



ST. MARY'S
UNIVERSITY

Digital Commons at St. Mary's University

Faculty Articles

School of Law Faculty Scholarship

2004

Insurance Decisions - A Survey and Empirical Analysis

Willy E. Rice

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

Follow this and additional works at: <https://commons.stmarytx.edu/facarticles>



Part of the [Insurance Law Commons](#)

Recommended Citation

Willy E. Rice, *Insurance Decisions - A Survey and Empirical Analysis*, 35 *Tex. Tech L. Rev.* 947 (2004)

This Article is brought to you for free and open access by the School of Law Faculty Scholarship at Digital Commons at St. Mary's University. It has been accepted for inclusion in Faculty Articles by an authorized administrator of Digital Commons at St. Mary's University. For more information, please contact sfowler@stmarytx.edu, egoode@stmarytx.edu.

INSURANCE DECISIONS—A SURVEY AND AN EMPIRICAL ANALYSIS

by Willy E. Rice*

I.	INTRODUCTION	949
II.	FIRST-PARTY INSURANCE CONTRACTS—STATE COMMON-LAW CLAIMS AND DECISIONS	952
	A. <i>Credit Life and Disability Insurance—Whether the McCarran-Ferguson Act Preempts the Application of the Federal Arbitration Act</i>	952
	B. <i>Homeowner's Insurance—Whether a Jury's "Bad-Faith" Verdicts Were Proper Under Mississippi Law</i>	956
	C. <i>Commercial Property Insurance—Whether the Prioritization of Insurance Proceeds Was Proper Under Louisiana Law</i>	959
	D. <i>Commercial Property Insurance—Whether the District Court Properly Applied "Occurrence" and "Proximate Causation" Principles Under Texas Law</i>	964
	E. <i>Marine Insurance—Whether Foreign or United States Law Determines the Existence of a Maritime Lien for Unpaid Insurance Premiums</i>	968
III.	FIRST-PARTY INSURANCE CONTRACTS—STATE STATUTORY CLAIMS AND DECISIONS	970
	A. <i>Health Maintenance Organization—Whether ERISA Preempts the McCarran-Ferguson Act and Texas's Power to Regulate the "Business of Insurance" Under an HMO Statute</i>	970
	B. <i>Property Insurance—Whether the Prioritization of Payments Among "Primary" and "Excess" Insurers Was Appropriate Under Louisiana Law</i>	973
	C. <i>Commercial Property Insurance—Whether a Jury's "Bad Faith" and Deceptive Trade Practices Verdicts Were Proper Under Texas Law</i>	976
	D. <i>Commercial Property Insurance—Whether an Insurer Acted in Bad Faith and Violated Texas's DTPA Statute for Refusing to Make First-Party Reimbursements Under a "Crime PLUS+" Insurance Contract</i>	981

* Professor of Law, St. Mary's University School of Law, San Antonio, Texas. M.A. 1972, Ph.D. 1975, University of North Carolina at Chapel Hill; Postdoctoral Fellow 1977, Johns Hopkins University; J.D. 1982, University of Texas at Austin; and an American Bar Foundation Scholar, 1987-88.

IV.	FIRST-PARTY INSURANCE CONTRACTS—FEDERAL STATUTORY CLAIMS AND DECISIONS: HEALTH INSURANCE (MEDICARE)—WHETHER THE MEDICARE SECONDARY PROVIDERS STATUTE PERMITS THE FEDERAL GOVERNMENT TO RECOUP MEDICARE REIMBURSEMENTS FROM ALLEGED SELF INSURERS	985
V.	THIRD-PARTY INSURANCE CONTRACTS—STATE COMMON-LAW CLAIMS AND DECISIONS	989
	A. <i>Automobile Insurance Contract—Whether An Insurer’s Refusal to Settle a Claim Before Trial Was Evidence of “Bad Faith” Under Louisiana Law</i>	989
	B. <i>Business Automobile Insurance Contract—Whether An Insured and Its Insurer Are Liable Under Louisiana Law for Failing to Procure Insurance for a Third Party</i>	992
	C. <i>Comprehensive Liability Contracts—Whether a Third Party May Sue a Tortfeasor’s Insurer for a Bad-Faith Refusal to Settle and for Contribution Under Louisiana Law</i>	993
	D. <i>Comprehensive Liability Contracts—Whether an Insurer Had a Duty to Defend and Indemnify Third-Party Contractors and Supervisors Under Louisiana Law . . .</i>	996
	E. <i>Comprehensive Liability Contracts—Whether an Insurer Had a Duty to Indemnify a Joint Venture Under Texas Law Absent an “Insurable Interest” Under the Contract</i>	1000
	F. <i>Directors and Officers Liability Contracts—Whether an Insurer Had a Duty to Defend and Indemnify Municipal Officials Under Mississippi Law</i>	1002
	G. <i>Directors and Officers Liability Contracts—Whether an Insurer Had a Duty to Defend Corporate Directors and Officers Against Intentional Tort Actions Under Texas Law</i>	1007
	H. <i>Directors and Officers Liability Contracts—Whether Insurers are Liable Under Texas Law for an Alleged Bad-Faith Refusal to Defend Corporate Directors and Officers</i>	1009
	I. <i>Third-Party Beneficiaries Life Insurance Contracts—Whether a Putative Spouse Qualifies as the Intended Beneficiary Under Louisiana Law</i>	1011
	J. <i>Professional Liability Contracts (Medical Malpractice)—Whether an Insurer and Hospital Had a Contractual Duty to Indemnify a Hospital Management Company Under Texas Law</i>	1013

VI.	THIRD-PARTY REINSURANCE TREATIES—STATE STATUTORY CLAIMS AND DECISIONS: WHETHER TEXAS COURTS HAVE AUTHORITY TO ENFORCE FOREIGN JUDGMENTS	1018
VII.	THIRD-PARTY INSURANCE CONTRACTS—FEDERAL STATUTORY CLAIMS AND DECISIONS: WORKERS' COMPENSATION INSURANCE CONTRACTS—WHETHER EMPLOYERS MAY COMMENCE A CLASS-ACTION LAWSUIT AGAINST INSURERS UNDER THE FEDERAL CIVIL RICO STATUTE	1022
VIII.	A BRIEF EMPIRICAL ANALYSIS OF THE FIFTH CIRCUIT'S DISPOSITION OF INSURANCE CONTRACT CASES DURING 2002-2003	1026
IX.	CONCLUSION	1035

I. INTRODUCTION

During the period from June 2002 to July 2003, the Court of Appeals for the Fifth Circuit decided twenty-two appeals originating in eight federal district courts.¹ Certainly, the greater majority of the insurance appeals involved recurring substantive and procedural conflicts. Major disagreements about the interpretation and enforcement of insurance contracts were before the court. Also, federal preemption questions and conflicts over subject-matter jurisdiction appeared in several cases. Furthermore, the Fifth Circuit addressed one case of first impression, and on remand from the Supreme Court, the appellate court modified and reinstated portions of a vacated opinion.²

More specifically, among the more frequently litigated conflicts, appellants asked the Fifth Circuit to decide the following substantive questions: (1) whether insurers were liable for a bad-faith refusal to pay first-

1. The Fifth Circuit delivered twenty-two decisions, but there were twenty-four conflicts. *See* Am. Heritage Life Ins. Co. v. Orr, 294 F.3d 702 (5th Cir. June 2002); Soblely v. S. Natural Gas Co., 302 F.3d 325 (5th Cir. Aug. 2002); Twin City Fire Ins. Co. v. City of Madison, 309 F.3d 901 (5th Cir. Oct. 2002); Louque v. Allstate Ins. Co., 314 F.3d 776 (5th Cir. Dec. 2002); Holden v. Connex-Metalna Mgmt. Consulting GMBH, 302 F.3d 358 (5th Cir. Aug. 2002); Hussain v. Boston Old Colony Ins. Co., 311 F.3d 623 (5th Cir. Oct. 2002); Rogers v. Samedan Oil Corp., 308 F.3d 477 (5th Cir. Oct. 2002); Sun Life Assurance Co. of Can. v. Richardson, 299 F.3d 500 (5th Cir. July 2002); Ill. Cent. R. Co. v. Dupont, 326 F.3d 665 (5th Cir. Apr. 2002); Liverpool & London S.S. Prot. & Indem. Ass'n v. Queen of Leman, 296 F.3d 350 (5th Cir. June 2002); Cochran v. B.J. Servs. Co. USA, 302 F.3d 499 (5th Cir. Aug. 2002); Fed. Ins. Co. v. CompUSA, Inc., 319 F.3d 746 (5th Cir. Feb. 2003); Thompson v. Goetzmann, 337 F.3d 489 (5th Cir. July 2003) (withdrawing Thompson v. Goetzmann, 315 F.3d 2002 (5th Cir. Dec. 2002)); Soc'y of Lloyd's v. Turner, 303 F.3d 325 (5th Cir. July 2002); Corp. Health Ins., Inc. v. Tex. Dep't of Ins., 314 F.3d 784 (5th Cir. Dec. 2002); Bott v. J.F. Shea Co., Inc., 299 F.3d 508 (5th Cir. Aug. 2002); Parkans Int'l L.L.C. v. Zurich Ins. Co., 299 F.3d 514 (5th Cir. Aug. 2002); Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. Willis, 296 F.3d 336 (5th Cir. June 2002); U.E. Tex. One-Barrington, Ltd. v. Gen. Star Indem. Co., 332 F.3d 274 (5th Cir. May 2003); Travelers Cas. & Sur. Co. of Am. v. Baptist Health Sys., 313 F.3d 295 (5th Cir. Dec. 2002); Quorum Health Res., L.L.C. v. Maverick County Hosp. Dist., 308 F.3d 451 (5th Cir. Sept. 2002).

2. Corp. Health Ins., Inc. v. Tex. Dep't of Ins., 215 F.3d 526 (5th Cir. 2000) [hereinafter *Corp. Health I.*].

party coverage and indemnification claims,³ (2) whether insurers were liable for a bad-faith refusal to settle and defend against third-party claims,⁴ (3) whether insurers were liable for arguably breaching both contractual and statutory duties after refusing to reimburse residential and commercial property owners for the latter's tangible and intangible property losses,⁵ (4) whether diverse insurance contracts provided primary or excess coverage,⁶ (5) whether an insured and its insurers were liable for failing to secure liability coverage for a third-party,⁷ and (6) whether district courts correctly applied an assortment of doctrines to interpret insurance contracts and insurance-related agreements.⁸ The court of appeals also decided whether the intended beneficiary under a life insurance policy was a putative spouse or a paramour.⁹

Among the recurring procedural questions, the Fifth Circuit resolved the following: (1) whether the McCarran-Ferguson Act preempted certain federal statutes that allegedly interfered with states' power to regulate the business of insurance,¹⁰ (2) whether federal courts had subject matter jurisdiction to decide

3. See *infra* notes 49-56, 131-33, 160-61 and accompanying text; see also Willy E. Rice, *Judicial Bias, the Insurance Industry & Consumer Protection: An Empirical Analysis of State Supreme Courts' Bad Faith, Breach-of-Contract, Breach-of-Covenant-of-Good-Faith and Excess-Judgment Decisions, 1900-1991*, 41 CATH. U. L. REV. 325, 337-40 (1992) (outlining the origin of the bad-faith doctrine and discussing the continuing judicial conflicts surrounding the application of the doctrine and the standard of proof that one must satisfy to prevail under the doctrine); see, e.g., *DeLeon v. Lloyd's London, Certain Underwriters*, 259 F.3d 344, 354 (5th Cir. 2001) (observing and reporting the following: 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."

(footnotes omitted)).

4. See *infra* notes 199-201, 216-19, 288 and accompanying text; see also *Gen. Star Indem. Co. v. Vesta Fire Ins. Corp.*, 173 F.3d 946, 949-50 (5th Cir. 1999) (observing and reporting the following:

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.* 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 since 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

. . . .

(footnotes omitted)).

5. See discussion *infra* Part II.B-C.

6. See discussion *infra* Part II.B-C.

7. See discussion *infra* Part V.B, E.

8. See discussion *infra* Part II.B, D, E and Part IV.F, I, J.

9. See discussion *infra* Part IV.I.

10. See discussion *infra* Part II.A; see also Willy E. Rice, *Federal Courts and the Regulation of the Insurance Industry: An Empirical and Historical Analysis of Courts' Ineffectual Attempts to Harmonize Federal Antitrust, Arbitration, and Insolvency Statutes with the McCarran-Ferguson Act—1941-1993*, 43

insurance-related “interpleader actions” and “actions in the nature of interpleader,”¹¹ (3) whether an insured employer had standing to commence a class action suit against a group of workers’ compensation insurers who allegedly committed fraud against the employer and similarly situated employers,¹² and (4) whether an insurance-defense lawyer’s claim for attorneys’ fees was sufficient to satisfy the jurisdictional amount for a diversity action.¹³

As mentioned earlier, the court of appeals decided one case of first impression that concerned a procedural question: whether the Medicare Secondary Providers statute permits the federal government to sue a Medicare recipient who was allegedly self insured and collect previously awarded Medicare payments.¹⁴ Another procedural question evolved out of a maritime insurance dispute.¹⁵ Several foreign marine insurers asked the court of appeals to declare whether American or English law determined the existence of maritime liens or, alternatively, whether lower courts could employ a conflict-of-law analysis and apply English law.¹⁶ Finally, appellants also asked the Fifth Circuit to decide whether foreign insurers could enforce foreign money judgments in American courts.¹⁷

To repeat, the Fifth Circuit’s twenty-two opinions covered a broad range of substantive and procedural questions. Therefore, Parts I through VI present a more thorough review of relevant facts and questions appearing in each decision.¹⁸ However, to obtain even greater insight into and appreciation of the appellate court’s deliberations, the author conducted a content analysis of the decisions, generated some percentages, and performed a limited empirical analysis of the findings.¹⁹

Part VII, therefore, presents several tables illustrating the types of legal questions, legal theories, plaintiffs, defendants, first- and third-party victims, and insurance contracts associated with the controversies.²⁰ That part also highlights and compares the dispositions of the cases within each of the eight federal district courts and in the Court of Appeals for the Fifth Circuit.²¹

CATH. U. L. REV. 399, 411-14 (1994) (discussing the development of the McCarran-Ferguson Act, the allocation of state and federal power under the Act, and the meaning of the term “business of insurance” as that phrase appears in the Act).

11. See discussion *infra* Part V.C.
12. See discussion *infra* Part VII.A.
13. See discussion *infra* Part II.C.
14. See discussion *infra* Part IV.A.
15. See discussion *infra* Part II.E.
16. See discussion *infra* Part II.E.
17. See discussion *infra* Part VI.
18. See discussion *infra* Parts I-VI.
19. See discussion *infra* Part VII and note 371.
20. See discussion *infra* Part VII.
21. See discussion *infra* Part VII.

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

A. Credit Life and Disability Insurance—Whether the McCarran-Ferguson Act Preempts the Application of the Federal Arbitration Act

The facts in *American Heritage Life Insurance Co. v. Orr* are not complicated.²² Several borrowers secured consumer loans from Republic Finance.²³ Under the terms of the loan agreement, the consumers had to purchase credit life and credit disability insurance to insure against sickness and death.²⁴ Republic Finance collected the premiums from the borrowers and purchased insurance from American Heritage Life Insurance Company and First Colonial Insurance Company of Florida on behalf of the borrowers.²⁵

As a condition precedent to securing a loan, the consumers had to sign a document entitled "Arbitration Agreement" that stated in relevant part,

[A]ny claim, dispute or controversy between undersigned . . . and lender . . . relating to the loan or . . . insurance written in connection herewith . . . shall be resolved by binding arbitration . . . in accordance with the Federal Arbitration Act, the expedited procedures of the commercial arbitration rules of the American Arbitration Association, and this agreement.

. . . .

The parties agree that Lender is engaged in interstate commerce, and the transaction is governed by the Federal Arbitration Act, 9 U.S.C. Section 1-16.

. . . .

In the event either party files a suit of any kind in any court against the other, . . . the defendant . . . can have the suit stayed and the other party required to arbitrate under this agreement.²⁶

American and First Colonial were not parties under the Arbitration Agreement.²⁷ But a contractual relationship did exist between the insurers and consumers.²⁸ After all, the borrowers paid the premiums.²⁹ In fact, the premiums generated much ill will and disagreement; therefore, the borrowers

22. See 294 F.3d 702 (5th Cir. 2002).

23. *Id.* at 705.

24. *Id.*

25. *Id.*

26. *Id.* at 705-06 (alterations in original). In addition, directly above the date and signature lines, the following language appeared in bold, capital letters: "THE PARTIES UNDERSTAND THAT BY SIGNING THIS ARBITRATION AGREEMENT, THEY ARE LIMITING ANY RIGHT TO PUNITIVE DAMAGES AND GIVING UP THE RIGHT TO A TRIAL IN COURT, BOTH WITH AND WITHOUT A JURY." *Id.* at 706 (emphasis added).

27. *Id.* at 705.

28. See *id.*

29. See *id.*

filed a civil action against Republic Finance and the two insurers in the Circuit Court of Clay County, Mississippi.³⁰

The complaint accused Republic Finance of fraudulently misrepresenting the terms and conditions associated with the consumer loan, conspiring with the insurers to sell unnecessary collateral protection insurance, and conspiring to collect “exorbitant premiums far in excess of the market rate.”³¹ On the other hand, the insureds claimed that American and First Colonial breached implied covenants of good faith and fair dealing and breached their fiduciary duties.³² In addition, the disgruntled insureds accused the two insurers of conspiring with Republic Finance’s agents “to sell unnecessary insurance at inflated rates.”³³

The insurers and lender initiated independent actions in the United States District Court for Northern District of Mississippi.³⁴ They asked the court to compel arbitration under the Federal Arbitration Act (FAA) and to stay the state court proceedings.³⁵ Even though the federal district court found enough evidence to suggest that the lender and insurers engaged in “substantially interdependent and concerted misconduct,” the federal district court issued an order compelling arbitration according to the terms outlined in the arbitration agreements.³⁶ The district court also stayed all related, state-court proceedings and closed the case without dismissing it.³⁷

30. *Id.* at 706.

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.* The FAA states in relevant part,

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 . . . for an order directing that such arbitration proceed in the manner provided for in such agreement 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 court 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, or if the matter in dispute is within admiralty jurisdiction, the court shall hear and determine such issue. Where such an issue is raised, the party alleged to be in default may, except in cases of admiralty, on or before the day of the notice of application, demand a jury trial of such issue, and upon such demand the court shall make an order referring the issues to a jury If the jury find that no agreement in writing for arbitration was made or that there is no default in proceeding thereunder, the proceeding shall be dismissed. If the jury find that an agreement for arbitration was made in writing and that there is default in proceeding thereunder, the court shall make an order summarily directing the parties to proceed with the arbitration in accordance with the terms thereof.

9 U.S.C. § 4 (2000).

36. *Am. Heritage*, 294 F.3d at 706.

37. *Id.*

The complaining consumers appealed the district court's ruling to the Fifth Circuit, but the lender and insurers protested.³⁸ They argued that the Fifth Circuit did not have jurisdiction to hear the Northern Mississippi District Court's ruling.³⁹ From the perspective of the lender and insurers, "the district court's order compelled arbitration and 'closed' the case instead of compelling arbitration and 'dismissing' the case."⁴⁰

The Fifth Circuit disagreed and declared that "[t]here is no practical distinction between 'dismiss' and 'close' for purposes of this appeal."⁴¹ The appellate court then held that a decision is final under section 16(a)(3) of the Federal Arbitration Act and appellate jurisdiction lies where (1) a district court has nothing before it but whether to compel arbitration and stay state-court proceedings, (2) the district court issues an order compelling arbitration, staying the underlying state court proceedings, and closing the case—thereby effectively ending the entire controversy on the merits, and (3) the district court has nothing left to do except execute the judgment.⁴²

The borrowers presented both procedural and substantive questions for the Fifth Circuit's consideration.⁴³ But only the substantive question is relevant for the present discussion.⁴⁴ Put simply, in the federal district court, the borrowers argued that the McCarran-Ferguson Act preempted the application of the FAA.⁴⁵ From their perspective, the arbitration agreement and the ancillary insurance contracts involved the business of insurance, activities that Mississippi's insurance commissioner had complete authority to regulate.⁴⁶ They produced an attorney general's opinion and the insurance department's regulations to support their assertion.⁴⁷

Therefore, according to the insured consumers, provisions in the respective insurance contracts rather than the arbitration clause in the third-party loan agreement—to which the insurers were not parties—should control.⁴⁸ But the district court had disagreed with that argument, concluding that the McCarran-Ferguson Act did not reverse-preempt the FAA, and the court of appeals affirmed that view.⁴⁹ Citing its decision in *Miller v. National*

38. *Id.*

39. *Id.* at 707.

40. *Id.*

41. *Id.* at 708.

42. *Id.*

43. The borrowers and insured maintained, "[U]nder §§ 2 & 4 of the FAA, they are entitled to a trial by jury on the issue of arbitrability." *Id.* at 710. And they argued, "[B]y forcing them to submit their claims to an arbitrator, the district court deprived them of their Seventh Amendment right to a trial by jury." *Id.* at 710. The court of appeals decided both questions against the consumers. *Id.*

44. *Id.* at 708.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.* Cf. *Ruthardt v. United States*, 303 F.3d 375, 380 (1st Cir. 2002) (stating, in *United States v. South-Eastern Underwriters Ass'n*, the Supreme Court held that insurance,

Fidelity Life Insurance Co., the Fifth Circuit held, “[The borrowers] fail[ed] to identify any [Mississippi] statute that would be impaired, invalidated, or superseded by the application of the FAA.”⁵⁰ Therefore, according to the appellate court, “[B]ecause no Mississippi statute addresses, much less prohibits or restricts, arbitration of credit insurance-related claims, disputes, or controversies, the Commissioner of Insurance for the State of Mississippi . . . is without regulatory authority to prohibit arbitration clauses relating to insurance.”⁵¹

Again, to reach that rather surprising and curious conclusion, the Fifth Circuit cited its ruling in *Miller v. National Fidelity Life Insurance Co.*: “‘The [business of insurance] test under McCarran-Ferguson is not whether a state has enacted statutes regulating the business of insurance, but whether such state statutes will be invalidated, impaired, or superseded by the application of federal law.’”⁵² It is significant that the Fifth Circuit issued *Miller* in January 1979.⁵³ For in February 1979, the Supreme Court decided *Group Life & Health Insurance Co. v. Royal Drug*, a case on appeal from the Fifth Circuit.⁵⁴ The *Royal Drug* Court outlined some general factors that courts might consider when determining what is the business of insurance and what practices an insurance commissioner may regulate.⁵⁵

But more important, three years after *Royal Drug*, the Court decided *Union Labor Life Insurance Co. v. Pireno*.⁵⁶ In *Pireno*, the Court presented a formal test to determine whether various practices are the business of insurance.⁵⁷ Writing for the majority, Justice Brennan ruled that a practice is part of the business of insurance if (1) “the practice has the effect of transferring or spreading a policyholder’s risk,” (2) “the practice is an integral part of the policy relationship between the insurer and the insured,” and (3) “the practice is limited to entities within the insurance industry.”⁵⁸ Justice

hitherto regulated by the states as a local activity, fell within the Commerce Clause Congress responded with the McCarran-Ferguson Act [Section 2(b)] immunizes against federal statutory preemption those state statutes enacted “for the purpose of regulating the business of insurance” [T]he Commissioner says that the . . . language [in Section 2(b)] means that the Federal Priority Act does not “supercede” this facet of the priority statute. In shorthand, this can be called “reverse preemption” —of federal law by state law—by Congress’ consent).

50. *Am. Heritage*, 294 F.3d at 708.

51. *Id.* at 709.

52. *Id.* at 708 (quoting *Miller v. Nat’l Fid. Life Ins. Co.*, 588 F.2d 185, 187 (5th Cir. 1979)).

53. *Miller*, 588 F.2d at 185.

54. 440 U.S. 205 (1979).

55. *Id.* at 215-16 (The Court in *Royal Drug* stated in dictum that the core of the business of insurance includes: (1) “the contract between the insurer and the insured;” (2) “the relationship between the insurer and the insured;” and (3) “the type of policy which could be issued, its reliability, interpretation, and enforcement.”).

56. 458 U.S. 119 (1982).

57. *Id.* at 120.

58. *Id.* at 129.

Brennan also stressed that “[n]one of these criteria is necessarily determinative in itself.”⁵⁹

Once more, it is extremely curious that the Court of Appeals for the Fifth Circuit failed to cite, discuss, or even mention the *Royal Drug* and *Pireno* tests in *American Heritage Life Insurance Co. v Orr*.⁶⁰ To be sure, such an omission clouds and raises a genuine question about the precise meaning of business of insurance in the Fifth Circuit.

B. Homeowner's Insurance—Whether a Jury's “Bad-Faith” Verdicts Were Proper Under Mississippi Law

The litigants in *Sobley v. Southern Natural Gas Company (Sobley II)* had previously appealed to the Fifth Circuit.⁶¹ Therefore, the facts here are reported as they appeared in *Sobley I*.⁶² Briefly stated, in 1993 the Sobleys built a house in Columbus, Mississippi and purchased homeowners' insurance from State Farm Lloyds.⁶³ Although disputed, the Sobleys alleged that water began to seep into their house through the walls and under several locations throughout the house.⁶⁴ Eventually, George Sobley discovered that water had saturated the ground around his pump house.⁶⁵ The water came from small holes in the pipes covering the lawn.⁶⁶ When he repaired the pipes, other holes would appear in pipes located several feet away.⁶⁷ After various tests, the homeowner discovered that electrolysis—an electrical current running through the pipe—caused the holes.⁶⁸ Later, he learned that a facility belonging to Southern Natural Gas Company (SONAT) produced the electrolysis.⁶⁹

The Sobleys filed a negligence action against SONAT in a Mississippi state court (*Sobley I*).⁷⁰ The homeowners, however, amended the complaint and added State Farm as a defendant.⁷¹ They wanted the insurer to pay for water damages under the terms of the homeowners' contract.⁷² Put simply, State Farm refused.⁷³ In March 1998, the Sobleys amended their complaint again, inserting a claim for punitive damages based on State Farm's allegedly

59. *Id.*

60. 294 F.3d 702 (5th Cir. June 2002).

61. 302 F.3d 325 (5th Cir. Aug. 2002).

62. *Sobley v. S. Natural Gas Co.*, 210 F.3d 561, 562-63 (5th Cir. 2000) [hereinafter *Sobley I*].

63. *Id.* at 562.

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.* at 563.

71. *Id.*

72. *Id.*

73. *Id.*

bad-faith denial of insurance coverage.⁷⁴

The *Sobley I* district court denied cross-motions for summary judgment.⁷⁵ In early January 1999, the parties held a pre-trial conference in which the Sobleys settled their claims against SONAT.⁷⁶ The suit against State Farm went to trial before a jury in which the trial court only permitted the Sobleys to present evidence about the denial of coverage.⁷⁷ The trial court deferred issues relating to punitive or extracontractual damages to a later phase of the trial.⁷⁸ In the end, the trial court in *Sobley I* issued a directed verdict in favor of State Farm and entered a judgment dismissing the Sobley's case against State Farm.⁷⁹

On appeal, the Fifth Circuit reversed and remanded *Sobley I*.⁸⁰ The appellate court's instruction included the following:

Under Mississippi law, a finding of coverage is a necessary predicate to bringing a punitive damages claim Once coverage is established, the issue of punitive damages should be submitted to the jury if the trial court determines that there are jury issues with regard to whether: (1) the insurer lacked an arguable or legitimate basis for denying the claims, and (2) the insurer committed a wilful or malicious wrong, or acted with gross and reckless disregard for the insured's rights.⁸¹

The Fifth Circuit also gave the following instruction: “[O]nce coverage is established, a court should evaluate whether there was an arguable basis for denial of coverage based solely on the reasons for denial of coverage given to the insured by the insurance company.”⁸²

On remand, the Sobleys and State Farm submitted motions for summary judgment in *Sobley II*; the district denied all motions *as a matter of law*.⁸³ The case proceeded to trial in January 2001, and through special interrogatories, the district court submitted the issues of coverage and bad faith—“whether State Farm committed a wilful or malicious wrong or acted with gross and reckless disregard for the Sobley's rights”—to the jury.⁸⁴ The jury found in favor of the Sobleys on each interrogatory.⁸⁵ After the parties stipulated about State Farm's net worth and presented additional closing arguments, the trial

74. *Id.* at 562.

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.* at 565.

81. *Id.* at 564.

82. *Id.*

83. *Sobley v. S. Natural Gas Co.*, 302 F.3d 325, 331 (5th Cir. Aug. 2002) [hereinafter *Sobley II*].

84. *Sobley I*, 210 F.3d at 564.

85. *Id.*

court submitted issues regarding the appropriate amounts of contractual and punitive damages to the jury.⁸⁶ The jury returned a verdict, awarding the Sobleys contractual damages of \$39,683 and punitive damages of \$1.25 million.⁸⁷ The trial court also awarded \$349,240 in attorneys' fees.⁸⁸ Finally, the *Sobley II* trial judge denied State Farm's posttrial motion for judgment as a matter of law or, alternatively, a new trial or remittitur.⁸⁹

State Farm appealed the *Sobley II* verdict and judgment to the Fifth Circuit Court of Appeals.⁹⁰ From the insurer's perspective, the trial court committed three reversible errors: (1) failing to follow "faithfully and accurately" the Fifth Circuit's remand instructions in *Sobley I*, (2) "allowing the Sobleys to proceed to trial on remand on an amended bad faith claim based on State Farm's post-denial and litigation conduct," and (3) failing to grant State Farm's motion for judgment as a matter of law by sending the punitive damages issue to the jury.⁹¹

The Fifth Circuit summarily dismissed State Farm's first two protestations.⁹² But ignoring the jury's finding to the contrary, the appellate court declared,

The evidence of State Farm's conduct in investigating and denying the Sobleys' claim . . . is simply not of such quality and weight that reasonable and fair-minded men in the exercise of impartial judgment might reach different conclusions as to whether State Farm engaged in gross and reckless disregard of the Sobleys' rights.⁹³

Finally, to justify its decision to reject the jury's punitive damages verdict and decide in favor of State Farm, the Fifth Circuit observed that Mississippi law is well-settled: "Punitive damages should be assessed with caution and within narrow limits as an example and warning' [;] . . . a plaintiff has a 'heavy burden' when seeking punitive damages based on a 'bad faith insurance claim.'"⁹⁴ But the Sobleys argued that on the basis of another Mississippi Supreme Court decision—*State Farm Mutual Automobile Insurance Co. v. Grimes*—the jury's bad-faith findings and award of punitive damages were reasonable.⁹⁵

86. *Id.*

87. *Id.* at 331.

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.* at 331-33, 335.

92. *Id.* at 335.

93. *Id.* at 338-39.

94. *Id.* at 338 n.30 (quoting *Jenkins v. Ohio Cas. Ins. Co.*, 794 So. 2d 228, 232 (Miss. 2001) (*en banc*)).

95. *Id.* at 340; see 722 So. 2d 637 (Miss. 1998). More specifically, the Sobleys argued, "State Farm's continued denial based on its self-serving, result-oriented investigation, together with its

Of course, the *Grimes* argument did not impress the Fifth Circuit.⁹⁶ The court was firm:

Based on our review of the entire record, we conclude that the Sobleys failed to present substantial evidence that State Farm acted with gross and reckless disregard for the Sobleys' rights. Accordingly, the trial court erred in denying State Farm's motion for judgment as a matter of law and submitting the bad faith issue to the jury.⁹⁷

C. Commercial Property Insurance—Whether the Prioritization of Insurance Proceeds Was Proper Under Louisiana Law

Fairly often, several parties compete for insufficient insurance proceeds immediately before or after an insurer becomes insolvent.⁹⁸ Or perhaps third-party creditors, governments, and lienholders' interests have been affected, threatened, or destroyed after an insured experienced a property loss.⁹⁹

unbelievable interpretations and application of policy provisions, sufficiently showed that State Farm's denial was not merely the product of simple oversight or a clerical mistake for which punitive damages would be improper." *Sobley II*, 302 F.3d at 340.

96. See *Sobley II*, 302 F.3d at 340.

97. *Id.* at 343.

98. See, e.g., *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 508-09 (1993).

We hold that the Ohio priority statute, to the extent that it regulates policyholders, is a law enacted for the purpose of regulating the business of insurance. To the extent that it is designed to further the interests of other creditors, however, it is not a law enacted for the purpose of regulating the business of insurance. Of course, every preference accorded to the creditors of an insolvent insurer ultimately may redound to the benefit of policyholders by enhancing the reliability of the insurance company

We also hold that the preference accorded by Ohio to the expenses of administering the insolvency proceeding is reasonably necessary to further the goal of protecting policyholders. Without payment of administrative costs, liquidation could not even commence. The preferences conferred upon employees and other general creditors, however, do not escape pre-emption because their connection to the ultimate aim of insurance is too tenuous.

Id.; see Paul M. Barrett, *Policyholders of Bankrupt Insurers Get Priority Over U.S. Claims, Justices Rule*, WALL ST. J., June 14, 1993, at 22.

The Supreme Court said states may protect the interests of policyholder over those of the federal government in liquidations of failed insurance companies.

However, states may not give priority to claims of business creditors or employees of failed insurers over those of the U.S. Treasury

The question of who gets precedence in the insurance bankruptcy proceedings has become increasingly important as insurance company failures have risen in recent years.

Barrett, *supra*, at 22.

99. Cf. Greg Hitt, *Asbestos Makers, Litigants: Uneasy Allies—Partial Alliance Prioritizes Seriously Ill Victims, Eases Firms' Financial Burden*, WALL ST. J., May 28, 2002, at A4.

The Asbestos Alliance, composed of the breakaway lawyers, the American Insurance Association and the National Association of Manufacturers, is asking Congress for a law that would give priority to the claims of the most seriously ill. They contend that cash-strapped corporations then could better manage their asbestos liabilities, ensuring a steady stream of payments to the most needy.

Id.

Without doubt, under this latter scenario, an insurer would want to ensure that the order of distribution was correct. Of course, the reason is not complicated: Serious adverse legal and financial consequences can arise for doing otherwise. Therefore, determining which party has top priority under a commercial property or business insurance contract is paramount.

To illustrate, consider the facts in *Hussain v. Boston Old Colony Insurance Company*.¹⁰⁰ Javid Hussain owned Sheik's Oriental Rugs, Inc.¹⁰¹ Early on, under a promissory note, Hussain obtained a \$177,699 loan from Hibernia National Bank.¹⁰² A chattel mortgage on Hussain's inventory secured the note.¹⁰³ In addition, before receiving the loan, Hussain had to warrant that the mortgaged property was " 'free and clear from any adverse claim, mortgage, lien, security interest, privilege, or encumbrance.' "¹⁰⁴

Boston Old Colony Insurance Company (BOC) insured the property up to \$500,000.¹⁰⁵ The policy listed Hibernia Bank as a "loss payee."¹⁰⁶ A 1991 fire destroyed Sheik's Oriental's inventory of rugs.¹⁰⁷ After the fire, Hussain defaulted on the bank loan.¹⁰⁸ In 1992, as holder of the secured note, Hibernia sued Hussain in a Louisiana court and obtained a default judgment against Hussain in 1994.¹⁰⁹ Hibernia still had a continuing security interest in the insured property even though it had been destroyed.¹¹⁰ As a loss payee under Hussain's property insurance contract, Hibernia Bank filed a separate state court action against both Hussain and BOC to recover a portion of the policy proceeds.¹¹¹

In 1993, Hussain also retained an attorney and sued BOC in a Louisiana court to recover damages under the policy.¹¹² Later, the court consolidated the two suits that Hibernia and Hussain filed against the insurer.¹¹³ For reasons unknown, Hussain hired two new attorneys—Steven Rando and Glenn Woods—and executed a contingency-fee agreement that gave one-third of any recovery to the new attorneys.¹¹⁴

100. 311 F.3d 623, 623 (5th Cir. Oct. 2002).

101. *Id.* at 627.

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.* The Policy's "Loss Payable" provision reads as follows: "For covered property in which both you and a Loss Payee . . . have an insurable interest, we will . . . [p]ay any claim for loss or damage jointly to you and the Loss Payee, as interests may appear." *Id.*

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.*

112. *Id.*

113. *Id.*

114. *Id.*

At trial, BOC defended its action by arguing that arson caused the fire and property losses.¹¹⁵ The state court disagreed and issued a directed verdict, ruling that BOC owed Hussain and Hibernia \$500,000 plus interest, costs, and fees.¹¹⁶ After several unsuccessful appeals, the Louisiana Supreme Court denied certiorari, and the trial court's ruling against BOC became final on November 13, 2000.¹¹⁷

On December 8, 2000, the Internal Revenue Service (IRS) notified the insurer and reported that federal tax liens had been filed against Hussain's property.¹¹⁸ Interestingly, on the same day, Hussain executed a new fee agreement giving the new attorneys a thirty-nine percent interest "in and to any gross recovery I/we may have in this matter."¹¹⁹ Shortly thereafter, BOC filed a motion—rather than an interpleader action—and asked the court to determine the proper amount of funds and the priority of distribution for each party.¹²⁰ BOC also secured and served an order requiring the IRS to show cause why it should participate in the distribution of funds.¹²¹ Later, the federal government then moved the case to the Eastern District Court of Louisiana on January 17, 2001.¹²²

The district court ruled that Hibernia National Bank had first priority since it was the loss payee under Hussain's property insurance contract.¹²³ Rando and his partners occupied second place, receiving 33.3 percent of the remainder in attorneys' fees after Hibernia's claim had been fully paid.¹²⁴ Finally, the federal government had priority ahead of all other creditors.¹²⁵ The district court only had \$500,000 to distribute, but the attorneys reminded the court that they had spent \$368,449 to represent Hussain's interests.¹²⁶ The court refused to alter the distribution of funds, and the attorneys appealed the ruling.¹²⁷

The Fifth Circuit had to resolve a major procedural question before examining the controversy on the merits.¹²⁸ The attorneys argued that the

115. *Id.*

116. *Id.*

117. *Id.* at 627-28.

118. This assertion, however, was not true. *See id.* at 628 ("[T]he IRS first . . . file[d] a notice of its tax lien in the records of Orleans Parish on January 9, 2001. . . ."). *But see id.* at 628 n.2 (citing *United States v. McDermott*, 507 U.S. 447, 448 (1993)) ("In this case the point at which the IRS filed its lien does not affect the priority of claims adjudicated here. The law provides that a federal tax lien arises upon assessment of the tax, and thus does not impose any filing requirement.").

119. *Hussain*, 311 F.3d at 628.

120. *Id.*

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.* at 627.

127. *Id.*

128. *Id.* at 629. Another procedural question concerned whether the Louisiana state court judgment

Eastern Louisiana District Court did not have subject matter jurisdiction to hear and decide the case.¹²⁹ As was mentioned earlier, the insurance company initially sought equitable relief by filing a Motion to Determine Amount and Distribution of Funds in a Louisiana state court.¹³⁰ In addition, BOC secured and served an order forcing the IRS to appear in the state court to explain why the government should be included in the distribution of any insurance proceeds.¹³¹

The United States appeared and “waived” its immunity from private actions under 28 U.S.C § 2410(a).¹³² But the federal government exercised its right under 28 U.S.C § 1444 and moved the case to the federal district court.¹³³ According to the appellants, the conditions for the removal did not strictly conform to the requirements under section 2410(a).¹³⁴ Put simply, the

was final for purpose of an appeal. *Id.* at 639. The Fifth Circuit addressed that concern this way:

[E]ven though Hussain and Hibernia’s judgment against BOC is a final, unalterable state court judgment, it is not ‘established’ in the sense of Louisiana jurisprudence and does not preclude a subsequent interpleader-like action under these unique facts Allowing this action may actually bring a benefit to Hussain, because it preempts separate litigation between him and the government and, as a result, saves him attorney fees in such an action. Thus, because these proceedings do not threaten relitigation or the reconsideration of BOC’s liability, but instead provide a potential benefit to Hussain, we see no reason why an interpleader-like action should not have proceeded in this particular case.

Id.

129. *Id.*

130. *Id.* at 628; see *supra* text accompanying note 125.

131. *Hussain*, 311 F.3d at 628.

132. *Id.* at 630.

In the instant case, the government maintains an outstanding tax lien on Hussain’s property. Thus, § 2410(a) appears applicable. Although the applicability of § 2410(a)(5) to the suit as a whole remains to be discussed, our prior holdings and our understanding of congressional intent predispose us to accept the government’s presence in this case despite its unique mode of entrance.

Id. (emphasis added). Section 2410(a) provides,

Under the conditions prescribed in this section and section 1444 of this title for the protection of the United States, the United States may be named a party in any civil action or suit in any district court, or in any State court having jurisdiction of the subject matter—

- (1) to quiet title to,
- (2) to foreclose a mortgage or other lien upon,
- (3) to partition,
- (4) to condemn, or
- (5) of interpleader or in the nature of interpleader with respect to, real or personal property on which the United States has or claims a mortgage or other lien.

28 U.S.C. § 2410(a) (2000) (emphasis added).

133. *Hussain*, 311 F.3d at 628 n.2. Section 1444 states, “Any action brought under section 2410 of this title against the United States in any State court may be removed by the United States to the district court of the United States for the district and division in which the action is pending.” 28 U.S.C. § 1444 (2000).

134. *Hussain*, 311 F.3d at 629.

The law is well settled that the government is not subject to suit unless it has waived its sovereign immunity Such waiver, however, must be narrowly construed to comport precisely with congressional intent [N]o suit may be maintained against the United States unless the suit is brought in exact compliance with the terms of a statute under which the

insurer's equitable action was based on a motion while section 2410(a) required the filing of an "interpleader" action or an action "in the nature of an interpleader."¹³⁵ Although acknowledging that the form of the BOC's pleading deviated from standard federal practice,¹³⁶ the Fifth Circuit declared that it was harmless error¹³⁷ and ruled that the district court had proper jurisdiction over the controversy.¹³⁸

On appeal, the attorneys raised two major substantive issues: (1) whether they had super-priority over the IRS under 26 U.S.C. § 6323(b)(8), which required the district court to use the gross rather than the net distribution of insurance proceeds to calculate attorneys' fees and (2) whether they should receive an additional \$196,377 in attorneys' fees, an amount based on the 2000 fee agreement (thirty-nine percent) rather than on the 1995 contingent-fee agreement (thirty-three percent).¹³⁹ The Fifth Circuit decided both questions against the attorneys.¹⁴⁰

sovereign has consented to be sued.

Id. (quoting *Koehler v. United States*, 153 F.3d 263, 265-66 (5th Cir. 1998)).

135. *Id.* at 631.

A traditional interpleader suit is an equitable action available to a plaintiff-stakeholder who is, or may be, exposed to multiple liability or multiple litigation, usually when two or more claims are brought that are mutually inconsistent. The purpose of interpleader is to enable the plaintiff-stakeholder to avoid "the burden of unnecessary litigation or the risk of loss by the establishment of multiple liabilit[ies] when only a single obligation is owing." Thus, traditionally the claims of the defendant claimants must be mutually exclusive and adverse to one another such that one claimant's gain in the stake would be another claimant's loss. In contrast to the subsequently evolved bill in the nature of interpleader, the stakeholder in a strict bill of interpleader maintains no claim or interest in the stake.

An "action in the nature of interpleader" is a term of art that refers to those actions in which an interpleading plaintiff asserts an interest in the subject matter of the dispute. In all other respects, actions in the nature of interpleader are identical to traditional interpleader suits.

Id. (footnotes omitted).

136. *Id.* at 633 ("It is true here that the motion practice of the parties did not use the same labels as actions taken to initiate an interpleader proceeding. Regardless of the misleading case caption, however, the substantive posture of the parties mirrored the substance of an action in interpleader.").

137. *Id.* at 634 ("[I]n conformity with the expansive approach taken toward this form of the equitable relief, the actions of BOC were sufficient in fact to constitute interpleader against the government under the requirements of § 2410(a)(5).").

138. *Id.* at 635. ("In sum, the district had federal subject matter jurisdiction because this case met the requirements of § 2410(a) as well as those of § 1444.").

139. *Id.* at 628, 642-44.

140. *Id.* at 645 ("We conclude that only the fees earned in litigating BOC's liability deserve super-priority under § 6323(b)(8), and these fees are assessed pursuant to the original 33 1/3% contingent fee agreement. As this is the approach taken by the district court, we affirm its ruling on the issue."). The court of appeals also concluded that an expert's fees could not be taxed as costs under Louisiana law. *Id.* at 646 n.101. 26 U.S.C. § 6323(b)(8) states,

Even though notice of a lien imposed by section 6321 has been filed, such lien shall not be valid—

....

(8) With respect to a judgment or other amount in settlement of a claim or of a cause of action, as against an attorney who, under local law, holds a lien upon or a contract enforceable against such judgment or amount, to the extent of his reasonable compensation for obtaining

D. Commercial Property Insurance—Whether the District Court Properly Applied “Occurrence” and “Proximate Causation” Principles Under Texas Law

The facts in *U.E. Texas One-Barrington, Ltd. v. General Star Indemnity Co.* are not terribly difficult, but the Fifth Circuit’s holding is unduly complex and strained.¹⁴¹ Arguably, it is a results-oriented decision since the appellate court totally disregarded and misapplied some settled principles under Texas insurance law.¹⁴²

Texas One owned the Oak Meadow complex in San Antonio, Texas.¹⁴³ Oak Meadow is a residential community and was built in 1974.¹⁴⁴ It comprises thirty residential buildings, three office buildings, and other facilities.¹⁴⁵ Each residential building contained at least four apartments.¹⁴⁶ General Star insured Oak Meadow under a commercial property insurance policy, and Fireman’s Fund provided excess coverage under a commercial excess property policy.¹⁴⁷

According to the property owners, moisture changes in the soil beneath the foundations of several buildings caused earth movement, which in turn caused property losses above the ground.¹⁴⁸ Texas One hired experts to determine the source of moisture.¹⁴⁹ Tests revealed that leaks in water pipes under fourteen buildings produced the moisture.¹⁵⁰ The owners asked General Star to pay the cost of determining the moisture’s origin and property damage.¹⁵¹ The primary insurer ultimately refused, although General Star admitted that it had an obligation to pay the access costs.¹⁵² Later, the insurer made a partial payment to satisfy Texas One’s cost for determining the cause

such judgment or procuring such settlement, except that this paragraph shall not apply to any judgment or amount in settlement of a claim or of a cause of action against the United States to the extent that the United States offsets such judgment or amount against any liability of the taxpayer to the United States.

26 U.S.C. § 6323(b)(8) (2000).

141. See 332 F.3d 274 (5th Cir. May 2003).

142. Cf. *United Artists Theatre Co. v. Walton*, 315 F.3d 217, 237-38 (3d Cir. 2003) (Rendell, J., concurring).

Further, I cannot imagine what guidance we are giving to the District Court by changing the rules midstream, much less what implications this poses for indemnity agreements already in force. The rationale for adopting this test—namely, an aversion to a ‘results-oriented’ approach to liability, and therefore, indemnity—goes far beyond the parameters of our judicial function, into the sphere of policy making.

143. *U.E. Tex. One-Barrington, Ltd.*, 332 F.3d at 276.

144. *Id.*

145. *Id.*

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.*

of the loss.¹⁵³

Then, Texas One asked its excess property insurer to pay for the losses.¹⁵⁴ After all, under the terms of the contract, Fireman's Fund agreed to pay "a maximum . . . of \$13,267,000 *per occurrence*," and "100% of the *ultimate net loss excess* over and above \$1,000,000 ultimate net loss . . . in each and every loss occurrence."¹⁵⁵ The first-party insurance contract defined "loss occurrence" as "the total loss by perils insured against arising out of a single event."¹⁵⁶ Of course, from the excess insurer's perspective, Texas One could not meet those conditions precedent.¹⁵⁷ Nineteen buildings were damaged, generating a net loss of more than \$1 million.¹⁵⁸ However, damage to any single unit did not exceed \$1 million.¹⁵⁹ More important, the excess carrier insisted that there were nineteen occurrences (losses) rather than one requiring nineteen deductibles.¹⁶⁰

After General Star and Fireman's Fund decided not to make Texas One whole, the property owners filed a breach of contract suit against the primary and excess insurers in a Texas state court.¹⁶¹ The insurers moved the case to the Western District Court of Texas and filed a motion for summary judgment.¹⁶² First, Texas One asked the district court to declare that General Star was liable for the cost of accessing and repairing the plumbing problems—the cause of the leaks and moisture under the buildings.¹⁶³ The district court declined.¹⁶⁴ Citing its fairly recent decision in *General Accident Insurance Co. v. Unity/Waterford-Fair Oaks, Ltd.*, the Fifth Circuit upheld the district court's decision.¹⁶⁵

153. *Id.*

154. *Id.*

155. *Id.* at 277 (emphasis added). The Fireman's Fund policy stated in pertinent part, "This Company shall be liable in respect of each and every loss occurrence, irrespective of the number and kinds of risks involved, for 100% of the ultimate net loss excess over and above \$1,000,000 ultimate net loss to the Insured in each and every loss occurrence."

....

The term loss occurrence means the total loss by perils insured against arising out of a single event.

Id. (quoting the Fireman's Fund policy) (alteration in original).

156. *Id.*

157. *See id.* at 276-77.

158. *Id.* at 277.

159. *Id.*

160. *Id.*

161. *Id.* at 276.

162. *Id.*

163. *Id.*

164. *Id.* at 276-77.

165. *Id.* at 276.

The plaintiff, owner of apartment buildings, sued the defendant, its insurer, under a commercial property insurance policy to recover for damage to the foundations of buildings resulting from seepage or leakage from underground pipes and drains and for the cost of accessing and repairing that underground plumbing. The district court's summary judgment held that the policy does not cover the losses. We affirm.

In the federal district court, Texas One argued that only one occurrence caused the total loss since the parties agreed that all “leaks existed continuously and repeatedly for more than 14 days prior to discovery of the damage.”¹⁶⁶ From Texas One’s viewpoint, the immediate leaks—covered perils under the property insurance contract—were the “efficient proximate cause” of the total loss.¹⁶⁷ Texas One did not claim that the total loss originated from defective materials in or the poor installation of the underground plumbing system years earlier.¹⁶⁸ However, accepting Fireman’s argument, the district court declared that nineteen occurrences, not one, generated the total damages.¹⁶⁹ Consequently, there were nineteen deductibles; therefore, Texas One could not satisfy the \$1 million per occurrence target to recover under the Fireman’s contract.¹⁷⁰

On appeal, the Fifth Circuit affirmed the district court’s ruling.¹⁷¹ The appellate court declared,

[W]e should not focus on *the alleged overarching cause, but rather on the specific event that caused the loss*. In this case the losses arose when the pipes broke, not when they were installed. The parties have stipulated that a different leak was responsible for the damage to each building, and as such we agree with the district court that each leak constitutes a separate occurrence as a matter of law.¹⁷²

Gen. Accident Ins. Co. v. Unity/Waterford-Fair Oaks, Ltd., 288 F.3d 651, 651-52 (5th Cir. 2002).

166. *U.E. Tex. One-Barrington, Ltd.*, 332 F.3d at 276.

167. *See, e.g., Stoburg v. Ins. Co. of N. Am.*, 464 S.W.2d 827, 831 (Tex. 1971).

[W]e have held that “‘proximate cause’ as applied in insurance cases has essentially the same meaning as that applied by our own courts in negligence cases, *except that in the former the element of foreseeableness or anticipation of the injury as a probable result of the peril insured against is not required.*” . . . By this rule a remote cause of a cause would not be a proximate cause.

Id. (quoting Fed. Life Ins. Co. v. Raley, 109 S.W.2d 972, 974 (Tex. 1937) (emphasis added)).

[I]n cases where the insurance policy does not in express terms so provide, . . . the insurer [does not] become[] liable for a loss unless the loss is proximately caused by the peril insured against. . . . Moreover, . . . the term “proximate cause” as applied in insurance cases has essentially the same meaning as that applied by *our own courts in negligence cases, except that in the former the element of foreseeableness or anticipation of the injury as a probable result of the peril insured against is not required.*

Raley, 109 S.W.2d at 947 (emphasis added).

168. *U.E. Tex. One-Barrington, Ltd.*, 332 F.3d at 277.

169. *Id.*

170. *See id.*

171. *Id.*

172. *Id.* (emphasis added). The court refuted the dissent’s argument as follows:

The dissent goes to substantial effort to distinguish cases defining “occurrence” in *general liability policies* from “occurrence” in *property loss policies*. Even if the dissent’s policy arguments are correct, however, *this court has already rejected any such distinction*. In *Ran-Nan Inc.*, we stated that

General Accident contends that decisions utilizing “cause” analysis such as *H.E. Butt* and *Maurice Pincoffs* are distinguishable as construing *general liability insurance policies* instead of *employee dishonesty insurance policies* It is true that no

To be sure, Judge Jerry Smith's stinging, well-reasoned dissenting opinion was warranted for several reasons.¹⁷³ First, the Fifth Circuit mischaracterized Texas One's proximate cause argument.¹⁷⁴ To repeat, the company did not advance that reason for the total loss.¹⁷⁵ But more important, Judge Smith correctly observed that the court of appeals (1) inaccurately applied Texas law regarding the facts of this case,¹⁷⁶ (2) created a new tort liability test for property insurance cases "with no useful meaning,"¹⁷⁷ and (3) showed little appreciation for the clear distinction under Texas law between first-party property insurance and third-party liability insurance.¹⁷⁸ Clearly, determining when an insurer becomes responsible for paying first- and third-party claims requires different tests.¹⁷⁹ Simply put, in *U.E. Texas One-Barrington, Ltd. v. General Star Indemnity Co.*, the Fifth Circuit created,

Texas case specifically applies "cause" analysis to employee dishonesty policies, but this widely accepted method for calculating the number of "occurrences" is consistent with the *general principles* of Texas law.

Id. at 277 n.2 (emphasis added) (quoting *Ran-Nan Inc. v. Gen. Acc. Ins. Co. of Am.*, 252 F.3d 738, 740 (5th Cir. 2001)).

173. *Id.* at 278.

174. *Id.* at 279.

175. *Id.* at 283.

176. *Id.* at 281.

[T]he "liability-triggering event" test from *H.E. Butt and Pincoffs* . . . has no applicability to the facts at issue here. *H.E. Butt and Pincoffs* held that the court should look to the events that gave rise to the liability of the *insured to other parties*. The insured here, Texas One, has no liability to anyone. The only liability at issue is the *insurer's* to the insured. As applied to this case, then, this test points to no events at all.

Id. (footnote omitted).

177. *Id.*

The majority's characterization of *Goose Creek* creates a test with no useful meaning. The loss occurrence definition is designed to help the parties determine the event or events that give rise to the insurer's liability. The majority holds that the number of events that cause the insurer's liability determines the number of loss occurrences, *creating a circular definition*.

Id. (emphasis added).

178. *Id.*; see, e.g., *Warrilow v. Norrell*, 791 S.W.2d 515, 527 (Tex. App.—Corpus Christi 1989, no writ). *Warrilow* fails to differentiate between property loss coverage under a first-party insurance policy, typically an all-risk homeowner's policy, and tort liability coverage under a third-party insurance policy, as the *Peacemaker* policy in the present case. *Id.* This distinction is critical. The California Supreme Court recently elaborated on its *Partridge* rationale: " 'Liability and corresponding coverage under a third-party insurance policy must be carefully distinguished from the coverage analysis applied in a first-party property contract. Property insurance, unlike liability insurance, is unconcerned with establishing negligence or otherwise assessing tort liability.' " *Garvey v. State Farm Fire & Cas. Co.*, 770 P.2d 704, 710 (Cal. 1989) (quoting *Bragg, Concurrent Causation and the Art of Policy Drafting: New Perils for Property Insurers*, 20 FORUM 385, 386 (1985)). Coverage in a property policy is commonly provided by reference to causation, such as loss caused by certain enumerated forces. *Id.* It is precisely these physical forces that bring about the loss. *Id.* In Texas, if one force is covered and one force is excluded, the insured must show that the property damage was caused solely by the insured force, or he must separate the damage caused by the insured peril from that caused by the excluded peril. See *Travelers Indem. Co. v. McKillip*, 469 S.W.2d 160, 162 (Tex 1971). The coverage analysis in the property insurance context examines the relationship between perils, those that are covered under the policy and those that are excluded, focusing on the exclusions that limit loss coverage. *Garvey*, 770 P.2d at 710.

179. See *Garvey*, 770 P.2d at 710.

applied, and defended unashamedly bad law.¹⁸⁰

E. Marine Insurance—Whether Foreign or United States Law Determines the Existence of a Maritime Lien for Unpaid Insurance Premiums

Two consolidated cases originating in the Eastern and Middle District Courts of Louisiana appear in *Liverpool & London S.S. Protection & Indemnity Ass'n v. Queen of Leman*.¹⁸¹ Both controversies involved the interpretation of choice-of-law provisions under marine insurance contracts.¹⁸²

The first dispute had the following multiple claimants: (1) Liverpool and London Steamship Protection and Indemnity Association ("Liverpool"), who insured the owners and operators of the ship, Queen of Leman; (2) Tokio Marine and Fire Insurance Company ("Tokio"), who insured the cargo on the ship; and (3) Fuji Vegetable Oil, Inc. ("Fuji"), the cargo owners.¹⁸³ Under the terms of Liverpool's steamship protection and indemnity contract, the insurer had the right to assert and file maritime liens against the ship owners to collect unpaid premiums.¹⁸⁴

Therefore, Liverpool commenced an action in the Eastern District Court of Louisiana to seize the Queen of Leman for unpaid insurance premiums under Rule 9(h) and Rules B and C of the Supplemental Rules for Certain Admiralty and Maritime Claims.¹⁸⁵ Tokio and Fuji appeared and filed a motion for summary judgment.¹⁸⁶ They argued that Liverpool "did not have a maritime lien for unpaid insurance premiums under Rule C."¹⁸⁷ From their viewpoint, English substantive law governed the interpretation and enforcement of Liverpool's marine insurance contract; consequently, the application of English law did not create a maritime lien.¹⁸⁸ The Eastern District Court of Louisiana agreed and granted summary judgment in favor of Tokio and Fuji.¹⁸⁹ Liverpool timely appealed.¹⁹⁰

Multiple parties also appeared in the second marine dispute.¹⁹¹ Kappa Shipping Company, Ltd. ("Kappa") managed a fleet of separately owned vessels, including the M/V ARBA (ex KAPPA UNITY), a Cyprus flag bulk

180. See *U.E. Tex. One-Barrington, Ltd.*, 332 F.3d at 276-83.

181. 296 F.3d 350 (5th Cir. June 2002).

182. *Id.* at 351.

183. *Id.*

184. *Id.*

185. See *id.* at 353-54 & nn.2-4.

186. *Id.* at 351.

187. *Id.*

188. *Id.*

189. *Id.* at 351-52.

190. *Id.* at 352.

191. *Id.*

carrying cargo vessel.¹⁹² Again, Liverpool was the insurer.¹⁹³ Allegedly, Kappa did not pay the 1994-1999 insurance premiums for the fleet and the ARBA, \$829,509 and \$229,102 respectively.¹⁹⁴ In the spring of 2000, Interforce Shipping Ltd. ("Interforce") purchased the vessel, later asserting that it had no knowledge of Kappa's outstanding debt.¹⁹⁵

To collect the debt on the ARBA, Liverpool filed a complaint in the Middle District Court of Louisiana asking the court to issue a warrant of maritime arrest.¹⁹⁶ The district court granted the relief.¹⁹⁷ A few days later, Liverpool amended the complaint to include the debt for the entire fleet.¹⁹⁸ Interforce appeared to claim the vessel under Rules C and E and to defend against Liverpool's in rem action to collect the unpaid premiums.¹⁹⁹

The Middle District Court of Louisiana upheld the arrest.²⁰⁰ And after examining Liverpool's insurance contract, the court declared that the United States law governed the existence of a maritime lien.²⁰¹ After discovering that the Eastern District Court of Louisiana reached a different conclusion in *Queen of Leman*, Interforce moved for reconsideration and certification for interlocutory appeal.²⁰² After Liverpool endorsed the motion, the Middle District Court of Louisiana certified the choice-of-law issue for immediate interlocutory appeal.²⁰³

Again, the Fifth Circuit consolidated these cases, and the central question was whether English law or a federal statute—the Federal Maritime Lien Act—determined the existence of a maritime for unpaid insurance premiums.²⁰⁴ The difference is significant, and the appellate court explained it this way:

[The insurer] would have a lien against ships only to the extent that they were still the property of the debtor party. The central difference between a maritime lien and [this] personal right under English law is that a maritime lien is an in rem proceeding protecting a right that relates back to the time

192. *Id.*

193. *Id.*

194. *Id.*

195. *Id.*

196. *Id.*

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.*

201. *Id.*

202. *Id.*

203. *Id.*

204. *Id.* Section 31342(a), establishing maritime liens, reads,

Except as provided in subsection (b) of this section, a person providing necessities to a vessel on the order of the owner or a person authorized by the owner—

(1) has a maritime lien on the vessel;

(2) may bring a civil action in rem to enforce the lien; and

(3) is not required to allege or prove in the action that credit was given to the vessel.

46 U.S.C. § 31342(a) (2000).

when it attached. As a result, the maritime lien remains with the ship even though the ship is transferred to another party.²⁰⁵

By comparison, “under United States law, the Federal Maritime Lien Act . . . establishes a maritime lien for the provision of necessities, which include marine insurance.”²⁰⁶ To resolve the intracircuit conflict, the court of appeals declared that lower courts must apply United States substantive law to determine the existence of maritime liens.²⁰⁷

III. FIRST-PARTY INSURANCE CONTRACTS—STATE STATUTORY CLAIMS AND DECISIONS

A. Health Maintenance Organization—Whether ERISA Preempts the McCarran-Ferguson Act and Texas’s Power to Regulate the “Business of Insurance” Under an HMO Statute

Corporate Health Insurance, Inc. v. Texas Department of Insurance (Corporate Health I) has a fairly long history involving a complex set of facts and several procedural questions.²⁰⁸ Here, the author presents a synopsis of the most pertinent information. On May 22, 1997, Texas Senate Bill 386 became effective and generated a lot of controversy within the health community, among health insurers, and in the legal community.²⁰⁹

The bill created a statutory cause of action against managed care entities that fail to exercise ordinary care when treating patients.²¹⁰ The liability section of the statute stated,

A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.²¹¹

The “Independent Review Organization” (IRO) provisions established procedures for the independent review of health care determinations to decide whether they were appropriate and medically necessary.²¹² Finally, the law

205. *Queen of Leman*, 296 F.3d at 352 n.1.

206. *Id.* at 353.

207. *Id.* at 355.

208. 215 F.3d 526 (5th Cir. 2000) [hereinafter *Corp. Health I*].

209. Tex. S.B. 386, 75th Leg., R.S. (1995) (codified at TEX. CIV. PRAC. & REM. CODE § 88.001 *et seq.*); TEX. INS. CODE Art. 20A.09(e) (formerly (a)(3)); Art. 20A.12(a), (b), Art. 20A.12A; Art. 21.58A § 6(b), (c); Art. 21.58A § 6A; Art. 21.58A § 8(f); Art. 21.58C).

210. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (Vernon 2003).

211. *Id.*

212. *Corp. Health I*, 215 F.3d at 537.

protected physicians from health maintenance organizations' (HMO) mandatory indemnity clauses and from HMOs' retaliation for advocating medically necessary cares for patients.²¹³

Corporate Health Insurance, Inc., Aetna Health Plans of Texas, Inc., Aetna Plans of North Texas, Inc., and Aetna Life Insurance Company sell health insurance in Texas.²¹⁴ However, they are not plans under the Employee Retirement Income Security Act of 1974 (ERISA).²¹⁵ Aetna Health Plans of Texas is a licensed HMO.²¹⁶ It has contracts with more than 2,900 independent health care providers and thirty-nine hospitals.²¹⁷ Aetna Life Insurance Company also sells various health insurance products to employers, including programs available through a preferred provider organization (PPO).²¹⁸

After Texas Senate Bill 386 became law, Aetna promptly filed an action in the Southern District Court of Texas, claiming that ERISA and the Federal Employees Health Benefit Act (FEHBA) preempted the new act.²¹⁹ Put simply, they argued that section 515 of ERISA preempts " 'any and all state laws insofar as they . . . relate to any employee benefit plan.' " ²²⁰ The defendants—Texas and the federal government—argued that the allegedly preempted independent review provisions were saved under ERISA's "saving clause," which protects states' right to regulate the business of insurance.²²¹

The district court partially granted the parties' cross-motions for summary judgment.²²² On appeal, the Fifth Circuit applied the business of insurance analysis as outlined in *Union Labor Life Insurance Co. v. Pireno* and in its progeny of decisions.²²³ But the appellate court did not stop there.²²⁴ Applying the Supreme Court's savings clause analysis in *Pilot Life v. Dedeaux*, the court of appeals observed, "[E]ven if the provisions would

213. *Id.* at 531.

214. *Id.*

215. *Id.* at 532; 29 U.S.C. § 1144(a) (2000).

216. *Corp. Health I*, 215 F.3d at 531.

217. *Id.*

218. *Id.* at 532.

219. *Id.* at 531-32.

220. *Id.* (quoting 29 U.S.C. § 1144(a)).

221. 29 U.S.C. § 1144(b)(2)(A).

222. *Corp. Health I*, 215 F.3d at 532.

223. *Id.* at 537 & nn. 44-46.

The Supreme Court has interpreted the clause as designed to preserve Congress's reservation of the business of insurance to the states under the McCarran-Ferguson Act. In determining whether the clause applies, the Supreme Court considers whether the rule regulates insurance as a commonsense matter, looking as well to the three McCarran-Ferguson factors as "guideposts": (1) whether the practice has the effect of transferring or spreading the policyholder's risk; (2) whether it is an integral part of the policy relationship between the insured and the insurer; and (3) whether the practice is limited to entities in the insurance industry. The law need not satisfy each of these tests.

Id. at 537.

224. *Id.* at 537-38.

otherwise be saved, they may nonetheless be preempted if they conflict with a *substantive provision* of ERISA.²²⁵

Ultimately, the Fifth Circuit declared that (1) ERISA preempts Articles 20A.12A, 21.58A § 6(c), and 21.58A § 6A of the Texas Insurance Code, which allow patients to appeal managed-care entities' adverse determinations to outside state administrative utilization review agents; (2) the liability provisions of the Texas statute and the independent review provisions, insofar as they are merely a prerequisite to the filing of suit, are not preempted under ERISA nor under FEHBA because the liability provisions allow suit only for health services actually delivered and not for coverage disputes; and (3) the anti-indemnity and antiretaliation provisions are not preempted because those provisions also address traditional state concerns regarding the quality of health care.²²⁶

Disgruntled parties then appealed the case to the Supreme Court, and the Court accepted it for review, given that the Fifth Circuit's holding conflicted with the Seventh Circuit's ruling.²²⁷ The latter circuit had decided similar issues under an Illinois statute.²²⁸ The Court vacated *Corporate Health I* and remanded it for further consideration in light of the Court's decision in *Rush Prudential HMO, Inc. v. Moran*.²²⁹

On remand, the Fifth Circuit declared the following in *Corporate Health Insurance, Inc. v. Texas Department of Insurance (Corporate Health II)*:

[T]he *Moran* opinion requires that our opinion *be modified in part*. We hold that the IRO provisions of the Texas statute *are not preempted* by ERISA because they are within the saving clause of ERISA and do not offer an additional remedy in conflict with ERISA's exclusive remedy. Because self-funded ERISA plans are not covered by ERISA's saving clause, ERISA

225. *Id.* at 538. The Fifth Circuit also observed the following:

The Court interpreted Congress's intent regarding the exclusivity of ERISA's enforcement scheme very broadly, concluding that the scheme preempts not only directly conflicting remedial schemes, but also supplemental state law remedies. Thus, the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan.

Id. at 538-39 (citing *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987)) (footnote omitted).

226. *Id.* at 537-39.

227. *Montemayor v. Corp. Health Ins.*, 536 U.S. 935 (2002).

228. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).

229. *Id.*; see also *Corp. Health Ins., Inc. v. Tex. Dep't of Ins.*, 314 F.3d 784, 785-86 (5th Cir. Dec. 2002) [hereinafter *Corp. Health II*].

Moran made the same three inquiries in examining a similar Illinois statute. As we found in examining the Texas statute, *Moran* found that the Illinois statute related to ERISA, but was an insurance regulation under the ERISA saving clause. However, in examining whether the statute was preempted as conflicting with ERISA's exclusivity of remedy, the Court held that it was not. While *Moran* recognized that any state law that created a new cause of action or alternative ultimate remedy would be preempted by ERISA, it held that the independent review provision did not offer a new cause of action or ultimate remedy.

Corp. Health II, 314 F.3d at 785-86.

preempts any application of the IRO provisions to self-funded plans.

Accordingly, we reinstate our opinion as modified herein.²³⁰

B. Property Insurance—Whether the Prioritization of Payments Among “Primary” and “Excess” Insurers Was Appropriate Under Louisiana Law

The conflict in *Holden v. Connex-Metalna Management Consulting GMBH* involved several insurers clashing over who had primary and secondary responsibility to reimburse the insured for property losses.²³¹ Each insurer claimed that it was the excess rather than the primary carrier.²³²

In early 1998, IC RailMarine decided to construct a bulk cargo terminal in Convent, Louisiana.²³³ The company hired Connex-Metalna to construct a 240-foot gantry crane capable of loading and unloading cargo from ships docked at the terminal.²³⁴ Connex-Metalna built and installed the crane, which unfortunately fell into the Mississippi River during a test load in early June of that year.²³⁵

When the loss occurred, Illinois Central Corporation was the parent company of both IC RailMarine and Illinois Central Railroad.²³⁶ Several property insurers covered various parts of those enterprises’ activities.²³⁷ But determining how much and when each insurer should pay after the accident created a conflict.²³⁸ To illustrate, Reliance National Insurance sold a builder’s risk policy to Illinois Central Railroad, one of the subsidiary companies.²³⁹ But the builder’s risk policy covered only property losses associated with the construction of IC RailMarine’s bulk terminal.²⁴⁰ The policy limit was \$19.42 million.²⁴¹

Lexington Insurance Company and Westchester Surplus Lines Insurance Company sold a joint blanket, or general property, policy to Illinois Central Corporation and its subsidiaries, including IC RailMarine.²⁴² The blanket policy “covered all real and personal property throughout the country.”²⁴³ Under the blanket policy, Lexington and Westchester Surplus agreed to pay

230. *Corporate Health II*, 314 F.3d at 786 (emphasis added).

231. 302 F.3d 358, 361 (5th Cir. Aug. 2002).

232. *See id.* at 362.

233. *Id.* at 361.

234. *Id.*

235. *Id.*

236. *Id.*

237. *Id.*

238. *See id.*

239. *Id.* at 361 n.1.

240. *Id.* at 361.

241. *Id.*

242. *Id.* at 361-62.

243. *Id.* at 361.

up to \$8 million for losses in excess of a \$2 million self-insured retention.²⁴⁴ The blanket policy, however, was not associated with property losses connected to the construction of the bulk terminal.²⁴⁵ Finally, to cover property losses above \$10 million, Illinois Central Corporation purchased a joint excess property policy issued by Westchester Fire Insurance Company and General Star Indemnity Company.²⁴⁶ The policy limit under the joint excess contract was \$15 million.²⁴⁷

Following the accident, RailMarine filed a property-loss claim under the following three insurance contracts: (1) Reliance's builder's risk insurance policy, (2) Lexington and Westchester Surplus's joint general property policy, and (3) Westchester Fire and General Star's joint excess property policy.²⁴⁸ In response, Reliance filed a declaratory judgment action in the District Court for the Eastern District of Louisiana asking the court to declare Reliance's rights and obligations under the builder's risk policy.²⁴⁹ Lexington, Westchester Surplus, Westchester Fire, and General Star intervened in the action, and RailMarine commenced an action, also.²⁵⁰ The court consolidated the actions, and all parties filed cross motions for summary judgment.²⁵¹

Reliance argued that a peril insured against under the builder's risk policy did not cause the crane accident.²⁵² The general, or blanket, insurers—Lexington and Westchester Surplus—argued that they were not obligated to cover losses caused by the crane accident until the policy limits under Reliance's builder's risk policy that specifically covered the construction project had been exhausted.²⁵³ Shortly before the trial began, IC RailMarine settled its claims against Reliance, Lexington, and Westchester Surplus for \$11.5 million.²⁵⁴ Under the terms of the settlement, each insurer reserved the right to litigate any share it might own of the \$11.5 million settlement amount.²⁵⁵ And they did.²⁵⁶

In the district court, the parties proffered parol evidence as a means to determine which property insurer had primary and secondary responsibilities under the various contracts.²⁵⁷ Rejecting the parol evidence as well as the

244. *Id.* at 362.

245. *Id.* at 361.

246. *Id.* at 362.

247. *Id.*

248. *Id.* at 361.

249. *Id.* at 362.

250. *Id.* at 362 & n.3.

251. *Id.* at 362.

252. *Id.*

253. *Id.*

254. *Id.* at 365 n.4 ("In a separate agreement, IC RailMarine settled its claim under Royal's policy covering the general property policy deductible for \$1.975 million. IC RailMarine thus settled all of its insurance claims associated with the crane accident for a total of \$13.475 million.").

255. *Id.* at 362.

256. *See id.* at 362-63.

257. *Id.* at 362 n.5.

doctrine of ambiguity,²⁵⁸ the district court applied the doctrine of plain meaning and declared that (1) Lexington and Westchester Surplus's joint blanket policy clearly provided primary coverage for the crane accident losses and (2) Westchester Fire and General Star's joint policy was a true excess insurance contract under the plain meaning of its terms.²⁵⁹ This latter policy did not provide any coverage until the proceeds under the primary policy had been exhausted.²⁶⁰ Therefore, the court declared that of the \$11.5 million IC RailMarine settlement, Reliance, Lexington, and Westchester Surplus were responsible for \$8.165 million, \$2.084 million, and \$1.251 million respectively.²⁶¹ The insurers appealed.²⁶²

The central question before the Fifth Circuit was whether Lexington and Westchester Surplus's joint blanket policy provided primary coverage for the losses associated with the crane accident.²⁶³ Reliance argued that the general property insurers should provide primary coverage because each agreed to insure the same property and risk.²⁶⁴ Lexington and Westchester Surplus argued that their blanket property policy did not provide coverage for the same losses as Reliance's builder's risk policy.²⁶⁵

Citing *Fasullo v. American Druggists' Insurance Co.*, the general insurers argued that "Louisiana law establishes different levels of priority for insurance coverage depending on whether the coverage is 'general' or 'specific.'" ²⁶⁶ Therefore, the coverage under Reliance's builder's risk policy should be exhausted before triggering coverage under their joint blanket property policy.²⁶⁷ But again, the district court found that the Lexington and Westchester Surplus policy provided primary coverage after considering and rejecting the analysis and principle outlined in *Fasullo*.²⁶⁸

258. *Id.* at 362 ("The district court held that the proffered parol evidence was not admissible under Louisiana law because the language in the relevant insurance policies was unambiguous."); see also *Succession of Fannaly v. Lafayette Ins. Co.*, 805 So. 2d 1134, 1138 (La. 2002) (repeating that "the ambiguous contractual provision is construed against the insurer who furnished the contract's text and in favor of the insured").

259. See *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").

260. *Holden*, 302 F.3d at 362.

261. *Id.* at 363.

262. *Id.*

263. *Id.* at 364.

264. *Id.*

265. *Id.*

266. *Id.* (citing *Fasullo v. Am. Druggists' Ins. Co.*, 262 So. 2d 810 (La. App. 1972)).

267. *Id.*

268. *Id.* at 366 n.9.

The district court declined to apply *Fasullo* because other Louisiana courts have not followed it. It would appear, however, that no other Louisiana court has had occasion to address this issue. The district court also observed that the Louisiana First Circuit Court of Appeal in *Prudential Assur. Co. Ltd. v. London & Hull Maritime Ins. Co., Ltd.*, 621 So. 2d 1165, 1167 (La. App. 1 Cir.1993), asserted that *Fasullo* is "no longer 'good law.' "

To resolve the controversy, the Fifth Circuit declared,

Applying [*Fasullo*] . . . to the facts of the present case, we hold that the builder's risk policy issued by Reliance provides primary coverage for the losses caused by the crane accident, while the blanket property policy issued by Lexington and Westchester Surplus provides coverage for losses in excess of the builder's risk policy limit. As a consequence, the district court erred in holding that Lexington and Westchester Surplus were primary insurers of the IC RailMarine construction project and shared in the liability for the damages associated with that project.²⁶⁹

The Fifth Circuit then reversed the district court's prioritization, or apportionment, judgment and remanded the case.²⁷⁰

C. Commercial Property Insurance—Whether a Jury's "Bad Faith" and Deceptive Trade Practices Verdicts Were Proper Under Texas Law

Although the facts and legal questions appearing in *Parkans International L.L.C. v. Zurich Insurance Co.* are not terribly complex, the analysis and disposition of this case are rather baffling.²⁷¹ Parkans International agreed to purchase scrap metal from Adusa Export.²⁷² Parkans also promised to use an irrevocable letter of credit to pay for the products.²⁷³ Parkans and Adusa chose Marine Midland Bank and Wells Fargo Bank as the institutions that would issue and confirm (receive) the letter of credit.²⁷⁴ Marine Midland withdrew nearly \$1 million from Parkans's bank account and transferred it to Wells Fargo.²⁷⁵

Parkans had instructed Wells Fargo to pay Adusa's representative when that individual presented "certain non-negotiable documents."²⁷⁶ Although Adusa never shipped the scrap metal, the company presented fraudulent documents, and under the letter of credit, Wells Fargo Bank gave nearly \$1 million to Adusa.²⁷⁷ To be sure, Adusa committed a major criminal act and is presumably still at large.²⁷⁸

When the theft by forgery occurred, Zurich Insurance Company covered Parkans International under a primary property insurance contract, the

Id.

269. *Id.* at 366-67.

270. *Id.* at 367.

271. See 299 F.3d 514 (5th Cir. Aug. 2002).

272. *Id.* at 515.

273. *Id.*

274. *Id.*

275. *Id.*

276. *Id.*

277. *Id.*

278. *Id.*

Commercial Package Policy (CPP); that contract insured against certain perils, including criminal acts.²⁷⁹ An excess insurance policy, Custom Cover Policy (CCP), also covered Parkans's property.²⁸⁰ Therefore, Parkans submitted a notice-of-loss claim to Zurich asking the insurer for indemnity under the primary policy.²⁸¹ Zurich refused to provide coverage under either policy and denied any wrongdoing.²⁸²

In response, Parkans filed a breach of contract action against Zurich in the District Court for the Southern District of Texas.²⁸³ According to the insured, Zurich breached a contractual duty to indemnify under the respective insurance contracts.²⁸⁴ Parkans also initiated two tort-based actions against the insurer, an independent tort of bad faith and an action under the Deceptive Trade Practices Act (DTPA) for allegedly violating Article 21.21 of the Texas Insurance Code.²⁸⁵ Parkans filed a motion requesting partial summary judgment on the primary policy, claiming that the crime-coverage provision covered theft by forgery.²⁸⁶ Zurich moved for summary judgment with respect to all actions and claims.²⁸⁷ The court granted Parkans's motion, holding that the crime clause in the primary policy provided coverage; the district court denied Zurich's motion.²⁸⁸

The remaining issues went to trial, and the jury found against Zurich after the judge instructed the panel "that the loss was covered under the primary policy and that Zurich's failure to pay the claim was a breach of the primary policy."²⁸⁹ The jury also found that Zurich violated the DTPA and acted in bad faith by knowingly engaging in unfair and deceptive practices.²⁹⁰ The jury awarded \$1.34 million for breach of contract, \$1.29 million for the tort claims, and \$350,000 for attorneys' fees.²⁹¹ The district judge, however, entered a

279. *Id.*

280. *Id.*

281. *Id.*

282. *Id.*

283. *Id.*

284. *Id.*

285. *Id.* Section 17.50(a)(4) of the DTPA provides, "A consumer may maintain an action where any of the following constitutes a producing cause of economic damages or damages for mental anguish: . . . (4) the use or employment by any person of an act or practice in violation of Art. 21.21, Insurance Code." TEX. BUS. & COMM. CODE ANN. § 17.50(a)(4) (Vernon 2000); see *Viles v. Sec. Nat'l Ins. Co.*, 788 S.W.2d 566, 567 (Tex. 1990) (creating an independent tort of bad faith by holding that "a breach of the duty of good faith and fair dealing will give rise to a cause of action in tort that is separate from any cause of action for breach of the underlying insurance contract"); *Vail v. Tex. Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 136 (Tex. 1988) (holding that "[t]he Vails stated and proved a cause of action under section 17.50(a)(4) of the DTPA and article 21.21, § 16 of the Insurance Code by pleading and proving that Texas Farm had committed an unlisted deceptive trade practice under section 17.46 of the DTPA").

286. *Zurich*, 299 F.3d at 516.

287. *Id.*

288. *Id.*

289. *Id.*

290. *Id.*

291. *Id.*

final judgment against Zurich only for the breach of contract action.²⁹² The court also awarded attorneys' fees, interest, and statutory damages.²⁹³ Dissatisfied with the verdict and judgment, Zurich appealed.²⁹⁴

The overarching question before the Fifth Circuit was whether the district court should have granted Zurich's motion for judgment as a matter of law.²⁹⁵ The jury found that Zurich acted in bad faith and knowingly engaged in deceptive practices.²⁹⁶ However, citing *Transportation Insurance Co. v. Moriel*, the Fifth Circuit declared that the district court should have granted Zurich's motion as a matter of law.²⁹⁷ From the appellate court's perspective, the insurer did not act in bad faith.²⁹⁸ Instead, the insurer "had a reasonable basis" for refusing to indemnify Parkans: "[T]here was a bona fide dispute"²⁹⁹ Consequently, that reasonable foundation shielded Zurich from any tort-based liability under Texas's common and statutory laws.³⁰⁰

The Fifth Circuit also held that the district court should have granted Zurich's summary judgment motion regarding the breach of contract action.³⁰¹ The crime coverage provision appearing in the primary insurance contract stated,

We will pay for loss involving Covered Instruments resulting directly from the Covered Causes of Loss.

1. *Covered Instruments*: Checks, drafts, promissory notes, or similar written promises, orders or directions to pay a sum certain in "money" that are:
 - a) Made or drawn by or drawn upon [the insured];
 - b) Made or drawn by one acting as [the insured's] agent; or that are purported to have been so made or drawn.

292. *Id.*

293. *Id.*

294. *Id.*

295. *Id.*

296. *Id.* at 518-19 n.4.

297. *Id.* at 519 (citing *Transp. Ins. Co. v. Morel*, 879 S.W.2d 10 (Tex. 1994) (holding that an insured who alleges bad faith "must prove that the insurer had no reasonable basis for denying or delaying the payment of the claim"))).

298. *Id.* The court of appeals also cited the followings cases to buttress its declaration: *Higginbotham v. State Farm Mutual Automobile Insurance Co.*, 103 F.3d 456, 460 (5th Cir. 1997) (declaring that claims under the DTPA and article § 21.21 of the Texas Insurance Code require the same predicate to recovery as a bad-faith cause of action); *Emmert v. Progressive County Mutual Insurance Co.*, 882 S.W.2d 32, 36 (Tex. App.—Tyler 1994, writ denied) (concluding that an insurer who refuses to pay will not face a tort-based action—under the Texas Insurance Code, the Deceptive Trade Practices Act or common law—if there was any reasonable basis for denying the claim); *Lyons v. Millers Casualty Insurance Co.*, 866 S.W.2d 597 (Tex. 1993).

299. *Zurich*, 299 F.3d at 519.

300. *Id.*

301. *Id.* at 517.

2. *Covered Causes of Loss: Forgery or alteration of, on or in a Covered Instrument.*³⁰²

On the basis of summary judgment evidence, the district court found that Adusa Export presented forged certificates and a forged bill of lading to secure money illegally from Wells Fargo.³⁰³ Adusa presented the forged documents, ostensibly to satisfy the requirements outlined in the letter of credit.³⁰⁴ Still, Zurich argued that, even if forgeries occurred, the forged documents were not perils insured against.³⁰⁵ More specifically, the insurer maintained that the forged certificates and bill of lading were not forged covered instruments under the terms of the primary contract.³⁰⁶

The Fifth Circuit agreed.³⁰⁷ However, the court of appeals substantially deviated from fairly settled principles of Texas insurance law to reach a bewildering conclusion. The Texas Supreme Court has embraced or formally adopted the following five legal doctrines to interpret the terms under an insurance contract: (1) general rules of contract construction,³⁰⁸ (2) the doctrine of plain meaning,³⁰⁹ (3) the doctrine of ambiguity,³¹⁰ (4) the doctrine of reasonable expectation,³¹¹ and (5) the adhesion doctrine.³¹² Yet the court of appeals did not embrace a single doctrine to interpret the meaning of the terms in the Zurich primary insurance contract.³¹³

Instead, citing a Texas lower-court case—*Gulf Metals Industries, Inc. v. Chicago Insurance Co.*—the Fifth Circuit declared, “A contextual analysis of the contract is the proper approach to determine the meaning of contractual

302. *Id.* at 519 (alterations in original).

303. *Id.* at 517.

304. *Id.* at 516. “[A] weight certificate [came] ostensibly from Alfred H. Knight (a surveying firm) and bills of lading [came] ostensibly from Crowley American Transport (a shipping company), although all the documents were fraudulent.” *Id.* at 517.

305. *Id.*

306. *Id.*

307. *Id.*

308. *See 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).

309. *See 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 there is no ambiguity).

310. *See Nat’l Union Fire Ins. Co. v. Hudson Energy Co.*, 811 S.W.2d 552, 555 (Tex. 1991) (re-emphasizing that ambiguous language in an insurance contract must be construed in favor of the insured).

311. *See 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, 140 n.8 (Tex. 1994) (observing that Texas law does not recognize the doctrine of reasonable expectation as a basis to disregard unambiguous policy provisions).

312. *See 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 they “allow unscrupulous insurers to take advantage of their insureds’ misfortunes” during the bargaining process).

313. *See Parkans Int’l L.L.C. v. Zurich Ins. Co.*, 299 F.3d 514, 514-20 (5th Cir. Aug. 2002).

terms."³¹⁴ After performing a contextual analysis of the crime provision and facts, the court of appeals concluded, "To be a 'covered instrument,' a document must be a check, draft, promissory note, or *similar written promise*, order or direction to pay 'Made or drawn by or drawn upon [Parkans]; Made or drawn by one acting as [Parkans's] agent" ³¹⁵ The appeals court then reversed the partial summary judgment favoring Parkans and rendered a judgment for Zurich, finding that no coverage existed under the primary policy.³¹⁶

Bluntly put, the Texas Supreme Court has not recognized a contextual analysis doctrine to interpret insurance contracts.³¹⁷ And in his dissenting opinion, Judge Dennis underscored that point: "The majority's interpretation conflicts with basic principles of Texas insurance law. When interpreting an insurance contract, Texas courts will read its terms in their plain, ordinary, and popular sense unless the policy defines a term in some other way."³¹⁸ But more important, Judge Dennis appropriately observed, "Contextual arguments like the one used in *Gulf Metals* are useful for interpreting terms that have multiple common meanings, but not for choosing a technical interpretation over a reasonable common interpretation."³¹⁹

Furthermore, the dissenting judge correctly observed,

[T]here is nothing in the context of the [insurance] policy that limits word[s] . . . to . . . [their] technical meaning under the UCC. . . . [A]nd the policy makes no reference to the Texas Business and Commerce Code. Under

314. *Id.* at 517 (emphasis added). What's more, the Fifth Circuit implicitly acknowledged that Texas has adopted other doctrines to interpret insurance policies. *Id.* (citing *Nat'l Union Fire Ins. Co. v. CBI Indus., Inc.*, 907 S.W.2d 517, 520 (Tex. 1995) (reaffirming that a contract term that can be given a definite or certain legal meaning in an insurance contract is not ambiguous)). Still, the court employed an unwarranted contextual analysis. *See also Zurich*, 299 F.3d at 521.

The majority rejects this plain reading of the policy in favor of a more technical one. Relying on *Gulf Metals Industries, Inc. v. Chicago Insurance Co.*, the majority argues that the policy must be read in the commercial paper context and according to UCC definitions. The majority's reliance on *Gulf Metals* is, however, misplaced.

Id. (Dennis, J., dissenting).

315. *Id.* at 517 (alterations in original).

316. *Id.*

317. *Id.* at 520 & n.1.

318. *Id.* (Dennis, J., dissenting); *see Puckett v. U.S. Fire Ins. Co.*, 678 S.W.2d 936, 938 (Tex. 1984) ("[I]t is the court's duty to give the words used their plain meaning."); *Ramsay v. Md. Amer. Gen. Ins. Co.*, 533 S.W.2d 344, 346 (Tex. 1976) ("With no definition in the policy, we must first determine whether the term has a readily ascertainable meaning in the plain, ordinary and popular sense of the words themselves."); 45 TEX. JUR.3D *Insurance Contracts & Coverage* § 109 (1995).

Contracts of insurance must be construed, as other contracts, according to the terms that the parties have used, to be taken and understood, in the absence of ambiguity, in their plain, ordinary, and popular sense, unless there are other provisions indicating a contrary intention of the parties. Thus, if the insurance policy does not define the terms used, they are to be given their plain, ordinary, and generally accepted meaning.

45 TEX. JUR.3D *Insurance Contracts & Coverage* § 109.

319. *Zurich*, 299 F.3d at 522 (Dennis, J., dissenting).

Texas insurance law, if Zurich intended for the term to have a definition other than an ordinary one, it was required to define the term accordingly.³²⁰

Finally, dissenting Judge Dennis intelligently noted, "Texas courts disfavor interpretations that limit coverage, and they construe ambiguities in favor of the insured."³²¹

D. Commercial Property Insurance—Whether an Insurer Acted in Bad Faith and Violated Texas's DTPA Statute for Refusing to Make First-Party Reimbursements Under a "Crime PLUS+" Insurance Contract

The Fifth Circuit decided *Travelers Casualty & Surety Co. of America v. Baptist Health System* four months after deciding *Parkans*.³²² This is somewhat significant. The controversy in both cases involved nearly identical insurance contracts, and the court of appeals reached the same conclusion in each case using the same questionable legal doctrine.³²³ Only the facts in *Travelers* and in *Parkans* differ.³²⁴

During the late 1990s, Marshall R. Shepherd was a vendor doing business as a Medical Resource Assistance.³²⁵ He sold medical supplies and services to Baptist Health System (BHS) in San Antonio, Texas.³²⁶ The terms of the vendor's agreement required Shepherd to submit invoices to BHS's financial services department.³²⁷ A manager in that department would examine the invoices, approve the payment of bills, sign the invoices by initialing them, and send the invoices to the accounts payable department.³²⁸ After the accounts payable department received the signed invoices, that department would pay suppliers.³²⁹ According to BHS, a signed invoice was an instruction to the employees in the accounts payable department to pay the invoice.³³⁰

320. *Id.* at 522 & n.11 (Dennis, J., dissenting); see *W. Reserve Life Ins. Co. v. Meadows*, 261 S.W.2d 554, 557 (Tex. 1953) (stating that the terms of an insurance contract "are to be given their plain, ordinary and generally accepted meaning unless the instrument itself shows them to have been used in a technical or different sense"); 45 TEX. JUR.3D. *Insurance Contracts & Coverage* § 109 ("[I]f the insurance policy does not define the terms used, they are to be given their plain, ordinary, and generally accepted meaning.") (alteration in original).

321. *Zurich*, 299 F.3d at 520-21 & n.2 (Dennis, J., dissenting); see *Puckett*, 678 S.W.2d at 938 ("It is well established that insurance policies are strictly construed in favor of the insured in order to avoid exclusion of coverage."); *Ramsay*, 533 S.W.2d at 349 ("When the language of a policy is susceptible of more than one reasonable construction, the courts will apply the construction which favors the insured and permits recovery.")

322. *Travelers*, 313 F.3d 295 (5th Cir. Dec. 2002); *Zurich*, 299 F.3d at 514.

323. *Travelers*, 313 F.3d at 296-99; *Zurich*, 299 F.3d at 515-19.

324. *Travelers*, 313 F.3d at 296-97; *Zurich*, 299 F.3d at 515-16.

325. *Travelers*, 313 F.3d at 296.

326. *Id.*

327. *Id.*

328. *Id.*

329. *Id.*

330. *Id.*

Once the financial services department signed an invoice, the accounts payable department did not have discretion to refuse payment.³³¹

Marshall Shepherd committed several criminal acts by fraudulently taking advantage of BHS's procedures for paying suppliers and service providers.³³² Specifically, the vendor created invoices for work that he did not perform, and he forged the signatures of BHS's managers on the invoices.³³³ Also, instead of submitting the invoices to BHS's financial services department, Shepherd delivered the forms directly to the accounts payable division.³³⁴ Believing the signatures were genuine, the latter department sent \$876,545 in checks to Shepherd.³³⁵

Aetna Casualty and Surety Company and its successor, Travelers Casualty and Surety Company, insured BHS under a "Crime Policy" and a "Crime PLUS+" contract, respectively.³³⁶ Therefore, after discovering Shepherd's fraud, BHS notified and sent a proof-of-loss statement to Travelers, asking for indemnification under the Crime PLUS+ policy.³³⁷ Travelers denied the claim, asserting that (1) the fraudulent invoices were not covered instruments under the policies and (2) the money had not been drawn

331. *Id.*

332. *Id.*

333. *Id.*

334. *Id.*

335. *Id.*

336. *Id.* at 296-98. Aetna's policy covered "the period of August 31, 1996, to August 31, 1998," and Travelers's policy covered "the period of August 31, 1998, to August 31, 1999." *Id.* at 296. BHS cancelled the Aetna contract after Travelers issued its policy. *Id.* Later however, "Travelers acquired Aetna's business and succeeded to the rights and obligations under the Aetna policy." *Id.* at 297. Aetna's "Crime Policy" reads,

A. Coverage

We will pay for loss involving Covered Instruments resulting directly from the Covered Causes of Loss.

1. Covered Instruments: Checks, drafts, promissory notes, or similar written promises, orders or directions to pay a sum certain in "money" that are:
 - a. Made or drawn by or drawn upon you;
 - b. Made or drawn by one acting as your agent; or that are purported to have been so made or drawn.

2. Covered Causes of Loss: Forgery or alteration of, on or in any "Covered Instrument."

Id. at 298. The relevant portion of the Travelers's "Crime PLUS+" policy states,

II. Forgery or Alteration:

We will pay for loss resulting directly from "Forgery" or alteration of, on or in "Covered Instruments" that are:

1. Made or drawn by or drawn upon you; or
2. Made or drawn by one acting as your agent; or that are purported to have been so made or drawn

....

"Covered Instruments" means checks, drafts, promissory notes or similar written promises, orders or directions to pay a sum certain in "Money."

"Forgery" means the signing of the name of another person or organization with intent to deceive, it does not mean a signature which [,] consists in whole or in part of one's own name signed with or without authority, in any capacity for any purpose.

Id.

337. *Id.* at 297.

upon BHS as required by the Crime Plus+ contract.³³⁸

Travelers then filed a declaratory judgment action in the District Court for the Western District of Texas asking the court to declare whether Travelers had a duty to indemnify BHS.³³⁹ In a Texas state court, BHS filed two actions against the insurer, a common law action for breach of contract and a DTPA action for allegedly violating the Texas Insurance Code.³⁴⁰ After removing the state case to the federal district court, the judge consolidated BHS's and Travelers's action for declaratory relief.³⁴¹

BHS moved for summary judgment on the breach of contract action.³⁴² The insured invoked the doctrine of ambiguity, cited the Texas Supreme Court's decision in *State Farm Fire & Casualty Co. v. Reed*, argued that the contractual terms in both the Crime and Crime PLUS+ policies were ambiguous, and asked the court to construe any ambiguity strictly in favor of BHS.³⁴³ Alternatively, BHS argued that a plain and ordinary reading of the terms in the contracts required Travelers to make reimbursements for the losses.³⁴⁴ Travelers filed a cross-motion for summary judgment, maintaining that the policy was unambiguous and that its plain meaning did not allow coverage.³⁴⁵

Applying the doctrine of ambiguity, the federal district court granted BHS's motion for partial summary judgment.³⁴⁶ But the court denied Travelers's motion, concluding that the terms "covered instruments" and "drawn upon" were ambiguous.³⁴⁷ Therefore, construing the ambiguity against Travelers, the court declared that Shepherd's forged invoices were "made or drawn by or drawn upon" BHS or its agents or, alternatively, were "purported to have been so made or drawn."³⁴⁸ In addition, Travelers had argued that covered instruments included only negotiable instruments.³⁴⁹ However, the Western District Court of Texas rejected that interpretation, observing that the insurance contract did not expressly use the term negotiable.³⁵⁰ The judge entered a final judgment disposing of all claims after awarding statutory interest, pre and post judgment interest, and attorneys' fees.³⁵¹

338. *Id.* at 296-97.

339. *Id.* at 297.

340. *Id.*

341. *Id.*

342. *Id.*

343. *Id.* at 296-99 (citing *State Farm Fire & Cas. Co. v. Reed*, 873 S.W.2d 698, 699 (Tex. 1993) (declaring that "if a contract of insurance is susceptible to more than one reasonable interpretation, . . . [courts] . . . must resolve the uncertainty by adopting the construction most favorable to the insured")).

344. *Id.*

345. *Id.*

346. *Id.* at 297-99.

347. *Id.* at 298.

348. *Id.*

349. *Id.*

350. *Id.*

351. *Id.*

Travelers appealed the outcome to the Fifth Circuit.³⁵² That tribunal invested very little effort to reverse the district court's conclusion and ruled in favor of the insurer.³⁵³ More important, the court of appeals deliberately chose not to employ one of several traditional doctrines to interpret Travelers's insurance contracts.³⁵⁴ Instead, the appeals court cited *Parkans International*, which it decided four months earlier.³⁵⁵ The court reviewed the coverage provisions and performed another contextual analysis—a highly questionable and unprecedented methodology for interpreting insurance contracts originating in the State of Texas.³⁵⁶

The Fifth Circuit acknowledged that Shepard's forged invoices ultimately caused BHS's bank to deduct funds from BHS's account, print checks, and

352. *Id.*

353. *See id.* at 299.

354. *See id.*

355. *Id.* The Fifth Circuit stated, "Since the district court ruling, we have rejected *Omnisource's* expansive reading of the term 'drawn' as used in insurance contract clauses [that are] nearly identical to . . . [those] . . . in the Travelers and Aetna policies." *Id.*

356. *Id.* On other occasions, the Fifth Circuit has cited Texas Supreme Court cases to create and apply—out of the proverbial thin air—a contextual analysis in disputes involving Texas's insurers and insureds. *See, e.g., Mustang Tractor & Equip. Co. v. Liberty Mut. Ins. Co.*, 76 F.3d 89 (5th Cir. 1996). Consider, for example, the language appearing in *Mustang Tractor & Equipment Co. v. Liberty Mutual Insurance Co.*:

Courts must read all provisions of an agreement together, interpreting the agreement so as to give each provision its intended effect. *Forbau*, 876 S.W.2d at 133. We must be particularly wary of isolating individual words, phrases, or clauses and reading them out of the context of the document as a whole. *State Farm Life Ins. Co. v. Beaton*, 907 S.W.2d 430, 433 (Tex. 1995)

.....

So we must examine the context in which the word is used.

Mustang Tractor & Equip. Co., 76 F.3d at 91-92 (emphasis added). To be blunt, the Fifth Circuit's reliance on *Beaton* and *Forbau* is misleading at best and, at worst, both worrisome and highly suspect. *See Forbau v. Aetna Life Ins. Co.*, 876 S.W.2d 132 (Tex. 1994); *State Farm Life Ins. Co. v. Beaton*, 907 S.W.2d 430 (Tex. 1994). In *Forbau v. Aetna Life Ins. Co.*, the Texas Supreme Court neither adopted nor employed a contextual analysis to interpret one's rights and obligations under an insurance contract. *Forbau*, 876 S.W.2d at 132. In fact, the word "context" only appears twice in *Forbau*. In one instance, the Texas Supreme Court states, "We therefore address the merits of Amy's claim in the context of ERISA." *Id.* at 137 (emphasis added). And on the other occasion, the Supreme Court of Texas inserts the following language in a footnote: "While the right to trial by jury is a substantive liberty guarantee of fundamental importance, it has been considered a procedural right in the context of state enforcement of federal rights." *Id.* at 145 n.19. But more disturbing, neither context, contextual, nor contextual analysis appears in *Beaton*. *See Beaton*, 907 S.W.2d at 430. Without doubt, the infusion of bad law—originating out of thin air in a federal circuit court—can easily undermine a state court's application or enforcement of settled legal principals within a state. *See, e.g., Gulf Metals Indus., Inc. v. Chicago Ins. Co.*, 993 S.W.2d 800, 805-06 (Tex. App.—Austin. 1999, pet. denied).

Thus, our inquiry is whether the construction advanced by Gulf Metals of the phrase "sudden and accidental" as used in the qualified polluter's exclusion clause is a reasonable interpretation In its analysis, the *Mustang Tractor* court concluded that the context in which a word is used must control its definition We find *Mustang Tractor's* analysis persuasive and agree that contextual inquiry is the approach to follow here To allow the existence of more than one dictionary definition to be the *sine qua non* of ambiguity would eliminate contextual analysis of contractual terms.

Id.

issue the checks.³⁵⁷ Still, the court declared that (1) “the checks were not forged,” and (2) the “forged invoices were not made, drawn by, or drawn upon BHS as those terms are used in *the commercial paper context or under the Uniform Commercial Code.*”³⁵⁸

To be sure, the Fifth Circuit’s application of a so-called contextual analysis to resolve the disputes in *Travelers* and *Parkans* is truly perplexing, especially when viewed against the background of settled principles of Texas insurance law and in light of Circuit Judge Dennis’s carefully researched and thoroughly intelligible dissenting opinion in *Parkans*.³⁵⁹ Arguably, the majority’s opinions in *Travelers* and *Parkans* could very well cause otherwise reasonable insurance consumers, the business community, and jurists in Texas to seriously question whether the Fifth Circuit can deliver thoroughly researched, well-reasoned, and fair insurance-law decisions.³⁶⁰

IV. FIRST-PARTY INSURANCE CONTRACTS—FEDERAL STATUTORY CLAIMS AND DECISIONS: HEALTH INSURANCE (MEDICARE)—WHETHER THE MEDICARE SECONDARY PROVIDERS STATUTE PERMITS THE FEDERAL GOVERNMENT TO RECOUP MEDICARE REIMBURSEMENTS FROM ALLEGED SELF INSURERS

Thompson v. Goetzmann originated in the Northern District Court of Texas, and it presented a question of first impression for the Fifth Circuit: whether the federal government may recoup expenditures from a Medicare recipient who was allegedly self insured.³⁶¹ Unlike the court’s analyses in other cases reported in this presentation, the Fifth Circuit arguably invested an inordinate amount of time researching and critiquing all the major subissues presented in the case.³⁶² And even though this was a case of first impression for the Fifth Circuit, the court gave one of the parties, the federal government, a written thrashing for employing heavy handed tactics to recoup monies from Medicare recipients.³⁶³ In fact, the court of appeals even threatened the federal government with sanctions for bringing an allegedly frivolous lawsuit.³⁶⁴

What generated the Fifth Circuit’s wrath? Bernice Loftin is a Medicare recipient, and she had surgery in June of 1993.³⁶⁵ The doctors removed

357. *Travelers*, 313 F.3d at 299.

358. *Id.* (emphasis added) (“In the commercial paper context [,] the phrases ‘drawn by’ and ‘drawn upon’ are not ambiguous and have a definite legal meaning.”).

359. *See id.*; *Parkans Int’l L.L.C. v. Zurich Ins. Co.*, 299 F.3d 514, 520-23 (5th Cir. Aug. 2002) (Dennis, J., dissenting).

360. *See Travelers*, 313 F.3d at 295; *Parkans*, 299 F.3d at 514.

361. 315 F.3d 457 (5th Cir. Dec. 2002).

362. *See supra* note 353 and accompanying text; *Thompson*, 315 F.3d at 457.

363. *Thompson*, 315 F.3d at 470.

364. *Id.*

365. *Id.* at 458.

Loftin's hip joint and replaced it with a prosthesis.³⁶⁶ Zimmer, Inc. manufactured the prosthesis.³⁶⁷ The federal government paid for the product and other medical costs through the Medicare program.³⁶⁸ Complications arose requiring Loftin to undergo a second surgery and additional medical treatment.³⁶⁹ Medicare paid Loftin \$143,881 for her two surgeries and medical treatment.³⁷⁰

Dissatisfied with the hip prosthesis, Loftin hired attorney Stephen Goetzmann to commence a products liability suit against Zimmer, Inc.³⁷¹ Goetzmann filed the action, alleging that Zimmer placed a defectively designed product into the stream of commerce.³⁷² The suit sought damages for the medical expenses, which the Medicare program had already paid.³⁷³ Eventually, Loftin and Zimmer settled the claim.³⁷⁴ Without admitting liability, Zimmer paid Goetzmann \$256,000.³⁷⁵ Attorney Goetzmann received the money, deducted his forty percent contingency fee (\$102,400), and distributed the balance (\$153,600) to Loftin.³⁷⁶ The record reveals that Zimmer paid the entire settlement without any assistance from an insurance company.³⁷⁷

After learning about the Loftin settlement, the federal government—the Secretary of the Department of Health and Human Services (HHS)—filed a statutory action under the Medicare Secondary Provider (MSP) statute in the Northern District Court of Texas.³⁷⁸ The complaint listed Goetzmann, Loftin, and Zimmer as defendants.³⁷⁹ According to HHS, when Medicare pays a recipient's medical bills and a self-insurance plan covers those expenses, the MSP authorizes the government to recoup all Medicare payments from that self-insurance plan.³⁸⁰

366. *Id.*

367. *Id.*

368. *Id.*

369. *Id.*

370. *Id.*

371. *Id.*

372. *Id.*

373. *Id.*

374. *Id.*

375. *Id.*

376. *See id.*

377. *Id.*

378. *Id.*; 42 U.S.C. § 1395y(b) (2000).

379. *Thompson*, 315 F.3d at 458.

380. 42 U.S.C. § 1395y(b)(2)(A)(ii); *see Thompson*, 315 F.3d at 458. In pertinent part, the MSP statute states,

Payment under [the Medicare program] . . . may not be made . . . with respect to any item or service to the extent that—

(i) payment has been made, or can reasonably be expected to be made, . . . as required [under a group health plan] . . . , or

(ii) payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen's compensation law

HHS alleged that Zimmer was self insured to cover Loftin and other similarly situated consumers' injuries.³⁸¹ After all, as a putative tortfeasor, Zimmer did not receive any financial support from a primary or excess carrier when Zimmer settled the Loftin suit.³⁸² Furthermore, to underscore its justification for commencing the MSP statutory action, the government stressed the following: (1) A reading of the MSP's legislative history revealed that Congress wanted to reduce Medicare expenditures; (2) The statute tried to achieve that end by recouping Medicare payments from any self-insurance plan;³⁸³ (3) Under the statute, an entity was self insured when it made or became responsible for making payments to a Medicare recipient,³⁸⁴ and (4) The statute created a right of action for the government to sue self-insurance plans to recoup expended Medicare funds.³⁸⁵ Therefore, "the government sought reimbursement from Goetzmann and Loftin and double damages from Zimmer, Inc."³⁸⁶

The district court dismissed the government's complaint, holding that, as a matter of law, the MSP statute did not apply to Zimmer, Inc.³⁸⁷ The district court also granted Goetzmann and Loftin's motions for summary judgment, concluding that they did not have to reimburse the government.³⁸⁸ From the court's viewpoint, Loftin and Goetzmann did not receive any payment from

or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insurance plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan to the extent that clause (i) applies, and a workman's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies.

42 U.S.C. § 1395y(2)(A).

381. *Thompson*, 315 F.3d at 459.

382. *Id.*

383. 42 U.S.C. § 1395y(b)(2)(A)(ii).

384. *Id.* § 1395y(b)(2)(B)(ii). In pertinent part, the MSP statute states,

(i) Primary Plans

Any payment under this subchapter . . . shall be conditioned on reimbursement to the appropriate Trust Fund established by this subchapter when notice or other information is received that payment for such item or service has been or could be made under such subparagraph. . . .

(ii) Action by United States

In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible (directly, as a third-party administrator, or otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan . . . or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service.

Id. § 1395y(b)(2)(B)(i)-(ii).

385. *Id.* § 1395y(b)(2)(B)(ii).

386. *Thompson*, 315 F.3d at 459.

387. *Id.*

388. *Id.*

an insurer or a self-insurance plan.³⁸⁹ The government appealed.³⁹⁰

Writing for the court, Circuit Judge Weiner immediately attacked the government and established an arguably anti-HHS tone that appears throughout the opinion.³⁹¹ Significantly, the court attacked the government for continually ignoring settled federal law.³⁹² Judge Weiner wrote, “Notably, the government’s prior efforts have proved uniformly feckless—every court that has heard its arguments on this issue, including the district court in the instant case, has rejected the government’s expansive interpretation of the MSP statute.”³⁹³ In addition, Judge Weiner denounced the federal government for “retread[ing] the same unsuccessful arguments that it has advanced in these prior cases.”³⁹⁴

Furthermore, concluding that the district courts’ statutory analyses in prior cases were sound, Judge Weiner and the other justices reminded the government “that the law has not changed, and that the government has not adduced any new facts that require us to reconsider the meaning or scope of the MSP statute.”³⁹⁵ But more significantly, the court of appeals declared, “To entice us to consider the lengthy and abstruse legislative history of the MSP statute, the government urges us to agree with it that the statute is ambiguous; however, we decline to find ambiguity where none exists.”³⁹⁶

Surprisingly and unlike its conduct in *Travelers* and *Parkans*, the Fifth Circuit passionately cited settled federal principles of law,³⁹⁷ legal treatises,³⁹⁸ and even dictionaries³⁹⁹ to reach a conclusion. Writing emphatically and

389. *Id.*

390. *Id.*

391. *See id.*

392. *See id.*

393. *Id.*

394. *Id.*

395. *Id.* at 460.

396. *Id.* at 462 (footnote omitted).

397. *Compare id.* at 462 & n.19 (“We must, accordingly, look to the ordinary meaning of these terms.”), with *Parkans Int’l L.L.C. v. Zurich Ins. Co.*, 299 F.3d 514, 520 (5th Cir. Aug. 2002) (“To the detriment of the insured, the majority gives the terms of this insurance policy their technical, rather than popular, meaning. Because this method of interpretation contravenes established canons of Texas insurance law, I respectfully dissent.”) (Dennis, J., dissenting); *Travelers Cas. & Sur. Co. of Am. v. Baptist Health Sys.*, 313 F.3d 295 (5th Cir. Dec. 2002).

398. *See, e.g., Thompson*, 315 F.3d at 463 n.23 (“Recognizing that ‘[t]he term “self-insurance” had no precise legal meaning,’ a leading insurance treatise nonetheless confirms this definition of ‘self-insurance,’ noting that to meet the conceptual definition of self-insurance, an entity would have to engage in the same sorts of underwriting procedures that insurance companies employ.”); *Id.* at 464 n.27 (“Furthermore, the well-known interpretative canon, *expressio unius est exclusio alterius*—‘the expression of one thing implies the exclusion of another,’—confirms that the government is advocating an unreasonably broad interpretation of the MSP statute.”) (quoting 73 AM. JUR. 2D *Statutes* § 129 (2002)).

399. *Compare Parkans Int’l*, 299 F.3d at 517 (emphasis added) (“A contextual analysis of the contract is the proper approach to determine the meaning of contractual terms We will not therefore interpose multiple dictionary usages.”), with *Thompson*, 315 F.3d at 463 n.20 (citing *Babbitt v. Sweet Home Chapter of Communities for a Great Oregon*, 515 U.S. 687 (1995) (“Dictionaries are a principal source for ascertaining the ordinary meaning of statutory language.”)).

unapologetically for the court, Judge Weiner stated,

In assessing whether the MSP statute applies to Zimmer's settlement agreement with Loftin, we must start with the actual words of the MSP statute, for it is the words of the statute that set the metes and bounds of the authority granted by Congress. . . . [W]e need not—and, indeed, should not—look to legislative history when the statute is clear on its face. When “the language of the federal statute is plain and unambiguous, it begins and ends our enquiry.”⁴⁰⁰

Although the Fifth Circuit withdrew parts of its decisions in a later opinion, it ruled against the government.⁴⁰¹ And to repeat, it gave the federal government a thrashing for continually ignoring “the burgeoning weight of jurisprudence,” which clearly undermines the government's position.⁴⁰² And unexpectedly, the Fifth Circuit issued a warning:

Although we might applaud [the federal government's] . . . motive in seeking to recoup funds it has disbursed for Medicare treatment and services, the government's desire to expand the list of those responsible for reimbursement likely should be directed to Congress *rather than to the courts*, lest future repetitions be met with sanctions for unnecessarily *protracting baseless or even frivolous* litigation.⁴⁰³

V. THIRD-PARTY INSURANCE CONTRACTS—STATE COMMON-LAW CLAIMS AND DECISIONS

A. Automobile Insurance Contract—Whether An Insurer's Refusal to Settle a Claim Before Trial Was Evidence of “Bad Faith” Under Louisiana Law

Louque v. Allstate Insurance Co. is another case in which the insured

400. *Thompson*, 315 F.3d at 460 & nn.10-12 (footnotes omitted) (quoting *United States v. Osborne*, 262 F.3d 486, 490 (5th Cir. 2001)).

401. See *Thompson v. Goetzmann*, 337 F.3d 489, 492 (5th Cir. July 2003) (July 14, 2003).

On petition for rehearing, we amend our opinion by deleting Part B.4, titled “Zimmer Cannot Pay for Medical Services Promptly,” and Thereby Fails the MSP Statute's Requirement for a ‘Self-Insurance Plan,’ ” in its entirety, and, deleting, in Part B.2, the italicized portion of the following sentence: “*Although we agree with the district court's determination that Zimmer is not liable under the MSP statute because it could not be reasonably expected to pay ‘promptly’ for Loftin's medical care, we also agree with the other district courts that have concluded that an alleged tortfeasor who settles with a plaintiff is not, ipso facto, a ‘self-insurer’ under the MSP statute.*”

Id.

402. *Thompson*, 315 F.3d at 469-70 (“In this case, the government brings nothing new to the table in support of the very same interpretation of the MSP statute that it has repeatedly advanced and had repeatedly rejected by the courts. Rather, the government simply regurgitates yet again the same unavailing arguments.”).

403. *Id.* at 470 (emphasis added).

sued an insurer for allegedly acting in bad faith.⁴⁰⁴ Allstate insured Robin Louque, the named class representative, under an automobile insurance contract.⁴⁰⁵ The policy limit was \$10,000 for liability coverage.⁴⁰⁶ Louque injured a third-party victim in an automobile accident.⁴⁰⁷ The victim sued Louque, and the insured asked Allstate to settle the claim.⁴⁰⁸ Allstate refused to settle.⁴⁰⁹ In the underlying third-party action, the Louisiana state court entered a \$7,569 judgment against Louque and Allstate.⁴¹⁰ The court also awarded \$5,000 in statutory penalties against the insurer.⁴¹¹

Later, Louque filed a class-action suit against Allstate, listing several causes of action in her complaint—an action for a breach of contract, a bad-faith action based on a breach of fiduciary duty, and a statutory action.⁴¹² Louque cited an article under the Louisiana Insurance Code that requires an insurer to make a reasonable effort to settle both first- and third-party claims.⁴¹³ According to the insured, Allstate had an insidious guiding principle: Never settle any “minor-impact, soft-tissue (MIST) claims”—even meritorious ones—when claimants hire attorneys to represent claimants’ interests.⁴¹⁴

Allstate moved the lawsuit to the Eastern District Court of Louisiana.⁴¹⁵ Louque asked the district court to remand the case, asserting that the jurisdictional amount for a diversity action was absent.⁴¹⁶ The district judge disagreed, citing section 22:658 of the Louisiana Statutes.⁴¹⁷ Allstate filed a motion to dismiss.⁴¹⁸ The district court granted the motion, ruling that Robin

404. 314 F.3d 776, 778 (5th Cir. Jan. 2002).

405. *Id.*

406. *Id.*

407. *Id.*

408. *Id.*

409. *Id.*

410. *Id.*

411. *Id.*

412. *Id.*

413. *Id.* Louque sued under section 22:1220(A) of the Louisiana Statute, which provides in relevant part, “An 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.” LA. REV. STAT. ANN. § 22:1220(A) (West Supp. 2003) (emphasis added).

414. *Louque*, 314 F.3d at 778.

415. *Id.*

416. *Id.*

417. *Id.* Section 22:658 (A) provides in pertinent part,

(1) All insurers . . . 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.

(2) All insurers . . . shall pay the amount of any third party property damage claim and of any reasonable medical expenses claim due any bona fide third party claimant within thirty days after written agreement of settlement of the claim from any third party claimant.

LA. REV. STAT. ANN. § 22:658(A).

418. *Louque*, 314 F.3d at 778.

Louque failed to state a claim upon which the court could grant relief.⁴¹⁹ She appealed.⁴²⁰

First, the Fifth Circuit addressed Robin's procedural question—whether section 22:658 applied and, if not, whether Allstate's removal to federal court satisfied the requisite amount in controversy, at least \$75,000, for a diversity action.⁴²¹ The court of appeals held that the district court had jurisdiction, stating that

[a] successful result for Louque on the merits of her claims that Allstate failed "to adjust all claims fairly and promptly and to make reasonable efforts to settle" would put her in line to recover class action attorney's fees far exceeding \$75,000. The court accordingly had jurisdiction over her claim and, through its exercise of supplemental jurisdiction, over the claims of the class.⁴²²

Addressing the merits of the lawsuit, the Fifth Circuit found several flaws in Louque's two-page brief.⁴²³ First, the court took issue with Louque's failure to cite any case law.⁴²⁴ Second, Louque never quoted or cited to the insurance contract during arguments.⁴²⁵ Third, Louque simply concluded that "Allstate breached its fiduciary duty to her."⁴²⁶ The court concluded that "Louque's brief, in short, may not even pass muster under the minimum criteria that we require for a reasoned, record-based presentation of a party's position."⁴²⁷

Still, even if those defects in the pleading were absent, the insured would not have prevailed. "To state a claim for breach of an insurance contract under Louisiana law, a plaintiff must allege a breach of a specific policy provision [A]lthough Louque claim[ed] that Allstate refused to settle 'valid' claims, she fail[ed] to cite any policy provision that requir[ed] Allstate to settle claims before trial."⁴²⁸ Furthermore, "Louisiana law does not recognize an extracontractual obligation where there is no risk of exposing the insured to excess liability."⁴²⁹ Therefore, her bad-faith claim would have fallen. But Louque "failed to state a claim upon which relief . . . [could] be granted."⁴³⁰

419. *Id.*

420. *Id.*

421. *Id.* at 778-79; see 28 U.S.C. § 1332 (2000).

422. *Louque*, 314 F.3d at 782.

423. See *id.*

424. *Id.*

425. *Id.*

426. *Id.*

427. *Id.*

428. *Id.*; see *Bergeron v. Pan Am. Assurance Co.*, 98-CA-2421 (La. App. 4 Cir. 4/7/99), 731 So. 2d 1037, 1045.

429. *Louque*, 314 F.3d at 783; see, e.g., *Ragas v. MGA Ins. Co.*, 1997 WL 79357, at *2 (E.D. La. Feb. 21, 1997) (holding that an insured has no cause of action against its insurer for bad-faith refusal to settle in the absence of an adjudicated excess judgment against the insured).

430. *Louque*, 314 F.3d at 783; see FED. R. CIV. PROC. 12(b)(6).

Therefore, the district court properly granted Allstate's motion to dismiss.

B. Business Automobile Insurance Contract—Whether An Insured and Its Insurer Are Liable Under Louisiana Law for Failing to Procure Insurance for a Third Party

The facts in *Illinois Central Railroad Co. v. Dupont* are not tantalizing or difficult.⁴³¹ The case, however, presents an interesting and infrequently litigated question: whether an insured has a federal statutory duty to insure or purchase business automobile insurance to cover a third party's liabilities—intentional-tort and negligence-based claims under federal and state laws.⁴³²

Denmar Logging, Inc. was a Louisiana logging company that hired drivers to haul logs.⁴³³ Whether the haulers were salaried employees or independent contractors was open for debate.⁴³⁴ Also, whether Denmar requires haulers to use their personal trucks or Denmar's trucks was unclear.⁴³⁵ Nevertheless, one of Denmar's haulers, Ronald Dupont, had an accident while using a personal rather than a company truck to haul logs.⁴³⁶ In Louisiana, Dupont's vehicle collided with one of Illinois Central Railroad's (ICR) trains.⁴³⁷

ICR filed a negligence action against Denmar in the Middle District Court of Louisiana.⁴³⁸ After learning about the suit, Underwriters Insurance Company—Denmar's automobile insurer—intervened and filed an action for declaratory relief.⁴³⁹ Underwriters asked the district court to determine whether Denmar's insurance policy covered the accident.⁴⁴⁰ Of course, the insurer argued that the policy did not cover Dupont's alleged negligence.⁴⁴¹

ICR disagreed.⁴⁴² Citing the Motor Carrier Act of 1980 (MCA) and its regulations, the railroad company claimed that Denmar had a duty under a special endorsement in its insurance policy to cover Denmar and its drivers' negligence.⁴⁴³ ICR also asserted that the duty remained regardless of whether

431. 326 F.3d 665 (5th Cir. Apr. 2003).

432. *See id.*

433. *Id.* at 666.

434. *Id.* at 666 n.1 ("The Railroad argue[d] that Dupont was . . . Denmar[s] employee rather than an independent contractor, but we do not reach this issue.").

435. *See id.*

436. *Id.*

437. *Id.* at 666.

438. *Id.*

439. *Id.*

440. *Id.*

441. *Id.*

442. *Id.*

443. *Id.* at 666-67. This act establishes the minimum financial responsibility for transporting property. And it reads in pertinent part,

(b) GENERAL REQUIREMENT AND MINIMUM AMOUNT.—(1) The Secretary of Transportation shall prescribe regulations to require minimum levels of financial responsibility sufficient to satisfy

Denmar's covered or uncovered vehicles caused the injuries.⁴⁴⁴ Put simply, the endorsement is known as the MCS-90 endorsement.⁴⁴⁵ As the Fifth Circuit previously observed, even if a company's commercial automobile policy does not cover a particular motor vehicle, the insurer is still liable under MCS-90 for all third-party injuries emanating from the insured's negligent use of any motor vehicle.⁴⁴⁶

After hearing arguments, the Louisiana Middle District Court granted the insurer's petition for declaratory relief.⁴⁴⁷ The court noted that a section under the Motor Carrier Transportation Act restricts the Secretary of Transportation and the Surface Transportation Board's jurisdiction over transportation if motor vehicles transport agricultural or horticultural commodities.⁴⁴⁸ Therefore, the regulation that required the MCS-90 endorsement in liability insurance contracts did not apply to Denmar's logging operations "because trees and logs are agricultural or horticultural commodities."⁴⁴⁹

The district court also held that, even assuming that the regulations required the MCS-90 endorsement, "Underwriters [would still] . . . not be held liable for failing to include the endorsement, since there is no federal remedy imposing such a liability on Underwriters."⁴⁵⁰ The Fifth Circuit affirmed the district court's declaration, holding that a reformation of the policy to include the endorsement was inappropriate and Underwriter was not liable.⁴⁵¹

C. Comprehensive Liability Contracts—Whether a Third Party May Sue a Tortfeasor's Insurer for a Bad-Faith Refusal to Settle and for Contribution Under Louisiana Law

The broad question in *Rogers v. Samedan Oil Corp.* is very similar to the one appearing in *Illinois Central Railroad Co. v. Dupont*: whether coverage exists under an insurance endorsement.⁴⁵² Given that this controversy involves

liability amounts established by the Secretary covering public liability, property damage, and environmental restoration for the transportation of property for compensation by motor vehicle in the United States between a place in a State and—

(A) a place in another State;

(B) another place in the same State through a place outside of that State; or

(C) a place outside the United States.

(2) The level of financial responsibility established under paragraph (1) of this subsection shall be at least \$750,000.

49 USCA § 31139(b)(1)-(2) (2000).

444. *Ill. Cent. R.R. Co.*, 326 F.3d at 667.

445. 49 C.F.R. § 387.15 (2002); see 49 U.S.C. § 13506(a)(6)(B).

446. See *T.H.E. Ins. Co. v. Larsen Intermodal Servs., Inc.*, 242 F.3d 667, 671 (5th Cir. 2001).

447. *Ill. Cent. R.R. Co.*, 326 F.3d at 666.

448. *Id.*; 49 U.S.C. § 13506(a)(6)(B).

449. *Ill. Cent. R.R. Co.*, 326 F.3d at 667.

450. *Id.*

451. *Id.* at 669.

452. *Id.*; *Rogers v. Samedan Oil Corp.*, 308 F.3d 477, 479 (5th Cir. Oct. 2002).

a third-party victim, the facts are somewhat complicated.⁴⁵³ Two suits were filed—an underlying lawsuit between the third-party victim and the insured and a “contribution” or “present” suit between two insurers.⁴⁵⁴

Consider the facts in the underlying lawsuit. Samedan Oil Corporation owns an oil-drilling platform, along with certain rights and licenses to drill in various oil fields.⁴⁵⁵ Pride Offshore, Inc. owns and operates a drilling rig.⁴⁵⁶ Samedan hired Pride as an independent contractor to drill for oil.⁴⁵⁷ Charles Rogers, an employee, worked for Pride Offshore, Inc.⁴⁵⁸ Rogers was injured while working on Samedan’s oil-drilling platform off the coast of Louisiana.⁴⁵⁹ Rogers commenced a personal injury suit against Samedan in a Louisiana state court.⁴⁶⁰ Several other parties were added thereafter.⁴⁶¹ Samedan removed the diversity action to a federal district court.⁴⁶²

When the injury occurred, Commercial Underwriters Insurance Company insured Samedan Oil under a commercial general liability (CGL) contract, and Lexington Insurance Company covered Pride’s activities and property under two contracts—a CGL contract and an umbrella policy.⁴⁶³ Before trial, the parties settled Rogers’s third-party claim for \$475,000.⁴⁶⁴ Samedan Oil contributed \$100,000, and its insurer—Commercial Underwriters—contributed \$274,250.⁴⁶⁵

To recoup their contributions to the settlement, Samedan and Commercial Underwriters sued Pride’s insurer—Lexington Insurance—in the Eastern District Court of Louisiana.⁴⁶⁶ In particular, Samedan asked the district court to award \$374,250, attorneys’ fees, and statutory penalties for Lexington’s allegedly bad-faith refusal to defend and indemnify.⁴⁶⁷ Samedan established that it was an additional named insured under the respective endorsements in Pride’s CGL and umbrella policies.⁴⁶⁸ Samedan, not Pride, gave Lexington Insurance Company \$2,000 per year in premiums to secure coverage under

453. See *Rogers*, 308 F.3d at 479-80.

454. *Id.*

455. *Id.* at 479.

456. *Id.*

457. *Id.*

458. *Id.*

459. *Id.*

460. *Id.* at 480.

461. *Id.*

462. *Id.*

463. *Id.* at 479.

464. *Id.*

465. *Id.* The facts surrounding the settlement are not very clear in the Record. The settlement was \$475,000, of which Samedan and its insurer contributed \$374,250. That left \$100,750 for someone else to pay. Whether Pride or its insurer—Lexington—paid the remainder is unclear. See *id.*

466. *Id.*

467. *Id.*; see LA. REV. STATS. ANN. §§ 22:658, 22:1220 (West Supp. 2003).

468. *Rogers*, 308 F.3d at 479, 482. “Special endorsements entitled ‘Louisiana Anti-Indemnity Statute Coverage’ . . . were later added [,] . . . naming Samedan as an additional insured in the Lexington Policies.” *Id.* at 479 (footnote omitted).

both endorsements.⁴⁶⁹ Yet Lexington refused to defend Samedan in the underlying lawsuit and refused to make contributions to the settlement.⁴⁷⁰

Lexington filed a motion for summary judgment.⁴⁷¹ The insurer argued that the endorsements covering Samedan in Pride Offshore's insurance contracts were unenforceable as they violated the Louisiana Oilfield Indemnity Act (LOIA).⁴⁷² The most relevant part of the act—Subsection G—states, “Any provision in any agreement arising out of the operations, services, or activities [covered by LOIA requiring] . . . additional named insured endorsements, or any other form of insurance protection which would frustrate or circumvent the [provisions of LOIA] . . . shall be null and void and of no force and effect.”⁴⁷³

The district court denied Lexington's summary judgment motion, ordering Lexington to pay attorneys' fees and \$374,250 to cover the settlement costs.⁴⁷⁴ The Eastern District Court of Louisiana refused to find, however, that Lexington acted in bad faith when the insurer decided to stop defending Samedan in the underlying action.⁴⁷⁵ Lexington and Samedan appealed to the Fifth Circuit.⁴⁷⁶ That tribunal affirmed the district court's rulings.⁴⁷⁷

First, the Fifth Circuit agreed that under the LOIA an agreement is null and void and against Louisiana's public policy if it requires someone other than the negligent or responsible party to defend a third-party, personal injury suit or make reimbursements.⁴⁷⁸ But the appellate court rejected Lexington's argument that the endorsements appearing in Lexington insurance policies

469. *Id.* at 480 (“The Lexington Endorsements were added before Rogers' accident [.] Lexington charged Samedan two thousand dollars per year for the coverage These separate premiums were paid directly by Samedan with no contribution from Pride.”).

470. *Id.* (“[F]ollowing [Samedan's] demand . . . for [a] defense and indemnification, Lexington assumed Samedan's defense of the Roger's suit. However, . . . after the Louisiana First Circuit Court of Appeal denied rehearing, . . . Lexington informed Pride that it was withdrawing its defense and indemnity of Samedan.”).

471. *Id.*

472. *Id.*; LA. REV. STAT. ANN. § 9:2780 (West Supp. 2003).

473. LA. REV. STAT. ANN. § 9:2780(G).

474. *Rogers*, 308 F.3d at 480.

475. *Id.*

476. *Id.*

477. *Id.* at 484.

478. *Id.* at 480-81; see LA. REV. STAT. ANN. § 9:2780(A) (West Supp. 2003). The Louisiana statute reads,

The legislature finds that an inequity is foisted on certain contractors and their employees by the defense or indemnity provisions, either or both, contained in some agreements pertaining to wells for oil, gas, or water, or drilling for minerals which occur in a solid, liquid, gaseous, or other state, to the extent those provisions apply to death or bodily injury to persons. It is the intent of the legislature by this Section to declare null and void and against public policy of the state of Louisiana any provision in any agreement which requires defense and/or indemnification, for death or bodily injury to persons, where there is negligence or fault (strict liability) on the part of the indemnitee, or an agent or employee of the indemnitee, or an independent contractor who is directly responsible to the indemnitee.

LA. REV. STAT. ANN. § 9:2780(A).

violated the LOIA.⁴⁷⁹ The court cited and applied the exception to the rule.⁴⁸⁰ The LOIA's purposes are not frustrated when a principal pays the entire cost of insuring itself and becomes a named insured in an endorsement appearing in an independent contractor's insurance policy.⁴⁸¹ Therefore, the insurance coverage in the present case was valid, and the endorsement was enforceable.⁴⁸²

Finally, the Fifth Circuit also embraced the district court's view that Lexington did not act in bad faith.⁴⁸³ The appellate court explained its decision this way, "[G]iven the confused state of the law regarding the enforceability of the additional insured endorsement under . . . LOIA, Lexington's actions did not rise to the level of bad faith."⁴⁸⁴

D. Comprehensive Liability Contracts—Whether an Insurer Had a Duty to Defend and Indemnify Third-Party Contractors and Supervisors Under Louisiana Law

Cochran v. B.J. Services Co. USA is another personal injury case that originated in the oil fields of Louisiana.⁴⁸⁵ Actually, the facts and legal question appearing in *Cochran* are quite similar to those appearing in *Rogers v. Samedan Oil Corp.*⁴⁸⁶ Again, like *Rogers*, two suits appear in this controversy—an underlying third-party action and an insurance-defense action between an insured and its insurer.⁴⁸⁷ But more important, the litigants asked federal courts to determine whether a contractor's insurer must pay damages for allegedly negligent activities that occurred at a principal's place of business.⁴⁸⁸

Multiple parties were involved in this case.⁴⁸⁹ Union Pacific Resources Company (UPRC) was in the oil business.⁴⁹⁰ Drillmark Consulting, Inc.; Nabors Drilling USA, Inc.; and B.J. Services Company were independent

479. *Rogers*, 308 F.3d at 482.

480. *Id.* at 480-82.

481. *Id.* at 481.

482. *Id.*; see *Marcel v. Placid Oil Co.*, 11 F.3d 563, 569-70 (5th Cir. 1994).

We now adopt the exception created in *Patterson* as law of this Circuit and find that it has potential application here. The LOIA is aimed at preventing the shifting of the economic burden of insurance coverage or liability onto an independent contractor. If the principal pays for its . . . liability coverage, however, no shifting occurs. We see no need to prevent such an arrangement in order to give effect to the LOIA.

Rogers, 308 F.3d at 487 (footnote omitted).

483. *Rogers*, 308 F.3d at 484.

484. *Id.*

485. 302 F.3d 499 (5th Cir. Aug. 2002).

486. See *id.*; see discussion *supra* Part V.C.

487. *Cochran*, 302 F.3d at 500-01.

488. *Id.* at 501.

489. *Id.* at 500-01.

490. *Id.* at 500.

contractors.⁴⁹¹ Each formed a contract with UPRC to perform various services at an oil-drilling site.⁴⁹² More specifically, Drillmark Consulting, Inc. accepted responsibility for supervising the overall operations at UPRC's site and for sending periodic reports to UPRC regarding the other contractors' activities and performance.⁴⁹³ Drillmark chose Roy Springfield—a "company man"—to supervise the entire UPRC site.⁴⁹⁴

Nabors Drilling employed Cory Cochran as a derrick hand.⁴⁹⁵ On July 5, 1997, Cochran was injured while removing a cement head from a head casing on the drilling rig.⁴⁹⁶ B.J. Services owned the cement head.⁴⁹⁷ When the accident occurred, Roy Springfield—Drillmark's supervisor—was not present at the scene.⁴⁹⁸ Cochran filed a negligence action in the Western District Court of Louisiana.⁴⁹⁹ The complaint listed UPRC, Drillmark, B.J. Services, and Nabors as defendants.⁵⁰⁰ Later, Cochran amended the complaint and added Mid-Continent Casualty Company—a subsidiary of the Mid-Continent Group—as a defendant.⁵⁰¹

Drillmark Consulting—rather than UPRC—was the named insured described in the Mid-Continent commercial general liability (CGL) contract.⁵⁰² Under the terms of the insurance contract, Mid-Continental agreed to defend and indemnify Drillmark if the insured satisfied certain conditions precedent.⁵⁰³ Therefore, after Cochran received his injuries, Drillmark asked Mid-Continental for assistance.⁵⁰⁴ The insurer cited the professional services exclusion provision appearing in the CGL policy and denied Drillmark's request.⁵⁰⁵ Then, Mid-Continent asked the district court to grant a motion for

491. *Id.*

492. *Id.*

493. *Id.*

494. *Id.*

495. *Id.*

496. *Id.*

497. *Id.*

498. *Id.* at 500-01. Cochran alleged that Drillmark was liable for negligent supervision, given that Springfield was absent when the accident occurred. *Id.* at 501.

499. *Id.* at 500.

500. *Id.* at 501 n.1.

501. *Id.* at 501 & n.1.

502. *Id.*

503. *Id.* at 501 n.1. A standard coverage clause appeared in the policy: Mid-Continental agreed to pay "those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" " and asserted a "right and [a] duty to defend the insured against any "suit" seeking those damages." *Id.*

504. *Id.* Whether Drillmark asked the insurer to defend or indemnify is not clear. *See id.*

Mid-Continent asserts that [a legal] defense is not a subject of this appeal, only indemnification[.] . . . Mid-Continent is already providing [a] defense. The record on appeal and the district court's decision fail[ed] to clarify this point. Because . . . [we declare] . . . as a matter of law [that the exclusion clause does not apply], any issue with respect to the duty to defend is not material to our determination on appeal.

Id.

505. *Id.* at 501.

summary judgment.⁵⁰⁶

The professional-services exclusion clause in the Mid-Continent policy reads in relevant part,

EXCLUSION—ENGINEERS, ARCHITECTS OR SURVEYORS PROFESSIONAL LIABILITY This insurance does not apply to “bodily injury[.]” [or] “property damage” . . . arising out of the rendering of or failure to render any professional services by [Drillmark] or any engineer, architect or surveyor who is either employed by [Drillmark] or performing work on [Drillmark’s] behalf in such capacity. *Professional services include:* 1. The preparing, approving, or failure to prepare or approve maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; and 2. Supervisory, inspection, architectural, or engineering activities.⁵⁰⁷

The district court studied the exclusion clause and granted the insurer’s motion for summary relief, holding as a matter of law that Mid-Continent had no duty to defend or indemnify Drillmark.⁵⁰⁸ All defendants filed timely appeals to the Fifth Circuit except B.J. Services.⁵⁰⁹ At the out set, the court of appeals observed that it had addressed the scope of a professional-service exclusion clause on two other occasions with mixed outcomes, and in both instances, the exclusion provisions were materially indistinguishable from the one appearing in the Mid-Continental contract.⁵¹⁰

For example, in *Natural Gas Pipeline Co. of America v. Odom Offshore Surveys, Inc.*, the Fifth Circuit decided in favor of the insured.⁵¹¹ The appellate court declared that a professional-services exclusion provision excluded coverage for property damage arising out of a surveyor’s allegedly negligent placement of an anchor on a pipeline.⁵¹² To arrive at that conclusion, the *Odom* court cited Louisiana law and applied the doctrine of plain meaning.⁵¹³

506. *Id.*

507. *Id.* at 502 (second emphasis added) (alterations in original).

508. *Id.* at 501.

509. *Id.* at 501 & n.2.

510. *Id.* at 503.

511. 889 F.2d 633, 634 (5th Cir.1989).

512. *Id.* at 636.

513. *Id.* The court stated the following:

The pivotal questions . . . become whether Odom itself was a surveyor and whether the damage to the pipeline arose out of Odom’s rendering of professional services.

NGPL argues that the services performed by Quarles and Chamblee were not “professional services,” and that the exclusion does not apply for that reason.

Because we read National Union’s policy to consider Odom, rather than Quarles and Chamblee; as the policy insured, we concentrate on the actions of Quarles and Chamblee . . . [to determine] whether the damage to the NGPL pipeline arose out of professional services. To segregate the actions of Quarles and Chamblee . . . would violate a plain reading of the insurance policy language. We find that the actions of Quarles and Chamblee easily fall within the “professional services” category.

But in *Thermo Terratech v. GDC Enviro-Solutions, Inc.*, the Fifth Circuit ruled in favor of the insureds after citing Louisiana law and applying the doctrine of ambiguity.⁵¹⁴ The *Thermo* court declared that a professional services exclusion provision did not exclude coverage for fire damage.⁵¹⁵ In that case, an allegedly negligent employee who worked for the design contractor removed a part on a hazardous waste incinerator, causing a fire and property damages.⁵¹⁶

To reach its conclusion in the present case, the Western District Court of Louisiana cited the decision in *Odom*.⁵¹⁷ In *Cochran v. B.J. Services Co.*, however, the Fifth Circuit found the facts to be more analogous to *Thermo* than to *Odom*.⁵¹⁸ Writing for the circuit, Chief Judge King correctly observed and outlined the following well-settled principles under Louisiana law: (1) Courts may not grant summary judgment and declare that an insurance contract does not cover the insured where undisputed material facts do not permit a reasonable interpretation of the contract;⁵¹⁹ (2) Courts must construe “all insurance contract exclusion provisions . . . ‘strictly . . . against the insurer, and any ambiguity . . . in favor of the insured;’ ”⁵²⁰ and (3) An insurer “has the burden of proving that an exclusion unambiguously applies.”⁵²¹

In light of these principles, Chief Judge King concluded the following: A professional-services exclusion provision in a CGL contract will not bar coverage for obligations arising from an insured contractor’s negligence if the contractor’s negligence does not involve professional expertise or skill.⁵²² But the chief justice also observed, “[C]ontrary to the district court’s portrayal, Louisiana law places a heavy burden on Mid-Continent when that insurer [tries] to exclude . . . coverage . . . [under the] . . . professional services provision at issue in this case, *especially on motion for summary judgment*.”⁵²³ In closing, the appellate court declared that Mid-Continental had a duty to defend and indemnify Drillmark in the underlying third-party suit.⁵²⁴

Id. (emphasis added).

514. 265 F.3d 329, 334-35, 337 (5th Cir. 2001) (citing Louisiana law and stating that a court “must adopt the interpretation that provides coverage to the insured” where an insurance exclusion is susceptible to more than one reasonable interpretation).

515. *See id.* at 336 (holding that the plaintiff’s employer’s actions did not constitute professional services to which such an exclusion would apply).

516. *Id.* at 332.

517. *Id.* at 336.

518. 302 F.3d 499, 507 (5th Cir. Aug. 2002).

519. *Id.* at 503 (citing *Smith v. Travelers Prop. Gas*, 811 So. 2d 1097, 1100 (La. Ct. App. 2002)).

520. *Id.* at 502 (quoting *Ledbetter v. Concord Gen. Corp.*, 665 So. 2d 1166, 1169 (La. 1996)).

521. *Id.*; *see Arnette v. NPC Servs., Inc.*, 808 So. 2d 798, 802 (La. Ct. App. 2002) (citing *Gaylord Chem. Corp. v. ProPump, Inc.*, 753 So. 2d 349, 352 (La. Ct. App. 2000)).

522. *Cochran*, 302 F.3d at 508.

523. *Id.* at 503 (emphasis added).

524. *Id.* at 508.

E. Comprehensive Liability Contracts—Whether an Insurer Had a Duty to Indemnify a Joint Venture Under Texas Law Absent an “Insurable Interest” Under the Contract

In some respects, the facts, controversy, and results in *Bott v. J.F. Shea Co.* parallel those observed in each of the previous three cases—*Illinois Central Railroad Co. v. Dupont*, *Rogers v. Samedan Oil Corp.*, and *Cochran v. B.J. Services Co. USA*.⁵²⁵ But the central substantive question is the same: whether an agent’s insurance company must defend or indemnify a principal in a third-party liability suit.⁵²⁶

In *Bott*, J.F. Shea and L.J. Keefe Company formed a joint venture (Shea/Keefe).⁵²⁷ Shortly thereafter, the City of Houston awarded several sewer-line construction projects to the joint venture.⁵²⁸ Shea/Keefe hired a subcontractor—Gulf Coast Grouting, Inc.—to do the grouting work on the projects.⁵²⁹ Under the terms of the subcontractor’s construction agreement, Gulf Coast had to add an endorsement to its liability insurance policy that listed the joint venture—Shea/Keefe—as an additional insured.⁵³⁰ Gulf Coast secured the insurance from Mid-Continental Casualty Company, the same defendant-insurer appearing in the *Cochran* case discussed above.⁵³¹ The endorsement, however, listed J.F. Shea rather than Shea/Keefe as the additional insured.⁵³²

The facts surrounding the underlying suit are simple. John Bott was a Gulf Coast employee.⁵³³ He was injured while working in a sewer-line tunnel shaft.⁵³⁴ Bott originally filed a negligence action, naming just two defendants—J.F. Shea and the joint venture.⁵³⁵ Later, he amended the complaint and named the subcontractor and the insurer—Gulf Coast and Mid-Continent, respectively—as additional defendants.⁵³⁶ The jury “found both Shea and

525. *Bott v. J.F. Shea Co.*, 299 F.3d 508 (5th Cir. Aug. 2002); see *Ill. Cent. R.R. Co. v. Dupont*, 326 F.3d 655 (5th Cir. Apr. 2003); *Rogers v. Samedan Oil Corp.*, 308 F.3d 477 (5th Cir. Oct. 2002); *Cochran v. B.J. Servs. Co. USA*, 302 F.3d 499 (5th Cir. Aug. 2002).

526. *Bott*, 299 F.3d at 510-11.

527. *Id.* at 510.

528. *Id.*

529. *Id.*

530. *Id.*

531. *Id.*

532. *Id.*

After the insurance was obtained from Mid-Continent, Gulf Coast sent certificates of insurance to Shea/Keefe indicating that J.F. Shea was an additional insured on the policy on two separate occasions. Shea/Keefe did not object to the certificates naming J.F. Shea as an additional insured and allowed work to commence on the project.

Id.

533. *Id.*

534. *Id.*

535. *Id.*

536. *Id.*

Shea/Keefe liable for Bott's injuries.⁵³⁷ Bott settled the claims, and it appears from the record that Shea/Keefe paid the entire amount to settle the case.⁵³⁸

Citing the endorsement in Gulf Coast's liability insurance contract, Shea/Keefe asked Mid-Continent Casualty to reimburse the costs of settling the Bott's case.⁵³⁹ The insurer refused to indemnify the joint venture, claiming that Shea/Keefe was not the named insured in the endorsement.⁵⁴⁰ In addition, citing the subcontractor's construction agreement, Shea/Keefe asked Gulf Coast to reimburse what the joint venture paid to settle the case.⁵⁴¹ After all, Bott was Gulf Coast's employee.⁵⁴² Gulf Coast also refused to pay.⁵⁴³ Shea/Keefe then filed an action for contribution against Gulf Coast or, alternatively, an action for breach of contract.⁵⁴⁴ Additionally, the joint venture filed an action for contribution against Mid-Continent Casualty.⁵⁴⁵ All actions originated in the Southern District Court of Texas, and all parties filed cross motions for summary judgment.⁵⁴⁶ The district court granted Mid-Continental's motion for summary relief and denied the others.⁵⁴⁷

The district court held that the doctrine of quasi-estoppel precluded Shea/Keefe's receiving summary judgment relief on the breach of contract issue.⁵⁴⁸ Furthermore, the district court decided that Shea/Keefe was not an additional insured under the Mid-Continental policy; therefore, the insurer had no duty to indemnify because no contractual relationship existed between Shea/Keefe and Mid-Continental.⁵⁴⁹ Finally, although acknowledging that J.F. Shea was an additional insured in the Mid-Continental policy, the court declared that Mid-Continental had no duty to reimburse him since J.F. Shea's liability, if any, stemmed from the joint venture's negligent activities.⁵⁵⁰

537. *Id.* at 512. *But see id.* at 511 ("[T]he jury found that Bott's injuries were caused solely by Shea/Keefe").

538. *Id.* at 510. The record states, "Bott's claims against Shea/Keefe were settled by Shea/Keefe." *Id.* However, whether the joint venture also paid J.F. Shea's part is not clear. *See id.*

539. *Id.*

540. *Id.* "Gulf Coast obtained insurance from Mid-Continent Casualty Company . . . listing J.F. Shea as an additional insured. *By letter, Shea/Keefe instructed Gulf Coast to name J.F. Shea as the additional insured although the subcontract provided that Shea/Keefe was to be named as an additional insured."* *Id.* (emphasis added).

541. *See id.*

542. *Id.*

543. *Id.*

544. *Id.*

545. *Id.*

546. *Id.* at 511.

547. *Id.* at 510-11. The district court denied the following motions for summary judgment: (1) Shea/Keefe's and Gulf Coast's motions regarding indemnity and contribution actions; (2) Shea/Keefe's motion respecting the joint venture's breach of contract action against Gulf Coast for allegedly failing to secure insurance coverage naming Shea/Keefe as an additional insured; and (3) Gulf Coast's motion, in which Gulf Coast argued that Shea/Keefe was estopped from asserting the breach of contract action. *Id.*

548. *Id.* at 511.

549. *Id.*

550. *See id.*

Shea/Keefe and J.F. Shea filed a motion for new trial; the district court denied the request.⁵⁵¹

On appeal, the Fifth Circuit decided two substantive questions.⁵⁵² But only one concerned insurance: whether Shea/Keefe—the joint venture—was an additional insured under the Mid-Continental insurance contract.⁵⁵³ And the Fifth Circuit expended very little effort to give an answer.⁵⁵⁴ First, the appellate court declared that Shea's negligence arose out of Shea/Keefe's negligence.⁵⁵⁵ And invoking the doctrine of ambiguity, the Fifth Circuit found that the policy's exclusion clause unambiguously prevented coverage for parties who were not insureds under the contract.⁵⁵⁶ To address the joint venture's question regarding its status under the Mid-Continental policy, the Fifth Circuit simply stated, "We therefore affirm the district court's determination that Shea/Keefe was not entitled to coverage."⁵⁵⁷

F. Directors and Officers Liability Contracts—Whether an Insurer Had a Duty to Defend and Indemnify Municipal Officials Under Mississippi Law

On the one hand, the controversy between the insured and insurer in *Twin City Fire Insurance Co. v. City of Madison* is very sad because it demonstrates how an insurance-defense firm and its associate's carelessness can negatively affect both insureds' and an insurer's legitimate interests.⁵⁵⁸ On the other hand, *Twin City* also presents an excellent discussion for insurance-defense firms and counsels.⁵⁵⁹ In particular, it gives a short refresher course on (1) how to avoid conflict of interests; (2) how to obtain a client's informed consent; (3) how not to prejudice client's interest; and (4) how to avoid, possibly, a legal malpractice suit and the accompanying severe penalties for failing to give clients undivided loyalty.⁵⁶⁰

551. *Id.*

552. *Id.* at 511-13.

553. *Id.* at 511.

554. *Id.* at 511-12.

555. *Id.*

556. *Id.*

Section II of the policy, defining who is an insured, contains a final clause stating that "no person or organization is an insured with respect to the conduct of any current or past partnership or joint venture that is not shown as a Named Insured in the Declarations." Because liability arose out of the joint venture, which is not an insured, Shea is not entitled to coverage.

. . . . Shea asserts that the additional insured endorsement renders the joint venture exclusion inapplicable, and the policy language is ambiguous because it does not refer to additional insureds. The policy is not ambiguous nor does the additional insured endorsement render the joint venture clause inapplicable.

Id.

557. *Id.* at 512.

558. 309 F.3d 901 (5th Cir. Oct. 2002); see *infra* notes 560-04 and accompanying text.

559. See *infra* notes 560-04 and accompanying text.

560. See *Twin City*, 309 F.3d at 905-10.

Twin City is a rather complicated case because multiple parties and a lot of facts were involved, spanning two underlying lawsuits against the insured and several present actions—the insured’s equitable-estoppel and personal injury actions and the insurer’s declaratory judgment action.⁵⁶¹ First, the City of Madison is located in West Central Mississippi.⁵⁶² In 1986, Madison enacted the Impact Fee Ordinance (IFO).⁵⁶³ To obtain a building permit, housing developers had to file a preliminary subdivision plat.⁵⁶⁴ After the city approved the plat, developers then had to pay per-lot fees.⁵⁶⁵

When the City of Madison enacted the ordinance, Twin City Fire Insurance Company insured the city and its governmental officials under a standard “Public Official Errors and Omissions Liability Insurance Policy.”⁵⁶⁶ Under the coverage provision, Twin City agreed to pay or reimburse the city for damages when Madison became “legally obligated to pay because of errors or omissions of public officials.”⁵⁶⁷ The exclusion clause, however, stated that Twin City would not pay for liability “arising out of any insured[’s] obtaining remuneration or financial gain to which such insured was not legally entitled.”⁵⁶⁸

In 1995, Home Builders Association of Mississippi and an assortment of other developers filed a federal civil rights suit under section 1983 against Madison in federal district court.⁵⁶⁹ The developers asked the court for “(1) a declaration that the impact fee ordinance was unconstitutional, (2) an injunction prohibiting the assessment, collection and expenditure of impact fees, and (3) a refund of all impact fees collected in advance of the litigation.”⁵⁷⁰ The district court found that the IFO was a tax and dismissed the action for lack of jurisdiction under the Tax Injunction Act.⁵⁷¹ The Fifth

561. *See id.* at 903.

562. *See id.*

563. *Id.* at 903-04.

564. *Id.* at 904.

565. *Id.*

566. *Id.* at 903.

567. *Id.*

568. *Id.* at 904 (quotation omitted).

569. *Home Builders Ass’n of Miss., Inc. v. City of Madison*, 143 F.3d 1006 (5th Cir. 1998). Section 1983 creates a civil action for deprivation of rights. The most pertinent part states,

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 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 [;] . . . injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable.

42 U.S.C. § 1983 (2000).

570. *Home Builders Ass’n of Miss.*, 143 F.3d at 1009.

571. *Id.* at 1009. The Tax Injunction Act provides, “The district courts shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State.” 28 U.S.C. § 1341 (2000).

Circuit affirmed the dismissal, finding that the IFO was indeed a tax and not a fee.⁵⁷²

Shortly after the developers and builders filed an action in state court against Madison alleging a violation of state law and an unconstitutional taking, the parties settled the claims for \$250,000.⁵⁷³ In a separate agreement with the city, the insurer agreed to pay the settlement cost on behalf of Madison, but Twin City reserved its right to file a declaratory judgment action in an attempt to recoup the \$250,000 from Madison.⁵⁷⁴ Of course, the insurer filed an action in the Southern District Court of Mississippi asking the court to declare that Twin City had no obligation to pay the settlement costs and to force the City of Madison to reimburse the funds.⁵⁷⁵

At that time, Madison raised an equitable-estoppel argument.⁵⁷⁶ The city petitioned the court to find coverage and prevent the insurer from invoking the exclusion clause as a defense.⁵⁷⁷ In essence, Madison asked the district court to apply the doctrine of estoppel and declare that the policy covered the city's liability for illegally collecting a tax.⁵⁷⁸ Also, at the same time and in the same court, Madison filed multiple tort-based actions—a bad-faith action for breach of a fiduciary duty, gross negligence, an action for the tortious interference with a contract, misrepresentation, and fraud—against several of Twin City's insurance adjusters.⁵⁷⁹ From Madison's viewpoint, Twin City's affiliates mishandled and failed to process the city's insurance claims in a timely and professional manner.⁵⁸⁰

The Southern District Court of Mississippi (1) granted Twin City's motion for summary judgment, citing the policy's exclusion clause, and ordered Madison to reimburse the insurer for paying the \$250,000 settlement; (2) decided against Madison, holding that the doctrine of equitable estoppel could neither create nor expand coverage under the insurance contract to cover Madison's third-party liability claims; and (3) granted the insurance adjusters' motion for summary judgment, finding no genuine issue of material fact to justify a trial by jury.⁵⁸¹ The City of Madison appealed.⁵⁸²

572. *Home Builders Ass'n of Miss.*, 143 F.3d at 1013.

573. *Twin City*, 309 F.3d at 904.

574. *Id.*

575. *Id.* at 903.

576. *Id.*

577. *Id.* at 905.

578. *Id.*

579. *Id.* at 908. Those third-party defendants were Hartford Fire Insurance Company, Twin City's parent corporation; Hartford Financial Services Group, Inc.; Specialty Risk Services, Inc., a Hartford subsidiary; Michael P. Dandini, a Hartford claims consultant; and Kimberly J. Chabert, one of Specialty Risk Services' claims consultant. *Id.*

580. *Id.* at 905-06.

581. *Id.* at 903.

582. *Id.*

The Fifth Circuit affirmed the district court's conclusion that the insurer did not have to pay \$250,000 for the settlement: "Since the ordinance created a tax, and the City lacked specific authority to impose such a tax, the collection of monies thereunder fits squarely within exclusion 3(h)."⁵⁸³ On the other hand, barring one defendant-adjuster, the court of appeals declared that the district court inappropriately granted the adjusters' motion for summary judgment.⁵⁸⁴ Quite simply, genuine issues of facts regarding the tort claims remained for a jury's deliberation.⁵⁸⁵

But more important, the Fifth Circuit accepted the City of Madison's equitable-estoppel argument or retort, even after finding that the exclusion clause excluded the city's liability for imposing the illegal tax.⁵⁸⁶ How is this possible? The doctrine of equitable estoppel is based upon fundamental notions of justice and fair dealing.⁵⁸⁷ The Mississippi Supreme Court has embraced this equitable remedy.⁵⁸⁸ In *O'Neill v. O'Neill*, the Supreme Court of Mississippi identified two elements that a plaintiff must establish before a court will apply the doctrine.⁵⁸⁹ A disgruntled complainant must prove (1) that he changed his position after relying on another party's behavior and (2) that his reliance upon another party's conduct produced a change of position and an unwarranted detriment.⁵⁹⁰

In *Twin City*, the Fifth Circuit declared that the City of Madison proved both elements.⁵⁹¹ First, the insurer sent three reservation-of-rights letters, but neither letter disclosed that Twin City, rather than a subsidiary, would pay the settlement costs.⁵⁹² One correspondence did disclose that Twin City reserved the right to initiate a declaratory judgment action to recoup the \$250,000, but it was untimely.⁵⁹³ To be sure, this was not a minor oversight, for the law in

583. *Id.* at 905.

584. *Id.* at 909. ("Finding no fact issue [regarding the liability] . . . of Hartford Financial Services Group, . . . we affirm the summary judgment in favor of that third-party defendant.")

585. *Id.* ("These facts in dispute leave a question regarding third parties' gross negligence in claim handling. A fact finder might consider that coverage analysts having unfettered access to privileged information from appointed defense counsel in the presence of an undisclosed conflict support the tort claims asserted herein.")

586. *Id.* at 907-08.

587. *See, e.g., O'Neill v. O'Neill*, 551 So. 2d 228 (Miss. 1989).

588. *Id.*

589. *Id.*

590. *Id.* at 232.

591. *Twin City Fire Ins. Co. v. City of Madison*, 309 F.3d 901, 904 (5th Cir. Oct. 2002).

592. *Id.*

593. *Id.*

The City of Madison complains that the reservation-of-rights letters were insufficient. Twin City's first two letters to Madison did not identify Twin City at all but reserved rights to "Hartford Insurance Co."

Although these first two reservation-of-rights letters were delivered shortly after the Home Builders filed the two lawsuits against Madison (November 1995 and October 1998), it was January 2000, with the Home Builders' trial less than a month away, when Twin City sent a third reservation-of-rights letter which identified Twin City as the party reserving rights and informed

Mississippi is clear: Given the inherent conflict of interests associated with insurance-defense litigation, insurers have a higher obligation to protect the insured's interests, especially when insurers reserve and later assert the right to defend their own interests.⁵⁹⁴

The insurer's second mistake, however, was probably the most serious.⁵⁹⁵ Twin City disclosed that Attorney Terry Levy—along with his law firm, Daniel & Coker—would represent the City of Madison in the underlying lawsuits.⁵⁹⁶ But the letter did not disclose that Levy also reported insurance-defense matters and strategies directly to the insurer's claims adjusters.⁵⁹⁷ This created a severe conflict of interests.⁵⁹⁸ To repeat, Madison had asserted major bad faith and other claims against Twin City's adjusters.⁵⁹⁹

The Fifth Circuit cited settled principles regarding an insurance defense firm's and counsel's legal and fiduciary obligations when an actual or apparent conflict of interests exists.⁶⁰⁰ First, when an insurer defends under a reservation of rights, the insurer should immediately inform the insured of a possible conflict of interest between the insured's interests and the interests of the insurance company, allowing the insured to make an informed decision regarding whether to hire another attorney.⁶⁰¹ Second, when an insurer defends under a reservation of rights, "the insurance carrier should afford the insured ample opportunity to select his own independent counsel to look after his interest."⁶⁰² And finally, an insurance defense firm, including partners and associates, must give a client undivided loyalty and must protect the client's interests against all other competing interests.⁶⁰³

Therefore, after examining the facts and considering the doctrine of equitable estoppel, the Fifth Circuit held, "[W]e see the need for a trial. . . . Because these fact issues are germane to the question [of] whether Twin City discharged its duty to defend or mishandled the claim, they may provide grounds to estop Twin City from denying liability. Accordingly, we find summary judgment inappropriate on the counterclaim by Madison."⁶⁰⁴

the insured of its position.

Id.

594. See, e.g., *Moeller v. Am. Guar. & Liab. Ins. Co.*, 707 So. 2d 1062, 1069 (Miss.1996).

595. See *Twin City*, 309 F.3d at 905.

596. *Id.*

597. *Id.* at 905-06.

598. *Id.*

599. *Id.* at 908.

600. *Id.* at 906.

601. *Id.* (citing John Alan Appleman, 7C APPLEMAN INSURANCE LAW & PRACTICE § 4694 at 365 (1979)).

602. *Moeller v. Am. Guar. & Liab. Ins. Co.*, 707 So. 2d 1062, 1069 (Miss. 1996).

603. See *id.* at 1071 ("A law firm which cannot be one hundred percent faithful to the interests of its clients offers no defense at all.").

604. *Twin City*, 309 F.3d at 908.

G. Directors and Officers Liability Contracts—Whether an Insurer Had a Duty to Defend Corporate Directors and Officers Against Intentional Tort Actions Under Texas Law

Federal Insurance Co. v. CompUSA, Inc. is another case involving the liability of officers and directors.⁶⁰⁵ In an underlying state court lawsuit, COC Services, Ltd. (COC) sued CompUSA; James F. Halpin, CompUSA's President and Chief Executive Officer; and other directors and officers.⁶⁰⁶ COC alleged that CompUSA breached a joint venture agreement to expand CompUSA's personal computer business into Mexico.⁶⁰⁷ Later, COC amended the complaint and sued Halpin individually for fraud, tortious interference, conspiracy, and unjust enrichment.⁶⁰⁸ A Texas jury returned a verdict against Halpin and three other defendants for intentionally interfering with an existing contract.⁶⁰⁹ The jury awarded \$90 million and \$175.5 million in compensatory and punitive damages, respectively.⁶¹⁰ And Halpin had to pay sixty-five and one hundred percent of those amounts, respectively.⁶¹¹

When the underlying suit commenced, Federal Insurance Company insured CompUSA—including the company's officers and directors—under a claims-made liability policy.⁶¹² And unlike an occurrence policy, Federal's claims-made policy required CompUSA to report all third-party claims during the policy period, regardless of when third-party injuries or accidents occurred.⁶¹³ Of greater significance, the officers and directors contract contained a "reporting and notice" provision, which read in pertinent part, "[A]s a condition precedent to exercising their rights, . . . [the insureds must give Federal] written notice as soon as practicable of any Claim made against

605. 319 F.3d 746 (5th Cir. Feb. 2003).

606. *Id.* at 748.

607. *Fed. Ins. Co. v. CompUSA, Inc.*, 239 F. Supp. 2d 612, 613 (N.D. Tex. 2002), *aff'd* 319 F.3d 746 (5th Cir. Feb. 2003).

608. *Id.* at 614.

609. *Id.*

610. *Id.*

611. *Id.*

612. *Fed. Ins. Co. v. CompUSA, Inc.*, 319 F.3d 746, 752 (5th Cir. Feb. 2003). The coverage clause stated,

The Company shall pay on behalf of each of the Insured Persons all Loss for which the Insured Person is not indemnified by the Insured Organization and which the Insured Person becomes legally obligated to pay on account of any Claim first made against him, individually or otherwise, during the Policy Period or, if exercised, during the Extended Reporting Period, for a Wrongful Act committed, attempted, or allegedly committed or attempted by such Insured Person before or during the Policy Period.

Id.

613. *Id.* at 754; *see also* *Yancey v. Floyd West & Co.*, 755 S.W.2d 914, 918 (Tex. App.—Fort Worth 1988, writ denied) (" 'An "occurrence" policy covers all claims based on an event occurring during the policy period, regardless of whether the claim or occurrence itself is brought to the attention of the insured or made known to the insurer during the policy period.' ").

any of them for a Wrongful Act.”⁶¹⁴

CompUSA’s general counsel sent a letter to Federal informing the insurer about COC’s lawsuit and the jury’s verdict.⁶¹⁵ The letter was the first formal announcement in which the insured gave notice and asked the insurer for reimbursements in the event that COC prevailed in the underlying action.⁶¹⁶ But the letter arrived eleven months after COC filed its suit and six days after a jury delivered a verdict in favor of COC.⁶¹⁷ Before the verdict, CompUSA’s general counsel and executives decided to defend themselves without notifying Federal.⁶¹⁸ The executives adamantly believed that COC’s suit was frivolous and that the Texas court would summarily dismiss the action as a matter of law.⁶¹⁹ Of course, that did not happen, but the state court did overturn the verdict.⁶²⁰

Federal filed a declaratory judgment action in the Northern District Court of Texas asking the court to declare that it had no obligation to indemnify the officers and directors for any loss arising from the COC suit.⁶²¹ From the insurer’s perspective, the insureds breached the condition precedent and failed to give Federal written notice of the underlying lawsuit as soon as practicable.⁶²² Federal also argued that the absence of timely notice prejudiced the investigation of the third-party claims, the legal defense, and the likely settlement of the COC suit.⁶²³ The insurer moved for summary judgment.⁶²⁴

CompUSA claimed that it gave Federal formal notice as soon as practicable.⁶²⁵ But the district court observed that the insured did not give formal notice until eleven months after one of its executives had been served, and under Texas law, that was unreasonable.⁶²⁶ In addition, the district court refused to embrace CompUSA’s alternative argument that it gave actual notice that satisfied the condition precedent.⁶²⁷ Finally, according to the insured,

614. *Fed. Ins. Co.*, 319 F.3d at 752.

615. *Id.* at 751.

616. *Id.*

617. *Id.*

618. *Id.*

619. *Id.*

620. *Id.*

621. *Id.*

622. *Id.*

623. *Id.*

624. *Id.*

625. *Id.*

626. *Id.* at 752; *see also* *Chicago Ins. Co. v. W. World Ins. Co.*, 1998 WL 51363, at **2-3 (N.D. Tex. Jan. 23, 1998) (observing that “[c]ontractual language requiring notice ‘as soon as practicable’ has been construed by Texas courts as equivalent to ‘within a reasonable time There is ample Texas authority that taking 11 months to notify an insurer is not ‘as soon as practicable.’ ”) (citations omitted); *Allen v. W. Alliance Ins. Co.*, 162 Tex. 572, 349 S.W.2d 590, 594 (1961) (declaring that giving notice 107 days after an occurrence was unreasonable); *Klein v. Century Lloyds*, 154 Tex. 160, 275 S.W.2d 95, 97 (1955) (declaring that giving notice thirty-two days after an occurrence was unreasonable).

627. *Fed. Ins. Co.*, 319 F.3d at 753-54.

Federal and CompUSA contractually agreed, as a condition precedent, that written notice of a

Federal still had a duty to indemnify because the insurer could not demonstrate actual prejudice even if CompUSA had breached the condition precedent.⁶²⁸ The Northern District Court of Texas cited the Fifth Circuit's opinion in *Matador Petroleum Corp. v. St. Paul Surplus Lines Insurance Co.* and rejected CompUSA's final retort to Federal's affirmative defense.⁶²⁹ On appeal, the Fifth Circuit affirmed the district court's conclusions by adopting the trial judge's opinion in its entirety.⁶³⁰

H. Directors and Officers Liability Contracts—Whether Insurers are Liable Under Texas Law for an Alleged Bad-Faith Refusal to Defend Corporate Directors and Officers

The underlying conflict and the question for appellate review in *National Union Fire Insurance Co. of Pittsburgh, PA v. Willis* are remarkably similar to those in *CompUSA*.⁶³¹ CyberServe, Inc.; WSHS Enterprises, Inc.; and William Stuart—collectively CyberServe—sued EqualNet, Netco Acquisition, Mark Willis, and Willis Group in a Texas state court.⁶³² The lawsuit contained an abundance of mixed claims and actions sounding in both tort and contract.⁶³³

National Union Fire Insurance Company insured EqualNet and Willis, an officer and director of EqualNet, under three directors, officers, and corporate liability insurance contracts.⁶³⁴ All contracts were claims-made policies.⁶³⁵ National agreed “to ‘pay the Loss of each and every Director or Officer of the

claim would be made as soon as practicable. Because there is no indication that such a limit on liability violates a Texas statutory prohibition or public policy, the notice provision must be enforced as written. The court therefore rejects defendants' reliance on actual notice not given in the manner the Policy required.

Id.

628. *Id.* at 754.

629. *Id.*; see *Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co.*, 174 F.3d 653, 658-59 (5th Cir. 1999).

Courts have not permitted insurance companies to deny coverage on the basis of untimely notice under an “occurrence” policy unless the company shows actual prejudice from the delay. In the case of a “claims-made” policy, however, notice itself constitutes the event that triggers coverage. Courts strictly interpret notice provisions in a “claims-made” policy. Thus, an insurance company may deny coverage under a “claims-made” policy without a showing of prejudice.

Fed. Ins. Co., 319 F.3d at 754.

630. *Fed. Ins. Co.*, 319 F.3d at 750.

631. See 296 F.3d 336 (5th Cir. June 2002).

632. *Id.*

633. *Id.* at 338. The various causes of action were fraud, fraudulent inducement, statutory fraud in a stock transaction, tortious interference with a contract, conspiracy, and negligent misrepresentation. *Id.* Also, the third-party plaintiffs sued EqualNet and the Willis Group for breach of contract and *quantum meruit*. *Id.*

634. *Id.*

635. *Id.* at 339.

Company arising from a Claim . . . for any actual or alleged Wrongful Act.’⁶³⁶ To reiterate, unlike occurrence policies, claims-made policies have strict notice and reporting requirements, obligating the insured to report claims during a specific period.⁶³⁷ Therefore, whether a trier of facts ultimately finds a director or an officer liable for committing a wrongful act does not remove the insured’s obligation to report claims “as soon as practical” and within the policy period.⁶³⁸

The third-party complainants initiated their lawsuit in September 1998, but EqualNet and Willis did not give notice until seventeen and twenty months later in February and May of 2000.⁶³⁹ National Union denied coverage and refused to give money for the defense.⁶⁴⁰ The insurer argued that the insureds did not report the underlying claims and actions in a timely manner as required under the notice provisions of the claims-made contracts.⁶⁴¹ Willis and EqualNet agreed that they failed to notify National Union about the CyberServe lawsuit during the 1998 policy period.⁶⁴² These insureds stressed, however, that they were not required to give notice unless the insurance policy covered a claim.⁶⁴³

The district court disagreed and granted the insurer’s motion for summary judgment.⁶⁴⁴ The insureds appealed.⁶⁴⁵ The Fifth Circuit carefully examined settled principles of insurance law in Texas.⁶⁴⁶ The court also reviewed its

636. *Id.* at 343.

637. *See* Resolution Trust Corp. v. Ayo, 31 F.3d 285, 289 (5th Cir. 1994) (observing that a claims-made policy has strict reporting requirements and limits an insurer’s liability to a fixed period of time).

638. *Willis*, 296 F.3d at 343 (“Clearly, the ‘as soon as practical’ language in section 7(a) of the 1998 policy was intended to prevent an insured from waiting to notify the insurer of the existence of a claim.”).

639. *Id.* at 338.

640. *Id.*

641. *Id.* at 339-40. Section 7(c)—the notice provision—provides in part,

. . . If during the Policy Period or during the Discovery Period . . . the Company or the Insureds shall become aware of any circumstances which may reasonably be expected to give rise to a Claim being made against the Insureds and shall give written notice to the Insurer of the circumstances and the reasons for anticipating such a Claim, with full particulars as to dates, persons, and entities invoked, then any Claim which is subsequently made against the Insureds and reported to the Insurer alleging, arising out of, based upon or attributable to such circumstances or alleging any Wrongful Act which is the same as or related to any Wrongful Act alleged or contained in such circumstances, shall be considered made at the time such notice of such circumstances was given.

Id.

642. *Id.* at 338.

643. *Id.* at 340-41.

According to Willis, requiring the insured to give notice of circumstances likely to give rise to a claim ignores the plain language of the insurance policy’s notice requirement. Willis contends that the applicable provision “permitted but did not require Mr. Willis to give notice of any circumstances which might reasonably be expected to give rise to a claim being made against him that had not yet resulted in a claim that is covered by the policies.”

Id. at 340.

644. *Id.* at 338.

645. *Id.* at 339.

646. *Id.* (observing and embracing the notion that “Texas law requires an insurance policy to be

decision in *Matador Petroleum Corp. v. St. Paul Surplus Lines Insurance Co.*,⁶⁴⁷ and after conducting an intelligible and a thoughtful analysis, the court of appeals affirmed the district court's ruling.⁶⁴⁸

I. Third-Party Beneficiaries Life Insurance Contracts—Whether a Putative Spouse Qualifies as the Intended Beneficiary Under Louisiana Law

Neither the facts nor legal issues in *Sun Life Assurance Co. of Canada v. Richardson* are complicated or unfamiliar.⁶⁴⁹ In fact, the controversy appearing in this case occurs all too frequently. Melvin Richardson worked for Highlines Construction Company in Louisiana.⁶⁵⁰ Sun Life Assurance Company of Canada insured Melvin under a life insurance policy.⁶⁵¹ On June 29, 1989, he secured a change-of-beneficiary form and inserted the name of his girlfriend—Diana James—as the beneficiary under the insurance policy.⁶⁵² About four years later, Melvin and Diana stopped dating, but they continued to be friends.⁶⁵³

On June 6, 1998, Melvin married Sheila Richardson.⁶⁵⁴ Shortly thereafter, he went to Highlines's benefits office and directed the benefits manager, Linda Lee, to change everything over to Sheila, his new wife.⁶⁵⁵ In light of Melvin's limited reading and writing skills, Melvin's wife filled out the forms.⁶⁵⁶ Melvin signed the forms and returned them to Highlines's benefits office.⁶⁵⁷ But "Linda never gave Melvin the change of beneficiary form when she gave him the paperwork concerning his other benefit plans."⁶⁵⁸

construed against the insurer and in favor of the insured"); see also *Puckett v. U.S. Fire Ins. Co.*, 678 S.W.2d 936, 938 (Tex. 1984) (holding that an insurance policy's exceptions and limitations are construed in favor of the insured in order to avoid exclusion of coverage); *Balandran v. Safeco Ins. Co. of Am.*, 972 S.W.2d 738, 741 (Tex. 1998) (declaring that courts must remember that giving effect to the written expression of the parties' intent is the primary goal when interpreting an insurance policy); *Kelley-Coppedge, Inc. v. Highlands Ins. Co.*, 980 S.W.2d 462, 464 (Tex. 1998) (holding that courts must interpret insurance contracts in such a way to ensure that each term's effect will not be rendered meaningless); *State Farm Life Ins. Co. v. Beaton*, 907 S.W.2d 430, 433 (Tex. 1995) (declaring that all provisions in an insurance contract should be considered in light of the whole contract so that no single provision controls).

647. 174 F.3d 653, 658-59 & n.2 (5th Cir.1999) (declaring that a claim must be made against the insured during the policy's period and the insured must notify the insurer of the claim during the same period in order to invoke coverage under a claims-made policy).

648. *Willis*, 296 F.3d at 343.

649. 299 F.3d 500 (5th Cir. July 2002).

650. *Id.* at 501.

651. *Id.* at 502.

652. *Id.* at 501.

653. *Id.*

654. *Id.*

655. *Id.* at 501-02.

656. *Id.* at 502.

657. *Id.*

658. *Id.*

On February 23, 2000, Melvin died from an accidental electrocution while working for Highlines.⁶⁵⁹ After Melvin's death, Sheila learned that she was the beneficiary under his workmen's compensation and 401(k) retirement plans.⁶⁶⁰ At that time, Sheila also discovered that Diana, Melvin's former girlfriend, was still the beneficiary under Melvin's life insurance policy.⁶⁶¹ Following Melvin's death, Sun Life filed an interpleader action in the Eastern District Court of Louisiana to determine who was the legal beneficiary.⁶⁶² The insurer listed Sheila, Diana, and Melvin's sister—Shirley Ann Richardson—as defendants.⁶⁶³ Later, the sister withdrew from the case.⁶⁶⁴

Louisiana has embraced the strict compliance doctrine, which requires the owner of a life insurance policy—typically the insured—to comply strictly with the terms of the contract before changing the beneficiary.⁶⁶⁵ The owner must complete and sign a change-of-beneficiary form.⁶⁶⁶ The doctrine of substantial compliance, however, is an exception to the general rule.⁶⁶⁷ The general rule permits a change of beneficiary after the insured's death when evidence suggests that the owner of the policy did “substantially all that lay within his power to do to effect a change in the beneficiary” before the insured's death.⁶⁶⁸

Citing the substantial compliance doctrine, the district court found that Melvin had complied with Louisiana's law when he attempted to designate his wife as the beneficiary before his death.⁶⁶⁹ The court observed that Linda—Highlines's benefits manager—unintentionally failed to give a change-of-beneficiary form to Melvin.⁶⁷⁰ Consequently, the district court entered a judgment in favor of Melvin's wife, Sheila, and awarded her \$104,000.⁶⁷¹ Diana, his former girlfriend, appealed.⁶⁷²

The Fifth Circuit decided the case quickly, declaring that “Louisiana law requires strict compliance with an insurance contract's terms to effect a change of beneficiary.”⁶⁷³ In addition, the court of appeals noted,

659. *Id.*

660. *Id.*

661. *Id.*

662. *Id.*; see FED. R. CIV. P. 22.

663. *Richardson*, 299 F.3d at 502.

664. *Id.*

665. *Id.*; see *Am. Gen. Life Ins. Co. v. Fine*, 944 F.2d 232, 234 & n.5 (5th Cir. 1991).

666. *Fine*, 944 F.2d at 234.

667. *Richardson*, 299 F.3d at 503.

668. *Bland v. Good Citizens Mut. Ben. Ass'n*, 64 So. 2d 29, 33-34 (La. Ct. App. 1953).

669. *Richardson*, 299 F.3d at 502.

670. *Id.* (“In support of this conclusion, the district court found that two witnesses corroborated Sheila's testimony that Linda had told her that Melvin wanted to change ‘everything’ to Sheila's name, but that Linda had ‘overlooked’ the life insurance policy because it was in a separate place.”)

671. *Id.*

672. *Id.*

673. *Id.* at 503; see *Am. Gen. Life Ins. Co. v. Fine*, 944 F.2d 232, 234 & n.5 (5th Cir. 1991).

There is no evidence whatsoever that Diana, the named beneficiary of Melvin's life insurance policy, interfered with Melvin's ability to change the beneficiary to Sheila Likewise, there is no evidence that Melvin ever received a change of beneficiary form which he filled out and returned to his insurance company for processing.⁶⁷⁴

Therefore, the Fifth Circuit held that the district court erred and reversed in favor of Diana James, Melvin's former girlfriend.⁶⁷⁵

J. Professional Liability Contracts (Medical Malpractice)—Whether an Insurer and Hospital Had a Contractual Duty to Indemnify a Hospital Management Company Under Texas Law

Quorum Health Resources, L.L.C. v. Maverick County Hospital District presents an extremely interesting set of facts and questions involving both insurance law and an underlying medical malpractice action.⁶⁷⁶ Quorum Health Resources is a hospital management company.⁶⁷⁷ In 1990, the Maverick County Hospital District in Texas entered into a five-year management agreement with HCA Management Company, Quorum's predecessor, for the period of May 14, 1990 to May 14, 1995.⁶⁷⁸ Maverick Hospital and Quorum renewed the management agreement in May 1995 for the period of May 14, 1995 to May 13, 2000.⁶⁷⁹

Identical indemnification clauses appeared in the 1990 and 1995 agreements.⁶⁸⁰ Maverick Hospital agreed to protect Quorum from medical malpractice and other third-party actions arising out of the hospital's conduct.⁶⁸¹ Additionally, in the event a court ordered Quorum to pay damages for the hospital's negligence or other violations, Maverick Hospital agreed to

674. *Richardson*, 299 F.3d at 503.

675. *Id.* at 503-04.

676. 308 F.3d 451 (5th Cir. Sept. 2002).

677. *Id.* at 454.

678. *Id.* at 454 n.1.

679. *Id.*

680. *Id.* at 455-56. The indemnity provision in 1990 and 1995 management agreements read in pertinent part,

[The] Hospital agrees to indemnify and hold harmless Quorum . . . from and against any and all losses, claims, damages, liabilities, costs and expenses (including reasonable attorneys' fees and expenses related to the defense of any claims), joint or several, which may be asserted against any of the Quorum Indemnified Parties . . . including but not limited to: (i) alleged or actual failure by the Board to perform any of its duties hereunder, (ii) any pending or threatened medical malpractice or other tort claims asserted against Quorum; . . . (iv) any act or omission by any Hospital employee, Medical Staff member, or other personnel[,] . . . provided that such claims have not been caused by the gross negligence or willful or wanton misconduct of the Quorum Indemnified Party seeking indemnification pursuant to this Agreement.

Id. (emphasis added).

681. *Id.* at 455.

indemnify the management company.⁶⁸² A slightly modified indemnity provision outlining Quorum's reciprocal obligations also appeared in the 1990 and 1995 agreements.⁶⁸³

In June of 1996, David and Veronica Rodriguez lived in Maverick County, Texas.⁶⁸⁴ In June of 1996, they filed a medical malpractice suit in a Texas court on behalf of themselves and their minor daughter, Cristina.⁶⁸⁵ The complaint listed several defendants—the county, Maverick Hospital, an obstetrician, three registered nurses, and a nurse practitioner.⁶⁸⁶ In March of 1997, the Rodriguezes added Quorum as a defendant.⁶⁸⁷ The third-party plaintiffs alleged that the defendants were negligent during Cristina's delivery, leaving the child severely mentally and physically disabled.⁶⁸⁸

The Texas Hospital Insurance Exchange and Texas Hospital Insurance Network (collectively, THIE) insured Maverick Hospital; the policy also identified Quorum as an additional named insured.⁶⁸⁹ Under the terms of the insurance policy, the insurer agreed to defend the hospital and its management company until the company's liability had been exhausted.⁶⁹⁰ But there was a

682. *Id.*

683. *Id.* at 455-56. The 1990 provision that outlined Quorum's indemnity obligation states, [Quorum] agrees to indemnify and hold harmless the Hospital and its shareholders, directors, officers or trustees ("Hospital Indemnified Party") from and against all losses, claims, damages, liabilities, costs and expenses (including reasonable attorney's fees and expenses related to the defense of any claims), joint or several, which may be asserted against any Hospital Indemnified Party ("Hospital claim"), as a result of any personnel or other action brought against the Hospital Indemnified Party by any Key Person [the Administrator and Controller] relating to any acts performed by such Key Person within the scope of his or her employment by [Quorum]; provided that such Hospital Claims have not been caused by the gross negligence or willful or wanton misconduct of the Hospital Indemnified Party seeking indemnification pursuant to this Agreement.

Id. at 456 (alterations in original). The provision in the 1995 agreement reads as follows:

Quorum would indemnify the Hospital for "losses, claims, damages, liabilities, costs and expenses" as a result of actions brought by a "Key Person." However, the 1995 Agreement added that Quorum would indemnify the Hospital for "losses, claims, damages, liabilities, costs and expenses" from claims asserted against the Hospital "as a result of . . . the sole negligence of Quorum outside the scope of its employment; provided that such Hospital Claims have not been caused by the gross negligence or willful or wanton misconduct of the Hospital Indemnified Party seeking indemnification pursuant to this Agreement."

Id.

684. *Id.* at 454.

685. *Id.*

686. *Id.*

687. *Id.*

688. *Id.*

689. *Id.* at 454 n.2 ("The policy provides for coverage of \$100,000 per medical incident and \$300,000 aggregate.")

690. *Id.* at 456-57. The insurance policy provided in relevant part,

[THIE] shall have the right and duty to defend any suit against the insured seeking damages because of such injury even if any of the allegations of the suit are groundless, false, or fraudulent. The company may make such investigation and, with the written consent of the insured; such settlement of any claim or suit, as it deems expedient. The company shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the

provision requiring the insureds to help the insurers to prepare a defense.⁶⁹¹ Also, the insureds had to satisfy a condition precedent before commencing a legal action against THIE if the insurers breached the contract.⁶⁹²

Maverick Hospital informed THIE about the malpractice suit in a timely manner.⁶⁹³ And although THIE hired a law firm to represent all defendants, the management company selected its own defense firm.⁶⁹⁴ Quorum's excess insurer—American Continental Insurance Company—paid for Quorum's defense.⁶⁹⁵ Ultimately, the trial proceeded before a jury.⁶⁹⁶ Quorum was the only defendant in the simple and gross negligence actions.⁶⁹⁷ The attending obstetrician was the single defendant in the medical malpractice action.⁶⁹⁸

The jury found Quorum and the attending obstetrician responsible—sixty percent and thirty-five percent, respectively—for Cristina Rodriguez's injuries.⁶⁹⁹ The jury awarded \$52 million in actual damages and awarded an additional \$7.5 million in exemplary damages, finding that Quorum had engaged in malicious conduct.⁷⁰⁰ In light of its liabilities and the large damages awards, Quorum filed a declaratory judgment action in the District Court for the Western District of Texas.⁷⁰¹ Quorum asked the federal court to declare that (1) Maverick Hospital had a contractual duty under the terms of the 1990 and 1995 management agreements to indemnify Quorum for monies spent to satisfy the *Rodriguez* judgment, (2) Maverick had a contractual duty under the hospital-management contracts to defend Quorum in the *Rodriguez* suit, (3) THIE breached its duty to defend Quorum under the insurance policy,

company's liability has been exhausted by payment of the judgment or settlements.

Id.

691. *Id.* at 456.

692. *Id.* at 457. The policy further provided that "the insured and each of its employees shall cooperate with the company and, upon the company's request, assist . . . in the conduct of suits No action shall lie against the company unless, as a condition precedent thereto, there shall have been full compliance with all the terms of this policy" *Id.*

693. *Id.* at 454.

694. *Id.*

695. *Id.* at 455.

696. *Id.*

697. *Id.* ("Before trial began, the *Rodriguez* plaintiffs nonsuited all the defendants except Quorum David and Veronica Rodriguez [also] nonsuited their individual claims against Quorum.")

698. *Id.* at 454.

699. *Id.*

700. *Id.* at 455.

Plaintiffs settled with the obstetrician before the verdict. In an Amended Final Judgment, the trial court deducted the amount of the settlement and added prejudgment interest, awarding actual damages of approximately \$57 million before post-judgment interest. The trial court disregarded the jury's finding of malice and ordered that plaintiffs not recover exemplary damages against Quorum.

Id.

701. *Id.*

and (4) THIE had a contractual duty to indemnify Quorum after the management company paid the *Rodriguez* damages.⁷⁰²

The district court issued several declarations, but only three are relevant for discussion here.⁷⁰³ First, the court declared that the indemnity provision in the 1990 and 1995 management agreements satisfied the requirements under the Texas express negligence rule.⁷⁰⁴ Consequently, Maverick Hospital had a duty to indemnify Quorum for damages stemming from Quorum's own negligence.⁷⁰⁵ The management company paid approximately \$31 million to settle the *Rodriguez* judgment.⁷⁰⁶

On the other hand, the district court declared that THIE "did not breach its duty to defend Quorum under the insurance policy."⁷⁰⁷ The court also held that THIE had no contractual obligation to indemnify Quorum for the *Rodriguez* judgment.⁷⁰⁸ The federal district court found that Quorum breached its contractual duty to cooperate with the insurer when Quorum rejected the insurance defense that THIE offered.⁷⁰⁹ Dissatisfied with the district court's conclusions, all parties appealed to the Fifth Circuit Court of Appeals.⁷¹⁰

At the very outset, Justice Rosenthal, writing for the appellate court, had to determine whether the nearly identical indemnity clauses in the two management agreements satisfied Texas's express negligence rule.⁷¹¹ In *Ethyl Corp. v. Daniel Construction Co.*, the Texas Supreme Court adopted that doctrine to interpret the parties' intent under indemnity contracts.⁷¹² Put simply, a party who is not necessarily in the business of insurance may contract to indemnify another party for the financial consequences of the latter party's negligence.⁷¹³ But Justice Rosenthal correctly observed that a party who agrees to underwrite the adverse consequences of another party's negligence "must express that intent in specific terms, within the four corners

702. *Id.*

703. *Id.* at 457. The federal district court also declared the following:

(2) the Hospital did not owe Quorum common law indemnification under Texas law; (3) the \$100,000 statutory damage cap applicable to the Hospital as a governmental unit of the State of Texas under the Texas Tort Claims Act did not limit the Hospital's obligation to indemnify Quorum; [and] (4) the Hospital did not owe Quorum a duty to defend because the Management Agreement permitted, but did not require, the Hospital to participate in the defense of any action against Quorum.

Id. (footnote omitted).

704. *Id.*

705. *Id.*

706. *Id.*

707. *Id.*

708. *Id.*

709. *Id.*

710. *Id.*

711. *Id.* at 458.

712. 725 S.W.2d 705 (Tex. 1987).

713. *Id.* at 708 (holding that "[i]ndemnitees seeking indemnity for the consequences of their own negligence which proximately causes injury jointly and concurrently with the indemnitor's negligence must also meet the express negligence test").

of the document.⁷¹⁴

After reviewing the agreements between Maverick Hospital and Quorum, the Fifth Circuit held that the district court erred when it decided in favor of Quorum.⁷¹⁵ The hospital management company argued that the hospital agreed “ ‘to indemnify and hold harmless Quorum . . . for any and all losses, claims, damages, liabilities, costs, and expenses . . . joint or several . . . arising in connection with the activity of the Hospital.’ ”⁷¹⁶ However, citing an array of Texas Supreme Court decisions, the Fifth Circuit stated that the language appearing in the agreements was insufficient.⁷¹⁷ Quite simply, those terms did not clearly express that the parties expected Maverick Hospital to indemnify Quorum for the latter’s own negligence.⁷¹⁸

Finally, as mentioned earlier, the insurer agreed to defend Quorum and, presumably, would have reimbursed all of Quorum’s expenditures and liabilities in the underlying suit.⁷¹⁹ But the management company secured separate counsel.⁷²⁰ According to Quorum, a conflict of interests arose involving the lawyer that THIE had selected to provide a defense.⁷²¹ Therefore, the district court should not have granted summary judgment in favor of THIE.⁷²² Reversing the district court and remanding the case, the Fifth Circuit declared,

The evidence does not support the conclusion that, as a matter of law, THIE met its duty to defend Quorum after the conflict of interests arose. Nor does the evidence support the conclusion that, as a matter of law, Quorum breached its duty of cooperation after THIE’s second lawyer declined the representation.⁷²³

714. *Quorum Health Res., L.L.C.*, 308 F.3d at 458. In fact, the Supreme Court of Texas has been adamant about parties’ strict compliance with the rule. See *Ethyl Corp.*, 725 S.W.2d at 707-08.

As we have moved closer to the express negligence doctrine, the scriveners of indemnity agreements have devised novel ways of writing provisions which fail to expressly state the true intent of those provisions. The intent of the scriveners is to indemnify the indemnitee for its negligence, yet be just ambiguous enough to conceal that intent from the indemnitor. The result has been a plethora of lawsuits to construe those ambiguous contracts. We hold the better policy is to cut through the ambiguity of those provisions and adopt the express negligence doctrine.

Id.

715. *Quorum Health Res., L.L.C.*, 308 F.3d at 468.

716. *Id.* at 463.

717. *Id.* at 464.

718. *Id.* at 463.

719. *Id.* at 454.

720. *Id.* at 455.

721. *Id.* at 469-70.

722. See *id.* at 471.

723. *Id.*

VI. THIRD-PARTY REINSURANCE TREATIES—STATE STATUTORY CLAIMS AND DECISIONS: WHETHER TEXAS COURTS HAVE AUTHORITY TO ENFORCE FOREIGN JUDGMENTS

Society of Lloyd's v. Turner involves a monetary dispute between the Society of Lloyd's in London and two Names, insurance underwriters, residing in Texas.⁷²⁴ At the outset, it is important to establish that Lloyd's of London, the Corporation of Lloyd's, and the Society of Lloyd's are labels for the same entity.⁷²⁵ The entity is more than three hundred years old.⁷²⁶ Lloyd's provides office space and administrative assistance for insurance underwriters.⁷²⁷ However, Lloyd's does not underwrite insurance; instead, it serves a market for Names—individual and corporate underwriters that insure all types of tangible and intangible interests worldwide through various syndicates.⁷²⁸ They also sell reinsurance contracts—Treaties of Reinsurance—to other insurers worldwide.⁷²⁹

The Council of Lloyd's controls Lloyd's administrative functions.⁷³⁰ The Council also develops regulations or bylaws for the syndicates and Names.⁷³¹ One regulation requires Names to become members of Lloyd's before they can participate in the insurance market.⁷³² Also, Names “must pass a means test to ensure their ability to meet their underwriting obligations.”⁷³³ But more important, they must appear in person before a representative of the Council in London and swear that they accept exposure to unlimited personal liability

724. 303 F.3d 325 (5th Cir. July 2002).

725. *Id.* at 326-27.

726. *Id.* at 326.

727. *Id.* at 327.

728. See Willy E. Rice, *Commercial Terrorism From the Transatlantic Slave Trade to the World Trade Center Disaster: Are Insurance Companies & Judges "Aiders and Abettors" of Terror?—A Critical Analysis of American and British Courts' Declaratory and Equitable Actions, 1654-2002*, 6 THE SCHOLAR: ST. MARY'S LAW REVIEW ON MINORITY ISSUES 1 (2003) (reviewing the evolution of Lloyd's of London and its celebrated—although infamous—names and chronicling their and other insurers participation in the terrors of the transatlantic slave trade).

729. See *Haynsworth v. The Corp.*, 121 F.3d 956, 958-59 (5th Cir. 1997). Foreign reinsurers are Underwriters and Underwriting Syndicates at Lloyd's of London, and foreign companies subscribing to reinsurance. . . .

A reinsurance treaty is an ongoing contractual relationship between two insurance companies in which the primary insurer agrees in advance to cede, and the reinsurer to accept, specified business that is the subject of the contract. Under a treaty, a reinsurer agrees to indemnify a primary insurer with respect to a portion of the primary insurer's liability in a designated line of business . . . [Typically], the reinsurance treaty involve[s] the participation of many reinsurers, each accepting a percentage of the total liability under a single treaty.

N. River Ins. Co. v. Philadelphia Reinsurance Corp., 63 F.3d 160, 162 (2d Cir. 1995); see also *In re Ins. Antitrust Litig.*, 938 F.2d 919, 923 (9th Cir. 1991) (“Reinsurance is arranged by specialized brokers and underwriters. Much reinsurance is done by syndicates doing business through Lloyd's of London.”).

730. *Turner*, 303 F.3d at 327.

731. *Id.*

732. *Id.*

733. *Id.*

for the privilege to underwrite insurance in the Lloyd's market.⁷³⁴

To be sure, the massive toxic-tort litigation and exposure during the late 1980s and earlier 1990s severely tested the Names' willingness and ability to honor various contractual agreements and to cover a colossal number of claims.⁷³⁵ Quite simply, an unacceptable number of Names miserably failed the test.⁷³⁶ Many underwriters could not cover billions of dollars in losses, thereby threatening the very existence of Lloyd's of London.⁷³⁷

To help arrest the problem, Lloyd's implemented the Reconstruction and Renewal Plan.⁷³⁸ Lloyd's arranged for Equitas Reinsurance Ltd. to sell a blanket reinsurance policy to cover the Names' pre-1993 toxic-tort liabilities.⁷³⁹ However, the Names had to pay the premiums.⁷⁴⁰ For the present discussion, the following two pertinent provisions appeared in the reinsurance contract: (1) A "pay now, sue later" clause required the Names to pay their premiums on time but allowed the underwriters to challenge the amount, and (2) A "conclusive evidence" provision stated that—absent any "manifest error"—Lloyd's calculation of the respective premiums was conclusive evidence of what Equitas should receive from each underwriter.⁷⁴¹

734. *Id.*

735. *See, e.g.,* Haynsworth v. The Corp., 121 F.3d 956, 960 (5th Cir. 1997).

Although underwriting at Lloyd's appears to have been a profitable endeavor up until the mid-1980's, at that time massive liability for pollution and asbestos-related injuries began to change the situation somewhat. According to the plaintiffs, when Lloyd's full-time members or "insiders" became aware of these risks, they concocted a sinister scheme to shift the liabilities onto unsuspecting American investors such as the plaintiffs.

In order to escape these liabilities, they claim[ed] the insiders recruited new Names and steered them into syndicates, where they unwittingly underwrote high-risk asbestos reinsurance and toxic waste obligations, of which policies the insiders wanted no part. As a consequence of being placed in these syndicates, the plaintiffs allege, they have incurred large financial losses already and remain liable for a great deal more.

The massive excess losses sustained by Names in the late 1980's and early 1990's—by Lloyd's estimate, something in the neighborhood of \$22 billion—have spawned a series of lawsuits throughout the United States.

Id.

736. *Turner*, 303 F.3d at 327.

737. *Id.* ("Because of the enormity of the outstanding liabilities and because of the Names' inability to satisfy their underwriting obligations, the very existence of Lloyd's was threatened.")

738. *Id.*

739. *Id.*

Equitas Reinsurance Ltd., Equitas Ltd., Equitas Management Servs. Ltd., Equitas Holdings Ltd., and Equitas Policyholders Trustee Ltd. (collectively, "Equitas") "are entities organized under the laws of England with their principal place of business in London, England."

The plaintiffs are reinsured under a series of contracts, known as the "reinsurance program contracts," . . . [which are] "intended to provide a uniform program of excess of loss reinsurance coverage in various layers over a number of years." The series of contracts . . . are known as the "blanket casualty treaty program."

Hartford Acc. & Indem. Co. v. Equitas Reinsurance Ltd., 200 F. Supp. 2d 102, 105 (D. Conn. 2002).

740. *Turner*, 303 F.3d at 327.

741. *Id.* at 327-28.

Unlike the overwhelming majority of Names, Percy Turner and Duncan Webb refused to accept the terms of the Equitas contract and did not pay the insurance premiums.⁷⁴² In response, Lloyd's appointed a substitute agent for Turner and Webb.⁷⁴³ Furthermore, as consideration for Lloyd's paying obstinate Turner and Webb's premiums, "Equitas assigned its right to collect the premiums to Lloyd's."⁷⁴⁴ In 1996, Lloyd's sued Turner and Webb in an English court, and after seemingly intractable litigation, Lloyd's secured a money judgment against each defendant in the Court of the Queen's Bench.⁷⁴⁵

In May of 2000, Lloyd's commenced two suits against Turner and Webb in separate divisions of the Northern District Court of Texas.⁷⁴⁶ In both proceedings, Lloyd's cited the Texas Uniform Foreign Money-Judgments Recognition Act and asked the respective judges to recognize and enforce the English monetary judgments against the delinquent underwriters.⁷⁴⁷ After considering cross motions for summary judgment, both divisions of the Northern District Court granted motions in favor of the Society of Lloyd's.⁷⁴⁸ Webb and Turner appealed to the Fifth Circuit, where the court consolidated the cases.⁷⁴⁹

742. *Id.* at 328.

743. *Id.*

744. *Id.*

745. See *Soc'y of Lloyd's v. Fraser & Ors*, (Q.B., Jan. 22 & Mar. 4, 1998). The Queen's Bench awarded approximately £71,000 and £66,000, respectively, in monetary judgments against Turner and Webb. *Turner*, 303 F.3d at 329.

746. *Turner*, 303 F.3d at 329.

747. *Id.* This act outlines various grounds or reasons not to recognize other countries monetary judgments. The Texas Uniform Foreign Money-Judgments Recognition Act states,

(a) A foreign country judgment is not conclusive if:

(1) the judgment was rendered under a system that does not provide impartial tribunals or procedures compatible with the requirements of due process of law;
 (2) the foreign country court did not have personal jurisdiction over the defendant; or
 (3) the foreign country court did not have jurisdiction over the subject matter.

(b) A foreign country judgment need not be recognized if:

(1) the defendant in the proceedings in the foreign country court did not receive notice of the proceedings in sufficient time to defend;
 (2) the judgment was obtained by fraud;
 (3) the cause of action on which the judgment is based is repugnant to the public policy of this state;

(4) the judgment conflicts with another final and conclusive judgment;

(5) the proceeding in the foreign country court was contrary to an agreement between the parties under which the dispute in question was to be settled otherwise than by proceedings in that court;

(6) in the case of jurisdiction based only on personal service, the foreign country court was a seriously inconvenient forum for the trial of the action; or

(7) it is established that the foreign country in which the judgment was rendered does not recognize judgments rendered in this state that, but for the fact that they are rendered in this state, conform to the definition of "foreign country judgment."

TEX. CIV. PRAC. & REM. CODE ANN. § 36.005 (Vernon 2003).

748. *Turner*, 303 F.3d at 329.

749. *Id.*

On appeal, the appellants argued that the district courts should not have recognized the Queen's Bench's monetary judgments against them because the English court had violated their right to due process of law.⁷⁵⁰ But the Fifth Circuit rejected that argument right away and reaffirmed the Seventh Circuit's observation in *Society of Lloyd's v. Ashenden*: "Any suggestion that . . . [the English] system of courts 'does not provide impartial tribunals or procedures compatible with the requirements of due process of law' borders on the risible."⁷⁵¹

Finally, Webb and Turner argued that the district judges contravened Texas's public policy when those judges enforced the Court of the Queen's Bench's judgments.⁷⁵² According to appellants, the standard of proof required to establish a breach of contract action in England deviates from the standard required in Texas.⁷⁵³ But the Fifth Circuit affirmed the district courts' rulings and held:

Accepting . . . [Webb and Turner's] characterization of English breach of contract law as true, the standard for non-recognition of a foreign judgment under the Texas Act is whether the "cause of action" is repugnant to state public policy, not whether the standards for evaluating that cause of action are the same or similar in the foreign country.⁷⁵⁴

750. *See id.*

751. 233 F.3d 473, 476 (7th Cir. 2000).

Moreover, our colleagues from the Seventh Circuit have already concluded that the particular English proceedings of which Webb and Turner complain here do not run afoul of the due process provision of the Uniform Money-Judgment Recognition Act We find their reasoning to be persuasive and adopt it as our own.

Turner, 303 F.3d at 331 n.22. (citation omitted).

752. *Turner*, 303 F.3d at 332.

753. *Id.* In England, "Lloyd's needed only to assert the existence of a contract and the amount owed." *Id.* In Texas, four elements must be established: "(i) the existence of a contract, (ii) proof of the plaintiff's performance, (iii) evidence of the defendant's breach, and (iv) damages." *Id.* (citing *Wright v. Christian & Smith*, 950 S.W.2d 411, 412 (Tex. App.—Houston [1st Dist.] 1997, no writ)). But note that in Texas, a complainant must prove five rather than four elements to establish a prima facie case for a breach of contract action. *See Villarreal v. Art Inst. of Houston, Inc.*, 20 S.W.3d 792, 798 (Tex. App.—Corpus Christi 2000, no pet.).

[To] send her breach of contract claims to the jury, Villarreal must have . . . produced evidence of: (1) the existence of a valid contract binding the institute to perform the promised act . . . ; (2) her performance or tender of performance given as consideration for that particular promise; (3) nonperformance on the part of the institute; and (4) damages resulting from the breach.

Id.; *see also Mead v. Johnson Group, Inc.*, 615 S.W.2d 685, 687 (Tex. 1981) ("The evidence must show that the damages are the natural, probable, and foreseeable consequences of the defendant's conduct."); *Stewart v. Basey*, 245 S.W.2d 484, 486 (Tex. 1952) ("In order to recover compensatory damages, the plaintiff must establish that he suffered some pecuniary loss as a result of [causation] the breach of the contract.").

754. *Turner*, 303 F.3d at 332 ("Because a breach-of-contract cause of action is not contrary to Texas public policy, the district courts did not err in rejecting the claims of Webb and Turner and in recognizing the English judgments.").

VII. THIRD-PARTY INSURANCE CONTRACTS—FEDERAL STATUTORY CLAIMS AND DECISIONS: WORKERS' COMPENSATION INSURANCE CONTRACTS—WHETHER EMPLOYERS MAY COMMENCE A CLASS-ACTION LAWSUIT AGAINST INSURERS UNDER THE FEDERAL CIVIL RICO STATUTE

Workers' compensation plans and markets are somewhat complex and diverse, requiring a dissertation to understand them fully.⁷⁵⁵ Here, of course, the author will not present such an exposition. But to receive more than a superficial discussion of workers' compensation insurance and to help readers to appreciate the significance and scope of the controversy in *Sandwich Chef of Texas, Inc. v. Reliance National Indemnity Insurance Co.*, Justice Fitzwater's observations are worth repeating at this point:

Most employers purchase workers' compensation coverage in the voluntary market. Those who cannot may obtain insurance through legislatively-established involuntary markets, sometimes called "residual markets," "assigned risk markets," or "assigned risk pools." Some states require workers' compensation insurance carriers to reinsure that "residual markets," which often results in additional costs When residual market assessments dramatically increased, insurers responded by factoring residual market expenses in the price of their voluntary market insurance. Insurance program documents identified these expenses as "residual market charges" (also known as "residual market loads" or "RMLs").⁷⁵⁶

In addition, the National Council on Compensation Insurance (NCCI) is a workers' compensation insurance ratings organization.⁷⁵⁷ It is a private enterprise although state insurance commissioners regulate and grant NCCI a license to operate within their borders.⁷⁵⁸ In fact, "NCCI is the official rating

755. See discussion *infra* Part VII.A.

756. 319 F.3d 205, 211-12 (5th Cir. Jan. 2003).

757. *Id.*

758. See, e.g., *Nat'l Council on Comp. Ins., Inc. v. Strickland*, 526 S.E.2d 924, 925 (Ga. App. 1999). The National Council on Compensation Insurance, Inc. ("NCCI") . . . serves as the "Administrator" of the Georgia Workers' Compensation Assigned Risk Insurance Plan under contract with the Georgia Insurance Commissioner As Administrator, NCCI receives and reviews applications for eligibility to the Assigned Risk Pool and for completeness, which is the extent of its duties and powers.

Id.; see *Aetna Cas. & Sur. Co. v. Stewart Const. Co.*, 00-CA-1332 (La. App. 5 Cir. 2/28/01), 780 So. 2d 1253, 1255.

This case involves the worker's compensation reinsurance pool as it existed prior to the creation of the Louisiana Workers' Compensation Corporation in La. R.S.23: 1393 et seq. At that time, all licensed carriers participated in a residual insurance mechanism or involuntary market designed to provide insurance for those employers who were unable to obtain worker's compensation coverage on a voluntary basis. This involuntary market was referred to as the "Assigned Risk Plan."

The National Council on Compensation Insurance (NCCI) administered this involuntary market, known as the "Louisiana Worker's Compensation Insurance Plan."

organization for many states.⁷⁵⁹ It develops and submits policy forms and manuals that state regulators approve or reject.⁷⁶⁰ Furthermore, NCCI handles rate plans with state regulators and verifies that employers' actual retrospective plans conform to state-approved plans.⁷⁶¹

"Premiums for retrospectively-rated workers' compensation insurance are based on expense factors and loss experience calculated as of the end of the policy period. Policyholders pay an initial premium, subject to a negotiated minimum and maximum range, and receive refunds or credits or pay additional premiums based on losses."⁷⁶² Option V is a rating plan for retrospectively rated workers' compensation insurance policies.⁷⁶³ NCCI approved the Option V rating plan in forty-five jurisdictions.⁷⁶⁴ "Insurers who sell Option V policies cannot deviate from these rates without regulatory approval."⁷⁶⁵

Sandwich Chef of Texas, Inc., d/b/a Wall Street Deli, manages delicatessens in several states.⁷⁶⁶ Reliance Insurance Company sold four workers' compensation insurance policies to Wall Street from 1991 to 1994.⁷⁶⁷ Wall Street was dissatisfied with the plans and commenced a putative class action suit in the Southern District Court of Texas.⁷⁶⁸ Wall Street sued 141 casualty insurance companies for violating the federal civil RICO statute.⁷⁶⁹

Among several allegations, Wall Street argued that the insurers (1) "committed mail and wire fraud . . . by charging excessive premiums on retrospectively rated workers' compensation insurance policies during a 14-year period," (2) corrupted NCCI and "used it as a racketeering enterprise to defraud policyholders and state regulators," and (3) "charged excessive premiums to thousands of employers in 44 states and the District of

Id.

759. *Id.* at 487-88.

760. *Id.*

761. *Sandwich Chef of Tex., Inc. v. Reliance Nat'l Indem. Ins. Co.*, 202 F.R.D. 484, 487-88 (S.D. Tex. 2001).

762. *Sandwich Chef of Tex., Inc.*, 319 F.3d at 211.

763. *Id.* at 212. Option V is specifically geared towards retrospectively rated workers' compensation insurance policies. *Id.*

764. *Id.*

765. *Id.*

766. *Id.* at 211.

767. *Id.* at 212.

768. *Id.* at 211-12.

769. *Id.* at 211; Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. § 1962(c)-(d) (2000).

This statute outlines certain prohibited activities:

(c) 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.

(d) It shall be unlawful for any person to conspire to violate any of the provisions of subsection (a), (b), or (c) of this section.

18 U.S.C. § 1962(c)-(d).

Columbia."⁷⁷⁰ Wall Street also alleged that the insurers caused NCCI to file false reports with insurance regulators, and the insurers inflated invoices and sent them to policyholders.⁷⁷¹ These allegations comprise Wall Street's theories of the case—the fraud-on-the-regulators theory and the invoice theory.⁷⁷²

Wall Street sought class certification.⁷⁷³ But the insurers opposed it.⁷⁷⁴ From their collective perspective, Wall Street failed to establish (1) "the adequacy and typicality requirements under [Federal Rule Civil Procedure] 23(a)" and (2) "the predominance, manageability, and superiority requirements of [Federal Rule Civil Procedure] 23(b)(3)."⁷⁷⁵ The district court disagreed and certified the class.⁷⁷⁶ The court explained that Wall Street could establish the causation element through the target wing of the Fifth Circuit's analysis in *Summit Properties Inc. v. Hoechst Celanese Corp.*⁷⁷⁷ Adopting the plaintiffs' fraud-on-the-regulator theory, the district court declared that class members would not have to demonstrate injury using individual proof.⁷⁷⁸

770. *Sandwich Chef of Tex., Inc.*, 319 F.3d at 211.

771. *Id.*

772. *Id.*

773. *Id.* at 213.

774. *Id.*

775. *Id.* Wall Street asserted that

proof concerning the fraud-based RICO claims would necessarily focus on the knowledge of the thousands of employers, brokers, agents, and other insurance personnel who participated in negotiating the insurance programs, and that a trial would consist of evidence concerning thousands of oral and written communications that formed essential parts of these negotiations. Defendants contended that individual issues concerning these communications and the knowledge of each transaction's participants would vastly predominate over any common issues.

Id. Rule 23(b) states,

An action may be maintained as a class action if the prerequisites of subdivision (a) are satisfied, and in addition:

.....

(3) the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. The matters pertinent to the findings include: (A) the interest of members of the class in individually controlling the prosecution or defense of separate actions; (B) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class; (C) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; (D) the difficulties likely to be encountered in the management of a class action.

FED. R. CIV. P. 23(b)(3).

776. *Sandwich Chef of Tex., Inc.*, 319 F.3d at 214-15.

777. *Id.* at 214. In *Summit*, the Fifth Circuit concluded that proximate cause in a RICO fraud case could be established if the plaintiff had either been the target of fraud—the target wing—or had relied on the fraudulent conduct of the defendants—the reliance wing. *Summit Props. Inc. v. Hoechst Celanese Corp.*, 214 F.3d 556, 558-61 (5th Cir. 2000).

778. *Sandwich Chef of Tex., Inc.*, 319 F.3d at 214-15. Pointing to its earlier decision in *Sandwich Chef of Texas, Inc. v. Reliance National Indemnity Insurance Co.*, the district court explained, "Wall Street could meet the requirement of proximate cause by establishing that class members had been injured by regulators' reliance on defendants' misrepresentations and omissions." *Id.* at 214.

In addition, the district court found that Wall Street could establish proximate cause without providing individual proof of reliance by relying on its invoice theory.⁷⁷⁹ From the district court's perspective,

[E]ach class member sustained the same injury: an overcharge caused by an inflated invoice. This was classic mail fraud because defendants knowingly sent policyholders invoices that they knew were higher than the filed rates. Since defendants' records provided all information needed to measure the injury for the class and each class member, the invoice theory did not raise complicating factors that would defeat Rule 23(b)(3) certification.⁷⁸⁰

The workers' compensation insurers appealed the case to the Fifth Circuit, claiming that the federal district judge's grant of class certification was an abuse of discretion.⁷⁸¹ The court of appeals agreed, asserting that the district court's reasoning was legally flawed.⁷⁸² First, the Fifth Circuit observed, "Wall Street and other class members individually negotiated with insurers regarding workers' compensation insurance premiums. A class cannot be certified when evidence of individual reliance will be necessary."⁷⁸³ More importantly, the appellate court declared that Wall Street's "invoice theory d[oes] not satisfy the reliance wing of *Summit* and eliminate individual issues of reliance and causation that w[ould] preclude a finding of predominance of common issues of law or fact."⁷⁸⁴

Finally, the court of appeals held that "the district court erred in concluding that the target theory could be invoked to excuse proof of individual reliance on fraudulent predicate acts. We have applied the target theory narrowly."⁷⁸⁵ Therefore, the Fifth Circuit reversed the district court's ruling, declaring that the "RICO fraud cases must be tried individually."⁷⁸⁶

779. *Id.* at 215.

780. *Id.*

781. *Id.* at 215-16.

782. *Id.* at 220.

783. *Id.* "Claims for money damages in which individual reliance is an element are poor candidates for class treatment, at best." *Patterson v. Mobil Oil Corp.*, 241 F.3d 417, 419 (5th Cir. 2001).

784. *Sandwich Chef of Tex., Inc.*, 319 F.3d at 221.

785. *Id.*; see also *Procter & Gamble Co. v. Amway Corp.*, 242 F.3d 539, 564 (5th Cir. 2001) (referring to the target theory set out in *Summit* as a narrow exception to the rule that in civil RICO claims in which fraud is alleged as predicate act reliance on fraud must be shown).

786. *Sandwich of Tex., Inc.*, 319 F.3d at 224. The court of appeals also stated,

Wall Street and other plaintiffs are entitled to prove at trial that the insurers with whom they contracted to provide workers' compensation insurance defrauded them, in violation of 18 U.S.C. § 1962, by charging premiums that exceeded approved rates. But defendants are equally entitled to defend themselves by offering, for example, evidence that an individual plaintiff, directly or through a broker, negotiated a premium that varied from the filed rate, was aware that the insurer was charging more than what regulators had approved, and therefore was not a victim of fraud.

Id.

VIII. A BRIEF EMPIRICAL ANALYSIS OF THE FIFTH CIRCUIT'S DISPOSITION OF INSURANCE CONTRACT CASES DURING 2002-2003

Without doubt, reporting and critiquing federal and state courts' findings and declarations comprise the bulk of traditional legal scholarship. However, in recent years, legal scholars have increasingly conducted empirical analyses of courts' reported decisions to gain greater insight into inconsistent and questionable rulings that traditional legal analysis often misses.⁷⁸⁷ For example, legal empiricists have discovered that federal appellate courts are often wittingly or unwittingly biased; they are significantly more likely to rule in favor of defendants than plaintiffs, even after controlling for the interplay of other legal and extralegal factors.⁷⁸⁸ But more important, such judicial bias often explains a flood of highly inconsistent, strained, and arguably unfair rulings.⁷⁸⁹

Here, a comprehensive empirical analysis of the Fifth Circuit's 2002-2003 Insurance decisions will not occur.⁷⁹⁰ Quite simply, the court of appeals decided just twenty-four cases.⁷⁹¹ That is an insufficient sample to perform an appropriate statistical analysis to measure a causal connection between insureds' and insurers' win-loss ratio and some selected legal and extralegal variables. However, when coupled with a case-by-case analysis of legal controversies, simple statistics often can enhance one's understanding of obscure rulings and declarations.⁷⁹² Furthermore, an examination of frequencies and percentages can reveal significant and unexpected patterns in judicial opinions. Therefore, the author decided to perform a content analysis

787. See generally Russell Korobkin, *Empirical Scholarship In Contract Law: Possibilities & Pitfalls*, 2002 U. ILL. L. REV. 1033, 1060-64 (documenting a fifteen-year rise in the use of empiricism to study judicial decisions and critiquing the efficacy of and the problems associated with empirical analysis when critiquing courts' disposition of contracts disputes).

788. 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 overwhelmingly in favor of defendants).

789. See generally Willy E. Rice, *Insurance Contracts and Judicial Decisions Over Whether Insurers Must Defend Insureds That Violate Constitutional and Civil Rights: A Historical and Empirical Review of Federal and State Court Declaratory Judgments 1900-2000*, 35 TORT & INS. L.J. 995, 1040-72, 1074-95 (2000) (chronicling inconsistent and biased rulings and reporting that defendants are more likely to prevail in federal and state declaratory judgment actions); 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).

790. See discussion *infra* notes 792-838.

791. See cases cited *supra* note 1.

792. See *infra* Tables A-D.

of the twenty-four cases and report a series of simple descriptive statistics in four tables.⁷⁹³

First, Table A presents frequencies and percentages for some selected demographic characteristics of insurers and insureds that petitioned the Fifth Circuit Court of Appeals for relief in 2002-2003.⁷⁹⁴ Clearly, 58% of the cases originated in Texas, and the remaining commenced in Mississippi and Louisiana—12.5% and 37.5%, respectively. However, nearly 63% of the controversies started in just three federal district courts—the Eastern District Court of Louisiana, the Northern District Court of Texas, and the Southern District Court of Texas.⁷⁹⁵

Table A. Some Selected Demographic Characteristics of Insurance Law Litigants Who Petitioned the Fifth Circuit Court of Appeals for Review — 2002-2003⁷⁹⁶

Demographic Characteristics	Frequencies (N = 24)	Percentages (100.0)
States Where Cases Originated:		
Louisiana	9	37.5
Mississippi	3	12.5
Texas	12	50.0
Federal Districts Where Cases Originated:		
Louisiana-Eastern District	6	25.0
Louisiana-Middle District	2	8.3
Louisiana-Western District	1	4.2
Mississippi-Northern District	2	8.3
Mississippi-Southern District	1	4.2
Texas-Northern District	4	16.7
Texas-Southern District	5	20.8

793. See Glenn A. Phelps & John B. Gates, *The Myth of Jurisprudence: Interpretive Theory in the Constitutional Opinions of Justices Rehnquist and Brennan*, 31 SANTA CLARA L. REV. 567, 588-95 (1991) (performing a content analysis to critique Justices Rehnquist and Brennan's opinions and discovering that both justices rely more heavily on precedents than on other methods to make arguments and reach conclusions); Darrell L. Ross, *Emerging Trends in Correctional Civil Liability Cases: A Content Analysis of Federal Court Decisions of Title 42 United States Code Section 1983: 1970-1994*, 25 J. CRIM. JUST. 501, 506-07 (1997) (employing a content analysis of 3,205 reported decisions and finding an unexpected overrepresentation of jail inmates in the sample).

794. See Table A, *infra* note 796.

795. See *id.*

796. Willy E. Rice, Table A. *Some Selected Demographic Characteristics of Insurance Law Litigants Who Petitioned the Fifth Circuit Court of Appeals for Review — 2002-2003* (2004) [hereinafter Table A].

Texas-Western District	3	12.5
Types of Plaintiffs:		
Insured Corporations	8	33.2
Insured Individuals	6	29.1
Excess Insurers	3	12.5
Assignees	1	4.2
Beneficiaries	1	4.2
Creditors	1	4.2
Joint Venture	1	4.2
Federal Government	1	4.2
Municipal Government	1	4.2
Types of Insurance Contracts		
Comprehensive General Liability	6	25.0
Commercial Property	4	16.7
Officers & Directors	3	12.5
Health/HMO/Medicare	3	12.5
Automobile	2	8.3
Marine	2	8.3
Homeowners/Fire	2	8.3
Life/Workers Compensation	2	8.3
Types of Insurance Complaints:		
First-Party Complaints	10	41.7
Third-Party Complaints	14	58.3

While a variety of persons petitioned the Fifth Circuit for relief, the overwhelming majority were insured corporations (33.2%), insured individuals (29.1%), and excess insurers (12.5%).⁷⁹⁷ In addition, nearly 42% of the underlying cases involved first-party complaints against the insureds, and 58% were third-party complaints.⁷⁹⁸ Of course, the latter percent would explain in part why the majority of appeals concerned disputes over terms, conditions, and exclusions in insurance contracts—comprehensive general liability (25.0%), officers and directors (12.5%), automobile (8.3%), and life and workers' compensation policies (8.3%)—which were purchased for the benefit of third parties.⁷⁹⁹

797. *Id.*

798. *Id.*

799. *Id.*

Table B presents frequencies and percentages for several fairly interesting and relevant variables.⁸⁰⁰ First, petitioners advanced a combination of legal theories.⁸⁰¹ In nearly 67% of the cases, insurers and insureds commenced declaratory judgment actions, asking the courts for declaratory relief.⁸⁰² Approximately 46% of the plaintiffs-insureds filed breach of contract actions.⁸⁰³ And an equal number of complainants filed bad-faith tort and fraud actions against insurers—12.5%, respectively.⁸⁰⁴

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 — 2002-2003⁸⁰⁵

Theories of Recovery, Remedies & Outcomes	Frequencies (N = 24)	Percentages (100.0)
†Petitioners' Legal Theories (Actions):		
Declaratory Judgment Action	16	66.7
Breach of Contract Action	11	45.8
Bad-Faith Tort Action	3	12.5
Fraud/RICO Action	3	12.5
†Remedies Sought:		
Declaratory Relief	16	66.7
Indemnification/Defense	10	41.8
Actual & Punitive Damages	7	29.2
Attorney Fees	2	8.3
Disposition of Cases in Federal District Courts:		
Plaintiffs/Insureds Won	8	33.3
Defendants/Insurers Won	16	66.7

800. See Table B, *infra* note 805.

801. *Id.*

802. See *id.*

803. *Id.*

804. *Id.*

805. Will E. Rice, *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 — 2002-2003 (2004)* [hereinafter Table B].

Disposition of Cases in the**Fifth Circuit Court:**

Plaintiffs/Insureds Won	7	29.2
Defendants/Insurers Won	17	70.8

Litigants' Success-Failure**Rate Before the Fifth Circuit:****Affirmed for Defendants/**

Insurers	12	50.0
-----------------	-----------	-------------

Affirmed for Plaintiffs/

Insureds	2	8.3
-----------------	----------	------------

Reversed Against Plaintiffs/

Insureds	5	20.8
-----------------	----------	-------------

Reversed Against Defendants/

Insurers	5	20.8
-----------------	----------	-------------

† Multiple causes of action appeared in several cases; therefore, the reported percentages can exceed one hundred percent.

Expectedly, plaintiffs sought a variety of remedies in the same lawsuit.⁸⁰⁶ To repeat, about 67% of the plaintiffs asked the court for declaratory relief.⁸⁰⁷ But 42% wanted the Fifth Circuit to declare specifically that insurers had a duty to defend and indemnify insureds.⁸⁰⁸ And in 29% of the cases, complainants asked the court to award both actual and punitive damages.⁸⁰⁹

What were plaintiffs-insureds' and defendants-insurers' win-loss ratios in the district courts and in the Fifth Circuit Court of Appeals? Stated simply, the federal courts exhibited very little sympathy for the insureds-plaintiffs' concerns or legal arguments.⁸¹⁰ The federal district courts' probability of deciding in favor of insurers-defendants was approximately 67%.⁸¹¹ More astounding, on appeal, the insurers' likelihood of prevailing was even greater: The Fifth Circuit decided in favor of the insurers-defendants nearly 71% of the time.⁸¹²

More important, the percentages associated with the last variable in Table B—Litigants' Success-Failure Rate—provide even greater insight into the plaintiffs' and defendants' win-loss ratios in the court of appeals.⁸¹³ First, the

806. *Id.*

807. *Id.*

808. *Id.*

809. *Id.*

810. *Id.*

811. *Id.*

812. *Id.*

813. *Id.*

Fifth Circuit affirmed 50% of the district courts' decisions in favor of the insurers and reversed in favor of defendants nearly 21% of the district courts' pro-plaintiff decisions.⁸¹⁴ On the other hand, the Court of Appeals for the Fifth Circuit affirmed only 8% of the district courts' decisions in favor of the insureds-plaintiffs, while reversing approximately 21% of the district courts' pro-defendant decisions.⁸¹⁵ Clearly, these findings support what other studies have revealed: Federal appellate courts are significantly more likely to decide in favor of defendants than plaintiffs.⁸¹⁶

As mentioned earlier, the small sample size in this study prevents the employment of statistical procedures that would help to answer the question: why are insurers-defendants tremendously more likely to prevail in the district courts and in the Fifth Circuit Court of Appeals than insureds-plaintiffs? The percentages reported in Table C reveals some fairly interesting patterns that might lead to a plausible answer.⁸¹⁷

Table C illustrates the relationships between the dispositions of the insurance-related actions and some selected demographic or background variables among the federal district courts and in the Fifth Circuit Court of Appeals.⁸¹⁸

814. *Id.*

815. *Id.*

816. *Id.*

817. *See* Table C, *infra* note 819.

818. *Id.*

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 — 2002-2003⁸¹⁹

Selected Demographic Variables	Disposition in the District Courts (N= 24)			Disposition in the Court of Appeals (N= 24)		
	Insureds Won	Insurers Won	Percent (100.0)	Insureds Won	Insurers Won	Percent (100.0)
Types of Insurance Complaints:						
First-Party Complaints	40.0	60.0	(N=10)	10.0	90.0	(N=10)
Third-Party Complaints	28.6	71.4	(N=14)	42.9	57.1	(N=14)
Litigants' Domicile (States):						
Louisiana	11.1	88.9	(N=9)	44.4	55.6	(N=9)
Mississippi	33.3	66.7	(N=3)	- 0 -	100.0	(N=3)
Texas	50.0	50.0	(N=12)	25.0	75.0	(N=12)
Federal Districts Where Cases Originated:						
Louisiana-Eastern District	16.7	83.3	(N=6)	50.0	50.0	(N=6)
Louisiana-Middle District	- 0 -	100.0	(N=2)	- 0 -	100.0	(N=2)
Louisiana-Western District	- 0 -	100.0	(N=1)	100.0	- 0 -	(N=1)
Mississippi-Northern District	50.0	50.0	(N=2)	- 0 -	100.0	(N=2)
Mississippi-Southern District	- 0 -	100.0	(N=1)	- 0 -	100.0	(N=1)
Texas-Northern District	50.0	50.0	(N=4)	50.0	50.0	(N=4)
Texas-Southern District	60.0	40.0	(N=5)	- 0 -	100.0	(N=5)
Texas-Western District	33.3	66.7	(N=3)	33.3	66.7	(N=3)

819. 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—2002-2003 (2004) [hereinafter Table C].

Among the controversies decided in the district courts, insureds only had an equal probability of winning (1) if they resided in Texas or (2) if they commenced their actions in either the Northern District Court of Mississippi or in the Northern District Court of Texas.⁸²⁰ Insureds' likelihood of winning increased more substantially, however, when they filed lawsuits in the Southern District Court of Texas.⁸²¹ The reported percentages for insureds and insurers in this latter district court are 60% and 40%, respectively.⁸²²

Of course, as we saw earlier, insureds' probability of winning dramatically decreased in the Fifth Circuit Court of Appeals.⁸²³ But the insureds-plaintiffs had an equal likelihood of prevailing in the court of appeals if their cases originated in the Eastern District Court of Louisiana or in the Northern District Court of Texas.⁸²⁴ Under all other circumstances, the insurers-defendants had a substantially greater likelihood of winning in both the district and appellate courts.⁸²⁵ Whether the insureds commenced first- or third-party complaints or whether they filed cases citing Louisiana, Mississippi, or Texas law, the Fifth Circuit still decided the overwhelming majority of the controversies in favor of the insurers-defendants.⁸²⁶

Finally, Table D presents a comparison of the insurers' and insureds' relative outcomes in the federal district courts and on appellate review in the Fifth Circuit Court of Appeals.⁸²⁷ A careful scrutiny of the percentages in Table D reveals that the Fifth Circuit affirmed in their entirety the findings and conclusions of the following district courts: the Middle and Western District Courts of Louisiana, the Southern District Court of Mississippi, and the Northern and Western District Courts of Texas.⁸²⁸

820. *Id.*

821. *Id.*

822. *Id.*

823. *Id.*

824. *Id.*

825. *Id.*

826. *Id.*

827. See Table D, *infra* note 829.

828. *Id.*

Table D. A Comparison of Insurers' and Insureds' Outcomes in Federal District Courts and on Appellate Review in the Court of Appeals for the Fifth Circuit — 2002-2003 (N = 24)⁸²⁹

Litigants' Outcomes	Outcomes in the Federal District Courts							
	Eastern District of Louisiana (N = 6)	Middle District of Louisiana (N = 2)	Western District of Louisiana (N = 1)	Northern District of Mississippi (N = 2)	Southern District of Mississippi (N = 1)	Northern District of Texas (N = 4)	Southern District of Texas (N = 5)	Western District of Texas (N = 3)
Plaintiffs/Insureds Won	16.7	- 0 -	- 0 -	50.0	- 0 -	50.0	60.0	33.3
Defendants/Insurers Won	83.3	100.0	100.0	50.0	100.0	50.0	40.0	66.7
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Outcomes on Appellate Review in the Fifth Circuit Court of Appeals								
Plaintiffs/Insureds Won	50.0	- 0 -	- 0 -	- 0 -	- 0 -	50.0	- 0 -	33.3
Defendants/Insurers Won	50.0	100.0	100.0	100.0	100.0	50.0	100.0	66.7
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

829. Willy E. Rice, *Table D. A Comparison of Insurers' and Insureds' Outcomes in Federal District Courts and on Appellate Review in the Court of Appeals for the Fifth Circuit — 2002-2003* (2004) [hereinafter Table D].

However, in two instances, the Fifth Circuit reversed the lower courts, which in turn increased the insurers' rate of success.⁸³⁰ More specifically, the Northern District Court of Mississippi decided two cases; the insured prevailed in one and the insurer prevailed in the other one, producing a fifty-fifty split.⁸³¹ However, on appeal, the Fifth Circuit decided both cases in favor of the insurers.⁸³² More revealing, the Southern District Court of Texas decided five cases.⁸³³ Of those, the district court decided 60% and 40%, respectively, in favor of the insureds-plaintiffs and the insurers-defendants.⁸³⁴ But again on appeal, the Fifth Circuit reversed the Southern District Court of Texas's pro-insured decisions and decided all of the controversies in favor of the insurers.⁸³⁵

Only a single instance occurred where a Fifth Circuit's reversal favored the insureds.⁸³⁶ Table D illustrates that the Eastern District Court of Louisiana decided 16.7% and 88.3% of six cases in favor of the insureds and insurers, respectively.⁸³⁷ However, on appeal, the Fifth Circuit reversed some of the Eastern Louisiana District Court's holdings, thereby deciding 50% of the cases in the insureds' favor and 50% in favor of the insurers.⁸³⁸

IX. CONCLUSION

To repeat an earlier observation, the Fifth Circuit decided a wide spectrum of procedural and substantive questions involving insurance law between 2002 and 2003.⁸³⁹ For the most part, the decisions adequately addressed litigants' concerns, and the court of appeals researched the laws of Louisiana, Mississippi, and Texas to reach intelligible and fair conclusions.

On the other hand, far too many of the Fifth Circuit's conclusions evolved out of thin air. This was especially true in controversies involving Texas litigants. The court of appeals either ignored or refused to apply Texas's undisputed principles of insurance law. Instead, the Fifth Circuit created new law and engaged in strained and convoluted analyses to reach, arguably, predetermined results. Once more, such an enterprise does little to garner respect for the court and for its rulings.

But more important, the Fifth Circuit's propensity to ignore settled principles of insurance law can easily cause learned jurists to conclude rightly

830. *Id.*

831. *Id.*

832. *Id.*

833. *Id.*

834. *Id.*

835. *Id.*

836. *Id.*

837. *Id.*

838. *Id.*

839. *See supra* notes 2-14 and accompanying text.

or wrongly that the court is biased against insureds. After all, two-thirds of the actions were declaratory judgment actions, requiring the court to make sound interpretations based on settled principles of law. Yet in two-thirds of the actions, the insurers defendants won. Statistically, the latter result is a very unexpected outcome, one that many other legal researchers have attributed to judicial bias.⁸⁴⁰

840. See *supra* notes 368-70 and accompanying text.