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TEXAS, A LIMITED DIRECT-ACTION STATE?

A recent opinion from the Fort Worth Court of Appeals holds that a third-party claimant can bring a declaratory judgment action against an insurance company seeking to have the insurance company defend and indemnify its insured, even before the underlying tort action is resolved. See *Richardson v. State Farm Lloyds Ins.*, 2007 WL 1018651 (Tex. App. — Fort Worth, April 5, 2007). In this case, State Farm issued a condominium policy to Robert F. Kays. The Richardson plaintiffs alleged that Kays killed their son by rolling over him with Kays' vehicle and that Kays was guilty of negligence for harassing their son and his roommate, trespassing on Richardson's property and disassembling their security equipment. State Farm denied coverage to Kays under the condominium policy relying primarily on the use of a vehicle exclusion. The Richardsons sued State Farm alleging that State Farm had wrongfully denied coverage under Kays' policy and sought a declaratory judgment that State Farm had a duty to defend or indemnify Kays for their claims against him. State Farm filed a plea to the jurisdiction stating that appellants had no standing to litigate whether State Farm had a duty to indemnify or defend its insured, because no relationship existed between State Farm and the Richardsons under Kays' policy, State Farm's duty to indemnify was not ripe for adjudication, and the Richardsons had suffered no injury by State Farm's decision not to defend Kays.

The court examined closely the Texas Supreme Court opinion in *Farmers Texas Cty. Mut. Ins. Co. v. Griffin*, 955 S.W.2d 81, 82 (Tex. 1997), holding that, while the insurer's duty to defend is separate and distinct from the insurer's duty to indemnify, the duty to indemnify may be justiciable before the underlying liability suit is resolved when an insurer has no duty to defend and the same reasons that negate the duty to defend likewise negate any possibility the insurer would have a duty to indemnify. The Fort Worth court also reviewed Texas Rule of Civil Procedure 51(b) regarding joinder which, in part, states: "This rule shall not be applied in tort cases so as to permit the joinder of a liability or indemnity insurance company, unless such company is by statute or contract directly liable to the person injured or damaged." The Richardsons' tort action against Kays had been severed by the trial court from the Richardsons' declaratory judgment action against State Farm. Following the holding in *Griffin*, the Fort Worth court held that a direct action against an insurer by a third-party claimant is permissible, in declaratory judgment form, to seek to have the insurance company defend or indemnify for the conduct of its insured. By this holding, the Fort Worth Court of Appeals has opened up any case in which an insurance carrier denies a duty to defend or indemnify to litigation by the underlying claimant – and has arguably permitted the claimant to sue the defendant's insurer on coverage even without a formal denial. This decision is a significant change in Texas law and may have a measurable effect on the amount of litigation insurers are subject to in this state. State Farm, who ultimately prevailed, has filed an appeal to the Texas Supreme Court.

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INTERPLEADER AND ARTICLE 542.051: *STATE FARM LIFE INSURANCE COMPANY V. MARTINEZ*

Can an insurer be liable for statutory penalties under the Texas prompt-payment statute after it interpleads policy proceeds to which there are rival claimants? The Texas Supreme Court said "no" in February, holding that interpleading the proceeds cut off the insurer's liability for statutory penalties.

In *State Farm Life Insurance Company v. Martinez*, the court considered the effect of State Farm's interpleader of life insurance proceeds on its liability for penalties under Texas Insurance Code Chapter 542. 2007 WL 431043, *1 (Tex. 2007). The events underlying the case surrounded the life of Ed Martinez, who divorced his wife, Linda, after 13 years of marriage in 1994. In their divorce agreement, Ed agreed to make monthly alimony payments to Linda of $5,000 over a ten-year period, for a total of $600,000. His estate was to pay the balance of the alimony if he died before the ten years expired. Ed also agreed to make Linda an irrevocable beneficiary on three life insurance policies, and he could only cancel the policies or change beneficiaries when the unpaid alimony was otherwise covered.

State Farm issued Ed a $500,000 policy that named as beneficiary "Linda Martinez, 41, ex wife, in accordance with divorce decree dated 09-15-94." But on August 1, 2002, Ed signed a State Farm change-of-beneficiary form naming Toni, his current wife, as beneficiary. State Farm refused to process the request and asked for proof that the change complied with the divorce agreement.

Ed died on August 25, 2002 before he was able to respond to State Farm's request. Within a few weeks after his death, State Farm had received three conflicting claims to the policy proceeds: (1) from Ed's daughter, Lisa, on September 2nd; (2) from Linda on September 5th; and (3) from Toni on September 10th. It was not until November 22nd that State Farm filed an interpleader by depositing $506,061 into the court's registry. This amount included the policy proceeds, plus interest and unused premium.

After Toni agreed to hold the policy proceeds in a constructive trust to secure Linda's alimony, the trial court awarded Toni summary judgment and denied Lisa's motion for summary judgment. The court's final judgment ordered State Farm to pay all of the policy proceeds to Toni, with $70,000 to be held in trust. The trust would pay $5,000 per month to Toni for as long as Ed's estate continued to pay the balance of Linda's alimony.

Toni also claimed that State Farm owed her attorney's fees and 18% interest as a penalty for failing to pay her claim within 60 days, as provided by sections 542.058 and 542.060 of the Texas Insurance Code. *Id.* at *1-*2. The 60-day period within which State Farm had to pay Toni's claim expired on November 10, 2002. The trial court assessed 18% penalty interest against State Farm in the amount of $76,520.19, as well as attorney's fees and prejudgment interest.

The court of appeals affirmed the summary judgment against Lisa and the judgment against State Farm. But it assessed penalty interest against State Farm for 274 days, thus reducing that award to $67,500. The court held that the 18% penalty interest should be assessed through the date of final judgment to promote the purpose of the statute. The court of appeals rejected State Farm's argument that penalty interest should be assessed only for the 12-day delay before interpleader. The Texas Supreme Court granted State Farm's petition to review the statutory penalties and attorney's fees assessed against State Farm.

As a preliminary matter, the Supreme Court rejected State Farm's contention that Toni was not covered by the prompt-payment statute

INTERPLEADER AND ARTICLE 542.051: *STATE FARM LIFE INSURANCE COMPANY V. MARTINEZ*, CONT'D

and could not be entitled to the penalties it provided. The court held that Toni became a "beneficiary named in the policy" under the statute when Ed signed and sent his request on State Farm's own printed form. The policy defined a "request" as one written in a form acceptable to State Farm. The policy also provided that the change of beneficiary would take effect when Ed signed a written request. The court concluded that State Farm's concern that Ed's attempt to change beneficiaries might violate the divorce decree did not make the request's form unacceptable. Ed's designation of Toni became effective retroactively as of the date Ed signed the change request, once Linda agreed during the course of the litigation to release her claims on the policy. *Id.* at *3. Noting the legislature's instruction to construe the statute liberally to ensure prompt payment of insurance claims, the court held that Toni was a named beneficiary entitled to prompt payment under the statute.

The court next analyzed State Farm's argument that the prompt-payment statute does not apply when an insurer files an interpleader in response to rival claims. Until 1991, Texas statutes had for many years punished an insurer's failure to pay promptly. The statutes provided generally that, if a life insurance claim went unpaid for 30 days, the insurer had to pay the policy beneficiary attorney's fees and penalty interest of 12%. As the court also pointed out during the same period, Texas common law allowed an insurer faced with rival claims to be discharged from further liability by interpleading the funds and joining the rivals who claimed them. The common law also allowed the stakeholder (insurer) to recover its attorney's fees from the interpleaded funds as long as there were rival claimants and the interpleader was not unreasonably delayed. In situations in which the statutory and common law standards overlapped, Texas courts held that the common law controlled over statute. That is, an interpleader filed within a reasonable time allowed the insurer to avoid statutory penalties regardless of the statutory deadlines.

The legislature modified the prompt-payment statute in 1991, raising the penalty interest to 18% and extending the deadline for payment in most cases to 60 days. Interpleader is not mentioned in either the statute or the legislative history for the 1991 changes.

The court cited three reasons for holding that the 1991 changes abrogated the common-law interpleader exception to the prompt payment statute. First, the court held that the 1991 amendments made substantial changes to the prompt payment statute. The statute clearly requires an insurer to pay statutory penalties, if it fails to pay the policy proceeds within 60 days. The statute makes no exception for interpleader. Second, the court remarked that the prompt payment statutes before 1991 were strictly construed, because they were considered penal in nature. *Id.* at *4. In contrast, the 1991 amendments provide that the statute is to be construed liberally to promote its purpose, and exempting interpleaders is not consistent with a liberal construction of the prompt payment statute. Finally, the court concluded that the statute's safe harbor of 60 days was sufficient to consider the interpleader exception to have been eliminated by the legislature's 1991 amendments.

While the court held that State Farm's interpleader did not affect the applicability of the prompt-payment statute, it further held that assessing penalties after interpleader is not consistent with the statutory and common-law rules. Texas law encourages insurers to interplead funds when faced with rival claims. Insurers thus cannot be punished with penalty interest and attorney's fees after engaging in the very procedure that Texas law sanctions. There is no indication in the 1991 amendments that the legislature intended to discourage interpleaders. Moreover, the statute's intended purpose of getting policies paid quickly is not furthered by paying the wrong party. Interpleader avoids this consequence – and, therefore, advances the statute's purpose – by

INTERPLEADER AND ARTICLE 542.051: *STATE FARM LIFE INSURANCE COMPANY V. MARTINEZ*, CONT'D

allowing courts to determine the proper claimant to whom to pay the proceeds. *Id*. at *5.

The court also commented that treating the interpleader as payment is consistent with its other holdings that the prompt-payment statute's penalties are payable only to those who can recover on the policy and can be assessed only on the amount "ultimately determined to be owed." Where an insurer tenders only part of the policy proceeds, it must pay penalties only on the remainder, unless the ultimate award is less than the tender. The court suggested that these rules support an analogous rule that "an insurer that interpleads the entire policy proceeds owes nothing more, and should not have to pay penalties on the presumption that it does." The court proceeded to hold that the only justification for continuing to assess statutory penalties after interpleader occurs is the absence of rival claims.

The court of appeals apparently rationalized larger penalties, because it believed that State Farm should have changed beneficiaries when it received Ed's written request. The supreme court held that whether State Farm should have added Toni as a beneficiary and whether it should have paid her are different questions. Also, an insurer's right to interpleader is determined under the conditions existing when it is filed, not at some later point in time. *Id*. at *6. Even assuming that State Farm should have changed Ed's beneficiary immediately upon receiving his change-of-request form, State Farm properly filed an interpleader after receiving good faith claims that were adverse.

Accordingly, State Farm owed nothing more on the policy, once it interpleaded the life insurance proceeds. *Id*. at *5. Because State Farm filed its interpleader 12 days after the 60-day prompt-payment deadline had passed, the trial court and the court of appeals erred by awarding penalty interest and attorney's fees for more than those 12 days.

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Carriers Argue Excess "Follow Form" Coverages Are not Bound by Primary Insurer's Policy Interpretation

The Supreme Judicial Court for the Commonwealth of Massachusetts (appellate level) recently solicited *Amicus Curiae* briefing on the issue of whether an excess insurer, having provided a "follow form" excess insurance policy, is bound by the primary insurer's coverage determination. *Allmerica Financial Corp., et al. v. Certain Underwriters at Lloyd's, London* (SJC-09834)[No. 02-2075, 2004 WL 2341388 (Mass. Super., 2004)].

The briefing on the follow form issue was requested after the trial court found Certain Underwriters at Lloyd's, London ("Underwriters"), the excess insurer for Allmerica Financial Corp., et al. ("Allmerica"), was not bound by the interpretation of the policy language given by the primary insurer, Columbia Casualty Insurance Company (CNA). The Underwriters excess policy purchased by Allmerica was a renewal "follow form" policy which incorporated the terms of a renewed CNA primary policy.

Complex Insurance Claims Litigation Association ("CICLA") submitted an *Amicus* brief which argues excess carriers issuing insurance pursuant to a follow form policy are not "bound" by the underlying insurer's interpretation. KeySpan New England, LLC ("KeySpan"), a public utility holding company involved in other coverage litigation in Massachusetts, also submitted an *Amicus Curiae* brief. KeySpan urged the court to recognize that a follow form insurer should, *at least in some circumstances*, be bound by evidence of the primary insurer's intent as to coverage.

The coverage issues arose in 1997 after a class action was filed against Allmerica (the *Bussie* Class Action) alleging improper sales practices by Allmerica's agents. Allmerica settled the *Bussie* Class Action at a substantial cost which reached into the excess layers of insurance. CNA found the *Bussie* Class Action claims to be covered under its primary policy and agreed to pay its policy limits. Upon reviewing the settlement agreement, Underwriters made a different determination regarding coverage.

As a result of Underwriters' determination regarding no coverage, Allmerica filed its breach of contract claim against Underwriters. Underwriters sought dismissal of Allmerica's claims through summary judgment, primarily claiming Underwriters were not bound by CNA's interpretation that the *Bussie* Class Action was within the coverage of the primary policy. In response, Allmerica argued the follow form excess insurer was bound by CNA's interpretation. The issue was one of first impression in Massachusetts.

The trial court agreed with Underwriters, reasoning that the *Bussie* Class Action was only settled as between CNA and Allmerica. Because settlements are negotiated for a variety of reasons, often wholly unrelated to liability: "CNA's concession of coverage in settling the *Bussie* Class Action could just have easily been made for business decision rather than the true application of the policy language. It is contrary to the underlying principles and policies of settlements, arbitrations, and preclusion to bind Underwriters to a decision made between CNA and Allmerica as business entities rather than a determination by a judgment of a court to which Underwriters was a party." *Allmerica Financial Corp., et al.*, 2004 WL 2341388 at *4 (internal citations omitted). The trial court's decision was appealed by Allmerica.

CICLA's *Amicus* brief argued that an excess insurer, by issuing a "follow form" policy, does not "divest itself of its identity and autonomy as an independent insurer." CICLA Brief at 5. This autonomy is based on the lack of direct relationship between the excess carrier and underlying insurers. *Id*. at 6. Moreover, CICLA argued if a primary carrier analyzes the policy terms incorrectly, or makes a coverage decision for business

CARRIERS ARGUE EXCESS "FOLLOW FORM" COVERAGES ARE NOT BOUND BY PRIMARY INSURER'S POLICY INTERPRETATION, CONT'D

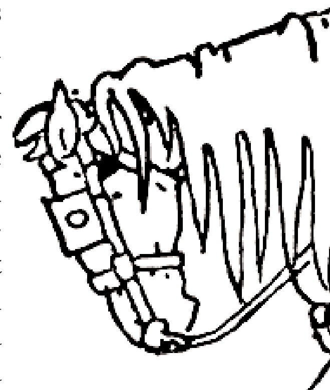
purposes, the excess carrier should not be forced to abide by the primary carrier's incorrect analysis or business decision. *Id.* at 7. CICLA additionally emphasized that an excess insurer's agreements to provide coverage in accordance with the primary policy's *provisions* is not the equivalent of providing coverage in accordance with the primary insurer's *interpretation* of those provisions.

In conclusion, CICLA also argued a primary carrier's "business decision" to settle is irrelevant in determining an excess carrier's duties to the policyholder. *Id.* at 11. CICLA further cited cases to support its argument that settlement by a primary carrier has no binding effect on the excess carrier because the policyholder still has the burden to prove that the primary policy limits have been exhausted properly. This follows a natural, linear analysis, consistent with the recognition that the excess liability insurer has no obligation to participate in the defense until the primary limits are exhausted. *Keck, Mahin & Cate v. National Union Fire Ins. Co.*, 20 S.W.3d 692, 700 (Tex. 2000).

. . .CICLA . . . argued a primary carrier's "business decision" to settle is irrelevant in determining an excess carrier's duties to the policyholder.

KeySpan's Amicus briefing does not take the polar opposite position from CICLA's. Instead, KeySpan argues that *some instances exist* in which the interpretation of the primary insurer should be considered as evidence of the parties' intent in the face of ambiguous policy language. For instance, if the negotiations regarding the decisions to use certain primary policy language provides insight into the policy interpretation, this meaning, "should dictate the obligations not just of the primary insurer, but of the follow form excess insurer as well." KeySpan Brief at 47.

In support of its position, KeySpan offered an overview of *Ford Motor Co. v. Northbrook Ins. Co.*, 838 F.2d 829, 831 (6th Cir. 1988). The court in this case used extrinsic evidence of the negotiations between Ford and its primary insurer to interpret several follow form excess policies. Likewise, KeySpan asserts evidence of the contracting parties' intent in negotiating the terms of the primary policy should be considered when interpreting the excess follow form policy, even if the excess insurer is not involved in the policy negotiations. In particular, KeySpan asserts that not considering such evidence enables an excess insurer to "wear blinders" and advance different interpretation following the negotiations. KeySpan Brief at 49.Based on the trial court's discussion and KeySpan's more limited or moderate arguments, it is anticipated that the Court will not strictly hold an excess insurer, having provided a "follow form" excess insurance policy, to the primary insurer's interpretation of the primary policy — at least where "intent" of the parties is not at issue. However, irrespective of the outcome, excess insurers may want to consider adding language to their policy to reiterate during the "tender of claim" stage, that although the excess policy is "follow form", the excess insurer does not adopt and is not "bound" by the underlying insurer's interpretation of the policy terms, conditions or exclusions.



Argument of the issue occurred on May 8, 2007; to follow the outcome, the Court's website is www.ma-appellatecourts.org/index.php.

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HOW COULD ONE SENTENCE CAUSE SUCH CONTROVERSY?

In a recent opinion, the San Antonio Court of Appeals held that §41.0105 of the Texas Civil Practice & Remedies Code limits a plaintiff from recovering medical expenses that have been adjusted or written off. *Mills v. Fletcher*, ____ S.W.3d ____, 2007 WL 1428883 (Tex. App.-San Antonio, May 16, 2007). The court interpreted the language of this one-sentence statute, written in the 2003 Legislative Session:

> In addition to any other limitation under law, recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant.

TEX. CIV. PRAC. & REM. CODE §41.0105.

The court held that the use of the words "actually paid" or "actually incurred" was intended by the Legislature to limit the plaintiff's recovery to expenses actually paid by the plaintiff or incurred after an adjustment of the healthcare provider's bill. The court also ruled that the statute did not violate substantive due process, did not violate the open court's provision of the Texas Constitution, and was not unconstitutionally vague. The court therefore reversed and remanded the trial court's judgment, which allowed an award of the full amount of the plaintiff's medical expenses.

This is the first reported appellate decision to interpret the language of §41.0105, although another case, *Gore v. Faya*, No. 07-0600218-CV, is currently before the Amarillo Court of Appeals. It will be interesting to see whether other courts of appeal follow the reasoning in the *Mills* decision.

The plaintiffs' bar has generally contended that §41.0105 should be more narrowly interpreted to allow recovery of total amount of medical bills; otherwise, a tortfeasor benefits from the fact that the claimant carried insurance. In fact, in an apparent attempt to satisfy this concern, the 2007 Legislature passed House Bill No. 3281, which would have limited the application of §41.0105 to medical malpractice claims. In other types of personal injury cases, the individual would have been allowed to recover the amount of medical expenses billed, and not solely the amount paid or actually incurred. Proponents of the bill argued that, as currently worded, §41.0105 would abrogate the "collateral source" rule, which prevents a defendant from introducing evidence that an insurance company, rather than an individual, paid all or a portion of the individual's medical bills.

On June 15, 2007, Governor Rick Perry vetoed the bill, noting that the purpose of damages in a civil suit is to make an injured individual whole by reimbursing the actual amount that he or she had been deprived by the defendant's actions, but is not to be used to artificially inflate the recovery by claiming economic damages that were never paid or never required to be paid. With respect to the "collateral source" rule issue, the Governor stated that nothing in §41.0105 allows a defendant to introduce evidence that an insurance company, rather than an individual, paid all or a portion of the medical bills, or hinders an individual's ability to recover the medical bills paid by his or her insurance company. Finally, the Governor indicated his position that §41.0105 does not apply to future medical expenses. Thus, §41.0105, as written in 2003, continues to be the law.

Aside from the issue of how other courts of appeal would interpret the statutory language, another significant question that has not been addressed in a reported decision is how the mandates of §41.0105 should be applied from an evidentiary standpoint. In other words, should adjustments and write-offs of medical bills be addressed before trial, such as in a motion in limine, so that the jury hears evidence of only the amount of medical expenses actually paid or incurred, or should an appropriate reduction be taken by the court post-verdict? The comments of Governor Perry might suggest that only the latter approach is appropriate, because to do otherwise would potentially violate the "collateral source" doctrine. That is, the jury would know that an insurance carrier (or a government program like Medicare or Medicaid) paid the medical expenses, because the total amount of the medical bills would not be considered. On the other hand, defense attorneys can argue that, because the total amount of the bills is irrelevant, the jury should not be allowed to consider this evidence. To allow consideration of the total amount is prejudicial because the award of non-economic damages almost always correlates to the amount of economic damages a plaintiff can prove. This is an issue that is likely to be hotly contested at trial until a more firm body of case law exists interpreting §41.0105.

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