The Weekly Update of Texas Insurance News
TEXAS INSURANCE LAW NEWSBRIEF
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A Service of Martin, Disiere, Jefferson & Wisdom L.L.P.
Principal Office 808 Travis, 20th Floor Houston, Texas 77002 713.632.1700 FAX 713.222.0101
900 S Capital of Texas Hwy, Suite 425 Austin, Texas 78746 512.610.4400 FAX 512.610.4401
16000 N Dallas Parkway, Suite 800 Dallas, Texas 75248 214.420.5500 FAX 214.420.5501

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PAID VS. INCURRED MEDICAL EXPENSES: TEXAS SUPREME COURT HOLDS THAT ONLY EVIDENCE OF RECOVERABLE MEDICAL EXPENSES IS ADMISSIBLE AT TRIAL.

In a paramount decision, the Texas Supreme Court recently held that only evidence of recoverable medical expenses, meaning those expenses, which have been or must be paid by or for the claimant, is admissible at trial. *Haygood v. DeEscobedo*, 2011 WL 2601363 (Tex. July 1, 2011).

The majority opinion, written by Justice Hecht, explains: "Damages for wrongful personal injury include the reasonable expenses for necessary medical care, but it has become increasingly difficult to determine what expenses are reasonable. Health care providers set charges they maintain are reasonable while agreeing to reimbursement at much lower rates determined by insurers to be reasonable, resulting in great disparities between amounts billed and payments accepted." Pursuant to Section 41.0105 of the Texas Civil Practice and Remedies Code, "recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant." In its opinion, Texas Supreme Court further explains that Section 41.0105 limits recovery, and consequently the evidence at trial, to expenses that the provider has a legal right to be paid.

In *Haygood*, a motorist who was injured in an automobile accident filed lawsuit against another motorist involved in accident. The District Court found that the defendant motorist's negligence caused the accident and awarded past medical expenses to Plaintiff in excess of those paid or owed. The court of appeals reversed, holding that section 41.0105 precluded evidence or recovery of expenses that "neither the claimant nor anyone acting on his behalf will ultimately be liable for paying." The Texas Supreme Court granted the injured motorist's petition for review to resolve the conflict between the two courts.

The Supreme Court's decision states: "The benefit of insurance to the insured is the payment of charges owed to the health care provider. An adjustment in the amount of those charges to arrive at the amount owed is a benefit to the insurer, one it obtains from the provider for itself, not for the insured…Thus, 'actually paid and incurred' means expenses that have been or will be paid, and excludes the difference between such amount and charges the service provider bills but has no right to be paid." As to admissibility of evidence, the Court held that since a claimant is not entitled to recover medical charges that a provider is not entitled to be paid, evidence of such charges is irrelevant to the issue of damages. The Court goes on to advise that the collateral source rule continues to apply to such expenses, and a jury should not be told that medical expenses will be covered in

whole or in part by insurance, nor should a jury be told that a health care provider adjusted its charges because of insurance.

FIFTH CIRCUIT DENIES COVERAGE OF $263 MILLION SETTLEMENT

On August 5, 2011, the Fifth Circuit Court of Appeals ruled that five insurers need not cover any part of Citigroup Inc.'s $263 million settlement of a statewide class action suit and a Federal Trade Commission action. *Citigroup, Inc. v. Federal Insurance Co.,* 2011 WL 3422073 (5th.Cir. 2011). The class action and FTC action suits alleged that Citigroup's predecessor, Associates First Capital Corporation, misrepresented the benefits of refinancing to customers regarding policies from primary insurer Certain Underwriters of Lloyd's of London ("Lloyd's") and nine excess insurers. Citigroup settled both cases for $263 million, with $15 million paid to Citigroup by Lloyd's (of its $50 million limits of liability), without obtaining the consent of the excess insurers.

Each excess insurer initially denied coverage causing Citigroup to file suit against them. Citigroup eventually settled with two of the excess insurers and claims against two other excess insurers proceeded to arbitration where they were stayed pending the outcome of Citigroup's case against the other insurers. As to the remaining five excess carriers, the Appeals Court affirmed the district court judgment holding that the five insurers were not required to cover any part of the settlement since the plain language of policies by excess insurers did not attach when Citigroup settled with Lloyd's for less than its policy limits of liability. Hence, the terms of Citigroup's settlement with the Lloyd's did not satisfy the requirements necessary to trigger the excess insurers' coverage.

The Court also held that Citigroup's claims against excess insurer, Twin City, was time barred since Twin City issued a letter effectively denying coverage in April of 2002 and suit was filed by Citigroup in October of 2006. The Court found that Twin City's April 2002 letter contained statements clearly communicating its denial and reasons for the denial even though it did not contain the word "denial."

HARRIS COUNTY COURT DISMISSES INSURANCE CLAIMS ASSERTED BY PLAINTIFFS WHO WERE DEEMED NOT TO BE BENEFICIARIES OF THE INSURANCE CONTRACT

Harris County District Judge Mike Miller granted summary judgment to USAA in a homeowner's policy dispute against plaintiffs represented by The Mostyn Firm in *Schramm, et al v. USAA Texas Lloyd's Company, et al,* Cause No. 2009-33822 (August 2011). Plaintiffs filed suit for breach of contract, insurance code violations and fraud against an insurer claiming they had standing as future owners of an insured property by virtue of a contract for deed. Plaintiffs argued they had equitable title and an insurable interest in the property so as to render them third-party beneficiaries under the insurance contract between the seller and the insurer. However, despite having possession of the property, the Court agreed with the insurer and found the plaintiffs were not third-party beneficiaries since there was no intention on the part of the insurer that plaintiffs benefit under the policy. The insurer further argued since Plaintiffs lacked standing to bring suit under breach of contract theories their claims for Insurance Code violations and bad faith were also without merit. The Court granted the insurer's motion for summary judgment for lack of standing as well as its no evidence motion for summary judgment on fraud claims prior to any depositions on the basis that Plaintiffs were unable to identify a single representation upon which they detrimentally relied. Plaintiffs' suit was dismissed in its entirety.

Editor's Note: MDJW congratulates USAA on this victory in an interesting dispute, involving novel theories of recovery. MDJW attorneys Chris Martin, Andrew Scott, and Tanya Dugas represented USAA in this matter.

GALVESTON FEDERAL COURT GRANTS MOTION FOR LEAVE TO AMEND PLEADINGS, WITH A WARNING THAT *TWOMBLY AND IGBAL* HAVE NOT RADICALLY ALTERED THE HEIGHTENED FEDERAL PLEADING REQUIREMENT AS OFTEN TOUTED BY DEFENDANTS

Cruz v. Allstate Texas Lloyds and Pilot Catastrophe Services, Inc. 2011 WL 3502772 (S.D. Tex., J. Froeschner, Aug. 10, 2011). The United States District Court in the Southern District of Texas in Galveston granted a plaintiff's motion for leave to amend its Complaint on August 10, 2011 allowing the plaintiff to add claims against a newly identified individual adjuster assigned by the Defendants to handle a property damage claim following Hurricane Ike. The crux of Defendants' opposition to the motion was that the factual allegations pleaded in the proposed amended complaint were insufficient to state a claim against the adjuster under the current federal pleadings standard.

In its opinion granting Plaintiff's motion, the Court warned that the Defendants, like many insurance companies and adjusters in similar property damage suits spawned by Hurricane Ike, sought too much protection from the post-*Twombly/Igbal* heightened federal pleading standard. The Court warned that *Twombly* and *Igbal* have not altered the pleading landscape as radically as so often touted by Defendants. According to the Court, the height of the pleading requirement should be relative to the circumstances of the case at hand, including heightened pleading requirements of Rule 9(b). The case before the Court (noting that there are a multitude of others like it on the Court's docket), is a noncomplex, straightforward property damage dispute involving allegations of substandard adjustment practices. In such cases, the Court held that all that need be alleged were "facts that, if proven, could make it reasonably possible for a Texas court to find" that a defendant violated certain provisions of the Texas Insurance Code or engaged in fraudulent behavior.

CORPUS CHRISTI APPEALS COURT HOLDS NO AMBIGUITY IN AN INSURANCE POLICY WHERE THE INSURED MUST PAY PREMIUM AS A CONDITION PRECEDENT TO THE INSURANCE CONTRACT GOING INTO EFFECT

In *Becerra v. Ball d/b/a Ball Insurance Agency*, 2011 WL 3366361 (Tex.App.—Corpus Christi [13th Dist.] 2011), the Corpus Christi-Edinburg Court of Appeals upheld a motion for summary judgment as to Plaintiff's breach of contract claims against defendants because Plaintiff failed to pay the premium for the policy which was a condition precedent for the policy to go into effect. Plaintiff/Appellant Mark Becerra alleged that an employee of the insurance agency failed to obtain an insurance policy on his behalf. Becerra argued that the terms of the contract were ambiguous and that the ambiguity created a material issue of fact as to when payment was due for the premium. The Appeals Court found no ambiguity in the insurance contract and that payment was necessary for insurance coverage to go into effect. Thus, the court overruled Becerra's request to overturn the lower court's dismissal of his breach of contract claims. As to whether the lower court erred in granting motion for summary judgment on Becerra's negligence claim, the appeals court found that summary judgment was improper where the Defendants/Appellees failed to state any grounds in their motion for which summary judgment could be granted. Specifically, they did not provide any relevant law identifying the "standard of

care" or causation requirement or provide any explanation of how the "undisputed facts" conclusively disproved the elements of Plaintiff's negligence claim.

APPELLATE COURT UPHOLDS DISMISSAL OF AN INSURED'S INSURANCE CLAIMS BASED ON A POLICY ENDORSEMENT EVEN THOUGH IT WAS NOT PROVIDED TO THE INSURED IN THE INSURANCE BINDER

On August 4, 2011, the First District Court of Appeals upheld the trial court's grant of final summary judgment in favor of the Defendant/Appellee Certain Underwriters at Lloyd's, London after finding that the policy at issue contained an endorsement precluding coverage for a fire loss where the insured failed to install and maintain a central fire alarm at the insured property. *QB Investments v. Certain Underwriters at Lloyd's, London*, 2011 WL 3359683 (Tex.App.—Houston [1st.Dist] 2011). Plaintiff/Appellant, QB Investments, LLC argued that the endorsement was not included in the insurance binder provided to it before the fire occurred and before it received the actual insurance policy. Citing to Texas case law holding that coverage provided under an insurance binder is based on reference to terms and conditions contained in the standard form policy issued by the insurer at the time the binder is issued, the Court of Appeals found that the protective safeguards fire endorsement was part of the policy when the fire occurred and that Lloyd's was not liable under the policy unless QB Investments demonstrated that it had complied with the terms of the endorsement.

COURT HOLDS INSURER HAS NO DUTY TO DEFEND AN INSURED WHO WAS NOT NAMED AS A DEFENDANT IN THE LAWSUIT AND WHERE THE INSURED DID NOT TENDER THE LAWSUIT TO THE INSURER.

In a case involving insurance coverage questions under a homeowners policy and related extra-contractual claims, a federal court in Dallas, held that an insurer did not have a duty to defend or indemnify the insured for lawsuits that alleged business-related claims, in which the insured was not a defendant, or that the insured did not tender to the insurer. The court also concluded that the insured could not recover based on theories of waiver and estoppel or based on extra-contractual claims. *Safeco Insurance Co. of Indiana v. Hiles*, 2011 WL 3500998 (N.D. Tex., J. Fitzwater, Aug. 9, 2011).

HOUSTON COURT OF APPEALS ORDERS SEVERANCE OF AN INSUREDS' BREACH OF INSURANCE CONTRACT CLAIM FROM THE INSUREDS' PROMPT PAYMENT CLAIM

On August 11, 2011, the Houston Court of Appeals ordered severance of breach of contract claim from extra-contractual claims and prompt payment claim in an insurance dispute. *In re Loya Insurance Co.*, 2011 WL 3505434 (Tex. App.—Houston [1st Dist.] August 11, 2011)

Represented by The Mostyn Firm, Fabian and Martha Jagrup sued Loya for breach of their homeowner's insurance policy, violations of the Texas Insurance Code and its Chapter 542 prompt payment provisions, violations of the common-law duty of good faith and fair dealing, and fraud. Loya then moved to sever and abate the Jagrups' breach of insurance contract claim from their extra-contractual claims. After the Jagrups agreed to sever their breach of contract claim from their extra-contractual claims, except their statutory claim for prompt payment, Loya Insurance Company sought mandamus relief from the trial court's order in which it refused to sever the insureds' prompt payment claim or to abate any of the extra-contractual claims pending

resolution of the breach of contract claim. The Houston Court of Appeals disagreed with the trial court, holding that Jagrups' breach of contract and prompt payment claims present distinct claims therefore severance was appropriate. The Court declined to address Loya's request for abatement, stating that absent any showing of prejudice, discovery and management of separate trials is within the sound discretion of the trial court.

11TH CIRCUIT COURT OF APPEALS FINDS THE INDIVIDUAL MANDATE IN THE OBAMA HEALTHCARE LEGISLATION UNCONSTITUTIONAL

On Friday, August 12, 0211, a federal appeals court in Atlanta struck down the "individual mandate" portion of the Patient Protection and Affordable Care Act. This 2-1 decision by a panel of three judges in the 11th U.S. Circuit Court of Appeals brings the ongoing legal dispute over the constitutionality of the healthcare legislation one step closer to the United States Supreme Court.

In their 207-page majority opinion, Chief Judge Joel Dubina and Circuit Judge Frank Hull found that the "individual mandate" provision of the law, which requires the uninsured to buy health insurance, violates the Constitution because it is beyond Congress' power to regulate such activity. The opinion admonishes that lawmakers cannot require residents to "enter into contracts with private insurance companies for the purchase of an expensive product from the time they are born until the time they die." The Court did find, however, that other provisions of the new law are permissible, including the expansion of Medicaid coverage.

In his lengthy dissent, Circuit Judge Stanley Marcus states that Congress generally has the constitutional authority to create rules regulating large areas of the national economy since Congress' commerce power has grown exponentially over the past two centuries.

Some 26 states, including Florida, Nebraska, Texas, and Utah, have challenged the legislation within the 11th Circuit. The decision contrasts with one by the Appeals Court for the 6th Circuit, based in Cincinnati, which upheld the individual mandate as constitutional. That case has already been appealed to the Supreme Court. Two more federal appeals courts, the 4th U.S. Circuit Court out of Virginia and the 3rd U.S. Circuit Court out of New Jersey, are expected to rule on the constitutionality of the new law before summer is through. It is predicted that Friday's 11th Circuit decision will precipitate an appeal to the United Supreme Court and that most of the merit briefs from the appeals courts should be on file with the Supreme Court by the end of the year.