INSURANCE

EIGHT CORNERS RULE PROVIDES THAT AN INSURER'S DUTY TO DEFEND IS DETERMINED BY THE LANGUAGE OF THE INSURANCE POLICY AND A LIBERAL INTERPRETATION OF THE ALLEGATIONS AGAINST THE INSURED

Am. Home Assurance Co. v. United Space Alliance, LLC, ____ S.W.3d ____ (5th Cir. 2004).

FACTS: This case involved an underlying third-party lawsuit arising out of a contract dispute between Hi-Shear Technology Corporation ("Hi-Shear") and United Space Alliance ("United"). United and Hi-Shear were general contractors for the NASA space shuttle program. In 1997, Hi-Shear and USBI Company entered into a contract under which Hi-Shear would provide delay cutter assemblies that are used to deploy parachutes on solid rocket boosters. United assumed the contract from USBI Company in late 1999. Hi-Shear sued United alleging that after the contract was made, United altered the terms of the contract by adding additional work on the part of Hi-Shear without providing additional compensation. United had purchased an insurance policy from National Union Fire Insurance Company of Pittsburgh ("NUFIC") and American Home Assurance Company ("AHAC") and requested that NUFIC and AHAC defend and indemnify United. NUFIC and AHAC both refused.

Both insurance companies filed summary judgments alleging they had no duty to defend Hi-Shear under their respective policies. The District court ruled, sua sponte, that AHAC and NUFIC had a duty to defend against the Hi-Shear action under their respective policies. The district court also held that the issue as to whether AHAC or NUFIC had breached their duty was a question for the jury. At trial, the jury found that AHAC breached the policy and awarded United the following: (1) $307,071 for the amount paid defending against the Hi-Shear suit; (2) $760,000 for future costs to complete the defense of the Hi-Shear suit; and (3) over $900,000 in attorney's fees. The jury found that NUFIC was not liable to United. AHAC appealed.

HOLDING: Affirmed in part, reversed in part, and remanded.

REASONING: The court held that the lower court correctly applied the eight corners rule in determining that AHAC had a duty to defend United under the terms of its policy. The eight corners rule provides that an insurer's duty to defend is determined by the language of the insurance policy and a liberal interpretation of the allegations against the insured, that if true, potentially state a cause of action covered by the policy. In determining coverage the court focused on the factual allegations that showed the origin of the damages rather than on the legal theories alleged. The court also found that the lower court was correct to hold that the exclusions listed in the policy did not preclude AHAC's duty to defend because some of the Hi-Shear allegations against United fell outside of the listed policy exclusions. An insurer must defend when there is at least one cause of action within the policy coverage, and once coverage has been found for any portion of a suit, an insurer must defend the entire suit.

The court held that the lower court correctly applied the eight corners rule in determining that AHAC had a duty to defend United under the terms of its policy.

STATE FARM PUNITIVE DAMAGES REDUCED

Campbell v. State Farm Mut. Auto. Ins. Co., ____ P.3d ____ (Utah 2004).

FACTS: Mr. Campbell was responsible for an automobile accident that disabled one person and killed another. State Farm, Mr. Campbell's insurer, chose not to settle the case, expressly assuring Mr. Campbell and his wife that their assets would not be placed at risk by the negligence and wrongful death suit brought against them. At trial Mr. Campbell was found 100 percent responsible and judgment was entered against him for $135,000, well in excess of the $25,000 coverage provided by Mr. Campbell's policy. State farm refused to pay the amount, suggesting instead that the Campbells put their house up for sale to pay off the judgment.

State Farm did eventually pay the judgment, but the Campbells nonetheless sued State Farm for bad faith. The jury found for the Campbells and awarded them $2,086.75 in special damages, $2.6 million in compensatory damages, and $145 million in punitive damages. The trial judge remitted the amount to $1 million in compensatory damages and $25 million in punitive damages. On appeal, the Utah Supreme Court reinstated the original jury verdict of $145 million in punitive damages. State Farm appealed the decision to the U.S. Supreme Court, which reversed and remanded to the Utah Supreme Court after determining that $145 million violated due process under the 14th Amendment.

HOLDING: Jury award for punitive damages reduced to $9,018,780.75.

REASONING: The US Supreme Court set the guidelines for punitive damage awards in BMW of North America, Inc. v. Gore, 517 U.S. 559 (1999), they include: (1) the degree of reprehensibility of the defendant's misconduct; (2) the disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury and civil penalties authorized or imposed in comparable cases.

With regard to the degree of reprehensibility, the Utah Court noted several measures fashioned by the Supreme court, including whether: "the harm was physical as opposed to economic; the tortuous conduct evinced an indifference to or a reckless disregard of the health or safety of others; the target of the conduct had financial vulnerability; the conduct involved repeated actions or was an isolated incident; and the harm was

the result of intentional malice, trickery, or deceit, or mere accident." Applying these factors to the case at bar, the Utah Court held that State Farm's conduct was in the "economic realm" and included harm beyond economic harm. The Court also held that State Farm was indifferent to the fact that its conduct would cause stress and trauma to the Campbells, that the Campbells were clearly financially vulnerable, that State Farm's defiance and continued assertion of blamelessness strongly suggested that it would not hesitate to repeat its behavior with other insured parties, and that the evidence proved State Farm acted with intentional malice, trickery and deceit.

With regard to the ratio of compensatory damages to punitive damages, the Utah Court noted that although the acts by State Farm were not so particularly egregious as to justify a ratio exceeding single-digits, they also were not so unremarkable as to justify a 1-to-1 ratio. Although the Campbells were awarded substantial noneconomic damages for emotional distress, even the Supreme Court noted that the distress caused by the outrage and humiliation the Campbells suffered from the actions by State Farm, represented the type of conduct that punitive damages were designed to discourage. Thus, in light of the Gore reprehensibility factors, the Utah Court held that a 9-to-1 ratio between compensatory and punitive damages served Utah's goals of deterrence and retribution within the limits of due process.

With regard to comparable civil and criminal penalties authorized or imposed in comparable cases, the Court pointed out that the most relevant civil sanction would have been a $10,000 fine for fraud. Since the Supreme Court, in endorsing a punitive damage award of $1 million, presumably did not feel that a 100-to-1 ratio between that damages award and the fine for fraud offended due process, all the Utah Court could surmise was that due process was violated somewhere between $1 million and $145 million. Thus, the Utah Court saw no basis for holding that a 9-to-1 ratio would offend due process and instituted a punitive damages award of $9,018,780.75.

COURT DENIES ARTICLE 21.55 OF THE INSURANCE CODE PAYMENT OF CLAIMS

Clements v. Minnesota Life Ins. Co., ____ S.W. 3d ____ (Tex. App.—Houston [1st Dist.] 2004).

FACTS: Minnesota Life Insurance issued a policy to Terry Clements. After her divorce and subsequent death, her ex-husband ("Clements"), as the beneficiary, notified Minnesota Life of his claim. Minnesota Life's policy required payment on receipt of proof of the insured's death, and despite receiving proof on August 20, 2001, Minnesota Life failed to pay the claim. Clements subsequently sued Minnesota Life under article 21.55 of the Texas Insurance Code for statutory damages and to recover the insurance policy proceeds. On March 27, 2002, Minnesota Life submitted the policy funds into the trial court's registry.

Clements and Minnesota Life both filed summary judgment motions. Clements's summary judgment motion asserted that he was entitled to the policy proceeds, prejudgment interest, and statutory damages under article 21.55 of the Texas Insurance Code. Minnesota Life's summary judgment motion responded that Clements was not entitled to prejudgment interest or statutory damages. In its order on both parties' cross-motions for summary judgment, the trial court took judicial notice of the summary judgment evidence and found that Clements was not entitled to recover damages under article 21.55 of the Texas Insurance Code, nor was he entitled to recover prejudgment interest or attorney's fees. Both parties appealed.

HOLDING: Affirmed

REASONING: In order to maintain a claim under article 21.55 of the Texas Insurance Code, a party must establish three elements: (1), a claim must be pursued under an insurance policy; (2) the insurer must be liable for the claim; and (3) the insurer must have failed to follow one or more sections of article 21.55 with respect to the claim. Allstate Ins. Co. v. Bonner, 51 S.W.3d 289, 291 (Tex.2001). If a party satisfies these elements, the insurer shall pay the beneficiary a certain amount of statutory damages.

Analyzing the facts under the Bonner elements, the court ruled that, first it was undisputed that Clements made his claim pursuant to an insurance policy. Second, upon receipt of proof of Terry's death, Minnesota Life was liable for the face value of the policy, however, Clements did not establish the third requisite element, that Minnesota Life violated any section of article 21.55 by not paying Clements's claim.

The purpose of interpleader is to allow an innocent stakeholder facing rival claims to let the courts decide who is entitled to the funds.

The court found that Minnesota Life complied with the requirements of article 21.55, thus releasing Minnesota Life from paying damages. Specifically, the court found that Minnesota Life: (1) was faced with conflicting claims to the life insurance policy proceeds (Terry Clements daughter had also filed a claim for the proceeds); (2) promptly and in good faith admitted its liability to pay the proceeds; and (3) filed its interpleader action and tendered the funds into the registry of the trial court. In arriving at its conclusion, the trial court stated that it considered Minnesota Life's interpleader action complied with the "safe harbor" afforded by section 9.301(c) of the Texas Family Code. A stakeholder may interplead funds when it is the subject of conflicting claims such that it is or may be exposed to double or multiple liability. Tex.R. Civ. P. 43. The purpose of interpleader is to allow an innocent stakeholder facing rival claims to let the courts decide who is entitled to the funds and, thus, avoid the peril of acting as judge and jury itself. The trial court correctly rejected Clements claim for statutory damages.

INSURANCE POLICY HAS SINGLE LIMIT OF $1 MILLION DOLLARS

Columbia Casualty Co. v. CP Nat'l, Inc., ____ S.W.3d ____ (Tex. App.—Houston [1st Dist.] 2004).

FACTS: Drs. Doyan and Pearce were employees of CPN, an affiliate of National Emergency Services ("NES"), which was a physician practice management company. Columbia Casualty Company provided NES and CPN with a "Claims-Made Medical Practitioners Policy" for certain professional liability insurance arising out of alleged medical malpractice cases. The underlying lawsuit arose when Howard Flax died from T-cell lymphoma as a result of a misdiagnosis and his wife sued the hospital and doctors, including, Drs. Doyan and Pearce. Pursuant to the Policy, Columbia defended NES, CPN, and Drs. Doyan and Pearce, however a dispute arose concerning the applicable limits of the Columbia Policy. Columbia claimed that the policy expressly provided for a single "per loss event" limit of liability of $1,000,000, whereas NES and CPN argued that the policy afforded a separate $1,000,000 limit each for claims against Drs. Doyan and Pearce, totaling $2,000,000. NES and CPN sought a declaratory judgment, among other claims, regarding the policy limits. Both parties filed for summary judgment and the court granted summary judgment for NES and CPN.
HOLDING: Reversed.
REASONING: Endorsement Number 12 of the Columbia Policy provided, "We agree with you,…liability limits…are amended to include the following: $1,000,000 Per Loss Event. The 'Per Loss Event' limit applies to all Insureds for all Damages to all persons for injuries to one patient." The court found the language in Endorsement 12 was clear and unambiguous. Breaking down the sentence into its logical parts, the per loss event limit applied to all insureds (NES, CPN, Dr. Doyan, and Dr. Pearce) for all damages (any damages sought in the Flax suit) to all persons (Mrs. Flax and the Flax estate) for injuries to one patient (Flax). If the court were to follow NES and CPN's reasoning, Columbia's limits would be meaningless, i.e., if 15 doctors over the course of a week, examined, misinterpreted, mishandled and mis-communicated the results of a patient's x-rays, then 15 limits of liability in the amount of $15,000,000 would be available under the policy for the claims made against 15 doctors. This was not the intention of Endorsement 12.

Columbia also argued that Section III of the Policy's Professional Liability Coverage further supported their position. "The limit of liability stated for 'each claim' is the limit of our liability for all injury or damage arising out of, or in connection with, the same or related medical incident….. This limit applies regardless of the number of persons or organizations who are covered under the policy." Columbia stated that in the instant case, the claims were related medical incidents. NES and CPN, however, argued that the doctors' actions were not causally related to one another and were therefore separate claims. The court looked to its ruling in Am. Physicians Ins. Exch. v. Garcia, 876 S.W.2d 842, 853 n. 21 (Tex.1994), where they held that although a malpractice event may involve numerous independent grounds of negligence that constitute a series of acts, they can still be related and form a single malpractice claim. The court ruled that all the medical incidents in the underlying case involved the same patient, at the same facility, during the same period of time, with regard to the same x-ray, with the same result. Therefore, the medical incidents that formed the basis of the underlying lawsuit were related medical incidents under the plain meaning of the policy. For these reasons, the court reversed the lower court ruling and held that Columbia's total liability under the policy was limited to $1,000,000.

IN INTERPRETING THE CONTRACT THE COURT MUST RESOLVE AMBIGUITY IN FAVOR OF THE INSURED

Royal Maccabees Life Ins. Co. v. James, 134 S.W.3d 906 (Tex. App.—Dallas 2004).

FACTS: This dispute arose out of a group life insurance policy issued by Royal Maccabees ("Royal") for City of Mesquite employees, including Donnie James. Under this policy, an eligible employee could elect coverage in incremental amounts up to $100,000. Plaintiffs contended Donnie James was eligible for, elected, and paid premiums for $100,000 in benefits, however, after James's death, Royal only paid his beneficiary $50,000 and disputed the remaining $50,000. This lawsuit and trial arose out of Royal's denial of the additional $50,000 in benefits for which James had paid premiums (through deductions from his paycheck) for four years and ten months prior to his death. After James's death, Royal refunded the premiums it had collected over the four-year period. Royal contended it had sent a letter requesting additional medical information about Donnie James from a doctor, but had received no response; additionally Royal had never issued approval of the policy increase. Neither the City of Mesquite, nor James's doctor had a copy of the letter requesting medical information. At trial the jury found Royal had breached the contract, violated the Deceptive Trade Practices-Consumer Protection Act, violated the Insurance Code, breached its duty of good faith and fair dealing, and committed fraud. Royal appealed.

The general rules of contract construction govern insurance policy interpretation.

HOLDING: Affirmed.
REASONING: The general rules of contract construction govern insurance policy interpretation. Tex. Farmers Ins. Co. v. Murphy, 996 S.W.2d 873, 879 (Tex. 1999). When ambiguous policy terms permit more than one interpretation, this court has construed the policy against the insurer. State Farm Fire & Cas. Co. v. Vaughan, 968 S.W.2d 931, 933 (Tex. 1998). This is especially the case when the policy terms excluded or limited coverage. Whether a contract is ambiguous is a question of law for the court to decide by looking at the contract as a whole in light of the circumstances present when the contract was entered. Columbia Gas Transmission Corp. v. New Ulm Gas., Ltd., 940 S.W.2d 587, 589 (Tex. 1996).

Donnie James did not receive written approval or disapproval from Royal. This created an ambiguity. In addition, the "Requirements of Good Health" section of the policy provided: If a Certificate holder is eligible for an amount of life insurance in excess of $50,000, he must submit an individual

health application to the Company. However, the application form and the schedule of benefits conflicted with the above language and could be interpreted to provide $100,000 coverage for Donnie James without written approval based on the health application. Another conflicting provision was apparent in the "Commencement of Coverage" and "Eligibility Requirement" sections. "The Commencement of Coverage" requirement stated that one who applied for coverage more than 31 days after the waiting period requirements must submit an individual health application to the Company. The "Eligibility Requirement" section, however, noted that there were no waiting period requirements for existing employees. Thus, Donnie James applied more than 31 days after the waiting period under the Commencement of Coverage requirement, but not under the Eligibility Requirement section.

As demonstrated, there were several conflicting provisions in the contract. Because there was more than one reasonable interpretation of the contract the court resolved the ambiguity in favor of the insured.

CONSUMER CREDIT

PLAINTIFF CAN SUE UNDER TILA EVEN THOUGH CREDITOR DID NOT SIGN CONTRACT

Bragg v. Bill Heard Chevrolet, Inc. 374 F.3d 1060 (11th Cir. 2004).

FACTS: On September 28, 2001, Bragg visited Bill Heard Chevrolet ("Heard") and decided to purchase a new 2002 Chevrolet Silverado truck. On that day, Bragg signed a Standard Purchase Contract ("Contract 1") and two standard Florida Simple Interest Vehicle Retail Installment Contracts ("RISC 1 and 2"). Heard did not sign these documents. Bragg also signed a Bailment Agreement for Vehicle Spot Delivery ("Bailment Agreement"). The Bailment Agreement explicitly incorporated the terms of the purchase contract. On October 1, 2001, Heard contacted Bragg and requested that he sign additional documents. Bragg signed two new Purchase Contracts ("Contracts 2 and 3") and two new RISCs ("RISCs 3 and 4"). All four of these contracts were backdated by Heard to the date of Bragg's first visit. On October 5, Heard assigned RISC 4 to Triad Financial Corporation, and Triad issued payment to Heard. This RISC was the only one signed by Heard.

On November 30, 2001, Bragg filed a class action suit against Heard in state court on five counts, including violations of the Truth in Lending Act ("TILA") and Regulation Z. Heard removed the case to federal district court and moved to dismiss all of Bragg's claims. After numerous motions and amended complaints the district court held that the first two RISCs were never consummated because the relevant agreements contained an unsatisfied condition precedent: specifically, neither party was "bound" until Bill Heard sold either of the RISCs to another lender, and hence no TILA violation occurred. Bragg appealed.

HOLDING: Reversed and remanded.

REASONING: The district court held that Bragg's obligations under the first and second RISCs never arose because they were contingent on Heard's obtaining financing. The court noted that the Purchase Contracts signed by Bragg set forth a condition precedent of financing approval. The Purchase Contracts provided that Heard would agree to sell the designated vehicle provided that the designated financial institution approved Bragg's request for a loan. In addition, the Bailment Agreement incorporated the terms of the Purchase Contracts and stated that it was "pending credit approval of buyer(s) by lending institution and completion of sales transaction."

Bragg contended that the district court erred in holding that no credit agreement was consummated. He maintained that consummation occurred not when title to the automobile passed or when a bilateral contract was formed, but rather when he signed the RISCs. Recently, the Fourth Circuit held that the TILA and consummation can encompass unfunded financing agreements. Nigh v. Koons Buick Pontiac GMC, Inc., 319 F.3d 119, 123 (4th Cir. 2003). When the consumer purchases credit, the consumer can be vulnerable to the lender in that the consumer can be bound to the lending contract at the option of the lender. Bryson of New York, 584 F.Supp. 1306 (S.D.N.Y.1984). Bragg also contended that the relevant Purchase Contracts and Bailment Agreement should not have been considered along with the RISCs because they were not "executed" within the meaning of the applicable Florida case law, as they were never signed by Heard. Bragg also maintained that those agreements were ambiguous, requiring construction against the drafter, Heard. In addition, the RISCs contained the following modification clause: "This contract contains the entire agreement between you and us relating to this contract. Any change to this contract must be in writing and we must sign it."

When the consumer purchases credit, the consumer can be vulnerable to the lender in that the consumer can be bound to the lending contract at the option of the lender.

Even assuming the RISCs contained a condition precedent, consummation does not occur only upon assignment of the loan. Under the district court's interpretation of Florida