for a first-year law course—civil procedure, contracts, or torts.[871] Although it presents multiple issues that first-year law students confront, the Fifth Circuit agreed to review the controversy in *Stewart* because the parties presented a persistent procedural issue that appears among insurance-related conflicts.[872] The central procedural conflict concerns judicial abstention; however, the court of appeals discussed other familiar procedural issues, which makes *Stewart* an excellent teaching tool.[873]

There are multiple parties in this case, but the facts are few.[874] So, the facts reported here are derived from a careful reading of the case in its entirety and secondary sources.[875] Boardwalk Lounge, Inc. (Boardwalk) owns an

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867. § 40:1299.44(D)(2)(b)(xi).

868. *Oversight Board*, 411 F.3d at 587.

869. *Id.* at 591.

870. *See generally* Stuka v. Fleming, 561 So.2d 1371, 1372-73; Mumphrey v. Gessner, 581 So.2d 357, 359-60 (La. Ct. App. 1991). In *Mumphrey*, the underlying plaintiff sued multiple healthcare providers and ultimately settled with one who paid the statutory limit of $100,000. *Mumphrey*, 581 So.2d at 360. The providers were released. *Id.* The settlement was approved, but the Fund challenged it by filing a third party action against the dismissed healthcare providers. *Id.* Relying in part on *Stuka*, the court held that the Fund could not seek contribution from the settling defendants through the collateral challenge. *Id.*

871. Stewart v. W. Heritage Ins. Co., 438 F.3d 488, 490 (5th Cir. Jan. 2006).

872. *Id.*

873. *See id.*

874. *Id.*

875. *Id.*; Thyrie Bland, *No Motive in Slaying Outside Lounge*, THE CLARION-LEADER (Jackson, MS), Nov.13, 2001, at 1B.

entertainment establishment with a similar name—Boardwalk Lounge (Lounge).[876] The business is located in Jackson, Mississippi.[877] Susie Pierce Stewart is Boardwalk's sole officer, shareholder, and registered agent.[878]

On November 9, 2001, Ryan Yates and his girlfriend, Rebecca Roberts, went to the Lounge, where they met Yates's sibling and friends for a Friday night's outing.[879] Suddenly, Yates "walked away from the group and left the Lounge without saying where he was going."[880] Given her concern and befuddlement, Roberts left the Lounge and returned to their car, looking for Yates.[881] As she approached the car, she saw Yates lying on the ground.[882] Although he had been shot and "was having problems breathing," Yates was still alive.[883] The next day, however, Yates died at the University of Mississippi Medical Center in Hinds County, Mississippi.[884] Later, Yates's survivors commenced a wrongful-death suit against Boardwalk.[885]

When Yates's survivors commenced their lawsuit, Western Heritage Insurance Company (Western) insured Boardwalk under a liability insurance contract.[886] And although Western contractually agreed to defend and indemnify Boardwalk against third party actions, the insurer refused to defend Boardwalk in the underlying lawsuit.[887] As a consequence, Yates's survivors secured a $1.4 million default judgment, because neither Boardwalk nor Western appeared and defended against the underlying wrongful-death action.[888] Shortly thereafter, both Boardwalk and its sole shareholder and agent, Stewart, filed for bankruptcy.[889]

Also, given that Western had refused to indemnify or provide a legal defense in the underlying action, Stewart sued the insurer on October 23, 2003.[890] Before the District Court for the Southern District of Mississippi, Stewart alleged that Western acted in bad faith and breached its contractual obligations under the insurance contract.[891] Western filed a motion for summary judgment, and the District Court for the Southern District of Mississippi set February 14, 2005 as the date for trial.[892]

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876. *Stewart*, 438 F.3d at 490.
877. *See* Bland, *supra* note 879, at 1B.
878. *Stewart*, 438 F.3d at 490.
879. *See* Bland, *supra* note 879, at 1B.
880. *Id.*
881. *Id.*
882. *Id.*
883. *Id.*
884. *Id.*
885. Stewart v. W. Heritage Ins. Co., 438 F.3d 488, 490 (5th Cir. Jan. 2006).
886. *Id.*
887. *Id.*
888. *Id.*
889. *Id.*
890. *Id.*
891. *Id.*
892. *Id.*

Nearly nine months after Stewart filed her lawsuit against Western, the bankruptcy trustee for Boardwalk filed a suit in the Circuit Court of Hinds County, Mississippi.[893] The trustee's complaint listed Western, Stewart, and Phillip Dunn, an insurance agent, among others, as defendants.[894] The trustees' lawsuit mirrored the Stewart's lawsuit against Western, barring two exceptions.[895] First, the trustee alleged that Stewart and Western had a fiduciary duty to protect Boardwalk's interests and they failed in this duty.[896] Second, the trustee alleged that Dunn had some unspecified duty and he breached that duty.[897] Western removed the state case to the District Court for the Southern District of Mississippi, claiming an improper joinder.[898] In response, the bankruptcy trustee moved to remand to the Circuit Court of Hinds County, Mississippi.[899]

The trustee's suit commenced and Stewart filed two motions to voluntarily dismiss that action.[900] Western opposed both motions.[901] Stewart also filed a motion to join Dunn as a party.[902] In addition, Western moved to join Boardwalk's trustee as a necessary party to Stewart's lawsuit against the insurer.[903] A magistrate judge granted Western's motion and ordered Stewart to serve the trustee with process.[904] The trustee, however, is not a party to this action because the trustee never became a party.[905]

The district court set a hearing to consider all pending motions, at which the federal district court stayed Stewart's lawsuit pending another court's ruling on the remand motion in the trustee's suit.[906] On March 22, 2005, another judge remanded the trustee's lawsuit to state court finding that Dunn had been properly joined.[907] On March 31, 2005, the federal district court judge issued an order that terminated all pending motions in Stewart's lawsuit.[908] In addition, the district court stayed Stewart's suit until the Mississippi state court resolved the controversy in the bankruptcy trustee's

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893. *Id.*

894. *Id.* Later, the state court dismissed the others from the suit. *Id.*

895. *Id.* at 490-91.

896. *Id.*

897. *Id.* at 491.

898. *Id.*

899. *Id.*

900. *Id.*

901. *Id.*

902. *Id.* at 491 n.1. Dunn joining the suit would have defeated diversity jurisdiction because Dunn and the Appellee were from Mississippi. *See* Cornhill Ins. PLC, v. Valsamis, Inc., 106 F.3d 80, 84 (5th Cir. 1997).

903. *Stewart*, 438 F.3d at 491.

904. *Id.*

905. *Id.* at 491 n.2. The Appellee stated that it never had an opportunity to join the trustee because the district court stayed the case. *Id.*

906. *Id.* at 481. The two cases were before different judges. *Id.*

907. *Id.*

908. *Id.*

lawsuit.[909] Western appealed that order, asserting that the District Court for the Southern District of Mississippi abused its discretion.[910]

The procedural question before the Fifth Circuit was whether the district court properly stayed the case pending the outcome of a parallel, Mississippi state court proceeding.[911] At the outset, the court of appeals reviewed and considered the Supreme Court's decision in *Colorado River Water Conservation District v. United States*.[912] *Colorado River* presented an abstention doctrine, which helps guide courts in deciding whether to enter a permanent stay when suits are parallel—those which have the identical parties and identical issues.[913]

Under *Colorado River*, a district court may abstain from deciding a case only under "exceptional circumstances."[914] The Court has identified six relevant factors to help lower courts determine whether an exceptional condition exists: (1) whether either court has assumed jurisdiction over a *res*, (2) the relative inconvenience of the forums, (3) whether the exercise of jurisdiction avoids piecemeal litigation, (4) the order in which the concurrent courts obtained jurisdiction, (5) whether and the degree to which federal rules will help to resolve the controversy on the merits, and (6) the degree to which state proceedings protect the rights of the party who wants federal jurisdiction.[915]

The Fifth Circuit found that the federal district court did not apply the *Colorado River* test when it stayed the proceedings.[916] Therefore, assuming rather than deciding that Stewart and the bankruptcy trustee's cases were parallel, the court of appeals reviewed the facts in light of the six factors outlined in the *Colorado River* test.[917] First, the Fifth Circuit found that "[n]either the state nor federal court has assumed jurisdiction over any *res* in this case" and rejected the argument that the absence of this factor has little significance.[918] Thus, the court of appeals concluded that the first factor

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909. *Id.*

910. *Id.*

911. *Id.* at 490.

912. *Id.* at 491 (citing Colo. R. Water Dist. v. United States, 424 U.S. 800, 813 (1976)).

913. Diamond Offshore Co. v. A&B Builders, Inc., 302 F.3d 531, 540 (5th Cir. 2002); RepublicBank Dallas, Nat'l Ass'n v. McIntosh, 828 F.2d 1120, 1121 (5th Cir. 1987) (concluding that if suits are not parallel, a federal court must exercise jurisdiction).

914. *Colorado R. Water Dist.*, 424 U.S. at 813 (describing abstention as "an extraordinary and narrow exception to the duty of a [d]istrict [c]ourt to adjudicate a controversy properly before it").

915. *See* Wilton v. Seven Falls Co., 515 U.S. 277, 285-86 (1995).

916. *Stewart*, 438 F.3d at 492.

917. *Id.*

918. *Id.* at 492 n.4 (citing Evanston Ins. Co. v. Jimco, Inc., 844 F.2d 1185, 1191 (5th Cir. 1988)) (finding that "the absence of this factor is 'a neutral item, of no weight in the scales.'"). But, the Fifth Circuit noted: "This holding in *Evanston Insurance* conflicts with the holding in *Bank One*. Because *Evanston Insurance* predated *Bank One*, the former controls our analysis. . . . The first factor, therefore, is relevant even if no *res* exists in the case." *Id.* at 492 n.4 (citing Bank One, N.A. v. Boyd, 288 F.3d 181, 185 (5th Cir. 2002)).

supports the district court's exercising federal jurisdiction.[919]

Second, the bankruptcy trustee filed his suit in a Mississippi state court, and Stewart sued Western in a federal district court.[920] Both courthouses are located in Jackson, Mississippi.[921] Therefore, the court of appeals declared that this close proximity supported federal jurisdiction and concluded that "[w]hen courts are in the same geographic location, the inconvenience factor weighs against abstention."[922]

Third, federal law does not bar duplicative litigation.[923] A federal court may hear a dispute that is also the source of controversy in a pending state court case.[924] But *Colorado River* prevents piecemeal litigation as well as "the concomitant danger of inconsistent rulings" involving a *res*.[925] In the present case, the Fifth Circuit observed that the potential for piecemeal litigating was present because the Mississippi court was "the only forum hearing the breach of fiduciary duty claims and claims against Dunn."[926] Thus, the appellate court found that condition favoring abstention, noting that inquiry should focus on "'how much progress has been made in the two actions.'"[927]

Finally, the Fifth Circuit also found that other factors argued against abstention: (1) the federal lawsuit had progressed further than the state court suit; (2) Stewart's lawsuit involved the state law issue in the trustee's case only minimally and insignificantly; and (3) whether the Mississippi state court could adequately adjudicate the case was not an issue.[928] Therefore, barring one exception, the piecemeal litigation issue, the Fifth Circuit concluded that every factor outlined in *Colorado River* weighed against abstention and in favor of federal jurisdiction.[929] The facts in the case simply could not overcome the "extraordinary and narrow exception" to the "virtually unflagging obligation of the federal courts to exercise [their proper] jurisdiction."[930]

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919. *Id.* at 492.

920. *Id.* at 490-91.

921. *Id.* at 492.

922. *Id.* (citing Murphy v. Uncle Ben's, Inc., 168 F.3d 734, 738 (5th Cir. 1999)).

923. *Id.*

924. Bank One, N.A. v. Boyd, 288 F.3d 181, 185 (5th Cir. 2002).

925. Black Sea Inv. v. United Heritage Corp., 204 F.3d 647, 650-51 (5th Cir. 2005).

926. *Stewart*, 438 F.3d at 492.

927. *Id.* at 492 & n.5 (citing Murphy v. Uncle Ben's, 168 F.3d 734, 738 (5th Cir. 1999)). "While the current captions suggest that different parties exist, the record is clear that the magistrate intended to have the trustee joined and the Appellee [was] attempting to join Dunn. These efforts and the ability of the trustee to file a cross-claim could [have mooted] these piecemeal characteristics." *Id.*

928. *Id.* at 493.

929. *Id.* at 493 ("Given that we must balance these in favor of the exercise of jurisdiction, abstention in this case is inappropriate.").

930. Colo. R. Water Dist. v. United States, 424 U.S.800, 814, 817 (1976).

5. Whether Under Texas's Doctrine of Equitable Subrogation a Commercial General Liability Insurer Has a Duty to Indemnify a Commercial Automobile Liability Insurer Who Defended Against and Settled an Underlying Wrongful Death Action on Behalf of an Insured Corporation

Like the third party complainants in *Stewart*, the aggrieved third party victims in *EMCASCO Insurance Co. v. American International Specialty Lines Insurance Co.* commenced a wrongful death action against the insured.[931] In both cases, however, the central controversy involved parties other than the insureds.[932] But unlike the procedural conflict in *Stewart*, a substantive question is the focus of attention in *EMCASCO*.[933] Furthermore, the action in *EMCASCO* sounds in equity rather than in contract or tort, which is a major departure from the majority of insurance cases that the Fifth Circuit decided and published this term.[934]

Also, like an inordinate number of the cases reported this term, the facts in *EMCASCO* are unduly sparse.[935] Moreover, they are strewn in small bits agonizingly and extensively throughout the long opinion.[936] Based on a careful reading of the case and secondary sources, the following facts, however, are incontrovertible.[937] First, Wilson-Riley, Inc. (Wilson) is a Texas corporation with its principal place of business located in Tyler, Texas.[938] Wilson operates a sand pit, and the company owns and operates trucks to transport the sand.[939] SLS Management Corporation (SLS) owns the land on which the sand pit is located.[940]

In February 2001, Jaime Langston was driving down a public, paved country road with her young son.[941] Suddenly, she skidded on a patch of slick mud, clay, or sand.[942] The car swerved off the road and struck a tree.[943] Jaime Langston received serious injuries, and Jamie's son died at the scene.[944] About a year later, the Langstons commenced a wrongful death action against Wilson and SLS in a Texas state court.[945] The original complaint alleged that Wilson's

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931. EMCASCO Ins. Co. v. Am. Specialty Lines Ins. Co., 438 F.3d 519, 520-21 (5th Cir. Jan. 2006).
932. *Id.*; *Stewart*, 438 F.3d at 490-91.
933. *EMCASCO*, 438 F.3d at 520-21.
934. *See id.*
935. *See id.*
936. *See id.* at 520-23.
937. *See id.*; *see* Construction Work, http://www.constructionwork.com/contractor2685808_wilson riley_inc.html (last vivsited Mar. 18. 2007).
938. *EMCASCO*, 438 F.3d at 521.
939. *Id.* at 521.
940. *Id.* at 521 n.1.
941. *Id.* at 521.
942. *Id.*
943. *Id.*
944. *Id.*
945. *Id.* at 521 n.1.

trucks tracked mud onto the public road when they left the sand pit.[946] Therefore, given the presence of heavy rains in the vicinity of the sand pit, the Langstons alleged that mud on the road was the primary cause of the accident.[947]

When the accident occurred, EMCASCO Insurance Company insured Wilson and SLS under a single commercial auto liability policy.[948] In addition, American International Specialty Lines Insurance Company (AISLIC) insured Wilson and SLS under two similar commercial general liability policies (CGL).[949] Wilson notified both insurers and demanded a legal defense.[950] After apparently reserving their rights under the respective insurance contracts, both EMCASCO and AISLIC hired defense counsel and began to defend Wilson in the underlying wrongful death lawsuit.[951]

Eventually, AISLIC decided to settle the third party claims against SLS and gave the Langstons $200,000.[952] After learning about that settlement, EMCASCO's counsel and Wilson's personal attorney contacted AISLIC and asserted that AISLIC's insurance contract also covered the Langstons' remaining claims against Wilson.[953] Thus, EMCASCO demanded that AISLIC share equally the cost of settling the third party claims against Wilson.[954] AISLIC refused to settle on behalf of Wilson, citing (1) facts in the underlying third party complaint, (2) probative evidence that might be introduced at trial, and (3) statements from the Langston attorney.[955]

In effect, AISLIC insisted that it had no contractual duty to settle under its CGL policy.[956] AISLIC also asserted that to the extent that Wilson was liable for the wrongful death of the child, EMCASCO had a duty to pay or

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946. *Id.*

947. *Id.*

948. *Id.*

949. *Id.*

950. *Id.*

951. *Id.* at 521-22.

> About seven weeks after the accident EMCASCO . . . hired defense counsel Mike Winchester to defend Wilson-Riley. In doing so, EMCASCO asserted its reservation of rights in defending the suit. In April 2002, AISLIC hired its own defense counsel, Chad Parker, to represent Wilson-Riley's interests in the Langston suit. AISLIC also issued Wilson-Riley a reservation of rights letter in which AISLIC advised that, in its view, the existence of the auto exclusion provision in the CGL policy precluded coverage in the Langstons' suit.

Id.; *see* Farmers Texas County Mut. Ins. Co. v. Wilkinson, 601 S.W.2d 520, 522 (Tex. Civ. App.—Austin 1980, writ ref'd n.r.e.) (observing that prior to a determination of an insured's liability in an underlying lawsuit, the insured and insurer agree not to invoke the doctrines of waiver and estoppel and that a "reservation of right" means that the insurer "reserves to itself all of its policy defenses" in the event a trier of fact ultimately finds the insured liable and the insurer decides to defend the insured nevertheless, even when coverage is in doubt).

952. *EMCASCO*, 438 F.3d at 522.

953. *Id.*

954. *Id.*

955. *Id.*

956. *Id.*

settle the claim under its automobile liability insurance contract.[957] Yet, AISLIC agreed to contribute $20,000 in the event that Wilson and the Langstons decided to settle.[958] EMCASCO, however, refused that offer, obtained a full release of Wilson's liability from the Langstons, and settled the lawsuit for $350,000.[959]

Shortly thereafter, EMCASCO filed an equitable subrogation action against AISLIC in the District Court for the Northern District of Texas.[960] The former insurer wanted the district court to declare that AISLIC had an equitable duty to pay all or a part of the $350,000 settlement.[961] EMCASCO and AISLIC filed motions for summary judgment.[962] The district court granted AISLIC's motion, finding that EMCASCO's automobile insurance liability policy covered the Langstons' claims and that AISLIC's CGL policy explicitly excluded the third party claims.[963]

More specifically, the district court found that mud erosion from the unpaved roadway next to Wilson's sand pit was not a separate or independent cause of the accident; therefore, coverage for the accident was not triggered under AISLIC's CGL policy.[964] On the other hand, the lower court found that Wilson's trucks tracked mud and clay onto the public road and that commercial activity triggered coverage under EMCASCO's automobile insurance policy.[965] EMCASCO appealed.[966]

On appeal, EMCASCO argued that (1) the district court's interpretation of the "automobile exclusion" clause in AISLIC's CGL policy was erroneous; (2) the damages that the Langstons sought did not arise out of the use of a vehicle; and (3) the district court's decision was erroneous because the lower court did not address the coverage issue, using one of Texas's doctrines of

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957. *Id.*

958. *Id.*

959. *Id.*

960. *Id.* at 520, 524 ("[I]n a subrogation case such as this, Texas law recognizes the right of one insurer to seek payment from a second insurer under the doctrine of equitable subrogation."); *see also* Gen. Star Indem. Co. v. Vesta Fire Ins. Co., 173 F.3d 946, 949 (5th Cir. 1999) (defining equitable subrogation as "the legal fiction through which a person or entity, the subrogee," becomes a substitute for the insured or one entitled to secure "the rights and remedies of another by virtue of having fulfilled an obligation for which the other was responsible"); 16 LEE R. RUSS & THOMAS F. SEGALIO, COUCH ON INSURANCE § 223:134, at 147-48 (3d. ed. 2000) (stating that generally, "under the doctrine of equitable subrogation . . . [when] an insured is entitled to receive recovery for the same loss from . . . the insurer and the tortfeasor, it is only after the insured has been fully compensated for all of the loss that the insurer acquires a right to subrogation"); 6A JOHN ALAN APPLEMAN & JEAN APPLEMAN, INSURANCE LAW AND PRACTICE § 4121, at 395 (1972) ("An insurer [will not] be subrogated to the rights of the insured unless it had paid the loss in full.").

961. *EMCASCO*, 438 F.3d at 520, 524.

962. *Id.* at 523.

963. *Id.*

964. *Id.*

965. *Id.*

966. *Id.*

contract interpretation.[967]

To address EMCASCO's concerns, the Fifth Circuit examined the coverage provision, "Insuring Agreement § 1(a)," in AISLIC's CGL policy.[968] It states:

> We will pay those sums that the insured becomes legally obligated to pay as damages because of bodily injury or property damage to which this Coverage applies. We will have the right and duty to defend any suit seeking those damages. However, we will have no duty to defend the insured against any suit seeking damages for bodily injury or property damage to which this Coverage does not apply. We may, at our discretion, investigate any occurrence and settle any claim or suit that may result.[969]

The court of appeals also reviewed the automobile exclusion clause, "Exclusions § 2(g): Aircraft, Auto or Watercraft," in AISLIC's insurance contract.[970] The exclusion clause read as follows: "This insurance does not apply to . . . [b]odily injury or property damage arising out of the ownership, maintenance, use or entrustment to others of any aircraft, auto or watercraft owned or operated by or rented or loaned to any insured. Use includes operation and loading or unloading."[971]

Under Texas law, the "eight corners rule" or "complaint allegation rule" determines whether an insurer has a duty to defend.[972] First, a court must examine the allegations in a third party victim's most recent amended pleading, along with the coverage clause in a liability insurance contract.[973]

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967. *Id.*

> [Conversely, AISLIC argued that] the policies . . . contain[ed] no ambiguity . . . . Second, it [argued] that EMCASCO's proposed reading of the policies [did] not favor the insured, Wilson-Riley, because EMCASCO's interpretation merely shift[ed] the coverage for the underlying settlement from EMCASCO to AISLIC, yielding no benefit to Wilson-Riley. Finally, AISLIC maintain[ed] that EMCASCO's interpretation of the policies [was] unreasonable because it [was] inconsistent with Texas law and relie[d] on caselaw that is inapposite to the facts.

Id.

968. *Id.*

969. *Id.* at 521.

970. *Id.*

971. *Id.*

972. *Id.* at 524.

973. *See* Canutillo Indep. Sch. Dist. v. Nat'l Union Fire Ins. Co., 99 F.3d 695, 701 (5th Cir. 1996) (applying Texas law and declaring that "[t]he duty to defend arises only when the facts alleged in the complaint, if taken as true, would *potentially* state a cause of action falling within the terms of the policy"); Rhodes v. Chi. Ins. Co., 719 F.2d 116, 119 (5th Cir. 1983) (holding that "[t]he duty to defend is determined by examining the latest amended pleading upon which the insurer based its refusal to defend the action"). Furthermore, the insured has the initial burden to show that the alleged facts in the third party petition state a potential claim against him. *Rhodes*, 719 F.2d at 119. To defeat the duty-to-defend claim, the insurer bears the burden of showing that the plain language of a policy exclusion or limitation allows the insurer to avoid coverage of *all* claims, also within the confines of the eight corners rule. *Id.*; *see* TEX. INS. CODE ANN. art. 21.58(b) (Vernon Supp. 1997); Calderon v. Mid-Century Ins. Co. of Tex., 1998 WL 898471, at *2 (Tex. App.—Austin Dec. 29, 1998, pet. denied) (citing E&L Chipping Co. v. Hanover Ins. Co., 962

"'If a petition does not allege facts within the scope of coverage, an insurer is not legally required to defend a suit against its insured.'"[974]

Furthermore, Texas courts must focus their inquiry on the third party's alleged facts and not on the asserted legal theories.[975] If doubt exists as to whether the third party's allegations state a cause of action under the coverage clause, courts must resolve all doubt in favor of the insured and order the insurer to defend the insured.[976] On the other hand, if the third party complaint only alleges facts which are excluded under the policy, the liability insurer has no duty to defend.[977]

In the Langstons' amended petition, they "alleged that the . . . wrongful death . . . was caused by an accident resulting from [Wilson's] . . . use [of] the trucks."[978] Reading that allegation in light of the coverage provision in EMCASCO's commercial auto liability, the Fifth Circuit declared the contract covered the accident and that EMCASCO had a duty to defend Wilson.[979] On appeal, however, EMCASCO argued that AISLIC had a duty to indemnify EMCASCO, a subrogee, under the doctrine of equitable subrogation.[980] Under Texas law, a duty to defend and a duty to indemnify are separate doctrines.[981] In addition, the duty to indemnify is not based on the allegations appearing in a third party complaint.[982] More important, no duty to indemnify arises in Texas unless the underlying litigation establishes liability for damages, which the liability insurance contract covers.[983]

S.W.2d 272, 274 (Tex. App.—Beaumont 1998, no pet.)); Butler & Binion v. Hartford Lloyd's Ins. Co., 957 S.W.2d 566, 568 (Tex. App.—Houston [14th Dist.] 1995, writ denied).

974. King v. Dallas Fire Ins. Co., 85 S.W.3d 185, 187 (Tex. 2002) (quoting Trinity Universal Ins. Co. v. Cowan, 945 S.W.2d 819, 821-22 (Tex. 1997)).

975. *See* St. Paul Fire & Marine Ins. Co. v. Green Tree Fin. Corp.-Tex., 249 F.3d 389, 392 (5th Cir. 2001) (applying Texas law).

976. *See* Nat'l Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc., 939 S.W.2d 139, 141 (Tex. 1997) (noting that courts give the petition's allegations a liberal interpretation).

977. *See* Fidelity & Guar. Ins. Underwriters, Inc. v. McManus, 633 S.W.2d 787, 788 (Tex. 1982); *see also Cowan*, 945 S.W.2d at 828-29 (declaring that facts ascertained before a suit, developed in the process of litigation, or determined by the ultimate outcome of the suit do not affect the duty to defend).

978. EMCASCO Ins. Co. v. Am. Specialty Lines Ins. Co., 438 F.3d 519, 524 (5th Cir. Jan. 2006).

979. *Id.*

980. *Id.*

981. *See* Farmers Tex. Co. Mut. Ins. Co. v. Griffin, 955 S.W.2d 81, 82 (Tex. 1997) (declaring that an insurer may have a duty to defend but no duty to indemnify).

982. *See, e.g.*, Tesoro Pet. Corp. v. Nabors Drilling USA, Inc., 106 S.W.3d 118, 125 (Tex. App.—Houston [1st Dist.] 2002, pet. denied) (declaring that facts rather than allegations determine an indemnitor's duty to indemnify).

983. *See Griffin*, 955 S.W.2d at 84 (holding that the duty-to-indemnify question is only justiciable under Texas law after liability has been established in the underlying suit unless "the same reasons that negate the duty to defend likewise negate any possibility the insurer will ever have a duty to indemnify"); Comsys Info. Tech. Servs., Inc. v. Twin City Fire Ins. Co., 130 S.W.3d 181, 190 (Tex. App.—Houston [14th Dist.] 2003, no pet.); Collier v. Allstate County Mut. Ins. Co., 64 S.W.3d 54, 62 (Tex. App.—Fort Worth 2001, no pet.) (declaring that "the duty to indemnify only arises after an insured has been adjudicated, whether by judgment or settlement, to be legally responsible for damages in a lawsuit").

So, did AISLIC have a duty to indemnify EMCASCO? Once more, the Langstons alleged that Wilson's use of trucks to haul sand was the cause of the wrongful death.[984] But the exclusion clause in AISLIC's insurance contract clearly stated that "[t]his insurance does not apply to . . . [b]odily injury . . . arising out of the . . . use . . . of any . . . auto . . . owned or operated by . . . any insured. Use includes operation and loading or unloading."[985] A fair reading of the language in the complaint and in the exclusion clause leads one to conclude that AISLIC's contract excluded coverage for the wrongful death, therefore obliterating AISLIC's alleged duty to indemnify EMCASCO.[986]

Curiously, the Fifth Circuit cited, misstated, and incorrectly applied Texas's "complete operation theory," thereby reaching a different and arguably extremely questionable conclusion.[987] In *Travelers Insurance Co. v. Employers Casualty Co.*, the Texas Supreme Court described the theory this way: Under a liability insurance contract, coverage is not limited to the insureds' acts when the insured simply loads or unloads a vehicle.[988] Instead, "loading and unloading" means the complete operation—the entire process of transporting goods between a vehicle and the places from which and to where they are delivered.[989]

The complete operation theory is designed to expand the definition of the term use under a liability insurance contract.[990] Without more, *Travelers* certainly could not help enhance either EMCASCO or AISLIC's defense, because use was not an issue before the district court.[991] Therefore, to present a more convincing analysis and conclusion, the current Fifth Circuit panel cited its own modified version of Texas's complete operation theory in *Red Ball Motor Freight, Inc. v. Employers Mutual Liability Insurance Co. of Wisconsin.*[992]

In *Red Ball*, a different Fifth Circuit panel incorrectly cited the Texas Supreme Court's ruling in *Travelers*[993] and held that federal courts must

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984. *EMCASCO*, 438 F.3d at 524.

985. *Id.* at 521.

986. *Id.* at 521-22.

987. *Id.*

988. Travelers Ins. Co. v. Employers Cas. Co., 380 S.W.2d 610, 612 (Tex. 1964).

989. *Id.* at 612.

990. *See id.*

991. *EMCASCO*, 438 F.3d at 521-23.

992. *Id.* (citing Red Ball Motor Freight, Inc. v. Employer's Mut. Liab. Ins. Co. of Wis., 189 F.2d 374, 377 (5th Cir. 1951)).

993. *Id.* at 524. The Fifth Circuit panel in *Red Ball* created a modified rule for Texas out of thin air. That panel stated:

> [T]he theory adopted in Texas [is] generally known as the 'complete operation theory,' [which] holds that the provision for use coverage extends to foreseeable consequences of what was done in connection with the use of the car, whether before, after, or during loading or unloading, so long as the act or thing done by the insured's employee which causes the accident arises out of the use of the insured's car.

Red Ball, 189 F.2d at 377. But, the Fifth Circuit did not cite any Texas cases that clearly outlined this

address two issues when applying Texas's complete operation theory: (1) "whether [an] insured's act was an act incident to . . . the use of [a] truck"[994] and (2) "whether that act proximately caused plaintiff's injury."[995] Applying the modified rule and considering the first element, the Fifth Circuit "reject[ed] EMCASCO's contention that . . . 'the phrase "arising out of" . . . the use . . . require[s a] contemporaneous use of the insured's vehicle.'"[996] Put simply, the opinion's analysis and conclusion are highly unintelligible and arguably irrelevant.[997]

The facts revealed that Wilson's trucks tracked mud onto the public road.[998] Therefore, turning to the second element, the Fifth Circuit stated the importance of determining whether the tracking of mud onto the highway was the proximate cause of the wrongful death.[999] The appeals court observed: "If the factfinder determines that the insured's act in connection with the use of the vehicle did not proximately cause the injuries, the insured is not liable, and the insurer has no duty to indemnify."[1000]

The Fifth Circuit found that AISLIC's policy covered the mud tracking which was "unrelated to the use of the trucks . . . ."[1001] Concluding that at least one genuine issue of material fact existed, the Fifth Circuit held that the district court's summary judgment in favor of AISLIC was improper.[1002] The court of appeals, therefore, remanded the case.[1003] The Fifth Circuit also instructed the district court to determine whether sufficient evidence existed to decide as a matter of law that heavy rains before the accident produced sufficient mud, which could have been the independent cause of the wrongful death, and whether that issue should be sent to a factfinder.[1004]

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expansion of Texas's complete operation theory. *Id.* The separate causation prong, foreseeable consequences, magically appeared in the doctrine.

994. *EMCASCO*, 438 F.3d at 525 n.3 (citing *Red Ball*, 189 F.2d at 377) (noting that coverage extends "so long as the act or thing done by the insured's employee which causes the accident arises out of the use of the insured's car).

995. *Id.* at 525 n.4 (citing *Red Ball*, 189 F.2d at 377) (stating that "the provision for use coverage extends to foreseeable consequences of what was done in connection with the use of the car").

996. *Id.* at 526 n.9.

997. *Id.* at 522-23.

998. *Id.* at 523.

999. *Id.* at 526.

1000. *Id.* at 526 n.10.

1001. *Id.* at 528.

> The non-excluded event, the washing of mud from the unpaved roadway, however, is covered by the general liability policy, because it could have independently caused the injuries. When two separate events—one that is excluded and one that is covered by the general liability policy —may independently have caused the accident, Texas law mandates that the general liability policy also provide coverage despite the exclusion.

Id. (citing Utica Nations Ins. Co. v. Am. Indem. Co., 141 S.W.3d 198, 204 (Tex. 2004)).

1002. *Id.*

1003. *Id.*

1004. *Id.*

Without doubt, *EMCASCO* is a poorly reasoned and an excruciatingly difficult to understand opinion, but it need not be. The complaining insurer simply asked the federal district and appellate courts, sitting in equity, to make a simple declaration.[1005] Instead, the district issued a summary judgment, and the Fifth Circuit wasted precious judicial resources attempting to explain why the summary judgment was erroneous.[1006] Elsewhere, this commentator has highlighted the problems and costs that summary judgment motions and practice present when litigants ask courts to make rulings in equitable actions, like those involving declaratory judgment and equitable subrogation.[1007]

Again, under Texas law, the doctrine of equitable subrogation allows a party or a subrogee who involuntarily pays another's debt to seek reimbursement from the person, who in equity and good conscience, should have paid the debt.[1008] Stated differently, equitable subrogation is intended to prevent the unjust enrichment of a debtor.[1009] To receive relief under an equitable subrogation action, a claimant must prove both that the other party or debtor was primarily liable for the debt and that the claimant paid the debt involuntarily.[1010] If the district and appellate courts had applied these rules, reviewed the undisputed facts carefully, and applied one of Texas's five doctrines of contract interpretation, the analysis in *EMCASCO* would have been more intelligible and the conclusion less troublesome.

6. Whether Under Texas Law a Liability Insurer Has a Duty to Defend and Indemnify an Insured Operator of a Refinery After the Refinery's Employees and Other Third Party Victims Commenced Personal Injury and Wrongful Death Actions Against the Refinery

The substantive question in *Motiva Enterprises, LLC v. St. Paul Fire and Marine Ins. Co.*, also centered on whether an insurer had a duty to defend and indemnify an insured, after third parties commenced a wrongful death and other tort actions against the insured.[1011] Motiva Enterprises, L.L.C. (Motiva)

1005. *Id.* at 519-28.

1006. *Id.* at 528.

1007. *See* Rice, *supra* note 77, at 638-39 nn.487-88.

> [T]exas's trial judges participate in another unsettling practice. Instead of conducting full-blown declaratory-judgment trials, trial judges regularly grant or deny summary-judgment motions without giving intelligible, meticulous, or studious explanations of their rulings. As a consequence, Texas's appellate courts must spend an enormous amount of time and limited judicial resources exploring various plausible theories to determine whether an unexplained summary-judgment ruling was sound or erroneous.

Id.

1008. *See* Brown v. Zimmerman, 160 S.W.3d 695, 700 (Tex. App.—Dallas 2005, no pet.).

1009. *See* First Nat. Bank of Kerrville v. O'Dell, 856 S.W.2d 410, 415 (Tex. 1993).

1010. *See* McBroome-Bennett Plumbing, Inc. v. Villa France, Inc., 515 S.W.2d 32, 36 (Tex. Civ. App. —Dallas 1974, writ ref'd n.r.e.); Argonaut Ins. Co. v. Allstate Ins. Co., 869 S.W.2d 537, 542 (Tex. App.—Corpus Christi 1993, writ denied).

1011. Motiva Enters., LLC v. St. Paul Fire & Marine Ins. Co., 445 F.3d 381, 381 (5th Cir. Mar. 2007).

is "a joint venture between Shell and Saudi Refining Inc. [that] refines, distributes, and markets oil products in the eastern and southern United States."[1012] In addition, Motiva refines and supplies gasoline to "approximately 7,600 Shell-branded gasoline stations."[1013] The company's principal place of business is Houston, Texas.[1014]

Motiva owns a refinery in Delaware, where John Beaver was an employee.[1015] In July 2001, a sulfuric acid storage tank at the Delaware refinery exploded.[1016] The explosion killed one employee and injured several others, including John Beaver.[1017] Along with numerous other victims, John and Pamela Beaver sued Motiva (the Beaver suit).[1018] Specifically, Motiva's coverage existed under two main "towers," which were known as the Continental Tower and St. Paul Tower.[1019] Both towers totaled seven insurance policies in all.[1020] Additionally, National Union Fire Insurance Co. of Pittsburgh (National) provided $25 million umbrella coverage, with the duty to indemnify and defend once the underlying insurance was exhausted.[1021]

Motiva contacted National in July 2002 and informed the insurer about the underlying lawsuits, including the Beaver suit.[1022] At that time, Motiva asked National to provide a legal defense.[1023] Initially, National balked.[1024] In May 2003, however, National sent a reservation-of-rights letter to Motiva that withdrew its denial of coverage but reserved the right to withhold or limit coverage under the terms and conditions of National's insurance contract.[1025] Two months later, Motiva informed National that St. Paul's insurance policy was exhausted and that the burden of defending the lawsuit shifted to National.[1026]

1012. *See* Motiva Enterprises, http://www.motivaenterprises.com/index.cfm (last visited Mar. 18, 2006).

1013. *Id.*

1014. *Id.*

1015. *Motiva*, 445 F.3d at 383.

1016. *Id.*

1017. *Id.*

1018. *Id.*

1019. *Id.*

1020. *Id.*

1021. *Id.*

1022. *Id.*

1023. *Id.*

1024. *Id.*

> In February 2003, National Union conditionally disclaimed coverage on the ground that the underlying insurance policies had not yet been exhausted. National Union reserved the right to supplement or amend its disclaimer in the future. When National Union did not withdraw its denial of coverage at Motiva's request, Motiva filed suit seeking a declaratory judgment of its coverage.

Id.

1025. *Id.*

1026. *Id.*

On August 6, National agreed to defend Motiva in the case and in the other pending lawsuits, but again, that defense was offered subject to a reservation of National's right to deny coverage.[1027] Under the insurance contract, Motiva had a duty to cooperate fully with National during the legal defense; therefore, National asked Motiva to participate in the Beaver mediation.[1028] But Motiva refused to give the Beaver documents to National.[1029] Still, a National representative attended the mediation, during which the *Beaver* complainants demanded $40 million to settle the lawsuit.[1030] Motiva, however, forced National's agent to leave and the mediation continued without National's presence.[1031] Motiva voluntarily settled the lawsuit voluntarily for $16,500,000.[1032]

Following the mediation, Motiva asked National to reimburse the settlement expenditures.[1033] National refused, asserting that Motiva had not secured its consent as required under the consent-to-settle clause in the insurance contract.[1034] Shortly thereafter, Motiva filed a breach-of-contract action against National in the District Court for the Southern District of Texas.[1035] In its complaint, Motiva argued that National had a duty to pay the cost of settling the Beaver claim.[1036] Both National and Motiva filed motions for summary judgment.[1037] Ultimately, the district court granted National's motion, holding that Motiva had breached conditions under the contract's consent-to-settle and cooperation clauses.[1038] Motiva appealed.[1039]

Before the Fifth Circuit, Motiva argued that the federal district court committed reversible error.[1040] First, reviewing the coverage clause, the court of appeals found that National indeed agreed to defend and indemnify Motiva once the underlying insurance policies were exhausted.[1041] But, as stated

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1027. *Id.*

1028. *Id.* at 383-84.

1029. *Id.*

> Motiva asked National Union to send a representative with full settlement authority to [mediate] the *Beaver* case that was scheduled for August 8, 2003. National Union immediately requested all documents related to *Beaver*, but on August 1, Motiva rejected the request, claiming that National Union had "never acknowledged coverage" for the *Beaver* claim. Despite that refusal, Motiva still demanded that National Union attend the mediation.

Id.

1030. *Id.* at 384.

1031. *Id.*

1032. *Id.*

1033. *Id.*

1034. *Id.*

1035. *Id.*

1036. *Id.*

1037. *Id.*

1038. *Id.*

1039. *Id.*

1040. *Id.*

1041. *Id.* at 383.

before, two conditions precedent were required.[1042] One condition appeared in the insurance contract's consent-to-settle provision: "No Insureds will, except at their own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent."[1043] The second condition appeared in the cooperation clause.[1044] It stated in pertinent part: "You and any other involved Insured must: . . . cooperate with us in the investigation, settlement or defense of the claim or suit."[1045]

Notwithstanding the conditions precedent appearing in those two clauses, Motiva insisted that it had a right to settle the Beaver lawsuit without consulting National and securing the insurer's consent.[1046] To justify its decision to settle the case independently, the company stressed that National's willingness to defend the underlying lawsuits was subject to a reservation of right to deny coverage at a later date.[1047] To prove that its decision to settle the suit without National's consent was legal, Motiva cited the Fifth Circuit's decision in *Rhodes v. Chicago Insurance Co.*[1048] In *Rhodes*, the court of appeals declared:

> If the insurer properly reserved its rights and the insured elected to pursue his . . . defense, the insurer is bound to pay damages which resulted from covered conduct and which were reasonable and prudent, up to the policy limits. . . . [T]he insured is not constrained by conditions in the policy which limit the insured's ability to settle the claim, and the insurer cannot complain about the insured's conduct of the defense.[1049]

But the present Fifth Circuit panel observed that the holding in *Rhodes* was an *Erie* guess of what the then Texas Supreme Court would have decided.[1050] Fifteen years after *Rhodes*, however, the Supreme Court of Texas decided *State Farm Lloyds Insurance Co. v. Maldonado*.[1051] In *Maldonado*, the supreme court held that an insured may sue an insurer and recover proceeds under a liability insurance contract, if the insurer agrees to defend the insured under a reservation of rights and the insured breaches a condition precedent in the insurance contract.[1052]

Therefore, embracing *Maldonado*, the Fifth Circuit concluded that the district court's ruling was proper: Even though National reserved its right to

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1042. *Id.* at 384.
1043. *Id.* at 383 n.1.
1044. *Id.*
1045. *Id.* at 383 n.2.
1046. *Id.* at 383.
1047. *Id.* at 384.
1048. *Id.* (citing Rhodes v. Chi. Ins. Co., 719 F.2d 116, 121 (5th Cir. 1983)).
1049. *Rhodes*, 719 F.2d at 121.
1050. *Motiva*, 445 F.3d at 385.
1051. State Farm Ins. Co. v. Maldonado, 963 S.W.2d 38, 38 (Tex. 1998).
1052. *Id.* at 40.

contest coverage and refused to offer an unqualified legal defense, Motiva had no right to breach the consent-to-settle clause and settle the underlying lawsuit without National's consent.[1053] Still, Motiva argued that National must pay the policy benefits, unless National could prove that Motiva's breach prejudiced the insurer's rights under the contract.[1054]

To prove that National had to show prejudice, Motiva cited the Texas Supreme Court's decision in *Hernandez v. Gulf Group Lloyds*.[1055] In *Hernandez*, the supreme court held that an insurer may escape liability—assuming the insured settled without the insurer's consent—only when the insured's breach of a condition actually prejudiced the insurer's interests or rights under the insurance contract.[1056] On the other hand, a court must force an insurer to fulfill its obligation and provide coverage when the insured's breach of a condition is not material and has not prejudiced the insurer's benefit of the bargain under the contract.[1057]

Citing a recent Fifth Circuit panel's application of *Hernandez* in *Ridglea Estate Condominium Ass'n v. Lexington Insurance Co.*, the current Fifth Circuit panel concluded that after an insured breaches a prompt-notice or a consent-to-settle provision, whether an insurer must demonstrate prejudice before breaching its obligations is not conclusively clear under Texas law.[1058] Therefore, without deciding whether the insurer must show prejudice to avoid its contractual obligations when the insureds breach the consent-to-settle provision, the Fifth Circuit concluded that National was prejudiced as a matter of law.[1059] And of course, that ruling removed the court of appeals' burden of

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1053. *Motiva*, 445 F.3d at 385 (citing *Maldonado*, 963 S.W.2d 38 at 38). An insurer that "tenders a defense with a reservation of rights is entitled to enforce a consent-to-settle clause." *Id.*

1054. *Id.*

1055. *Id.* (citing Hernandez v. Gulf Group Lloyds, 875 S.W.2d 691, 1692 (Tex. 1994)).

1056. *Hernandez*, 875 S.W.2d at 692.

1057. *Id.* at 693.

1058. *Motiva*, 445 F.3d at 386 (citing Ridglea Estate Condo. Ass'n v. Lexington Ins. Co., 415 F.3d at 476, 480 n.4 (5th Cir. July 2005)).

> [A] panel of this court recently applied *Hernandez* . . . . The insurer argued that it had no obligation under the policy because the insured failed to give "prompt notice of the loss or damage" to covered property. . . . The panel . . . concluded that although notice of damage was not prompt, the district court erred in holding that the insurer was not required to show prejudice in order to rely on the prompt notice provision as a defense. The panel carefully noted, however, that it "[did] not read *Hernandez* as necessarily creating a prejudice requirement for all insurance policies issued in Texas."

Motiva, 445 F.3d at 386. A breach of a notice provision is a "condition precedent" to the insurer's liability, not a "covenant"; thus, the insurer is not required to show prejudice from the breach. *Id.* at 386 n.5 (citing *PAJ Inc. v. Hanover*, 170 S.W.3d 258, 260-61 (Tex. App.—Dallas 2005)).

1059. *Id.* at 386-87.

> An insurer's right to participate in the settlement process is an essential prerequisite to its obligation to pay a settlement. When . . . the insurer is not consulted about the settlement . . . and the insurer has no opportunity to participate in or consent to the ultimate settlement decision, we conclude that the insurer is prejudiced as a matter of law. Under these circumstances the breach of the consent-to-settle provision in the policy precludes this action.

Id.

deciding whether Motiva's breach of the cooperation clause precluded recovery under the insurance contract.[1060]

7. Whether Under Texas Law an Excess Liability Insurer Has Duty to Defend and Indemnify Its Insured After the Receiver for the Injured Judgment Creditor Sues the Excess Insurer in a Third Party Personal Injury Suit

Minter v. Great American Insurance Co. of New York is another case in which a complainant asked the federal court to determine whether an insurer has a duty to defend and indemnify under a liability insurance contract.[1061] But unlike other cases discussed in this presentation, the facts in *Minter* are extremely complex.[1062] For that reason, the Fifth Circuit's analysis is quite extensive and complicated.[1063] Yet, if the court had spent less time sifting through arguably irrelevant facts and more time applying one of Texas's doctrines of contract interpretation, the analysis in *Minter* would have been more instructive.

Hammer Trucking, Inc. (Hammer) does business in Texas and elsewhere.[1064] Jerry Lee Largent was Hammer's employee.[1065] On June 27, 1996, JTM Materials, Inc. (JTM) leased an tractor-trailer truck from Hammer.[1066] Under the lease, Hammer assumed several contractual duties: (1) to maintain control of the truck, (2) to use the truck exclusively for the benefit of JTM, (3) to ensure the truck was safe and performed properly, (4) to pay all maintenance and operating expenses and (5) to select a driver and pay the driver's salary.[1067] To comply with the latter, Hammer selected Largent to drive the truck "exclusively for JTM's benefit."[1068]

Largent lived in Bridgeport, Texas, and in early November 1996, Don Hammer, the owner and president of Hammer Trucking, instructed Largent to deliver the truck to a maintenance facility near Decatur, Texas.[1069] Hammer had scheduled an inspection and services for the truck to comply with one of Hammer's duties under the lease.[1070] As Largent was driving the tractor-trailer truck to Decatur, he collided with another vehicle.[1071] Grant Morris was the

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1060. *Id.* at 387.
1061. Minter v. Great Am. Ins. Co. of N.Y., 423 F.3d 460, 462 (5th Cir. June 2005).
1062. *Id.*
1063. *See id.*
1064. *Id.*
1065. *Id.*
1066. *Id.*
1067. *Id.*
1068. *Id.*
1069. *Id.*
1070. *Id.*
1071. *Id.*

owner and driver in the other vehicle.[1072] Moreover, Largent was intoxicated when the accident occurred.[1073] Later, Largent pleaded guilty to the charge of driving while intoxicated.[1074]

In May 1997, Morris filed a multiple-claims lawsuit against Largent, Hammer Trucking, and JTM in a Texas court.[1075] At that time, St. Paul Fire and Marine Insurance Company (St. Paul), the primary insurer, insured JTM under a commercial automobile liability insurance contract.[1076] The policy limit was $1 million for each accident that a covered automobile caused.[1077] In addition, Great American Insurance Company (Great American) insured JTM under an excess liability insurance policy.[1078] Great American agreed to provide excess coverage after the primary insurance coverage was exhausted.[1079]

Therefore, in the underlying litigation, St. Paul defended JTM against Morris's actions, and the Texas court granted JTM's motion for summary judgment.[1080] A jury tried the suit against Hammer and Largent.[1081] But St. Paul did not defend Hammer or Largent.[1082] Instead, the latter defendants defended themselves pro se.[1083] Morris received a directed verdict against Hammer and Largent, finding that Largent was acting within the scope of his employment with Hammer when the accident occurred and that Largent was a permissive user of the truck.[1084] The jury awarded approximately $2.6 million in damages, along with very substantial pre- and post-judgment interest.[1085] The jury also found that Hammer and Largent's conduct was malicious.[1086] Consequently, they assessed $1.65 million and $300,000 in exemplary damages against Largent and Hammer, respectively.[1087]

1072. *Id.*
1073. *Id.*
1074. *Id.*
1075. *Id.* at 463. The complaint listed the following causes of action and allegations: (1) Largent's alleged common law negligence and negligence per se; (2) Hammer and JTM's alleged negligent hiring, retention and supervision of Largent, negligent entrustment, and vicarious liability; (3) JTM's liability based on joint enterprise, joint venture, and civil conspiracy theories; (4) JTM's liability for Largent's conduct based on statutory violation and on the doctrine of borrowed-servant; and (5) JTM's alleged liability under the Federal Motor Carrier Safety Regulations. *Id.*
1076. *Id.*
1077. *Id.* at 462.
1078. *Id.*
1079. *Id.*
1080. *Id.* at 463.
1081. *Id.*
1082. *Id.*
1083. *Id.*
1084. *Id.*
1085. *Id.*
1086. *Id.*
1087. *Id.*

Hammer and Largent did not appeal the verdict and judgment.[1088] Morris, however, appealed JTM's favorable summary judgment award to the Fort Worth Court of Appeals, where that Texas appellate court remanded the case to the trial court after partially affirming and vacating some of the lower court's rulings.[1089] But even before Morris's appeal, the Texas trial court had acted to ensure that Largent satisfied Morris's judgment.[1090] The lower court ordered Largent to transfer his assets to Darrell Minter, an appointed receiver for Morris.[1091]

Largent transferred all of his alleged claims and causes of action against St. Paul and Great American.[1092] The transferred claims against the primary an excess insurers included the following: (1) breach of contract for failing to defend Largent in the underlying lawsuit, (2) failure to indemnify Largent under JTM's insurance contracts, (3) common law, bad faith refusal to defend Largent in the underlying action, (4) statutory violation of the Unfair Competition and Unfair Practices Act, and (5) statutory violation of the Texas Deceptive Trade Practices Act.[1093]

To satisfy Morris's multimillion-dollar judgment, Minter sued St. Paul in a Texas state court.[1094] Ultimately, St. Paul paid $1.9 million, which effectively settled all of Morris's claims and actions against both JTM and Hammer.[1095] Although that settlement completely exhausted JTM's primary coverage under St. Paul's $1 million insurance contract, it did not cover the remaining part of the judgment against Largent.[1096] To secure the additional damages, Minter, Morris's receiver, filed a diversity lawsuit against Great American in the District Court for the Northern District of Texas.[1097] Both Great American and Minter moved for summary judgment.[1098]

1088. *Id.*

1089. *Id.* at 463-64.

> The Fort Worth Court of Appeals (1) vacated that judgment for part of the vicarious liability claims and for the claims for negligent hiring, retention, supervision, and entrustment, and remanded for trial on those issues, and (2) affirmed for *respondeat superior*, civil conspiracy, joint venture and joint enterprise. In vacating the summary judgment awarded JTM for part of Morris' vicarious liability claims, the court held: if JTM was a federally regulated motor carrier, it was liable, as a matter of law, under the Federal Motor Carrier Safety Regulations. Importantly, in affirming JTM's summary judgment against Morris' *respondeat superior* claim, the court held: Largent was *acting outside the scope of his employment* at the time of the collision. (The record is silent concerning the disposition of this matter on remand.).

Id. at 464-65 (citing Morris v. JTM Materials, Inc., 78 S.W.3d 28, 43, 51-53 (Tex. App.—Fort Worth 2002, no pet.)) (other citations omitted).

1090. *Id.* at 464.

1091. *Id.*

1092. *Id.*

1093. *Id.*

1094. *Id.*

1095. *Id.*

1096. *Id.*

1097. *Id.*

1098. *Id.* at 464.

The district court granted Great American's motion for summary judgment, in light of the Fort Worth Court of Appeals' favorable summary judgment ruling in favor of JTM.[1099] The district court found the following: (1) Minter was collaterally estopped from asserting that Largent was acting within the scope of his employment when the collision occurred; (2) Great American's assertion that Largent was not a permissive user of the trailer truck was a valid defense, notwithstanding the Texas trial court's judgment because this issue was vigorously litigated in the state court; (3) Largent's decision to use the truck while he was intoxicated was beyond the scope of Hammer or JTM's permission; (4) a TE 9916 endorsement and the "exclusive use" clause under the St. Paul policy did not cover the accident because Largent had no ownership interest in the truck; (5) the MCS-90 endorsement to the St. Paul insurance contract did not cover Largent because it served only as an independent basis for coverage when other coverage was absent; (6) Great American's excess policy did not cover the underlying third party claims because St. Paul's policy—the underlying primary insurance contract—did not cover the accident; and (7) because the Great American excess policy did not cover any of the third party claims, Minter's extra-contractual tort claims were barred as a matter of law.[1100] Minter appealed.[1101]

The Fifth Circuit began its analysis by examining the coverage clause in Great American's excess contract.[1102] Under sections II(B)(1) and II(B)(5) the definition of an "insured" included the following persons:

> "Your [JTM's] employees, other than your executive officers, but only for acts within the scope of their employment . . . . [and any] other person or organization who is insured under any policy of [the] 'Underlying Insurance.' The coverage afforded such 'Insureds' under this policy will be no broader than the 'Underlying Insurance' except for this policy's Limit of Insurance."[1103]

Also, St. Paul's primary insurance contract was catalogued in the Great American policy's schedule of underlying insurance contacts.[1104]

On appeal, Minter asserted that Largent was JTM's "statutory employee" under the Federal Motor Carrier Safety Regulations (FMCSR) and was acting within the scope of his employment.[1105] Consequently, according to Minter, JTM, and Great American were vicariously liable for Largent's negligence.[1106]

1099. *Id.*
1100. *Id.* at 464.
1101. *Id.* at 461.
1102. *Id.* at 465.
1103. *Id.*
1104. *Id.*
1105. *Id.*
1106. *Id.*

Great American disagreed.[1107] To resolve this issue, the Fifth Circuit had to determine whether Largent was an insured under either the excess or primary insurance contracts.[1108]

First, the court of appeals observed that the "permissive user" or "omnibus clause" in St. Paul's primary policy defined an "insured" as anyone who used a covered vehicle that JTM leased or borrowed with JTM's permission.[1109] Because all parties agreed that the truck was a covered auto under St. Paul's policy, the issue became whether Largent was using the vehicle with JTM's permission when the collision occurred.[1110] Under Texas law, an owner's "consent to use the vehicle at the time and place in question and in a manner authorized by the owner, either express or implied" is the definition of permissive use.[1111] Also, the Texas Supreme Court's ruling in *Royal Indemnity Co. v. H.E. Abbott & Sons, Inc.* is worth stating here: "[A]lthough express permission requires an affirmative statement," one may infer implied permission "'from a course of conduct or relationship between the parties in which there is mutual acquiescence or lack of objection signifying consent.'"[1112]

Examining the undisputed facts more closely, the Fifth Circuit found that Hammer Trucking had the exclusive responsibility for maintaining the truck.[1113] On the night of the collision, Largent had secured Don Hammer's express permission to drive the truck to the maintenance facility in Decatur, Texas.[1114] But the federal district court found that the accident occurred in Bridgeport as Largent returned home after visiting his sister's house.[1115] Great American argued Largent's visit to his sister's house was a personal errand.[1116] The district court agreed, finding that Largent's familial visit was deviation

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1107. *Id.*

1108. *Id.*

1109. *Id.* at 466; *see* BLACK'S LAW DICTIONARY 1121 (8th ed. 2004) (defining "omnibus clause" as "[a] provision in an automobile-insurance policy that extends coverage to all drivers operating the insured vehicle with the owner's permission").

1110. *Minter*, 423 F.3d at 466.

1111. Hartford Accident & Indem. Corp. v. Lowery, 490 S.W.2d 935, 937 (Tex. Civ. App.—Beaumont 1973, writ ref'd n.r.e.).

1112. Royal Indemnity Co. v. H.E. Abbott & Sons, Inc., 399 S.W.2d 343, 345 (Tex. 1966).

1113. *Minter*, 423 F.3d at 466.

1114. *Id.*

1115. *Id.* at 462.

> On the day of the collision, Largent, who lived in Bridgeport, Texas, was in the process of delivering the truck to a facility near Decatur, Texas, for scheduled maintenance .... That day, Largent had been instructed ... to deliver the truck by 9:00 a.m. the next day (Sunday ...). At approximately 11:00 p.m. Saturday ..., Largent drove the truck to his sister's house, also located in Bridgeport, in order for her to give him a ride back from the maintenance facility in Decatur. Because his sister could not give him a ride, Largent ... decided to return to his house and take the truck to the maintenance facility the next morning. The collision occurred while he was returning home.

Id.

1116. *Id.* at 466.

from the express, permissible bounds that Hammer had set before Largent began the trip to Decatur.[1117]

The Fifth Circuit, however, concluded that the district court's summary judgment ruling in favor of Great American was erroneous in part because whether Largent had express permission to drive the truck to his sister's house created a genuine material question of fact.[1118] Largent insisted that he had received Hammer's express permission to secure a ride from his sister after he delivered the truck.[1119] Furthermore, the Fifth Circuit found competent summary judgment evidence suggesting a genuine question of fact about another issue: whether Largent had implied permission to drive to his sister's house.[1120]

The court of appeals noted that Largent's sister lived "approximately one mile from [Largent's] apartment" and "Hammer allowed Largent to keep the truck at his apartment—because [Largent] had no other regular transportation to and from work."[1121] The Fifth Circuit concluded that these two bits of information could suggest that Hammer impliedly consented to Largent's deviating from a planned course of conduct.[1122] And that would preclude Great American's receiving a favorable summary judgment.[1123]

Still, even if Largent received Hammer's express or implied permission to drive to his sister's house, the court of appeals had to address another equally important issue before vacating the district court's summary judgment in favor of the excess insurer.[1124] The Fifth Circuit had to decide whether Largent's use of the truck while intoxicated was beyond Hammer's express or implied permission to operate the vehicle.[1125] And if so, the court of appeals had to decide whether that deviation was minor or material.[1126]

In *Coronado v. Employers' National Insurance Co.*, the Texas Supreme Court embraced the minor deviation rule to determine whether an operator's use of a vehicle deviated from the scope of the vehicle's intended use.[1127]

1117. *Id.*

> Driving to [Largent's] sister's house was outside the scope of the permission expressly granted to [him], as he was only given express permission to take the truck to the maintenance yard[, but] [a]t the state court trial . . . Don Hammer testified that he gave Largent permission to go to his sister's house to secure a ride back from the maintenance yard.

Id.

1118. *Id.* at 466-67.

1119. *Id.*

1120. *Id.* at 467.

1121. *Id.*

1122. *Id.*

1123. *Id.* at 467. "Implied permission may be inferred from a course of conduct or relationship between the parties in which there is mutual acquiescence or lack of objection signifying consent." *Id.* (citing Royal Indem. Co. v. H.E. Abbott & Sons, Inc., 399 S.W.2d 343, 345 (Tex. 1966)).

1124. *See id.*

1125. *See id.*

1126. *See id.*

1127. Coronado v. Employers' Nat'l Ins. Co., 596 S.W.2d 502, 503 (Tex.1979).

Under the rule, courts must determine whether the deviation was minor or material, taking into account a number of factors, including the extent of the spatial and temporal deviation, as well as the lender or owner's reasons for giving the operator permission to use the vehicle.[1128] Minor deviations do not create genuine issues of fact, although "more significant deviations may create triable questions of fact.[1129] Other deviations, however, will revoke a grantor's permission—as a matter of law—if a court concludes that those deviations are material.[1130]

In the present case, the federal district court found that Largent operated the truck while he was intoxicated and therefore deviated from the intended use of the truck.[1131] More important, the lower court found that Largent's driving while intoxicated was a material deviation as a matter of law and therefore, JTM and Hammer's permission was revoked.[1132] To decide whether that conclusion was warranted, the Fifth Circuit carefully reviewed the facts and holdings in three somewhat similar cases: *Coronado*, *Old American County Mutual Fire Insurance Co. v. Renfrow*, and *Royal Indemnity*.[1133]

In *Coronado*, the employee and driver of the company's pickup truck left work at 4:15 p.m. with his work crew.[1134] Instead of taking the crew members to their respective homes, however, the employee took them to a local bar.[1135] After leaving the bar eight hours later, the employee-driver collided with another vehicle, causing the death of a passenger.[1136] In the underlying wrongful death action, the third party asserted that the employer's liability policy contained an omnibus clause rendering the driver a permissive user.[1137] The Texas Supreme Court concluded that the eight-hour deviation was a gross, material deviation as a matter of law.[1138] The supreme court found that the employee's use of the vehicle exceeded the scope of the permission that the company had granted.[1139] Consequently, whether the employer had impliedly or expressly consented to the deviation was not a question of fact.[1140]

1128. *Id.* at 504-05.

1129. *Id.* at 506.

1130. *Id.*

1131. *Minter*, 423 F.3d at 467.

1132. *Id.* (citing Minter v. Great Am. Ins. Co., No. 3:02-CV-2040-K, 2004 WL 515615, at *7 (N.D. Tex. Feb. 27, 2004)).

1133. *Coronado*, 596 S.W.2d at 506; Old Am. County Mut. Fire Ins. Co. v. Renfrow, 130 S.W.3d 70, 74 (Tex. 2004) (per curiam); Royal Indem. Co. v. H.E. Abbott & Sons, Inc. 399 S.W.2d 343, 345 (Tex. 1966).

1134. *Coronado*, 596 S.W.2d at 503-04.

1135. *Id.* at 503.

1136. *Id.*

1137. *Id.* at 504.

1138. *Id.* at 506.

1139. *Id.*

1140. *Id.*

In *Renfrow*, a similar omnibus clause in an automobile liability insurance contract generated a heated debate.[1141] The employer gave an employee permission to drive the company's truck to the employee's home after work and instructed the employee to return the vehicle to the job site the next morning.[1142] Instead, the employee drove approximately forty miles from the work site to visit his girlfriend.[1143] The employee killed his girlfriend in a single-vehicle accident.[1144] The *Renfrow* court found that the employee removed the truck from the boundaries set by the employer and concluded, therefore, that the forty-mile trip to the girlfriend's house was a material deviation as a matter of law.[1145]

Finally, in *Royal Indemnity*, a ranch owner hired a laborer to work on his ranch that was located approximately fourteen miles northwest of Ballinger, Texas.[1146] The employee had permission to drive two trucks as needed in his duties.[1147] One Saturday, the rancher and laborer made a round-trip to Bronte, Texas.[1148] After returning to the ranch, each drank two bottles of beer.[1149] That same evening, and without receiving the rancher's permission, the employee drove one of the trucks to San Angelo, which is approximately fifty miles away from the ranch.[1150] The employee went to San Angelo for personal reasons.[1151]

During the trip, the worker bought and drank more beer.[1152] Eventually, the laborer lost control of the vehicle and ran into a building.[1153] A jury found that the worker's decision to drive the truck to San Angelo was within the scope of the rancher's implied permission; therefore, the omnibus clause in the rancher's automobile insurance contract covered the accident.[1154] The Texas Supreme Court disagreed, finding that the employee had never driven a work truck off the ranch, except when the rancher specifically instructed the employee to do so.[1155] In addition, the Texas Supreme Court found that the employee had never used the trucks for personal reasons.[1156] Therefore, the court reversed the jury's verdict and the lower court's judgment, concluding that the evidence did not show "a relationship nor a prior course of conduct

1141. Old Am. County Mut. Fire Ins. Co. v. Renfrow, 130 S.W.3d 70, 71-72 (Tex. 2004).
1142. *Id.*
1143. *Id.* at 71-72.
1144. *Id.*
1145. *Id.* at 73.
1146. Royal Indem. Co. v. H.E. Abbott & Sons, Inc., 399 S.W.2d 343, 344 (Tex 1966).
1147. *Id.*
1148. *Id.*
1149. *Id.* at 344-45.
1150. *Id.*
1151. *Id.* at 345.
1152. *Id.*
1153. *Id.*
1154. *Id.* at 344.
1155. *Id.* at 347.
1156. *Id.*

from which [an] implied permission might fairly be inferred."[1157]

After reviewing these cases, the Fifth Circuit observed that the *Royal Indemnity* court did not consider the employee's intoxication to reach a decision, even though undisputed facts indicated that the employee's intoxication caused the accident.[1158] Instead, the *Royal Indemnity* court focused primarily on the distance and length of the employees' deviation from the scope of the employers' permission.[1159] But the Fifth Circuit also observed that the *Coronado* court considered the employee's intoxication before finding a material deviation as a matter of law.[1160]

Embracing the view that intoxication is an "other factor" that courts must consider when determining whether a deviation is material or the extent of the deviation, the Fifth Circuit concluded that whether Largent's intoxication placed his use of the truck outside the scope of permission was a genuine question of fact.[1161] Reversing the district court's summary judgment award in favor of Great American, the appellate court stated that a jury could find that Largent's use of the truck complied with Hammer's permission and that Largent's intoxication revoked that permission.[1162] But the court of appeals was adamant about one issue: No Texas state law precedent supports a finding that Largent's failure to follow his employer's instruction is a material deviation as a matter of law without knowing more.[1163]

8. Whether Under Louisiana Law and a Service Agreement a Subcontractor Has a Duty to Indemnify the Contractor's Developer's Liability Insurer After the Insurer Settles a Personal Injury Claim of an Employee Who Worked for Both the Contractor and Subcontractor

The legal issue in *St. Paul Surplus Lines Insurance Co. v. Halliburton Energy Services, Inc.* also concerns whether one has a duty to indemnify.[1164] Here, the question is whether an alleged tortfeasor must indemnify a developer's liability insurer after the insurer settled an injured employee's third party suit.[1165] The case is somewhat complicated because both the insured employer and the alleged tortfeasor had a duty to protect the injured employee from harm.[1166]

1157. *Id.*
1158. Minter v. Great Am. Ins. Co. of N.Y., 423 F.3d 460, 469 (5th Cir. Aug. 2005).
1159. *Id.*
1160. *Id.*
1161. *Id.*
1162. *Id.*
1163. *Id.* at 470.
1164. St. Paul Surplus Lines Ins. Co. v. Halliburton Energy Srvcs. Inc., 445 F.3d 820, 821 (5th Cir. Apr. 2006).
1165. *Id.*
1166. *Id.*

LLOG Exploration Company (LLOG) develops and operates oil and gas properties.[1167] In March 2001, LLOG leased a drill barge from R&B Falcon Drilling USA, Inc. (Falcon).[1168] LLOG used the barge to help drill wells off the coast of Venice, Louisiana.[1169] The contract between LLOG and Falcon (Drilling Contract) stated that LLOG would hold Falcon harmless if LLOG's employees or invitees filed any third party injury claims against Falcon.[1170] The Drilling Contract also required LLOG to provide various services which a service company usually provides for persons working at oil and gas sites.[1171]

Founded in 1919, Halliburton Energy Services, Inc. (Halliburton) is one of the world's largest providers of products and services to the petroleum industry.[1172] To ensure that employees and others received the appropriate services at the well site, LLOG selected Halliburton to deliver those services.[1173] To consummate the agreement, LLOG and Halliburton executed a Master Service Contract (Service Contract).[1174]

Without doubt, under Louisiana law, Halliburton assumed at least a limited contractual duty to take care of two sets of employees at the site.[1175] Halliburton had a duty to protect its employees delivering the services and products, as well as other oil and gas employees at the work site.[1176] More important, the Service Contract obligated Halliburton to indemnify LLOG as well as LLOG's invitees—including Falcon—if Halliburton's employees filed third party claims against LLOG and its invitees.[1177]

In March 2001, one of Falcon's barges capsized.[1178] Gilbert Goldman, a Halliburton engineer and a LLOG invitee, was on the barge when the accident occurred.[1179] Goldman was injured, and he sued LLOG and Falcon to recover damages.[1180] Citing the Drilling Contract, Falcon, LLOG's invitee, demanded that LLOG provide a legal defense and indemnify Falcon for expenses associated with the third party suit.[1181] Initially, both LLOG and Halliburton rejected Falcon's demand.[1182] Falcon settled Goldman's claims for $550,000

1167. *Id.*

1168. *Id.*

1169. *Id.*

1170. *Id.*

1171. *Id.*

1172. *See* Halliburton Inc., Overview, http://www.halliburton.com/default.aspx?navid=337&pageid=706 (last visited Mar. 18, 2007).

1173. *Halliburton*, 445 F.3d at 821.

1174. *Id.*

1175. *See id.*

1176. *Id.* at 821-22.

1177. *Id.* at 821 n.1 ("The Service Contract was accompanied by a Rider executed by the parties which modified portions of its indemnity provisions.").

1178. *Id.* at 822.

1179. *Id.*

1180. *Id.*

1181. *Id.*

1182. *Id.*

and sought reimbursement from LLOG and St. Paul Surplus Lines Insurance Company.[1183] St. Paul insured LLOG's oil and gas operations under a liability insurance contract.[1184]

St. Paul and LLOG withdrew the denial of liability and reimbursed Falcon for $550,000.[1185] After studying the Drilling Contract's indemnity provisions, St. Paul decided to sue Halliburton to collect the $550,000 that the insurer paid to Falcon.[1186] From St. Paul's perspective, Halliburton was contractually obligated to indemnify LLOG and LLOG's invitee, Falcon, for monies paid for Halliburton's employees' injuries.[1187] The insurer filed the action in the District Court for the Eastern District of Louisiana.[1188] After considering cross motions for summary judgment, the district court granted Halliburton's motion.[1189] St. Paul appealed the case.[1190]

At the outset, the Fifth Circuit examined two documents that governed the contractual relationship between LLOG and Halliburton.[1191] First, the Service Contract began by defining the parties:

> [This contract is] made and entered into on the above date by and between [LLOG Exploration Company] (hereinafter referred to as "LLOG") and [Halliburton Company], its divisions [Halliburton Service] and [Halliburton Reservoir Services], and its subsidiaries [Halliburton Logging Service, Inc.],

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1183. *Id.*

1184. *Id.* at 821.

1185. *Id.* at 822 & n.2.

> LLOG initially rejected Falcon's demand for indemnity on the grounds that the Drilling Contract failed the 'express negligence test,' which provided that a party cannot be indemnified for its own negligence when the indemnity contract does not so provide expressly. Although LLOG and St. Paul initially refused to reimburse Falcon, they relented after this court concluded that the express negligence test would not operate to preclude claims asserted against Falcon based upon Falcon's negligence in *East v. Premier, Inc.*, a case involving an identical contract between Falcon and LLOG.

Id.

1186. *Id.* at 822.

1187. *Id.* at 822 n.3. "St. Paul also argue[d] that Halliburton [was] estopped from withholding reimbursement due to its representations and action in defending LLOG in the litigation." *Id.* But because the court declared that Halliburton was "obligated to indemnify LLOG under the Service Contract," the court did not address the equitable estoppel argument. *Id.*

1188. *Id.* at 822.

1189. *Id.*

> Both Halliburton and St. Paul filed motions for summary judgment. The district court granted the motion filed by Halliburton and denied St. Paul's motion. Because Halliburton did not expressly agree to indemnify LLOG for contractual claims, the district court concluded that Halliburton was not responsible for the defense or indemnity obligations [that LLOG] assumed . . . in its separate contracts with third parties.

Id.

1190. *Id.*

1191. *Id.*

and [Otis Engineering Company] (hereinafter referred to as "Contractor").[1192]

Second, Paragraph 4(a), the indemnity clause in the LLOG/Halliburton Service Contract, stated: "For the purposes of this section any reference to LLOG shall include . . . any or all agents, directors, officers, employees or invitees of LLOG or such co-lessees, or any or all of such parties."[1193]

The Fifth Circuit also reviewed a rider to the Service Contract.[1194] Although the rider did not modify Paragraph 4(a) in the indemnity clause, the rider certainly modified and revised the remaining sections of the indemnity clause.[1195] The rider's revised language stated in pertinent part:

> Section 4. INDEMNITY: Paragraphs (b) and (c) shall be amended and paragraphs (d), (e), (f), (g), (h) and (i) added to read:
>
> (b) Contractor shall be responsible, and LLOG shall never be liable, for property damage or personal injury to or death of Contractor's employees or the employees of Contractor's subcontractors and Contractor agrees to indemnify and hold LLOG harmless against any and all such claims, demands or suits which may be brought against LLOG by any such party, or the legal representative or successor of any such employee, in anywise arising out of or incident to the work to be performed under this contract by Contractor, or Contractor's subcontractors, irrespective of whether such claims, demands, or suits are based on the relationship of master and servant, third party, or otherwise, the unseaworthiness or unairworthiness of vessels or craft, or the negligence or strict liability, in whole or in part, of LLOG.[1196]

Before the court of appeals, St. Paul and LLOG argued that the rider required Halliburton to reimburse St. Paul and LLOG.[1197] They argued that the third party victim, Goldman, was Halliburton's employee and that Falcon was LLOG's invitee within the meaning of Paragraph 4(a).[1198] Halliburton embraced the view that Falcon was LLOG's invitee.[1199] The service company asserted, however, that the indemnity provision was defective.[1200] Halliburton stressed that the indemnity provision did not clearly state that Halliburton must

1192. *Id.* at 823.
1193. *Id.*
1194. *Id.*
1195. *Id.*
1196. *Id.*
1197. *Id.*
1198. *Id.*
1199. *Id.*
1200. *Id.*

indemnify LLOG after the latter company settled the third party injury claim.[1201]

The district court granted Halliburton's motion for summary judgment, relying on the Fifth Circuit's decisions in *Foreman v. Exxon Corp.* and *Corbitt v. Diamond M. Drilling Corp.*[1202] In both cases, the Fifth Circuit held that "'express notice is required [when] a party seeks to shift [their] contractual liability to indemnify a third party'" and that contractual language that creates an indemnity obligation—"'for injury to or death or illness of persons'"—only gives notice about tort-based, rather than contract-based claims.[1203]

But the court of appeals observed that it also addressed the present controversy in five other cases—*Sumrall v. Ensco Offshore Co.*,[1204] *Campbell v. Sonat Offshore Drilling, Inc.*,[1205] *Mills v. Zapata Drilling Co.*,[1206] *Kelly v. Lee's Old Fashioned Hamburgers, Inc.*,[1207] and *Lirette v. Popich Bros. Water Transport, Inc.*[1208] And in each, the Fifth Circuit cited the controlling language in the indemnity clauses and ordered the responsible tortfeasors to pay for third party injuries."[1209]

1201. *Id.* at 823 n.4.

> Halliburton also argues that the Service Contract Rider modified the contract to effectively remove "invitee" from Paragraph 4(a) of the Service Contract. However, the Service Contract Rider specifically enumerates which subsections of Paragraph 4 are to be modified, and leaves 4(a) untouched. The district court refused to read the Service Contract Rider as impliedly removing a class of potential indemnities from the Service Contract, and we agree with that reading.

Id.

1202. *Id.*

1203. *Id.* (quoting Foreman v. Exxon Drilling Corp., 770 F.2d 490, 496-97 (5th Cir. 1985); Corbitt v. Diamond M. Drilling Co., 654 F.2d 329, 333-34 (5th Cir. 1981)).

1204. Sumrall v. Ensco Offshore Co., 291 F.3d 316 (5th Cir. 2002).

1205. Campbell v. Sonat Offshore Drilling, Inc., 27 F.3d 185 (5th Cir. 1994).

1206. Mills v. Zapata Drilling Co., 722 F.2d 1170 (5th Cir. 1983).

1207. Kelly v. Lee's Old Fashioned Hamburgers, Inc., 908 F.2d 1218 (5th Cir. 1990) (per curiam).

1208. Lirette v. Popich Bros. Water Transp., Inc., 699 F.2d 725 (5th Cir. 1983).

1209. *See* St. Paul Surplus Lines Ins. Co. v. Halliburton Energy Servs. Inc., 445 F.3d 820, 825 (5th Cir. April. 2006) (stating, "[w]e subsequently applied *Lirette*'s conduit principle in *Mills*, 722 F.2d at 1175, *Campbell*, 27 F.3d at 187-88, and *Sumrall*, 291 F.3d at 320"); *see also Lirette*, 699 F.2d at 728.

> In *Lirette*, Popich Bros. Water Transport, Inc. . . . owned and operated a vessel time-chartered to Otto Candies, Inc. ("Candies"). The contract between Popich and Candies required that Popich indemnify Candies, as well as its "affiliated companies and anyone for whom the vessel may be working" against personal injury claims made by Popich employees.
>
> The [Fifth Circuit] concluded that: Popich was called upon to make good its contractual obligation to hold Candies (and Exxon) harmless from claims, suits or damage 'arising out of, or in any way connected [with] the operation of the vessel under this charter." Popich's obligation to reimburse Candies for amounts due Exxon arose because of Popich's express undertaking to make good to Exxon all such losses. Candies acting as a conduit did not alter that obligation.
>
> Because Exxon was a member of the class of "affiliated companies" named in the indemnity provision, Popich was obligated to indemnify Exxon, and Popich could not escape its obligation merely because Candies acted as a "conduit" for indemnification.

Halliburton, 445 F.3d at 824-25 (internal citations omitted).

To resolve the present controversy, the court of appeals relied heavily on those earlier decisions, especially its rulings in *Mills* and *Lirette*.[1210] Thus, the Fifth Circuit reversed the district court's ruling and declared that Halliburton had a contractual duty to reimburse LLOG and its insurer, St. Paul, for the expenses associated with settling the injured employee's third party lawsuit.[1211]

B. Third Party Liability Claims—Injury to Property

1. Whether Under Louisiana's Direct-Action Statute a Stevedoring Company's Marine Liability Insurer Has a Duty to Indemnify the Seller-Shipper of Cargo After the Cargo Was Severely Damaged

Earlier in this review, a discussion of the Fifth Circuit's analysis and conclusion in *Motiva* appears.[1212] Again, the insured in *Motiva* used its funds to settle a third party lawsuit.[1213] Afterward, the insured asked the insurer to reimburse the settlement expenditures.[1214] The insurer refused, arguing that the insured breached conditions in the insurance contract's consent-to-settle and cooperation clauses.[1215] More specifically, the insured did not secure the insurer's consent or cooperate with the insurer before settling the third party lawsuit.[1216]

The insured insisted, however, that the breach of conditions did not prejudice the insurer's interests as the insurer claimed.[1217] But, the Fifth Circuit panel deciding *Motiva* disagreed, even though the panel admitted that Texas law is unclear regarding whether an insurer must prove prejudice after an insured breached a prompt notice or a consent-to-settle provision.[1218] Still, rather than certifying the case to the Texas Supreme Court, the *Motiva* panel concluded that the insurer was prejudiced as a matter of law.[1219]

Similarly, the central question in *Thyssen, Inc. v. NOBILITY MV* also concerned whether an insured's breach of a prompt-notice clause prejudiced the insured and insurer's interests.[1220] But, unlike the *Motiva* panel, a different

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1210. *Id.* at 826.

> LLOG's claim for indemnity from Halliburton under the Service Contract is functionally indistinguishable from CNG's claim for indemnity in *Mills*. . . . Because this case is controlled by our decisions in *Lirette*, *Mills*, *Campbell*, and *Sumrall*, we reverse the judgment of the district court and render summary judgment in favor of St. Paul.

Id.

1211. *Id.*

1212. *See supra* Part IV.A.6.

1213. Motiva Enters., LLC v. St. Paul Fire & Marine Ins. Co., 445 F.3d 381, 381 (5th Cir. Mar. 2006)

1214. *Id.*

1215. *Id.* at 384.

1216. *Id.*

1217. *Id.*

1218. *Id.* at 386-87.

1219. *Id.*

1220. Thyssen, Inc. v. NOBILITY MV, 421 F.3d 295, 297 (5th Cir. Aug. 2005).

Fifth Circuit panel that decided *Thyssen* did not reach a questionable conclusion as a matter of law.[1221] Instead, the *Thyssen* panel considered and thoughtfully applied Louisiana law.[1222] As a consequence, the panel delivered an exceedingly thoughtful, lucid, and carefully researched decision.

Multiple parties were involved in *Thyssen*, and the relationships among them were complicated. Fenice Maritime Ltd. (Fenice) owns the MV NOBILITY (MV Nobility), a large vessel that transports containers and other cargo.[1223] Thyssen, Inc. (Thyssen) is presently doing business as ThyssenKrupp Materials North America, Inc.[1224] Thyssen is a Michigan corporation with its principal place of business located in Detroit.[1225] Among other enterprises, Thyssen processes and makes deliveries of high-grade steel to companies in North America.[1226] Its portfolio of steel-based products includes hot-rolled, cold-rolled, electro-galvanized, aluminized, and advanced high-strength steels.[1227] CPLA is Thyssen's customer.[1228] Thyssen purchased 243 cold-rolled steel coils (cargo) from CSN, the Brazilian subsidiary company.[1229] Thyssen intended to resell the steel coils to CPLA.[1230]

Clipper Bulk Shipping, Ltd. or Bossclip, Ltd. time chartered the MV Nobility from Fenice.[1231] CSN, the manufacturer of the coils, voyage chartered the vessel from the time charterers.[1232] The shipper incorporated the voyage

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1221. *Id.*

1222. *See id.* at 304-07.

1223. *Id.*

1224. *See* Jeffrey McCracken, *Ex-Thyssen Executives Guilty; 2 Face Federal Prison in Vendor Kickback Scheme*, DET. FREE PRESS, Aug. 13, 2004, at 1C.

> A federal jury in Detroit returned guilty verdicts on charges of conspiracy, money laundering and tax and mail fraud against Kenneth J. Graham, the former CEO of Thyssen Inc. N.A., and Kyle E. Dresbach, the Detroit-based company's former executive vice president. . . . Thyssen, which has because changed its name to ThyssenKrupp Materials North America, cooperated with the government on the case. It has about 400 employees in Michigan and 1,900 in the United States. It has annual sales of about $2 billion.

Id.

1225. *Id.*

1226. *See* ThyssenKrupp Steel N.A., Inc., http://www.tksna.com (last visited Mar. 18, 2007).

1227. *See id.*

1228. *Thyssen*, 421 F.3d at 297.

1229. *Id.*

1230. *Id.*

1231. *Id.* at 297 n.1.

> A time charter is a contract whereby a vessel is let to a charterer for a stipulated period, in exchange for a remuneration known as hire—a monthly rate per ton deadweight or a daily rate. The charterer is free to employ the vessel as it sees fit within the terms as agreed, but the shipowner continues to manage his own vessel through the master and crew who remain his servants.

Id.

1232. *Id.* at 297 n.2.

> A voyage charter is a contract under which the shipowner agrees to carry an agreed quantity of cargo from a specified port or ports to another port or ports for a remuneration called freight, which is calculated according to the quantity of cargo loaded, or sometimes at a lump sum freight.

charter date, February 19, 2001, into the bills of lading and listed the liability for Thyssen's cargo as "[f]ree in out stowed."[1233] The MV Nobility left Rio de Janeiro, Brazil in February 2001 and arrived in New Orleans, Louisiana in April 2001.[1234]

Pennant Shipping Services, Inc. (Pennant) is a Louisiana corporation, with its principal place of business located in Kenner, Louisiana.[1235] Pennant was Fenice's agent in New Orleans.[1236] Therefore, before the MV Nobility arrived, Pennant contacted Stafford & Stillwell Stevedoring, Inc. (S & S) and hired the company to unload the cargo.[1237] Pennant also contacted Thyssen, disclosing the vessel's discharge location and reporting that S & S's stevedores would unload the steel coils.[1238] Thyssen embraced Pennant's decision, thereby creating a binding contractual relationship between Thyssen and S & S.[1239]

The MV Nobility arrived in New Orleans on or about April 6, 2001.[1240] Shortly thereafter, Thyssen inspected the 243 cold-rolled steel coils while they were still aboard the MV Nobility.[1241] After discovering condensation and rust on the coils, Thyssen lodged a tentative water-damage claim with the MV Nobility's charterers.[1242] Subsequent examinations, however, strongly suggested that the stevedores' negligence was the cause of the rust damage.[1243] After learning about the damaged cargo, CPLA refused to purchase the coils from Thyssen.[1244]

Over the succeeding twenty-five months, Thyssen filed several supplemental and amended complaints against three defendants in the District Court for the Eastern District of Louisiana.[1245] First, the disgruntled company commenced a suit in rem against Fenice, MV Nobility's owner.[1246] Soon thereafter, Thyssen added S & S as a defendant, and during those long months, Thyssen discovered that USI Gulf Coast, Inc. (USI) was S & S's insurance

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Id.

1233. *Id.* at 297 & n.3. "Free Out" cargo is discharged at the risk and expense of the cargo interests. *Id.*

1234. *Id.* at 297.

1235. *See* Pennant Shipping, Company Information, http://www.masterseek.com/id/1229603/Pennant-Shipping.htm (last visited Mar. 18 2007).

1236. *Thyssen*, 421 F.3d at 297.

1237. *Id.*

1238. *Id.* at 297.

1239. *Id.* at 297-98.

1240. *Id.*

1241. *Id.* at 298.

1242. *Id.*

1243. *Id.* at 301. "Thyssen emphasize[d] that S & S was represented by its own surveyor, the firm Martin Ottoway, during the damage surveys. Martin Ottoway surmised the damage occurred . . . as a result of S & S['s] using improper equipment to handle the coils." *Id.*

1244. *Id.* at 298.

1245. *Id.*

1246. *Id.*

broker.[1247] USI disclosed to Thyssen that National Union Fire Insurance Company of Louisiana (National) insured S & S under a comprehensive marine liability (CML) policy.[1248]

Relying on USI's representation, Thyssen submitted its third party property loss claim to National.[1249] National refused to pay or settle the claim, arguing that Thyssen did not file the notice of loss in a timely manner.[1250] In response, Thyssen amended its complaint and sued National under the Louisiana Direct Action Statute (LDAS).[1251] LDAS allows a third party complainant to sue liability insurers directly.[1252] National answered Thyssen's original and amended complaints and filed a motion for summary judgment.[1253] Both Thyssen and Fenice opposed National's motion and, ultimately, the district court denied it.[1254]

S & S, however, did not answer after receiving notice and being served.[1255] More relevant, the stevedoring company did not have any legal representation at the hearing, neither retained representation or representation that National secured on behalf of S & S.[1256] Thyssen petitioned the federal district court for a default judgment.[1257] The court granted and entered a $160,696.28 default judgment against S & S.[1258] Nearly two years after Thyssen discovered the damaged cargo, a judge decided his action against National in a bench trial.[1259] At the trial's closing, the district judge granted National's motion for involuntary dismissal.[1260] Put simply, the court found that Thyssen's late reporting of the damaged cargo prejudiced National's interests.[1261]

1247. *Id.*
1248. *Id.*
1249. *Id.*
1250. *Id.*
1251. *Id.*; LA. REV. STAT. ANN. § 22:655 (2004).
1252. § 22:655(B)(1).

> The injured person or his or her survivors or heirs . . . , at their option, shall have a right of direct action against the insurer within the terms and limits of the policy; and, such action may be brought against the insurer alone, or against both the insured and insurer jointly and in solido, in the parish in which the accident or injury occurred or in the parish in which an action could be brought against either the insured or the insurer under the general rules of venue prescribed by Code of Civil Procedure Art. 42 only.

Id.
1253. *Thyssen*, 421 F.3d at 298-99.
1254. *Id.*
1255. *Id.* at 298.
1256. *Id.*
1257. *Id.*
1258. *Id.*
1259. *Id.* at 299.
1260. *Id.*
1261. *Id.*

Furthermore, a few months later, that same district court dismissed Thyssen's claim against Fenice.[1262] The court concluded that the Carriage of Goods by Sea Act (COGSA) shielded Fenice from liability for the damaged steel-rolled coils.[1263] Alternatively, the district judge concluded that, assuming the Harter Act applied, Fenice was not liable for Thyssen's damaged cargo under that federal statute.[1264] Thyssen timely appealed, and the appeals were consolidated.[1265]

Before the Fifth Circuit, Thyssen argued that the district court committed reversible error by concluding that Thyssen's default judgment against S & S *ipso facto* prejudiced National.[1266] More specifically, Thyssen strongly asserted that National failed to meet its burden in showing adequate prejudice on the present facts.[1267] To support that assertion, Thyssen observed that S & S's agent concluded that National could not have defended S & S successfully at the hearing during which the lower court awarded the default judgment.[1268] Additionally, Thyssen acknowledged that USI, the insurance broker, waited three weeks to notify and forward the property damage claim to National.[1269] But Thyssen insisted that National was not prejudiced because the limitation period for appealing the default judgment had not been exhausted prior to the notice of loss.[1270] Thyssen also stressed that National could have raised a Rule 60(b) motion to set aside the default judgment for good cause.[1271] Therefore, Thyssen argued that if National were prejudiced, the insurer's own inaction was the culprit.[1272]

On the other hand, National supported the Fifth Circuit's finding of prejudice as to the notice issue.[1273] And the insurer insisted that the default judgment and the absence of legal representation at the hearing established *ipso facto* prejudice.[1274] Essentially, National asserted that "late notice of the claim deprived it of the opportunities to promptly investigate the claim, to appoint counsel to represent S & S's interests, and to present any defense to Thyssen's claim."[1275]

1262. *Id.*

1263. *Id.* (citing Carriage of Goods by Sea Act, 46 U.S.C. app. §§ 1300-15 (2000)).

1264. *Id.* at 299 (citing Harter Act, 46 U.S.C. app. § 190 (2000)).

1265. *Id.* The non-insurance related question before the Fifth Circuit was whether the district court erred in dismissing Thyssen's in rem claim against the NOBILITY and against Fenice as vessel owner. *Id.* A discussion of the panel's disposition of that question does not appear in this review, but the panel concluded that the district court did not commit reversible error. *Id.* at 306-08.

1266. *Id.* at 300-01.

1267. *Id.* at 301.

1268. *Id.*

1269. *Id.*

1270. *Id.*

1271. *Id.* (citing FED. R. CIV. P. 60(b)).

1272. *Id.*

1273. *Id.*

1274. *Id.* at 302.

1275. *Id.*

The panel framed the central question this way: whether the district court, in granting National's motion for involuntary dismissal, committed reversible error after National proved sufficient prejudice to defeat Thyssen's LDAS action.[1276] And to determine if Thyssen or National's arguments were sound, the *Thyssen* panel began its deliberations by reviewing the notice-of-loss or notice-of-occurrence provision that appeared in S & S's CML insurance contract.[1277] It reads in pertinent part:

> Whenever the Assured has information from which the Assured may reasonably conclude that an occurrence covered [under this policy involves] . . . injuries or damages which . . . is likely to involve this Policy, notice shall be sent to: USI Gulf Coast, Inc. as soon as practicable, . . . however, . . . failure to notify the above firm of any occurrence which at the time . . . did not appear to involve this Policy, . . . shall not prejudice such claims.[1278]

A reporting-of-claims provision also appeared in the liability contract, specifying the proper procedure for filing claims.[1279] It stated in relevant part:

> In the event of an occurrence with respect to which insurances are afforded under this Policy, written notice containing particulars sufficient to identify the Assured and also reasonably obtainable information with respect to the time, place and circumstances thereof, and the names and addresses of available witnesses, shall be given by or for the Assured to this Company as soon as practicable.[1280]

Louisiana law is clear: An insurer must establish sufficient prejudice if an insurer wants to defeat a third party's action under the LDAS.[1281] Citing this rule, Thyssen asserted that National had to appeal the default judgment against S & S or exhaust other procedural remedies before attempting to prove prejudice.[1282] But the *Thyssen* panel found contrary authority.[1283] In *Elrod v. P.J. St. Pierre Marine, Inc.*, the Louisiana appellate court concluded that the following acts or conditions would support a finding of prejudice: (1) a court's entering a default judgment is evidence of prejudice; (2) an insurer's lost opportunity to defend an insured before a default judgment; (3) an insured's ability to secure legal representation in an underlying suit; and (4) a jury's verdict in favor of the third party plaintiff along with an unsettled

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1276. *Id.*
1277. *Id.*
1278. *Id.* at 300.
1279. *Id.*
1280. *Id.*
1281. *See* Auster Oil & Gas, Inc. v. Stream, 891 F.2d 570, 579 (5th Cir. 1990) (reaffirming Louisiana's law that an insurer can escape liability if the insurer shows prejudice at an adequate level).
1282. *Thyssen*, 421 F.3d at 303.
1283. *Id.*

dispute about damages.[1284]

National argued that it would have challenged the assertion that S & S's negligence, while unloading the cargo, was the cause in fact of the damaged cargo; the insurer insisted that it would have raised that defense before the lower court entered the default judgment against S & S.[1285] To establish prejudice on appeal, National presented prima facie evidence strongly suggesting that preloading activities and conditions on the MV Nobility were the cause in fact of the damaged cargo rather than S & S's alleged negligence.[1286] The insurer also presented evidence suggesting that the lower court's methodology for calculating damages prejudiced the insurer's interests.[1287] According to National, Thyssen's "late notice . . . deprived [the insurer of] . . . opportunities to promptly investigate the claim, to appoint counsel to represent S & S's interests, and to [defend against] . . . Thyssen's claim."[1288]

Embracing National's arguments, the *Thyssen* panel concluded that the district court did not commit reversible error.[1289] The Fifth Circuit panel affirmed the district court's finding that National and S & S's interests were sufficiently prejudiced when Thyssen breached the notice-of-loss clause in the comprehensive marine liability insurance contract.[1290]

1284. Elrod v. P.J. St. Pierre Marine, Inc., 663 So.2d 859, 859-64 (La. Ct. App. 1995) (noting the difficulty of conceiving "greater prejudice . . . than a demand for payment of a default judgment of which a defendant is totally ignorant").

1285. *Thyssen*, 421 F.3d at 301-02.

1286. *Id.* at 302.

> National Union attempts to shift some of the blame for the damage from S & S, noting that two preloading surveys indicated several of the outer covers of the coils were already bent and crimped. National Union also emphasizes Thyssen's persistent claims of rust damage prior to entry of the default judgment. Moreover, National Union contends Thyssen failed to mitigate any handling damages by S & S by not stopping the discharge operations when Thyssen was informed the coils were being damaged, and then by subsequently allowing S & S to load the coils onto trucks for transfer to the inspection site.

Id.

1287. *Id.* National Union argued that the method used in the default hearing to determine the amount of damaged coils was not equitable. *Id.* The insurer stressed that Thyssen calculated its damages inappropriately, assuming that all 243 coils were damaged. *Id.* A representative sample, however, estimated that only 80% of the cargo (194 coils) had been damaged. *Id.* The difference between the two calculations was nearly $22,000. *Id.* National Union also argued that certain "transportation fees, surveyor's fees, and storage charges" were improperly listed as damages, as Thyssen would have incurred those expenses even absent S & S's alleged negligence. *Id.*

1288. *Id.*

1289. *Id.* at 304.

1290. *Id.*

2. *Whether Under Texas Law an Environmental Impairment Liability Insurer Has a Duty to Indemnify its Insured—a Metals, Smelting and Refining Corporation—After the Insured Paid Fines Under the Federal Comprehensive Environmental Response, Compensation, and Liability Act*

Arguably, the findings in *International Insurance Co. v. RSR Corp.*, are the most intelligible, and the conclusions are the most carefully weighed among this year's reported insurance law cases.[1291] In addition, the reported facts in *RSR* are generous, thereby enabling jurists to understand the court's findings and conclusions.[1292] Also, the *RSR* panel carefully considered a variety of legal issues and thoroughly researched each one.[1293] But more important, the legal analysis in *RSR* is more outstanding than the greater majority of this term's insurance law decisions because the *RSR* panel embraced a simple, commonsense methodology, carefully considering and applying one of the five doctrines of contract interpretation.[1294] The *RSR* panel embraced a jury's definition of a disputed term in a policy, rather than spending an inordinate amount of judicial resources trying to define the elusive "true" meaning of a term.[1295]

The underlying controversy in *RSR* is fairly widespread in the United States, and the insurance law dispute is extremely common as well.[1296] Therefore, the pertinent facts in *RSR* are fairly interesting and easy to comprehend. RSR Corporation (RSR) is a Texas corporation with its headquarters located in Dallas, Texas.[1297] RSR is a leading lead smelter with several subsidiaries.[1298] Among other activities, RSR recycles scrapped lead-acid batteries and other lead-bearing materials.[1299] The end product is a refined material consisting of lead, calcium, and antimonial lead alloys.[1300] RSR operates recycling sites in several states, including its Harbor Island site near Seattle, Washington.[1301]

1291. Int'l Ins. Co. v. RSR Corp., 426 F.3d 281, 284 (5th Cir. Sept. 2005).

1292. *Id.*

1293. *Id.*

1294. *Id.* at 291-92.

1295. *Id.*

1296. *Id.* at 285.

1297. *Id.*

1298. *See id.* at 284. RSR's subsidiaries are Quemetco, Inc., Quemetco Metals Limited, Inc., f/k/a Murph Metals, Inc., Bestolife Corporation, and Revere Smelting & Refining Corporation of New Jersey, and in this presentation, they are referred to collectively as RSR. *Id.*

1299. *Id.*

1300. *Id.*

1301. *See* Lisa Stiffler, *$8.5 Million from Ex-Smelter Owner Will Aid Cleanup*, SEATTLE POST-INTELLIGENCER, Feb. 1, 2006, at B2.

> A former smelter owner has agreed to pay the federal government $8.5 million to help pay for the massive cleanup of lead and toxic chemicals on Harbor Island.
>
> . . . .
>
> Dallas-based RSR Corp. and two subsidiaries, Quemetco Inc. and Quemetco Realty Inc.,

In 1980, Congress enacted the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA).[1302] Congress responded to the public's concern about (1) the production and careless disposal of hazardous wastes and (2) the severe environmental and public health effects of hazardous substances.[1303] CERCLA has two stated purposes: to ensure the "prompt cleanup of hazardous waste sites" and to "impos[e] . . . all cleanup costs on the responsible party."[1304]

To achieve congressional intent, the Environmental Protection Agency (EPA) has the authority to remove hazardous spills and prevent the release of hazardous substances which "may present an imminent and substantial danger to the public health or welfare."[1305] The EPA may respond in two ways.[1306] The agency has authority to commence a removal action, which allows the EPA to take immediate action to clean up a hazardous release.[1307] In addition, the agency may commence a remedial action to prevent or minimize the release and migration of hazardous substances—those which present and are likely to present a substantial danger to public health or to the environment.[1308]

Furthermore, the EPA may ask the Attorney General to commence an action against an actual or potential polluter to prevent "imminent and substantial endangerment to the public health or welfare or the environment . . . ."[1309] Finally, after the United States or a state spends money to prevent pollution or to decontaminate a hazardous site, the EPA may account for the expenditures associated with a removal or a remedial action.[1310] CERCLA gives the EPA authority to recover money from all responsible persons, including the owners of contaminated sites.[1311]

Therefore, in December 1982, the EPA issued a press release, announcing that the agency would place Harbor Island on its proposed National Priorities List (NPL).[1312] At that time, North River Insurance Company (North River)

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were named in the consent decree settling the costs. Quemetco bought the Harbor Island smelter in 1969 and became a subsidiary of RSR three years later.

Id.

1302. *See* CERCLA, 42 U.S.C. § 9601 (2000).

1303. *See* Eagle-Picher Indus. v. EPA, 759 F.2d 922, 925-26 (D.C. Cir. 1985).

1304. Gen. Elec. Co. v. Litton Indus. Automation Sys., Inc., 920 F.2d 1415, 1422 (8th Cir. 1990).

1305. 42 U.S.C. § 9604(a)(1).

1306. § 9601(23)-(24).

1307. § 9601(23).

1308. § 9601(24).

1309. § 9606(a).

1310. § 9607.

1311. *Id.*

1312. *See* § 9605(a)(8)(A)(B).

[T]he President shall . . . revise and republish the national contingency plan for the removal of oil and hazardous substances . . . [The plan] . . . shall establish procedures and standards for responding to releases of hazardous substances, pollutants, and contaminants, which shall include at a minimum:

. . . .

insured RSR under an environmental impairment liability (EIL) insurance contract.[1313] The EIL policy covered RSR from September 4, 1981 to November 4, 1982, which included an extended reporting period until November 4, 1983.[1314] RSR gave written and oral notice of the EPA's intention to North River.[1315] Nearly a year later, the EPA included the Harbor Island site on the final NPL.[1316]

During the wrangling between the EPA and RSR, International Insurance Company (International) became North River's successor-in-interest.[1317] Therefore, believing that the EPA would file a lawsuit against RSR, International filed a declaratory judgment action in February 2000 against RSR in the District Court for the Northern District of Texas.[1318] The liability insurer asked the district court to declare that International had no contractual obligation to indemnify or reimburse RSR for any potential CERCLA remediation costs at the Harbor Island site.[1319]

In response, RSR filed a declaratory judgment suit, asserting that International had a duty to cover any actual or potential expenditures associated with the cost of remediation at the polluted Harbor Island site.[1320]

> (8)(A) criteria for determining priorities among releases or threatened releases throughout the United States for the purpose of taking remedial action and, to the extent practicable taking into account the potential urgency of such action, for the purpose of taking removal action. . . . ; [and]
> (B) based upon the criteria set forth in subparagraph (A) of this paragraph, the President shall list . . . national priorities among the known releases or threatened releases throughout the United States and shall revise the list no less often than annually. . . . In assembling or revising the national list, the President shall consider any priorities established by the States. To the extent practicable, the highest priority facilities shall be designated individually and shall be referred to as the "top priority among known response targets," and, to the extent practicable, shall include among the one hundred highest priority facilities one such facility from each State which shall be the facility designated by the State as presenting the greatest danger to public health or welfare or the environment among the known facilities in such State.

Id.

1313. Int'l Ins. Co. v. RSR Corp., 426 F.3d 281, 285 (5th Cir. Sept. 2005).

1314. *Id.*

1315. *Id.*

1316. *Id.*

> In late 1983, RSR sold the Harbor Island lead smeltery to Bergsoe Metals, which was owned by East Asiatic. On July 31, 1986 the EPA determined that Quemetco Realty, Inc., one of the RSR entities, was a potentially responsible party with respect to the environmental impairment of Harbor Island. The EPA requested information from Quemetco as to the ownership of the site and the activities being performed there along with other salient facts. The letter stated that as a potentially responsible party, Quemetco may be liable for all monies expended for corrective actions at the site.

Id.

1317. *Id.*

1318. *Id.*

1319. *Id.*

1320. *Id.* While RSR and International were suing each other in district court, the EPA filed a CERCLA action on May 22, 2000, against RSR in the District Court for the Western District of Washington.

Later, International filed a motion for summary judgment, but the district court denied International's motion.[1321] The court found two issues of material fact: whether the EPA had established a claim against RSR during the policy period regarding the pollution at Harbor Island and whether RSR waived its right to receive coverage for the Harbor Island site.[1322]

A jury found that the EPA submitted a covered claim under International's EIL policy when the agency demanded pollution remediation reimbursements from RSR during the policy period and that International failed to establish that RSR waived its right to coverage under the EIL policy.[1323] On the basis of those findings and the evidence introduced at trial, the district court granted RSR's request for declaratory relief, concluding that International had a contractual duty to reimburse RSR for the costs of decontaminating Harbor Island.[1324] The district court also denied International's motions for judgment as a matter of law and for a new trial.[1325] International timely appealed to the Fifth Circuit.[1326]

International presented two major issues on appeal.[1327] Again, the jury found that the EIL policy covered the EPA's CERCLA claim and that RSR was liable for damages.[1328] But the insurer insisted that the jury's finding was unwarranted because the supporting evidence was insufficient.[1329] To determine whether the liability insurance contract covered the EPA's claim, the Fifth Circuit panel reviewed the contract.[1330] It contained two types of coverage provisions.[1331] First, in one clause, International promised to indemnify RSR after the latter pays costs or settles third party environmental impairment claims.[1332] The indemnity provision stated that the insurer agreed

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Id. The EPA sought $8 million for the cost of removing the pollution at Harbor Island and money for future expenditures at the site. *Id.* The EPA did not serve RSR until the summer of 2000. *Id.*

1321. *Id.* at 286.

1322. *Id.*

1323. *Id.*

1324. *Id.*

1325. *Id.*

1326. *Id.*

1327. *Id.* Actually, six questions were raised on appeal, but this Article discusses only two. *Id.* The remaining four issues concern the district court's alleged abuse of discretion and erroneous jury charges, but the Fifth Circuit panel found no evidence to support International's assertion. *Id.* Those issues were: (1) whether "[t]he definition of 'claim' in the district court's jury charge was legally erroneous because it did not require that the jury find . . . that the EPA demanded money or action from RSR," (2) whether "[a] supplemental jury instruction misled and confused the jury because it conflicted with the definition of 'claim' in the jury charge," (3) whether "the district court abused its discretion in admitting the testimony of John Morrison because it contained privileged attorney-client communications," and (4) whether "the district court abused its discretion in excluding an excerpt from the deposition of Donald Brayer as evidence of his expert opinion." *Id.*

1328. *Id.*

1329. *Id.*

1330. *Id.* at 286-87.

1331. *Id.* at 286.

1332. *Id.* at 286-87.

to indemnify the insured for the indured's obligation to pay damages to the following: "[p]ersonal injury; [p]roperty damage; [i]mpairment or diminution or other interference with any other environmental right or amenity protected by law . . . and caused by [e]nvironmental impairment in connection with the [b]usiness of the insured . . . during the Policy Period."[1333]

Under the other coverage provision, the insurer promised to reimburse the insured for costs and expenses associated with the insured's voluntary cleanup operations.[1334] That provision stated in applicable part:

> [The insurer promises to] reimburse the insured for costs and expenses of operations . . . [which are] designed to remove, neutralize, or clean up any substance released or escaped which had caused Environmental impairment . . . to the extent that such costs and expenses have been incurred or have become payable[,] . . . provided that such costs and expenses . . . are incurred with prior written consent of insurer . . . ."[1335]

Upon closer inspection, the *RSR* panel discovered that the EIL policy did not explicitly define "claim."[1336] Instead, a definition of claim provision simply stated that a claim "comprises any single claim or any series of claims from one or multiple claimants resulting from the same isolated, repeated, or continuing environmental impairment."[1337] But the Fifth Circuit panel observed that a majority of federal and state courts have concluded that EIL insurance contracts cover "damages," a term that includes the insured's actual or potential liability for CERCLA-related response, remediation, and cleanup costs after the EPA or other third parties commence legal action.[1338] Also, a majority of courts have found that damages "may include 'response costs,' 'cleanup costs' and costs of remediation under CERCLA," and air, soil, and groundwater contamination from man-made pollutants may be properly characterized as property damage.[1339]

1333. *Id.*

1334. *Id.* at 286.

1335. *Id.*

1336. *Id.*

1337. *Id.* at 287 n.2.

1338. *Id.*; *see* Anderson Dev. Co. v. Travelers Indem. Co., 49 F.3d 1128, 1133 (6th Cir. 1995) (concluding that the EPA's mandated response and environmental clean-up costs are damages and "[t]he fact that the insured cooperates and assumes the obligation to conduct the clean-up, rather than forcing the EPA to incur the expenses of a clean-up and then bring a coercive suit, does not change the bottom line that a legal obligation exists"); Aetna Cas. & Sur. Co. v. Pintlar Corp., 948 F.2d 1507, 1511-12 (9th Cir. 1991); Indep. Petrochemical Corp. v. Aetna Cas. & Sur. Co., 944 F.2d 940, 946-47 (D.C. Cir. 1991); Morton Int'l, Inc. v. Gen. Accident Ins. Co. of Am., 629 A.2d 831, 845 (N.J. 1993); U.S. Aviex Co. v. Travelers Ins. Co., 336 N.W.2d 838, 843 (Mich. Ct. App. 1983) (concluding that the distinction between a government's recovery for cleanup costs and natural resources damages is merely fortuitous).

1339. *See, e.g.*, Gerrish Corp. v. Universal Underwriters Ins. Co., 947 F.2d 1023, 1024 (2d Cir. 1991); New Castle County v. Hartford Accident & Indem. Co., 933 F.2d 1162, 1162 (3d Cir. 1991); Avondale Indus. Inc. v. Traveler's Indem. Co., 887 F.2d 1200, 1206-07 (2d Cir. 1989); Port of Portland v. Water

But more relevant, under Texas law, environmental remediation or cleanup costs are damages within the meaning of an EIL insurance contract.[1340] For example, in *SnyderGeneral Corp. v. Century Indemnity Co.*, a different Fifth Circuit panel embraced Texas law and held that if the government incurs environmental cleanup costs under CERCLA or an individual incurs costs after voluntarily decontaminating a hazardous waste site, then the costs are damages under the liability insurance contract.[1341] Also, in *Bituminous Casualty Corp. v. Vacuum Tanks Inc.*, the Fifth Circuit cited a settled Texas principle: Courts must resolve disputes about insurance coverage in favor of the insured.[1342] After applying that principle, the *Bituminous* court concluded that the disputed coverage provision in the liability policy covered the government's CERCLA-related cleanup costs at a hazardous waste dumping site.[1343]

Citing the decisions in *SnyderGeneral* and *Bituminous*, the *RSR* panel concluded that the EPA's CERCLA claim triggered coverage under EIL's indemnification clause.[1344] The panel reached that conclusion even though the district court did not clearly state whether it was granting relief under the indemnification or the "voluntary cleanup operations" clause.[1345] But the Fifth Circuit panel stressed: "[W]e conclude that the district court's erroneous pre-trial contractual interpretation error . . . was harmless, because the district court reached results in its declaratory judgment and its post judgment rulings that

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Quality Ins. Syndicate, 549 F. Supp. 233, 235-36 (D. Or. 1982), *aff'd in part and rev'd in part*, 796 F.2d 1188 (9th Cir. 1986).

In cases discussing environmental coverage, most courts conclude that liability policies cover an insured's voluntary cleanup of the contamination before government demand and money owed after demand. *See, e.g.*, Upjohn Co. v. New Hampshire Co., 444 N.W.2d 813, 819 (Mich. App. 1989), *appeal granted in part, denied in part, and rev'd on other grounds*, 476 N.W.2d 392 (Mich. 1991); Metex Corp. v. Fed. Ins. Co., 675 A.2d 220, 224-30 (N.J. Super. Ct. App. Div. 1996; Broadwell Realty v. Fid. & Cas. Co., 528 A.2d 76, 81-83 (N.J. Super. Ct. App. Div. 1987); Weyerhaeuser Co. v. Aetna Cas. and Sur. Co., 874 P.2d 142,146 (Wash. 1994) (en banc); Compass Ins. Co. v. Cravens, Dargan & Co., 748 P.2d 724,727-28 (Wyo. 1988).

On the other hand, a minority of courts have distinguished between voluntary cleanups, those mandated by administrative agencies, and cleanups mandated by court order. *See, e.g.*, Certain Underwriters at Lloyd's of London v. Super. Ct. of L.A. County, 16 P.3d 94, 103-05 (Cal. 2001); N. Ill. Gas Co. v. Home Ins. Co., 777 N.E.2d 417, 421-22 (Ill. App. Ct. 2002).

1340. Int'l Ins. Co. v. RSR Corp., 426 F.3d 281, 288 (5th Cir. Sept. 2005).

1341. SnyderGeneral Corp. v. Century Indem. Co., 113 F.3d 536, 539 (5th Cir. 1997).

1342. Bituminous Cas. Corp. v. Vacuum Tanks Inc., 75 F.3d 1048, 1053 (5th Cir. 1996).

1343. *Id.*

1344. *Int'l Ins. Co.*, 426 F.3d at 288-89.

1345. *Id.* at 289-90.

> [A]pproving the pretrial order and in ruling on the motions for summary judgment[, the district court concluded] that RSR was entitled to coverage for indemnification against liability to the EPA only under [the voluntary cleanup operations clause.] [W]e conclude that the district court in trying the issue of indemnification that was not submitted to the jury may have continued with that mistaken view . . . or realized that RSR [was] entitled to indemnification against EPA claims under [the indemnification clause rather than under the voluntary cleanup operations clause].

Id.

are consistent with the correct interpretation of the policy."[1346]

The second issue on appeal was whether RSR waived its right to coverage under the EIL policy.[1347] The jury found no express or implied waiver.[1348] But International argued that the jury's finding was contrary to the greater weight and preponderance of the evidence.[1349] Therefore, according to International, the federal district court abused its judicial discretion when the court did not cancel the jury's finding, grant the insurer's motion for judgment as a matter of law, and grant International's alternative motion for a new trial.[1350]

To support the assertion that the jury's finding was incorrect, International presented the following evidence on appeal.[1351] On September 8, 1983, the EPA placed the Harbor Island site on the agency's final NPL.[1352] In late 1983, RSR sold its Harbor Island lead smeltery to Bergsoe Metals (Bergsoe), and the latter company had agreed to indemnify and reimburse RSR for any EPA response costs if RSR became liable.[1353] Therefore, at that time, RSR believed that neither it nor its insurer would be responsible for removing the lead from Harbor Island.[1354]

Additionally, Howard Myers was RSR's general counsel, and in 1995, Myers wrote a series of letters to North River Insurance Company, International's predecessor.[1355] In one letter, Myers disclosed that RSR did not intend to file a notice-of-loss claim, asking North River to pay the cost of decontaminating the Harbor Island site.[1356] During the trial, Myers stated that he expected Bergsoe to indemnify RSR for the EPA's response costs, thereby removing RSR's need to ask International for the insurance proceeds.[1357]

1346. *Id.* at 290.

1347. *Id.* at 300.

1348. *Id.*

1349. *Id.*

1350. *Id.* at 296-300. FED. R. CIV. P. 50(a)(1) states:

> If during a trial by jury a party has been fully heard on an issue and there is no legally sufficient evidentiary basis for a reasonable jury to find for that party on that issue, the court may determine the issue against that party and may grant a motion for judgment as a matter of law against that party with respect to a claim or defense that cannot under the controlling law be maintained or defeated without a favorable finding on that issue.

FED. R. CIV. P. 50(a)(1). FED. R. CIV. P. 50(b) states:

> If, for any reason, the court does not grant a motion for judgment as a matter of law made at the close of all the evidence, the court is considered to have submitted the action to the jury subject to the court's later deciding the legal questions raised by the motion. The movant may renew its request for judgment as a matter of law by filing a motion no later than 10 days after entry of judgment—and may alternatively request a new trial or join a motion for a new trial under Rule 59.

FED. R. CIV. P. 50(b).

1351. *Int'l Ins. Co.*, 426 F.3d at 285.

1352. *Id.*

1353. *Id.*

1354. *Id.*

1355. *Id.* at 300.

1356. *Id.*

1357. *Id.*

But Myers stressed that he did not waive and never intended to waive RSR's rights under the EIL policy.[1358] Still, International insisted that RSR and Myers's prior behaviors were inconsistent with their assertion of a right under the insurance contract.[1359] Citing Texas law, the Fifth Circuit refused to embrace International's argument.[1360] First, the *RSR* panel observed that "under Texas law, a waiver occurs when a party intentionally relinquishes a known right or intentionally engages in conduct that is inconsistent with claiming a known right."[1361] Second, Texas law requires an individual's words or conduct to manifest unequivocally the intent to relinquish a legal right.[1362] Affirming the district court's ruling, the Fifth Circuit concluded that the district court did not abuse its discretion because "a reasonable jury could have found that RSR did not permanently and unequivocally waive its right to recover from International."[1363]

3. Whether Under Texas Law a Commercial General Liability Insurer Has a Duty to Defend and Indemnify its Insured Homebuilder After Homeowners Sued the Builder for Negligently Designing and Constructing Their House

The litigants in *Lamar Homes, Inc. v. Mid-Continent Casualty Co.* also asked the Fifth Circuit to determine whether the insurer had a contractual duty to defend and indemnify the insured in an underlying action.[1364] Lamar Homes, Inc. (Lamar) designs and constructs homes.[1365] In April 1997, Vincent and Janice DiMare (DiMares) purchased a house from Lamar.[1366] Six years later, the DiMares sued the homebuilder and its subcontractor in a Texas state court.[1367] In the underlying complaint, the DiMares alleged that Lamar negligently designed and constructed the foundation of the DiMares' house.[1368] The homeowners also asserted that Lamar breached implied and express warranties because the house was not constructed and designed in a good and workmanlike manner.[1369]

1358. *Id.*
1359. *Id.*
1360. *Id.*
1361. *Id.* (citing Emscor Mfg., Inc. v. Alliance, Ins. Group, 879 S.W.2d 894, 917 (Tex. App.—Houston [14th Dist.] 1994, writ denied)).
1362. *See* Enter.-Laredo Assocs. v. Hachar's, Inc., 839 S.W.2d 822, 835 (Tex. App.—San Antonio 1992, writ denied).
1363. *Int'l Ins. Co.*, 426 F.3d at 301.
1364. Lamar Homes, Inc. v. Mid-Continent Cas. Co., 428 F.3d 193, 195 (5th Cir. Oct. 2005).
1365. *Id.* at 195.
1366. *Id.*
1367. *Id.*
1368. *Id.*
1369. *Id.*

When the DiMares filed their lawsuit, Mid-Continent Casualty Company (Mid-Continent) insured Lamar under a CGL insurance contract.[1370] Therefore, Lamar timely forwarded a copy of the DiMares complaint to Mid-Continent and asked the insurer for a legal defense and indemnification if Lamar paid out-of-pocket damages to satisfy a judgment or to settle the lawsuit.[1371] Mid-Continent refused to defend Lamar.[1372] In response, Lamar filed a declaratory judgment action against Mid-Continent in a Texas state court.[1373]

Before the Texas trial judge, the homebuilder asked the judge to declare that Mid-Continent's insurance contract covered the DiMares' third party claims and that Mid-Continent had a contractual duty to defend Lamar.[1374] Lamar also argued that Mid-Continent's failure to provide a legal defense violated Texas's Prompt Payment of Claims Statute.[1375] Citing a diversity of citizenship, Mid-Continent removed the declaratory judgment action from the Texas court to the District Court for the Western District of Texas.[1376]

Before the federal district court, both Lamar and Mid-Continent filed motions for summary judgment and agreed that the central question would be whether Mid-Continent had a duty to defend Lamar in the *DiMare* litigation.[1377] The district court found that the DiMares' "builder's construction errors," or faulty construction claims, were essentially breach-of-contract or breach-of-warranty claims.[1378] Consequently, Mid-Continent did not have a contractual duty to defend Lamar, because the DiMareses only sought damages for a pure economic loss and Mid-Continent's CGL insurance contract did not cover construction errors or faulty construction claims as a matter of law.[1379]

According to the district court, insurers sell builder's comprehensive liability insurance to insure builders against third party property loss or bodily

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1370. *Id.*

1371. *Id.*

1372. *Id.*

1373. *Id.*

1374. *Id.*

1375. *Id.*

1376. *Id.* at 195 n.1; TEX. INS. CODE ANN. art. 21.55 (Vernon Supp. 1997) (current version at TEX. INS. CODE ANN. § 542.051-.061 (Vernon Supp. 2006)).

1377. *Lamar Homes*, 428 F.3d at 196.

1378. *Id.*

1379. *Id.* at 196 n.2. The district court found that the Texas Supreme Court's decision in *Jim Walter Homes, Inc. v. Reed*, 711 S.W.2d 617, 617 (Tex. 1986) mandated this conclusion. *Id.* In *Jim Walter Homes*, the court held that "a homeowner could not recover punitive damages against a builder because the substance of the homeowner's claim was a breach of contract causing purely economic loss." *Jim Walter Homes*, 711 S.W.2d at 618. The decision in *Jim Walter Homes* persuaded the district court that the Texas Supreme Court wanted lower courts to examine an underlying petition "to determine if the cause of action sounds in contract or tort." *Lamar Homes*, 428 F.3d at 196 n.2. If a cause of action sounds in contract, then the court must find no occurrence or accident. *Id.*

injury claims—those that the builder's product causes.[1380] Builder's liability insurance is not sold to replace or repair a builder's product, such as a home.[1381] The district court also concluded that allowing a builder's liability insurance to cover construction deficiencies would allow a contractor to receive money from the homeowner after an initial sale and subsequent payment from the contractor's insurance company to repair and correct deficiencies in the builder's own work.[1382] From the district court's viewpoint, such a holding would transform a builder's liability policy into a performance bond.[1383] Therefore, the court found that Mid-Continent had no obligation to defend to Lamar in the underlying litigation.[1384]

Lamar appealed the case, and the first broad question before the Fifth Circuit was whether the district court correctly interpreted the meaning of an occurrence and "property damage" in the CGL insurance contract.[1385] The insurance contract defined an occurrence as "an accident, including a continuous or repeated exposure to substantially the same general harmful conditions."[1386] The contract defined property damage as "either (a) physical injury to tangible property, including all resulting loss of use of that property; or (b) loss of use of tangible property that is not physically injured."[1387] The CGL policy covers and pays damages for third party property damage if an occurrence causes the losses, and the losses are confined within a clearly defined "coverage territory."[1388]

The Fifth Circuit's research revealed that Texas courts as well as federal district courts in Texas are divided over whether shoddy workmanship or construction errors are occurrences under liability insurance contracts.[1389] Some Texas and federal courts conclude that construction errors are occurrences under a CGL insurance contract; therefore, the insurer must pay third party damages.[1390] Other courts, however, have held that a bad workmanship claim is essentially a breach-of-contract claim.[1391] Consequently, liability policies do not cover a contractor's shoddy construction because that type of construction is foreseeable rather than accidental or unexpected.[1392] These latter courts find that the builder's

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1380. *Id.*, 428 F.3d at 196 n.3.
1381. *Id.*
1382. *Id.* at 196 n.4.
1383. *Id.* at 196
1384. *Id.*
1385. *Id.*
1386. *Id.*
1387. *Id.*
1388. *Id.*
1389. *Id.* at 197. The court cites an extensive list of cases with holdings on both sides of the argument. *Id.* at 197 nn. 6, 7.
1390. *Id.* at 197.
1391. *Id.*
1392. *Id.* at 197 n.5. The court notes, regarding the present liability policy, that:

negligence rather than intentional conduct causes the shoddy workmanship; thus, the financial loss is unexpected and accidental.[1393]

The Fifth Circuit also discovered that state courts and federal district courts in Texas are divided over another question: whether defective workmanship is property damage under CGL insurance contracts.[1394] Some courts conclude that CGL policies do not cover defective workmanship claims for two reasons.[1395] First, some tribunals conclude that faulty workmanship claims are essentially pure economic loss claims, which "typically flow from a breach of contract."[1396] Second, some courts find that faulty workmanship is an inherent risk associated with the construction industry.[1397] Therefore, applying the business risk doctrine, these courts conclude that CGL policies do not insure against business risks because a CGL policy is not a performance bond.[1398] Of course, other courts have adopted a different view and concluded that defective workmanship is property damage under CGL insurance contracts.[1399]

Finally, as reported earlier, Lamar also argued that Mid-Continent violated Texas's Prompt Payment of Claims Statute when the insurer refused to defend Lamar in the underlying lawsuit.[1400] Put simply, the controversial article provides specific deadlines for an insurer to accept or reject insureds' claims.[1401] If an insurer does not comply with the statutory deadlines, the insurance company must pay the full amount of the requested damages, plus

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> The policy does not define the term "accident," but the Texas Supreme Court has held that an injury is accidental for purposes of coverage under a CGL policy if "[it is] not the natural and probable consequence of the action or occurrence which produced the injury . . . [and] if the injury could not reasonably be anticipated by [the] insured, or would not ordinarily follow from the action or occurrence which caused the injury."

Id. (quoting Mid-Century Ins. Co. v. Lindsey, 997 S.W.2d 153, 155 (Tex. 1999)).

1393. *Id.* at 197.

1394. *Id.* at 198. The court also cites here a list of cases with holdings on both sides of the argument. *Id.* at 198 nn. 8, 9.

1395. *Id.*

1396. *Id.*

1397. *Id.*

1398. *Id.*

1399. *Id.*

1400. *Id.* at 199.

1401. TEX. INS. CODE ANN. art. 21.55 § 2(a) (Vernon Supp. 1997) (current version at TEX. INS. CODE ANN. § 542.055(a) (Vernon Supp. 2006)).

> [A]n insurer shall, not later than the 15th day after receipt of notice of a claim . . . (1) acknowledge receipt of the claim; (2) commence any investigation of the claim; and (3) request from the claimant all items, statements, and forms that the insurer reasonably believes, at the time, will be required from the claimant.

Id.; TEX. INS. CODE ANN. art. 21.55 § 3(a) (Vernon Supp. 1997) (current version at TEX. INS. CODE ANN. § 542.056(a) (Vernon Supp. 2006)).

> [A]n insurer shall notify a claimant in writing of the acceptance or rejection of the claim not later than the 15th business day after the date the insurer receives all items, statements, and forms required by the insurer, in order to secure final proof of loss.

§ 3(a).

an additional eighteen percent of the damages and attorneys' fees.[1402]

The federal district court found that Mid-Continent did not breach a contractual duty to defend Lamar against the underlying third party claims.[1403] Thus, the district court did not address the question of whether an insured may commence a statutory action against an insurer and secure damages under article 21.55 when an insurer violates a duty-to-defend clause under a CGL policy.[1404] On appeal, however, Lamar raised the question and argued that an insured states a valid statutory claim under article 21.55 when an insurer refuses to provide a legal defense.[1405] The court noted that the statute defines a claim as a "first party claim made by an insured or a policyholder under an insurance policy or contract . . . that must be paid by the insurer directly to the insured or beneficiary."[1406]

And after combing Texas and federal courts decisions, the Fifth Circuit found yet another issue that divides these courts.[1407] One tribunal has concluded that the statute only covers first party claims—those in which the insured asks the insurer to pay proceeds or reimburse out-of-pocket expenditures to cover an insured's property losses or personal injuries.[1408] According to one court, a duty-to-defend claim is not valid under article 21.55 because it is a third party rather than first party claim.[1409] Other courts, however, have declared that an insured's request for a legal defense is a first party claim.[1410] Thus, article 21.55 covers that request and requires the insurer to defend the insured in the underlying third party action.[1411]

1402. TEX. INS. CODE ANN. art. 21.55 § 6 (Vernon Supp. 1997) (current version at TEX. INS. CODE ANN. § 542.600 (Vernon Supp. 2006)).

> In all cases [in which] a claim is made pursuant to a policy of insurance and the insurer liable therefore is not in compliance with the requirements of this article, such insurer shall be liable to pay the holder of the policy . . . in addition to the amount of the claim, 18 percent per annum of the amount of such claim as damages, together with reasonable attorney's fees.

§ 6.

1403. *Lamar Homes*, 428 F.3d at 200.

1404. *Id.*

1405. *Id.*

1406. *Id.*

1407. *Id.*

1408. *See* TIG Ins. Co. v. Dallas Basketball, Ltd., 129 S.W.3d 232, 240 (Tex. App.—Dallas 2004, pet. denied) (embracing the view that "[a]rticle 21.55 applies only to claims that trigger the insurer's duty under the policy to pay the insured").

1409. *Id.*; *see also* Universe Life Ins. Co. v. Giles, 950 S.W.2d 48, 53 n.2 (Tex. 1997) ("A first party claim is one in which an insured seeks recovery for the insured's own loss," while a third party claim is one "in which an insured seeks coverage for injuries to a third party.").

1410. *See* N. County Mut. Ins. Co. v. Davalos, 140 S.W.3d 685, 691 (Tex. 2004) (concluding that "[the insurer's] conduct in this case did not violate the terms of article 21.55, whether or not that statute properly applies to a liability insurer who fails to promptly accept or reject its insured's defense"); Rx.Com, Inc. v. Hartford Fire Ins. Co., 364 F. Supp. 2d 609, 612 (S.D. Tex. 2005) (embracing *Davalos*); Housing Auth. of City of Dallas v. Northland Ins. Co., 333 F. Supp. 2d 595, 601-02 (N.D. Tex. 2004) (embracing *Davalos*).

1411. *Id.*

Given that Texas and federal courts frequently litigate the substantive issues appearing in *Lamar* and that those issues continue to generate conflicting holdings among the courts, the Fifth Circuit could have made three *Erie* guesses about how the Texas Supreme Court would resolve the conflicts. Instead, the court of appeals correctly decided to certify three questions to the Texas Supreme Court.[1412] Those questions are:

> (1) When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege an "accident" or "occurrence" sufficient to trigger the duty to defend or indemnify under a CGL policy?
> (2) When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege "property damage" sufficient to trigger the duty to defend or indemnify under a CGL policy?; and,
> (3) If the answers to certified questions 1 and 2 are answered in the affirmative, does Article [ ] 21.55 [currently Article 542.055] of the Texas Insurance Code apply to a CGL insurer's breach of the duty to defend?[1413]

C. Third Party Liability Claims—Injury to Businesses and Professions

Collectively, the conflicts in the remaining two cases concern whether liability insurers have a duty to defend or indemnify business associations, officers, and directors or a right to sue insurance defense lawyers. Certainly, the issues in the underlying lawsuits are easy to comprehend as they concern primarily breach-of-contract and legal malpractice claims. Determining the Fifth Circuit's methodology for reaching its conclusion in at least one of these cases is, however, a bit problematic. Put simply, the court of appeals correctly identified the settled principles in Louisiana and Texas to resolve these remaining disputes. But the manner in which the Fifth Circuit applied Texas's duty-to-defend and duty-to-indemnify laws was less than ideal.

1412. *Lamar Homes*, 428 F.3d at 200-01.
1413. *Id.*

1. Whether Under Texas Law a Commercial General Liability Insurer Has a Duty to Defend and Indemnify Its Insured Corporation After a Third Party Company Sues the Insured for Its Allegedly Negligent Misrepresentations and After the Insured's Excess Professional Liability Insurer Pays All Defense and Indemnity Costs

In the immediately preceding section, an analysis of the three-judge panel's decision in *Lamar* appears.[1414] The observation is relevant because *Lamar* is a third party case, involving whether a comprehensive general liability insurer has a duty to defend and indemnify an insured homebuilder for construction defects.[1415] But the *Lamar* panel did not address the central appellate questions because an ancillary issue was present: whether a construction defect is an occurrence and, therefore, an accident which triggers an insurer's duty to defend and indemnify under a CGL policy.[1416] To secure a definitive answer, the *Lamar* panel certified the question to the Texas Supreme Court.[1417]

In *Federal Insurance Co. v. Ace Property & Casualty Co.* litigants also asked a different Fifth Circuit panel to declare whether a different comprehensive general liability insurer had a duty to defend and indemnify an insured.[1418] Once more, the secondary issue was whether an insured's conduct was an occurrence and, therefore, an accident that triggers the insurer's duty to defend and indemnify.[1419] But unlike the *Lamar* panel, the *Federal* panel issued a declaration, concluding that no need existed to certify the occurrence question to the Texas Supreme Court.[1420] The following discussion should illustrate why the *Federal* panel's decision not to certify a similar occurrence-accident question to the Texas Supreme Court was less than prudent.

Here are the pertinent facts in the underlying dispute between the insured and the third party complaints. Electronic Data Systems Corporation (EDS) is a global technology services company that regularly sells computer and electronic services to all sorts of consumers, including the North Atlantic Treaty Organization (NATO).[1421] EDS's contact person at NATO was an individual who identified himself as Colonel West.[1422] West allowed EDS to believe that he was in charge of a covert NATO procurement project.[1423] Reporting that NATO would purchase eighty to one hundred billion dollars

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1414. *See supra* Part IV.B.3.
1415. *See supra* Part IV.B.3.
1416. *See supra* Part IV.B.3.
1417. *Lamar Homes*, 428 F.3d at 195.
1418. Fed. Ins. Co. v. Ace Prop. & Cas. Co., 429 F.3d 120, 121 (5th Cir. Oct. 2005).
1419. *Id.*
1420. *Id.*
1421. *Id.*
1422. *Id.*
1423. *Id.*

worth of sophisticated electronic equipment, West encouraged EDS to join the clandestine operation and become the general contractor.[1424]

EDS accepted the offer and invited Akai Musical Instrument Corporation (Akai) and Pioneer New Media Technologies, Inc. (Pioneer) to submit bids.[1425] EDS informed Akai and Pioneer that their participation was subject to a condition precedent: the bidding process required Akai and Pioneer to ship samples of their electronic products to several NATO representatives.[1426] EDS also informed the suppliers that the representatives would have the right to destroy the samples in the course of NATO's testing procedures.[1427] Therefore, relying on EDS's representations, Akai and Pioneer signed respective Test to Destruction Authorization Agreements and shipped millions of dollars worth of electronic equipment to the supposed NATO representatives.[1428]

The shipments continued for three years, but eventually, the parties, EDS, Akai, and Pioneer, learned that West had deceived them.[1429] The so-called "NATO operation" was a fraud.[1430] In addition, they discovered that West was not a military officer and was not affiliated with NATO.[1431] More egregious, NATO representatives did not receive or use Akai and Pioneer's electronic equipment.[1432] Instead, West appropriated the equipment and disposed of it commercially for his private gain.[1433] Subsequently, Akai and Pioneer commenced a negligent-misrepresentation cause of action against EDS.[1434]

When the underlying lawsuit commenced, and during the period when Akai and Pioneer were shipping the products to West, Ace Property and Casualty Company (Ace) insured EDS under two primary, CGL policies.[1435] Additionally, Federal Insurance Company (Federal) insured EDS under an excess professional liability insurance contract.[1436] Because Ace was the primary insurer, EDS asked Ace to provide a legal defense.[1437] Ace refused, asserting that EDS's alleged negligent misrepresentations were not occurrences under Ace's CGL policies.[1438]

1424. *Id.*
1425. *Id.*
1426. *Id.*
1427. *Id.*
1428. *Id.*
1429. *Id.*
1430. *Id.*
1431. *Id.*
1432. *Id.*
1433. *Id.*
1434. *Id.*
1435. *Id.*
1436. *Id.*
1437. *Id.*
1438. *Id.* at 121-22.

EDS eventually settled the suit, and Federal, the excess insurer, paid the legal defense and indemnity costs—those exceeding EDS's deductible under the excess professional liability policy.[1439] Therefore, asserting its subrogation rights under the excess insurance contract, Federal filed a declaratory judgment action against Ace in the District Court for the Eastern District of Texas.[1440] The excess insurer asked the district court to declare that Ace had a contractual duty to defend EDS in the underlying suit and to order Ace to reimburse Federal for monies spent to settle and defend against Akai and Pioneer's five million dollar lawsuit.[1441]

Both insurers filed motions for summary judgment.[1442] Ultimately, the federal district court granted Ace's motion, concluding that EDS's alleged negligent misrepresentation was not an accident and, therefore, not an occurrence under the CGL policies.[1443] Therefore, the district court concluded that Ace had no duty to defend EDS and had no duty to pay Akai and Pioneer for their property loss.[1444] Federal appealed.[1445]

Before the Fifth Circuit, Federal insisted that the lower court's decision was erroneous and that an insured's allegedly negligent misrepresentation is an occurrence under a CGL insurance contract.[1446] To determine whether Federal's assertions were sound, the Fifth Circuit panel examined Ace's CGL policies and found that Ace promised to "pay those sums that [EDS] becomes legally obligated to pay as damages because of . . . property damage . . . ."[1447] Ace promised to pay damages, however, only if an occurrence causes property damage during the duration of the contracts.[1448]

The CGL policies defined property damage as a "[p]hysical injury to tangible property, including . . . use of that property" or "[l]oss of use of tangible property that is not physically injured."[1449] Under the contracts, an occurrence was "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."[1450] A definition of an accident did not appear in the CGL insurance contracts.[1451] In *Lamar* Mid-Continent insured Lamar under a similar CGL policy.[1452] Under both Mid-Continent's and Ace's polices, the definitions of property damage are

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1439. *Id.* at 122.
1440. *Id.*
1441. *Id.*
1442. *Id.*
1443. *Id.*
1444. *Id.*
1445. *Id.*
1446. *Id.*
1447. *Id.*
1448. *Id.*
1449. *Id.*
1450. *Id.*
1451. *Id.*
1452. Lamar Homes, Inc. v. Mid-Continent Cas. Co., 428 F.3d 193, 196 (5th Cir. Aug. 2005).

identical.[1453] In addition, the definition of an occurrence in Ace's liability insurance contract is similar to the definition appearing in Mid-Continent's CGL contract.[1454]

Returning to Federal's argument, the Fifth Circuit panel observed that the Texas Supreme Court and lower courts in Texas have not decided whether an insured's negligent misrepresentation is an occurrence under a liability insurance contract.[1455] But Federal invited the appellate court to consider and adopt the district court's ruling in *Aetna Casualty & Surety Co. v. Metropolitan Baptist Church*.[1456] In *Metropolitan*, a company negligently misrepresented the extent of coverage under the company's health insurance policy, and the district court concluded that the applicant's reliance on the negligent misrepresentation was an occurrence under a liability insurance contract.[1457] Surprisingly, the *Federal* panel concluded:

> We need not resolve today whether *Metropolitan* was correctly decided or whether, under Texas law, negligent misrepresentations can ever constitute an "occurrence" because . . . under the facts of the case before us, none of EDS's conduct nor any of its alleged omissions was an "accident" within the meaning of the policy.[1458]

To reach that rather unexpected conclusion, the panel cited the facts and the Texas Supreme Court's decision in *Argonaut Southwest Insurance Co. v. Maupin*, "[p]erhaps the most analogous Texas case" according to the panel.[1459] In *Argonaut*, the insured signed a contract under which he agreed to remove borrowed material from a tract of land that had been used during the construction of a highway.[1460] After removing and damaging a considerable amount of the material, the insured learned that the other party to the contract was a tenant rather than the owner of the land.[1461] Subseqently, the true owners of the property sued the insured, and the insured asked his insurance carrier to provide a legal defense or pay for the judgment rendered against the insured.[1462] The insurer refused.[1463]

Ultimately, the Texas Supreme Court ruled in favor of the insurer, finding that the insured intentionally committed an act, removing the material from the

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1453. *Id.*
1454. *Id.*; *Fed. Ins. Co.*, 429 F.3d at 122.
1455. *Fed. Ins. Co.*, 429 F.3d at 123.
1456. *Id.*; Aetna Cas. & Sur. Co. v. Metro. Baptist Church, 967 F. Supp. 217, 224 (S.D. Tex. 1996).
1457. *Metropolitan*, 967 F. Supp. at 223-24.
1458. *Fed. Ins. Co.*, 429 F.3d at 123.
1459. *Id.* at 123 n.7; Argonaut Sw. Ins. Co. v. Maupin, 500 S.W.2d 633, 633 (Tex. 1973).
1460. *Argonaut*, 500 S.W.2d at 635.
1461. *Id.*
1462. *Id.*
1463. *Id.*

property, even though the insured had no intent to injure the true owners.[1464] Stated slightly differently, the supreme court found that the insured's action was "voluntary and intentional," even though the result or injury "may have been unexpected, unforeseen and unintended."[1465]

In addition, the *Argonaut* court ruled that the insured's action was not an accident, even though (1) the insured mistakenly signed a contractual agreement with someone other than the true owners of the property, (2) the insured did not deal originally with the true owners of the property, and (3) the insured was completely ignorant about who actually owned the property.[1466] So, the Texas Supreme Court concluded that the insurer had no obligation to defend or indemnify because the insurance contract did not cover a property loss stemming from a mistake or an erroneous belief about the true ownership of the loss property.[1467]

The *Federal* panel also cited *King v. Dallas Fire Insurance Co.* and *Mid-Century Insurance Co. of Texas v. Lindsey* for support in stating: "[w]hether there has been an accident, and thus an occurrence, is judged from the viewpoint of the insured . . . ."[1468] Embracing the rulings in those decisions, the *Federal* panel concluded that EDS intended West to secure Akai and Pioneer's goods without returning the property to those companies.[1469] Or stated slightly differently, EDS expected that West would exercise control over Akai and Pioneer's property without ever returning the property to the two shippers.[1470] Furthermore, the panel concluded that even though EDS mistakenly characterized the property's intended use and was unaware of West's scam when EDS made representations to Akai and Pioneer, EDS's actions were not accidental.[1471]

But, the Fifth Circuit panel's reliance on the rulings in *Argonaut*, *King*, and *Mid-Century* to decide the conflict between Federal and Ace in the present case is unwarranted. In those cases, litigants asked the Texas Supreme Court to interpret the meaning of "intent" or "intended," as those terms appeared in the insurance contracts' coverage provisions.[1472] For example, in *Argonaut*,

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1464. *Id.*

1465. *Id.*

1466. *Id.*

1467. *Id.*

1468. Fed. Ins. Co. v. Ace Prop. & Cas. Co., 429 F.3d 120, 123 (5th Cir. Oct. 2005) (citing Mid-Century Ins. Co. of Tex. v. Lindsey, 997 S.W.2d 153 (Tex. 1999) (reaffirming that "an injury is accidental if from the viewpoint of the insured, [it is] not the natural and probable consequence of the action or occurrence which produced the injury"); King v. Dallas Fire Ins. Co., 85 S.W.3d 185 (Tex. 2002) (holding that under a policy with virtually identical provisions that an accident must be determined from the viewpoint of the insured)).

1469. *Id.* at 124-25 ("EDS did intend for Akai and Pioneer to [relinquish their property permanently, knowing] that the property might even be destroyed. The loss of Akai's and Pioneer's property 'ordinarily follow[ed]' from EDS's misrepresentations and the Test to Destruction Authorization Agreements.'").

1470. *Id.* at 123-24.

1471. *Id.* at 124.

1472. *See King*, 85 S.W.3d at 188; *Mid-Century*, 997 S.W.2d at 163.

the coverage clause and its endorsement stated in relevant part:

> [The insurer agrees to] pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of injury to or destruction of property, including the loss of use thereof, caused by [an] accident.
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> . . . .
>
> The word "occurrence" . . . shall mean either (a) an accident, or (b) . . . a condition for which the insured is responsible . . . [and that] causes physical injury to or [the] destruction of property which was not intended.[1473]

In the present case, however, a careful review of the CGL contract's coverage clause reveals that words like intent, intended, intend, and intentional do not appear.[1474] Why did the *Federal* panel spend precious judicial resources deciding a question involving intent that was foreign to the central question of whether Ace had a contractual obligation to defend the underlying third party actions and indemnify Federal for settling the claims against EDS.[1475] The *Federal* panel concluded that Ace had no duty to defend or to indemnify because EDS intended to produce Akai and Pioneer's losses and those losses were not caused by an accident.[1476]

Without doubt, the *Federal* panel should have embraced the *Lamar* panel's prudent approach and certified the following occurrence question to the Texas Supreme Court: whether a property loss is an occurrence and, therefore, an accident which triggers an insurer's duty to defend and indemnify under a CGL policy.[1477] The Supreme Court of Texas likely would have provided a clear answer, applied the eight corners doctrine and other doctrines of equity appropriately and completely, and avoided the *Federal* panel's poor analysis and extremely questionable conclusion.[1478]

1473. Argonaut Sw. Ins. Co. v. Maupin, 500 S.W.2d 633, 634 n.1.

1474. *Fed. Ins. Co.*, 429 F.3d at 125.

1475. *Id.* at 122.

1476. *Id.* at 125.

1477. *Id.*; *see* Lamar Homes, Inc., v. Mid-Continent Cas. Co., 428 F.3d 193, 199 (5th Cir. Oct. 2005).

1478. King v. Dallas Fire Ins. Co., 85 S.W.3d 185, 187 (Tex. 2002) (reiterating that under the eight corners rule, Texas courts must examine information appearing within the four corners of the pleadings along with the terms and conditions found within the four corners of the insurance contract to determine whether an insurer has a duty to defend an insured in Texas); *see, e.g.*, Farmers Tex. County Mut. Ins. Co. v. Griffin, 955 S.W.2d 81, 83 (Tex. 1997) (concluding that the duty to indemnify is properly justiciable by initiating a declaratory judgment action "before the rendition of a judgment in the underlying suit").

2. Whether Under Louisiana Law a Professional Liability Insurer May Commence a Legal Malpractice Action Against an Insurance Defense Law Firm After the Insurer Settles an Underlying Lawsuit But Before an Appeal of an Adverse Jury Verdict in the Underlying Suit

As discussed throughout this review, primary insurers hire attorneys and law firms to defend insureds against third party claims and lawsuits. And insurance defense lawyers often do not successfully defend insureds in underlying lawsuits. In Louisiana, Mississippi, and Texas, the law is clear: An attorney-client relationship exists between an insured and the insured's insurance defense attorney.[1479] Therefore, if an insured does not prevail in an underlying third party lawsuit, the unsuccessful insured may commence a legal malpractice action against an insurance defense lawyer or law firm.

On the other hand, whether a person's insurance company may commence a legal malpractice action against a person's insurance defense attorney is more problematic because an attorney-client relationship does not exist between the insurance carrier and the lawyer. The Supreme Court of Texas, however, has allowed insurers to file legal malpractice actions against insurance defense firms and lawyers under the doctrine of equitable subrogation.[1480] The Supreme Court of Mississippi has strongly suggested a willingness to do the same.[1481] The Louisiana Supreme Court has not ruled either way, which explains in part the Fifth Circuit's willingness to decide a novel procedural question in *American Reliable Insurance Co. v. Navratil* involving whether an insurer had a legal right to commence a legal malpractice action against an insurance defense firm.[1482]

The facts in *Navratil* are extremely meager.[1483] American Reliable Insurance Company (ARIC) insured Eli Prudhomme under a liability

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1479. *See generally* Robin v. Allstate Ins. Co., 844 So.2d 41, 44-46 (La. Ct. App. 2003); Hartford Accident & Indem. Co. v. Foster, 528 So.2d 255, 269-70 nn.8-9 (Miss. 1988); Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Keck, Mahin & Cate, 154 S.W.3d 714, 723-24 (Tex. App.—Houston [14th Dist.] 2004, pet. denied).

1480. *See* Am. Centennial Ins. Co. v. Canal Ins. Co., 843 S.W.2d 480, 484 (Tex. 1992) (recognizing an excess insurer's right to assert a legal malpractice claim against the insured's defense attorney under a theory of equitable subrogation and concluding that permitting an excess carrier to stand in the shoes of its insured and assert the insured's claims would not burden the existing attorney-client relationship with additional duties or create potential conflicts of interest for the attorney); Keck, Mahin & Cate v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 20 S.W.3d 692, 703 (Tex. 2000) (reaffirming an insurance carrier's right to commence a legal malpractice action against an insurance defense firm under the doctrine of equitable subrogation).

1481. *See* Baker Donelson Bearman & Caldwell, P.C. v. Muirhead, 920 So.2d 440, 448 (Miss. 2006) (suggesting that an assignment from an insured would permit the insurer to sue an insurance defense attorney for legal malpractice).

1482. *See* Am. Reliable Ins. Co. v. Navratil, 445 F.3d 402, 403 (5th Cir. Mar. 2006).

1483. *Id.* at 403.

insurance contract.[1484] The policy limit was $25,000.[1485] In addition, the contract had a duty-to-defend clause in which ARIC promised to defend Prudhomme under certain conditions.[1486] A third party complainant filed a lawsuit against Prudhomme in a Louisiana state court and ARIC retained the law firm of Navratil, Hardy & Bourgeois to defend Prudhomme.[1487] Boris Navratil (Navratil) was the attorney of record for the insured.[1488] A jury tried the underlying lawsuit and returned a verdict in favor of the third party complainant.[1489] Prudhomme and ARIC *in solido* had to pay $25,000 in damages—the insurance contract's policy limit.[1490] Prudhomme had to pay an additional $420,198.30 in damages to satisfy the judgment.[1491]

Believing that several legal theories could possibly reduce the size of the damages or change the allocation of damages, Navratil wanted to appeal the verdict and damages awards.[1492] Therefore, Navratil contacted ARIC and urged the insurer to appeal the case.[1493] At that time, Navratil also informed ARIC that Louisiana law required Navratil to appeal the adverse judgment against Prudhomme, even if ARIC would not directly benefit from an appeal.[1494] Still, ARIC ignored Navratil's recommendation and terminated Navratil's representation before the state court entered a final judgment on the verdict.[1495]

After firing Navratil, ARIC settled the underlying lawsuit with the third party complainant for $550,000, which greatly exceeded the jury's award.[1496] But the settlement amount was apparently less than the total anticipated judgment against Prudhomme.[1497] Furthermore, in exchange for ARIC's completely settling the third party lawsuit, Prudhomme assigned all of his contractual rights to ARIC and released the insurer from all liability.[1498]

Shortly thereafter, ARIC filed a legal malpractice action against Navratil in the District Court for the Western District of Louisiana.[1499] The insurer alleged that Prudhomme would have secured a better outcome in the underlying third party proceedings if Navratil had not deviated from the

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1484. *Id.*
1485. *Id.*
1486. *Id.* at 403 n.3.
1487. *Id.* at 403.
1488. *Id.*
1489. *Id.* at 404.
1490. *Id.* at 403.
1491. *Id.*
1492. *Id.*
1493. *Id.*
1494. *Id.* ("Navratil acknowledged in his letter that, given ARIC's $25,000 policy limit and the unlikelihood of a complete reversal, an appeal probably would not directly benefit ARIC.").
1495. *Id.*
1496. *Id.*
1497. *Id.*
1498. *Id.* at 403 n.3.
1499. *Id.* at 403-04.

standard of care expected of attorneys practicing law in Louisiana.[1500] Both ARIC and Navratil filed motions for summary judgment.[1501] The federal district court granted Navratil's motion and dismissed ARIC's legal malpractice action with prejudice.[1502] The federal judge held that ARIC's failure to appeal the jury verdict—before voluntarily settling the underlying third party lawsuit—barred ARIC's legal malpractice action against Navratil as a matter of state law.[1503] The insurer appealed the federal district court's adverse summary judgment.[1504]

The district court granted Navratil's summary judgment motion after relying almost exclusively on a Louisiana appellate court decision in *Gross v. Pieno* and making an *Erie* guess.[1505] On appeal, the Fifth Circuit made its own *Erie* guess about how the Louisiana Supreme Court would decide this controversy and reversed the district court's finding for two reasons.[1506]

First, the court of appeals found the district court's reliance on *Pieno* was overly broad.[1507] In *Pieno*, the clients' decision to settle the case before a pre-trial hearing, regarding the attorney's alleged abandonment, shortened the proceedings.[1508] Consequently, no court could determine whether the attorney had in fact harmed his clients.[1509] In stark contrast, the attorney in the present case represented his client continually and thoroughly until a jury decided against Prudhomme and awarded large damages to the third party complainants.[1510] Therefore, the Fifth Circuit concluded that, given the extensive record of the state court proceedings, a trier of fact could determine with certainty whether Navratil committed legal malpractice while

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1500. *Id.*; *see also* Francois v. Reed, 714 So.2d 228, 229-30 (La. Ct. App. 1998) (reaffirming that a complainant must prove three elements to establish a prima facie case of legal malpractice: (1) the presence of an attorney-client relationship, (2) the attorney's negligent representation, and (3) evidence that the attorney's negligence was the cause in fact and proximate cause of the client's loss in the underlying lawsuit).

1501. *Navratil*, 445 F.3d at 403-04.

1502. *Id.* at 404.

1503. *Id.*

1504. *Id.*

1505. *Id.* at 404 & n.7 (citing Gross v. Pieno, 892 So.2d 662 (La. Ct. App. 2004)).

> The district court, sitting in diversity, made an "*Erie* guess" in its effort to determine the applicable state law. In the absence of any controlling state statute or relevant decision of the Supreme Court of Louisiana, the district court appropriately turned to rulings of state appeal courts, here relying almost exclusively on the decision of one in *Pieno*. . . . We note that the Louisiana Supreme Court declined review in *Pieno*, as well as in the *Murphy* case on which *Pieno* relied.

Id.; *see also* Terrebonne Parish Sch. Bd. v. Columbia Gulf Transmission Co., 290 F.3d 303, 317 (5th Cir. 2002) (holding that decisions of the intermediate state courts are "not to be disregarded by a federal court unless it is convinced by other persuasive data that the highest court of the state would decide otherwise"); Murphy v. Gilsbar, Inc., 834 So.2d 669, 670 (La. Ct. App. 2002).

1506. *Navratil*, 445 F.3d at 407.

1507. *Id.* at 404.

1508. *Pieno*, 892 So.2d 664-65.

1509. *Id.*

1510. *Navratil*, 445 F.3d at 405.

representing Prudhomme in the matter all the way to verdict.[1511]

Second, Navratil suggested and the federal district court agreed that ARIC's decision to terminate Navratil's representation—before the Louisiana lower court entered a final judgment on the verdict in the underlying lawsuit—equitably estopped ARIC from commencing a legal malpractice action.[1512] But the Fifth Circuit disagreed.[1513] Again, making an *Erie* guess, the court of appeals declared:

> We are . . . convinced that the Supreme Court of Louisiana . . . would distinguish *Pieno* and hold that ARIC's settlement of the underlying case did not have the preclusive effect of barring the client from bringing an independent action for legal malpractice. . . . [T]he Supreme Court of Louisiana . . . would [not] apply equitable estoppel under the instant facts. . . . [We] reverse the summary judgment dismissal of ARIC's malpractice suit against Navratil . . . [and] hold that ARIC's decision not to pursue an appeal under these circumstances does not equitably estop [the insurer] from prosecuting its malpractice action against Navratil.[1514]

V. A BRIEF STATISTICAL REVIEW OF THE FIFTH CIRCUIT'S REPORTED 2005-2006 INSURANCE-RELATED OPINIONS

On another occasion, this commentator discussed the merits using simple statistics to help practicing attorneys and others to understand questionable and often conflicting judicial decisions that traditional legal analyses might explain fully.[1515] Fairly often, judges of all persuasions intentionally or unintentionally allow so-called extralegal factors—like plaintiffs' legal status or types of insurance contracts—to influence the disposition of cases.[1516] Courts are statistically and significantly more inclined to rule in favor of defendants rather than plaintiffs, even after a statistician removes or controls for the influence of other legal and extralegal variables.[1517] More disturbing, such

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1511. *Id.*

1512. *Id.*

1513. *Id.* ("Contrary to the suggestion of Navratil's argument, there is no indication that the *Pieno* court would have applied equitable estoppel to bar a malpractice action against the attorney if the judgment in that case had been final.").

1514. *Id.* at 404, 406-07.

1515. *See* Willy E. Rice, *Insurance Decisions—A Survey and An Empirical Analysis*, 35 TEX. TECH. L. REV. 947, 1026-28 (2004).

1516. *See, e.g.*, Willy E. Rice, *Insurance Contracts and Judicial Discord Over Whether Liability Insurers Must Defend Insureds' Allegedly Intentional and Immoral Conduct: A Historical and Empirical Review of Federal and State Courts' Declaratory Judgments—1900-1997*, 47 AM. U. L. REV. 1131, 1169-94, 1202-18 (1998) (chronicling intra-jurisdictional conflicts and arguably biased rulings, and reporting that defendants are more likely to prevail in federal and state declaratory judgment actions).

1517. *See, e.g.*, Kevin M. Clermont & Theodore Eisenberg, *Anti-Plaintiff Bias in the Federal Appellate Courts*, 84 JUDICATURE 128, 133-34 (2000) (finding that when controlling for the possibility of other influences or predictor variables, federal courts are still significantly more likely to decide

judicial bias often accounts for the ever increasing number of highly conflicting, unduly complicated, and arguably unfair rulings.[1518]

Certainly, this Part does not attempt to present an elaborate statistical analysis of the Fifth Circuit's 2005-2006 insurance decisions, as the court reported just twenty-four cases for publication.[1519] That relatively tiny number of cases precludes a more sophisticated analysis—one that would explain more completely and fittingly the concurrent influence of legal and extralegal variables on the likelihood of insureds and insurers' winning or losing in the Fifth Circuit.

Still, analyzing frequencies and percentages, along with a case-by-case legal analysis of courts' rulings, can enhance one's understanding of questionable summary and declaratory judgments. Moreover, simple statistics can also uncover important or unexpected patterns among judicial opinions. Therefore, given these positive benefits of statistical research, this commentator performed a content analysis of the twenty-four cases and reported a series of simple descriptive statistics in three tables, as follows.

First, Table A presents frequencies and percentages for some selected demographic attributes of insurers and insureds that petitioned the Fifth Circuit Court of Appeals for relief during the 2005-2006 session.

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overwhelmingly in favor of defendants).

1518. *See generally* Rice, *supra* note 664, at 1040-72, 1074-95 (chronicling inconsistent and biased rulings, and reporting that defendants are more likely to prevail in federal and state declaratory judgment actions).

1519. Texaco Exploration and Prod., Inc. v. AmClyde Eng'rd Prod. Co., 448 F.3d 760 (5th Cir. May 2006); St. Paul Surplus Lines Ins. Co. v. Halliburton Energy Servs., Inc., 445 F.3d 820 (5th Cir. Apr. 2006); Wallace v. La. Citizens Prop. Ins. Corp., 444 F.3d 697 (5th Cir. Mar. 2006); Am. Reliable Ins. Co. v. Navratil, 445 F.3d 402 (5th Cir. Mar. 2006); Motiva Enters., LLC v. St. Paul Fire & Marine Ins. Co., 445 F.3d 381 (5th Cir. Mar. 2006); Dale v. Colagiovanni, 443 F.3d at 425 (5th Cir. Mar. 2006); EMCASCO Ins. Co. v. Am. Int'l Specialty Lines Ins. Co., 438 F.3d 519 (5th Cir. Jan. 2006); Stewart v. W. Heritage Ins. Co., 438 F.3d 488 (5th Cir. Jan. 2006); Am. Bankers Ins. Co. of Fla. v. Inman, 436 F.3d 490 (5th Cir. Jan. 2006); Gallup v. Omaha Prop. & Cas. Ins. Co., 434 F.3d 341 (5th Cir. Dec. 2005); Fed. Ins. Co. v. Ace Prop. & Cas. Co., 429 F.3d 120 (5th Cir. Oct. 2005); Lamar Homes, Inc. v. Mid-Continent Cas. Co., 428 F.3d 193 (5th Cir. Oct. 2005); Int'l Ins. Co. v. RSR Corp., 426 F.3d 281 (5th Cir. Sept. 2005); Minter v. Great Am. Ins. Co. of N.Y., 423 F.3d 460 (5th Cir. Aug. 2005); Times-Picayune Publ'g Corp. v. Zurich Am. Ins. Co., 421 F.3d 328 (5th Cir. Aug. 2005); Thyssen, Inc. v. Nobility Mv, 421 F.3d 295 (5th Cir. Aug. 2005); Riverwood Int'l Corp. v. Employers Ins. of Wausau, 420 F.3d 378 (5th Cir. Aug. 2005); Coleman v. School Bd. of Richland Parish, 418 F.3d 511 (5th Cir. July 2005); Wentwood Woodside I, LP v. GMAC Commercial Mortgage Corp., 419 F.3d 310 (5th Cir. July 2005); Lifecare Hospitals, Inc. v. Health Plus of La., Inc., 418 F.3d 436 (5th Cir. July 2005); Ridglea Estate Condo. Ass'n v. Lexington Ins. Co., 415 F.3d 474 (5th Cir. July 2005); Wright v. Allstate Ins. Co., 415 F.3d 384 (5th Cir. June 2005); United Teacher Assocs. Ins. Co. v. Union Labor Life Ins. Co., 414 F.3d 558 (5th Cir. June 2005); La. Patients' Comp. Fund Oversight Bd. v. St. Paul Fire & Marine Ins. Co., 411 F.3d 585 (5th Cir. June 2005).

TABLE A. SOME SELECTED DEMOGRAPHIC CHARACTERISTICS OF INSURANCE LAW LITIGANTS WHO PETITIONED THE FIFTH CIRCUIT COURT OF APPEALS FOR REVIEW—2005-2006[1520]

Demographic Characteristics	Frequencies (N = 24)	Percentages (100.0)
States Where Cases Originated:		
Louisiana	11	45.8
Mississippi	3	12.5
Texas	10	41.7
Federal Districts Where Cases Originated:		
Louisiana-Eastern District	6	25.0
Louisiana-Western District	5	20.8
Mississippi-Southern District	3	12.5
Texas-Eastern District	1	4.2
Texas-Northern District	4	16.7
Texas-Southern District	3	12.5
Texas-Western District	2	8.3
Types of Plaintiffs:		
Insured Corporations	9	37.5
Insured Individuals	5	20.8
Primary Insurers	3	12.5
Excess Insurers	1	4.2
Receivers/State Regulators	3	12.5
Association/Partnership	2	8.3
Employer	1	4.2
Types of Insurance Contracts		
Liability	9	37.5
Flood	4	16.6
Property	3	12.5
Automobile	3	12.5
Health/HMO	2	8.3
Life	1	4.2
Malpractice	1	4.2
Marine	1	4.2

1520. Willy E. Rice, TABLE A. SOME SELECTED DEMOGRAPHIC CHARACTERISTICS OF INSURANCE LAW LITIGANTS WHO PETITIONED THE FIFTH CIRCUIT COURT OF APPEALS FOR REVIEW—2005-2006 (2006) [hereinafter Table A].

Types of Insurance Complaints:		
First party Complaints	9	37.5
Third-Party Complaints	15	62.5

Nearly forty-six percent (45.8%) of the cases originated in Louisiana, and litigants filed the remaining cases in district courts located in Mississippi and Texas, 12.5% and 41.75%, respectively.

More revealing, nine federal district courts are distributed across Louisiana, Mississippi, and Texas. Among the present twenty-four cases, however, nearly eighty-seven percent (86.7%) of the lawsuits began in only five federal district courts: the Eastern District Court of Louisiana (25.0%), the Western District Court of Louisiana (20.8%), the Southern District Court of Mississippi (12.5%), the Northern District Court of Texas (16.7%), and the Southern District Court of Texas (12.5%).

While a diversity of persons petitioned the Fifth Circuit to review adverse declaratory judgments, summary judgments, and other rulings, the overwhelming majority of plaintiffs were insured corporations (37.5%), insured individuals (20.8%), primary insurers (12.5%), and receivers and state regulators (12.5%). Unlike 2002-2004 insurance litigants, the distribution of 2005-2006 petitioners who filed first and third party complaints in the Fifth Circuit was skewed.[1521] Just thirty-eight percent (37.5%) of the underlying cases involved the insureds' first party claims and actions. On the other hand, an impressive sixty-three percent (62.5%) of the cases involved third party insurance claims and causes.

Among first party actions, disgruntled insureds quarreled with their respective insurers over whether insurers had a duty to pay various claims or to indemnify insureds under several types of personal insurance policies: flood (16.6%), property (12.5%), health/HMO (8.3%), marine (4.2%), and life (4.2.8%) insurance contacts. In contrast, among the cases in which third party victims sued insureds, insureds and subrogees clashed with insurance companies over whether insurers had a duty to defend, settle, or indemnify under several types of insurance contracts: comprehensive, commercial, educators', employers', environmental-impairment and general liability insurance contracts (37.5%), excess automobile liability insurance contracts (12.5%), and professional liability insurance contracts (4.2%).

Table B presents frequencies and percentages for several pertinent variables surrounding litigants' theories of recovery, the types of remedies that litigants sought, the types of remedies that the Fifth Circuit awarded, and the

1521. *Compare* Table A, *supra* note 1524, *with* Rice, *supra* note 1519, at 1026-31, *and* Rice, *supra* note 822, at 1017-23, *and* Rice, *supra* note 5, at 899-905.

general distribution of the claims and actions in the district courts and in the court of appeals.

TABLE B. THEORIES OF RECOVERY, REMEDIES, AND THE DISPOSITION OF INSURANCE LAW ACTIONS IN FEDERAL DISTRICT COURTS AND IN THE FIFTH CIRCUIT COURT OF APPEALS—2005-2006[1522]

Theories of Recovery, Remedies, and Outcomes	Frequencies (N = 24)	Percentages (100.0)
Types of Actions:		
Individual Actions	23	96.0
Class Actions	1	4.0
†Petitioners' Legal Theories (Causes):		
Breach of Contract	11	45.8
Declaratory Judgment	9	37.5
Negligence/Bad-Faith	7	29.0
Equitable Subrogation	3	12.5
Fraud	2	8.3
Unfair Business Practices	2	8.3
Federal RICO	1	4.2
†Remedies Sought:		
Indemnification	21	87.5
Declaratory Relief	13	29.2
Actual/Punitive Damages	5	20.7
Legal Defense	4	16.6
Grounds for Disposing Cases in Federal District Courts:		
On the Merits	15	62.5
Procedural	9	37.5
Disposition of Cases in Federal District Courts:		
Plaintiffs-Insureds Won	10	41.7
Defendants-Insurers Won	14	58.3
Disposition of Cases in the Fifth Circuit Court:		
Plaintiffs-Insureds Won	8	33.3
Defendants-Insurers Won	16	66.7

1522. Willy E. Rice, THEORIES OF RECOVERY, REMEDIES, AND THE DISPOSITION OF INSURANCE LAW ACTIONS IN FEDERAL DISTRICT COURTS AND IN THE FIFTH CIRCUIT COURT OF APPEALS—2005-2006 (2006) [hereinafter Table B].

Litigants' Success-Failure Rate Before the Fifth Circuit:		
Affirmed for Insurers-Defendants	3	12.5
Affirmed for Insureds-Plaintiffs	5	20.8
Reversed Against Insureds-Plaintiffs	6	25.0
Reversed Against Insurers-Defendants	3	12.5
Affirmed and Reversed in Part	7	29.2

† Multiple causes of action appeared in several cases; therefore, the reported percentages can exceed one hundred percent.

First, Table B illustrates that litigants raised and sought relief under an assortment of legal theories. In nearly forty-six percent (45.8%) of the cases, insureds and other plaintiffs filed breach-of-contract actions against the insurers. In nearly thirty-eight percent (37.8%) of the cases, both insurers and insureds commenced declaratory judgment actions, asking the courts for declaratory relief under a variety of insurance contracts. Furthermore, in twenty-nine percent (29.0%) of the cases, various complainants filed common law bad-faith and negligence-based actions against insurers. In addition, aggrieved parties filed equitable subrogation actions in nearly thirteen percent (12.5%) of the cases. An equal number of complainants, 83%, filed common law fraud and deceptive trade practices—statutory actions—against insurers.

Unlike the 2002-2004 litigants, the 2005-2006 petitioners asked the lower courts and Fifth Circuit to award a relatively small variety of remedies. First, in nearly eighty-eight percent (87.5%) of the filings, complainants asked the courts to declare that various defendants had a duty to indemnify—either insureds or insurers. In twenty-nine percent (29.0%) of the controversies, complaining parties asked the courts for declaratory relief. Aggrieved parties also asked federal courts to award various damages and declare that insurers had a duty to defend insureds in underlying third party actions. The reported percentages are 20.7% and 16.6%, respectively.

What were the win-loss ratios for the 2005-2006 plaintiffs-insureds and defendants-insurers in the district courts and in the Court of Appeals for the Fifth Circuit? The results are consistent and incontrovertible: Federal courts in the Fifth Circuit display a small amount of empathy for insureds-plaintiffs' predicament or legal arguments. Specifically, federal district courts ruled in favor of insurers-defendants about fifty-eight percent (58.3%) of the time. But more impressive, insurers-defendants' likelihood of prevailing on appeal was even larger. Put simply, the Fifth Circuit decided in favor of the insurers-defendants nearly sixty-seven percent (66.7%) of the time. Again, these 2005-2006 outcome percentages are similar to the 2002-2004 findings.

The last displayed percentages in Table B present some additional information about the way the Fifth Circuit disposed of the federal district courts' rulings. First, the Fifth Circuit affirmed nearly thirteen percent (12.5%)

of the district courts' decisions in favor of the insurers. But more telling, the court of appeals reversed, in favor of the insurers, twenty-five percent (25.0%) of the district courts' pro-insureds rulings. On the other hand, the Court of Appeals for the Fifth Circuit affirmed nearly twenty-one percent (20.8%) of the district courts' pro-insured decisions, while reversing nearly thirteen percent (12.5%) of the district courts' pro-insurer decisions. For sure, the Fifth Circuit affirmed and reversed in part twenty-nine percent (29.2%) of the lower-courts' rulings. The greater beneficiaries of those rulings, however, were defendants, who were primarily insurance companies.

Again, the small number of cases in this brief study prevented the author from applying more elaborate statistical measures to analyze the data. Therefore, as has been the case in previous years, this analysis cannot provide a definitive answer to the Fifth Circuit and district courts' substantially greater tendency to decide in favor of defendants-insurers.[1523] Still, the percentages reported in Table C show some trends among the small sample of data.

Table C illustrates the disposition of the insurance cases among federal district courts and in the Fifth Circuit. The reported percentages show the relationships between three selected background variables and the litigants' likelihood of success.

1523. *Compare* Table B, *supra* note 1526, *with* Rice, *supra* note 1519, at 1027 n.793, *and* Rice, *supra* note 822, at 1022-23, *and* Rice, *supra* note 5, at 901-04.

TABLE C. THE DISPOSITION OF INSURANCE-RELATED ACTIONS BY SELECTED DEMOGRAPHIC VARIABLES, IN THE FIFTH-CIRCUIT DISTRICT COURTS AND IN THE COURT OF APPEALS FOR THE FIFTH CIRCUIT — 2005-2006[1524]

Selected Demographic Variables	Disposition in the District Courts (N = 24)			Disposition in the Court of Appeals (N = 24)		
	Insurers Won	Insureds Won	Percent (100.0)	Insurers Won	Insureds Won	Percent (100.0)
Types of Insurance Complaints:						
First-Party Complaints	44.4	***55.6***	(N=9)	55.6	44.4	(N=9)
Third-Party Complaints	***66.7***	33.3	(N=15)	***73.3***	26.7	(N=15)
Litigants' Domicile (States):						
Louisiana	45.4	***54.6***	(N = 11)	***81.8***	18.2	(N=11)
Mississippi	-0-	100.0	(N = 3)	***66.7***	33.3	(N=3)
Texas	***90.0***	10.0	(N = 10)	50.0	50.0	(N=10)
Federal Districts Where Cases Originated:						
Louisiana-Eastern District	33.3	66.7	(N=6)	***83.3***	16.7	(N=6)
Louisiana-Western District	***60.0***	40.0	(N=5)	***80.0***	20.0	(N=5)
Mississippi-Southern District	- 0-	100.0	(N=3)	66.7	33.3	(N=3)
Texas-Eastern District	100.0	- 0 -	(N=1)	100.0	-0-	(N=1)
Texas-Northern District	***75.0***	25.0	(N=4)	- 0 -	100.0	(N=4)
Texas-Southern District	100.0	- 0 -	(N=3)	100.0	- 0 -	(N=3)
Texas-Western District	100.0	- 0 -	(N=2)	50.0	50.0	(N=2)

1524. Willy E. Rice, TABLE C. THE DISPOSITION OF INSURANCE-RELATED ACTIONS BY SELECTED DEMOGRAPHIC VARIABLES, IN THE FIFTH-CIRCUIT DISTRICT COURTS AND IN THE COURT OF APPEALS FOR THE FIFTH CIRCUIT—2005-2006 [hereinafter Table C].

First, the types of insurance complaints slightly influenced whether insureds-plaintiffs or insurers-defendants prevailed. Among the district court cases, insurers-defendants triumphed just forty-four percent (44.4%) of the time when the underlying lawsuits involved a first party claim. Conversely, in federal district courts, insurers prevailed in nearly sixty-seven percent (66.7%) of the cases when the underlying lawsuits involved third party claims. Generally, in the latter cases, insureds sued insurers for allegedly breaching a contractual duty to settle or defend insureds against third party lawsuits.

Furthermore, after the Fifth Circuit reviewed the district courts' rulings, insurers won seventy-three percent (73.3%) of the cases when the underlying lawsuits involved third party claims. More interesting, insurers also won the majority of disputes on appeal—nearly fifty-six percent (55.6%)—when insureds petitioned the Fifth Circuit to determine whether insurers had a duty to pay a first party claim.

Additionally, among the cases resolved in the federal district courts, insureds had a greater probability of winning only if they (1) resided in Louisiana (54.6%) or in Mississippi (100%), (2) filed their actions in the Eastern District Court of Louisiana (66.7%), or (3) commenced their suits in the Southern District Court of Mississippi (100.0%). Under all other circumstances, however, insurers had the greater likelihood of prevailing in federal district courts. Insurers experienced a greater rate of success if they were practicing the business of insurance in Texas—90.0%.

When considering the litigants' domicile and the origination the actions, the percentages show that insurers' likelihood of winning improved in the Fifth Circuit Court of Appeals. First, as reported above, insurers-defendants who resided in Texas won an impressive 90.0% of the cases in the federal district courts. On appeal, however, those same Texas insurers won only fifty percent (50.0%) of the cases. Still, the overwhelming majority of insurers doing business in Louisiana and Mississippi prevailed before the Fifth Circuit. The reported percentages are 81.8% and 66.7%, respectively.

Furthermore, only one instance occurred in which insureds-plaintiffs' success rate exceeded that of the insurers-defendants: Insureds who filed their complaints in the Northern District Court of Texas won every case (100%) in the court of appeals. But the general trend is incontrovertible: Under all other circumstances, insurers-defendants had an appreciably larger likelihood of prevailing in the Fifth Circuit Court of Appeals regardless of the federal district court in which the case originated.

In light of the results reported in the 2002-2004 studies and the findings reported here, evidence strongly suggests that some systemic bias exists in the Fifth Circuit's decisions. Little, if any, legal justification exists to explain insurers-defendants' persistently higher likelihood of success before that tribunal. But again, these brief annual studies will never prove definitively that bias is present. That proof will have to wait until we conduct a larger study—using more a appropriate methodology, statistical tool, and representative

sample of cases.

VI. CONCLUSION

The quality of the Fifth Circuit's application of legal principles and general analysis in twenty-four insurance law decisions was extremely mixed during the 2005-2006 session. For the most part, the Fifth Circuit's opinions were intelligible and well-reasoned. In addition, this term the Fifth Circuit panels were more likely to apply Louisiana's, Mississippi's, and Texas's settled principle fairly and thoughtfully. But more impressive, the Fifth Circuit was more likely to certify difficult or novel questions to the respective state supreme courts rather than embracing *Erie* guesses to resolve insurance related disputes.

On the other hand, the Fifth Circuit panels did not consistently apply the traditional rules of contract construction and interpretation,[1525] the doctrine of plain meaning,[1526] the adhesion doctrine,[1527] the doctrine of ambiguity,[1528] and the reasonable expectations doctrine[1529] when interpreting the rights and

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1525. *See, e.g.*, Ledbetter v. Concord Gen. Corp., 665 So. 2d 1166, 1169 (La. 1996) (holding that an insurance policy is an agreement between the parties and should be interpreted by using ordinary contract principles); Sessoms v. Allstate Ins. Co., 634 So. 2d 516, 519 (Miss. 1993) (embracing the position that "insurance policies which are clear and unambiguous are to be enforced according to their terms as written"); Balandran v. Safeco Ins. Co. of Am., 972 S.W.2d 738, 741 (Tex. 1998) (reiterating that insurance contracts are subject to the same rules of construction as other contracts).

1526. *See, e.g.*, La. Ins. Guar. Ass'n v. Interstate Fire & Cas. Co., 630 So. 2d 759, 763 (La. 1994) (holding that the parties' intent must "be determined in accordance with the general, ordinary, plain and popular meaning of the words used in the policy"); Blackledge v. Omega Ins. Co., 740 So. 2d 295, 298 (Miss. 1999) (holding that courts must give terms used in insurance policies their ordinary and popular definition"); Transp. Ins. Co. v. Standard Oil Co. of Tex., 337 S.W.2d 284, 288 (Tex. 1960) (reiterating that courts must give words appearing in insurance contracts their plain meaning when no ambiguity exists).

1527. *See, e.g.*, Duncan v. Kan. City S. Ry. Co., 747 So. 2d 656, 674 (La. App. 3d Cir. 1999) (observing the well-settled notion that "insurance policies are generally contracts of adhesion"); J & W Foods Corp. v. State Farm Mut. Auto. Ins. Co., 723 So. 2d 550, 551-52 (Miss. 1998) (concluding that insurance policies are contracts of adhesion and as such ambiguities are to be construed liberally in favor of the insured and against the insurer); Arnold v. Nat'l County Mut. Fire Ins. Co., 725 S.W.2d 165, 167 (Tex. 1987) (concluding without deciding definitively that insurance contracts are adhesion contracts because they "arise[] out of the parties' unequal bargaining power . . . [and] allow unscrupulous insurers to take advantage of their insureds' misfortunes").

1528. *See, e.g.*, Succession of Fannaly v. Lafayette Ins. Co., 805 So. 2d 1134, 1138 (La. 2002) (repeating that an "ambiguous contractual provision is construed against the insurer who furnished the contract's text and in favor of the insured"); Nationwide Mut. Ins. Co. v. Garriga, 636 So.2d 658, 662 (Miss. 1994) (embracing "the general rule that [ambiguous] provisions of an insurance contract are to be strongly construed against the insurance company"); Nat'l Union Fire Ins. Co. v. Hudson Energy Co., 811 S.W.2d 552, 555 (Tex. 1991) (reaffirming that ambiguous language in an insurance contract must be construed in favor of the insured).

1529. *See, e.g.*, La. Ins. Guar. Ass'n v. Interstate Fire & Cas. Co., 630 So. 2d 759, 764 (La. 1994) (holding that a court should construe an insurance contract "to fulfill the reasonable expectations of the parties in the light of the customs and usages of the industry"); Brown v. Blue Cross & Blue Shield of Miss., Inc., 427 So. 2d 139, 141 n.2 (Miss. 1983) (adopting the principle that the "objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be

obligations of insureds and insurers. Again, a significant percentage of the panels rarely cited, mentioned, or applied the five doctrines, even when the facts warranted such applications.

If the Fifth Circuit panels applied, for example, the plain meaning and ambiguity doctrines more often, rather than attempting to decipher questionable phrases or trying to define arcane words in insurance contracts, the intelligibility of the decisions would improve greatly. Put simply, some panels invest an awful amount of judicial resources trying to explain the meaning of words and phrases. Very often, however, their definitions and explanations conflict with prior or contemporaneous panels' definitions and explanations. To be sure, such conflicts are not helpful and should be avoided.

But more important, if the panels applied consistently the laws of the various states rather than the law of the Fifth Circuit or the law of the panel, the predictability of their insurance law decisions would definitely improve immensely. In many instances, the panels relied on the law of the panel, rather than the laws of Louisiana, Mississippi, and Texas. This practice creates needless strained, conflicting, and often questionable decisions.

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honored even though painstaking study of the policy provisions would have negated those expectations"); Kulubis v. Tex. Farm Bureau Underwriters Ins. Co., 706 S.W.2d 953, 955 (Tex. 1986) (permitting an innocent victim whose property had been destroyed to collect under an insurance contract for loss reasonably expected to be covered). *But see* Forbau v. Aetna Life Ins. Co., 876 S.W.2d 132, 145 n.8 (Tex. 1994) (observing that Texas law does not recognize the doctrine of reasonable expectation as a basis to disregard unambiguous policy provisions).