

FALL 2011 NEWSLETTER

INSURANCE LAW UPDATE

By Jennifer Kelley

THE FIFTH CIRCUIT

***Charles D. Cook d/b/a Oilfield Servs. v. Admiral Ins. Co.*, No. 10-10722, 2011 U.S. App. LEXIS 17439 (5th Cir. Aug. 19, 2011).**

In *Cook*, MJ Brogdin Consulting Co. (“Brogdin”) retained the services of Charles D. Cook (“Cook”) to deliver casing and oversee its installation in Brogdin’s oil well. During the execution of his work on the project, Cook delivered casing to the drill site, but thereafter made a counting error that caused him to take away more of that casing, as excess, than he should have. This error in turn resulted in the completion of the well at an incorrect depth, shallower than the zone targeted for completion. Consequently, Brogdin incurred increased costs to have the well reworked and casing reinstalled to the correct depth. Cook sued his commercial general liability insurance carrier, Admiral Insurance Company (“Admiral”), seeking a declaratory judgment that Admiral had to (1) defend Cook in any lawsuit brought against him by Brogdin and (2) indemnify Cook for all damages awarded to Brogdin in such a suit. Seeking a determination that it did not owe Cook a defense or indemnity, Admiral filed a motion for summary judgment, which the district court granted. The court reasoned that, because there was no “loss of use” of the Brogdin well, Cook’s acts did not result in “property damage” under the terms of Admiral’s policy, so Admiral had no duty to defend or indemnify Cook.

On appeal to the Fifth Circuit, the court affirmed the summary judgment, but for different reasons. The Fifth Circuit recognized the trial court’s analysis and reasoning regarding “loss of use” and “property damage,” but chose not to address the issue on those grounds. Instead the court noted that the policy excluded coverage for “property damage” to “real property on which you . . . are performing operations if the ‘property damage’ arises out of those operations”; or “property that must be restored, repaired or replaced because ‘your work’ was incorrectly performed on it.” Cook argued that the exclusion was inapplicable because there was a gap between the occurrence and loss of use. The Fifth Circuit disagreed, however, reasoning that there was no suspension of construction activities: “The well was completed to the incorrect depth, i.e., damaged, *while* Cook was ‘deliver[ing] and oversee[ing] the running of casing on [the] well’”. Cook also asserted that the defective work was the removal of casing and the loss of use was to the well, a separate property. Again the Fifth Circuit disagreed, concluding that there was no domino effect of damage to the entire well triggered by Cook’s defective work on one independent working part of the well; rather, Cook’s work was performed during the overall drilling and completion operation of the well and thus caused damage to the entire well when his work was incorrectly performed.

***Citigroup Inc. v. Fed. Ins. Co.*, No. 10-20445, 2011 U.S. App. LEXIS 16316 (5th Cir. Aug. 5, 2011).**

In *Citigroup*, Associates First Capital Corporation (“Associates”) purchased integrated risk policies from ten insurers that provided a total of \$200 million in coverage. The policies were arranged in three layers. The primary policy, issued by Lloyd’s of London (“Lloyds”), provided \$50 million in coverage. Once Associates incurred a covered loss exceeding the \$50 million of primary coverage from Lloyd’s, it could access \$25 million each in excess coverage from two of its excess insurers, known as the “Secondary Layer.” The third layer, provided an additional \$100 million of coverage, and was shared among seven additional insurers.

Citigroup, which acquired Associates, sought coverage from its insurers relating to two actions filed against Associates. Citigroup later entered into a settlement in those actions for \$240 million plus \$23 million in class counsel’s fees and costs, without obtaining the consent of the carriers. Each of the insurers initially denied coverage. However, Citigroup eventually entered into a settlement agreement with Lloyd’s, pursuant to which Lloyd’s paid Citigroup \$15 million of its \$50 million limits of liability in exchange for a release from coverage for the claims. The Secondary Layer and Third Layer insurers (collectively the excess insurers) continued to refuse coverage, and Citigroup filed suit in Texas state court. The district court granted summary judgment in favor of the excess insurers, holding that, per the excess insurers’ policies, their liability to provide coverage did not attach until Lloyd’s paid its full \$50 million limit of liability.

On appeal to the Fifth Circuit, the court affirmed the district court’s judgment, concluding that the following language in the excess insurers’ policies dictated that excess coverage did not trigger until the full policy limits of the primary policy had been exhausted:

(a) All Underlying Insurance carriers have paid in cash the full amount of their respective liabilities, (b) the full amount of the Underlying Insurance policies have been collected by the plaintiffs, the Insureds or the Insureds’ counsel, and (c) all Underlying Insurance has been exhausted.

The Insurer shall only be liable to make payment under this policy after the total amount of the Underlying Limit of Liability has been paid in legal currency by the insurers of the Underlying Insurance as covered loss thereunder.

. . . only after any Insurer subscribing to any Underlying Policy shall have agreed to pay or have been held liable to pay the full amount of its respective limits of liability as set forth in Item 5. (Item 5 stated that the “limit of liability” for the underlying insurer was \$50,000,000.)

. . . in the event of the exhaustion of all of the limit(s) of liability of such ‘underlying Insurance’ solely as a result of payment of loss thereunder.

THE SUPREME COURT OF TEXAS

***Tex. Mut. Ins. Co. v. Ruttiger*, No. 08-0751, 2011 Tex. LEXIS 600 (Tex. Aug. 26, 2011).**

Texas Mutual Insurance Co. involves a workers' compensation claimant, Ruttiger, who claimed he was injured on the job. Texas Mutual's investigation indicated that Ruttiger may have been injured while playing softball, and it filed a denial of the claim after issuing one income benefit payment. While his claim was still pending before the Texas Workers' Compensation Commission—now known as the Texas Department of Insurance, Division of Workers' Compensation referred to hereafter as "DWC"—and before Ruttiger had reached maximum medical improvement, he sued the insurer and adjuster for alleged violations of the Texas Insurance Code and Deceptive Trade Practices Act, and breach of the common law duty of good faith and fair dealing.

On petition to the Supreme Court of Texas, the Court held that claims against workers' compensation insurers for unfair settlement practices may not be made under the Insurance Code, thus eliminating DTPA claims arising under the Insurance Code as well. However, workers can still pursue claims against insurers under the Insurance Code for misrepresenting provisions of their policies. Additionally, seven members of the Court considered whether *Aranda*—case extending the common law action for breach of the duty of good faith and fair dealing to the workers' compensation system—should be overruled. Four justices would hold that *Aranda* should be overruled while three would not. However, because the court of appeals did not reach the issues involving the cause of action for breach of the duty of good faith and fair dealing, the Court remanded the issue for further proceedings.

In addressing Ruttiger's Chapter 541.060 Insurance Code claim for unfair settlement practices, the Court drew on its recent discussion of the relationship between a general statutory cause of action and one in which the statute had a more detailed, specific claims resolution process in *City of Waco v. Lopez*, 259 S.W.3d 147 (Tex. 2008) to find that allowing workers' compensation claimants to bring causes of action for unfair settlement practices under the Insurance Code would significantly undermine the Act which has carefully constructed rights, remedies and procedures. The Court also found that the limited definition of "settlement" in the Act does not fit with the construct of section 541.060. Thus, the Court held that Ruttiger may not assert a cause of action under section 541.060. Further, the Court held that the Legislature did not intend for workers' compensation claimants to have a cause of action under section 542.003—a claim that an insurer failed "to adopt and implement reasonable standards for prompt investigation of claims arising under its policies"—for the same reasons the Court found workers' compensation claimants cannot assert a cause of action under section 541.060.

Notably, the Court did not rule out all Insurance Code claims for workers' compensation claimants. The Court held that claims under section 541.061 for misrepresentation of an insurance policy are not at odds with the dispute resolution process of the workers' compensation system because section 541.061 does not specify that it applies in the context of settling claims. However, the Court then went on to find

that in Ruttiger's case, there was legally insufficient evidence to support a finding that Texas Mutual misrepresented its policy because the "dispute between Ruttiger and the insurer was over whether Ruttiger's claim was factually within the policy's terms—whether he was injured on the job."

With regard to Ruttiger's DTPA claim, the Court concluded that the viability of the DTPA claim depended on the validity of the Insurance Code claims. Thus, because all of Ruttiger's Insurance Code claims failed, he could not recover on his DTPA claim.

TEXAS COURTS OF APPEALS

***Zurich Am. Ins. Co. v. McVey*, 339 S.W.3d 724 (Tex. App.—Austin 2011, pet. denied).**

In *Zurich*, an operations manager for a landscaping company was required to attend a multiday leadership training conference in another city. Along the way, he planned to pick up a coworker who also was required to attend the conference. The route he took overlapped with the route he would have taken if he was traveling to the company's office in his city for his usual morning meeting with work crews. While driving to the coworker's house in a company truck, the manager was killed in a motor vehicle accident. The company's insurer denied benefits for his death. The manager's survivor sought review at the DWC, which found that the manager's death was compensable. The carrier then filed a suit for de novo judicial review of the DWC's decision in district court. The district court granted summary judgment in favor of the manager's survivor.

On appeal, the Austin Court of Appeals upheld the district court's judgment, holding that the manager was acting within the course and scope of his employment at the time of the accident and therefore his death was compensable. In reaching its conclusion, the court explained that the manager's travel did not fall within the coming and going rule because he was traveling in a company-owned truck. The insurer, however, argued that the manager was merely on his way to an alternate work site when he was killed. The court disagreed, stating that the manager was traveling to an overnight conference in a distant city, which was a "significant departure from his daily routine." The insurer emphasized that the manager was on the same road he would drive on when he would go to work on a regular day. The court pointed out, however, that the company encouraged its employees to travel efficiently, so the manager was picking up his coworker. Finally the court noted that it was "mere coincidence" that the routes overlapped.

***McDonald v. Home State County Mut. Ins. Co.*, No. 01-09-00838-CV (Tex. App.—Houston [1st Dist.] Mar. 24, 2011, pet. denied).**

In *McDonald*, McDonald was badly injured in a motor vehicle/pedestrian accident. Rangel, the driver of the insured vehicle, was intoxicated and swerved off the roadway and struck McDonald. McDonald was air flighted to Memorial Hermann hospital in Houston and received extensive medical care. Memorial Hermann filed a

notice of hospital lien. The amount of the lien claim exceeded the amount of Rangel's auto insurance policy provided by Home State.

Subsequently, the attorney for McDonald wrote a multi-page demand letter to Home State setting out the liability facts, the extent of injury, and the amount of medical cost in excess of policy limits. The letter also imposed the following acceptance requirement:

IF [Home State's agent/adjuster] FAILS TO ACCEPT THIS SETTLEMENT OFFER BY 5:00 P.M. ON FRIDAY JUNE 14, 2002, THIS SETTLEMENT OFFER WILL BE DEEMED TO HAVE BEEN REJECTED BY PARAGON INSURANCE GROUP. FURTHERMORE, ANY COUNTER-OFFER SUBMITTED ON BEHALF OF PARAGON INSURANCE GROUP'S INSURED WILL BE DEEMED AS A REJECTION OF THIS SETTLEMENT OFFER.

Home State attempted to comply but the attorney did not return the adjuster's telephone call. The settlement demand was deemed rejected by the attorney and suit was filed. After a jury trial, McDonald was awarded a judgment of almost \$1.4 million. Rangel was defended through trial and appeal by Home State. After appeal, the trial court made a "turnover order" turning over Rangel's claims against Home State to McDonald who then sued Home State to collect the excess judgment.

Home State filed a motion for summary judgment, arguing that the demand letter was defective because it did not offer a "full release" to Home State's insured, Rangel. That is, the demand letter did not recognize the hospital lien, offer to pay the hospital lien, or otherwise give assurance that when the insurance money was paid the insured would be fully released from all liabilities. McDonald replied that the demand letter "implied" a full release because everyone knows that if an insurer pays the money it gets a full release. The trial court declined to infer a full release from the words in the demand letter and granted summary judgment to Home State. McDonald appealed.

On appeal, McDonald again argued that the words of the settlement demand letter implied an offer of a full release to Rangel. To support the argument, McDonald argued that the adjuster knew or should have known that payment of the policy limits would result in a release of the insured. McDonald also argued that the hospital lien was invalid and did not need to be released. The court of appeals rejected the arguments, focusing on the words of the letter rather than the knowledge of the adjuster, stating:

Evidence about the insurers' claims investigation and conduct during settlement negotiations is necessarily subsidiary to the ultimate issue of whether McDonald's demand itself was such that an ordinarily prudent insurer would accept it. [Internal quotation marks omitted.]

Moreover, the failure to mention hospital liens in subsequent correspondence does not indicate that the insurers would not have required

protection from liens in any formal documentation of a settlement—none of the insurers’ communications were framed in the take-it-or-leave-it manner of McDonald’s exploding demand letter. Accordingly, we conclude that in this case there was neither an express nor an implied offer to release the hospital lien in McDonald’s settlement demand.

Thus, the court of appeals did not accept the argument of an “implied” offer of a release and concluded that the demand letter was not adequate to put Home State at risk of payment of the excess judgment. Notably, the Supreme Court of Texas has declined to review this case.