INSURANCE

SEPARATE LEAKS ARE SEPARATE OCCURRENCES FOR PURPOSE OF INSURANCE POLICY

U. E. Texas One-Barrington, Ltd. v. General Star Indemnity, Co., 332 F.3d 274 (5th Cir. 2003).

FACTS: U. E. Texas One-Barrington, Ltd ("Texas One") owned the Oak Meadow Apartments complex in San Antonio, Texas, which consists of thirty residential buildings, three office buildings, and other facilities. General Star insured Oak Meadow pursuant to a commercial property policy effective from October 21, 1995 to October 21, 1996. During that period Fireman's Fund provided excess coverage pursuant to a commercial excess property policy. Around October 1, 1996, Texas One discovered that several of the buildings had suffered foundation movement and above ground damage. The foundation movement and damage resulted from moisture changes in the soil beneath the foundations. Tests revealed that nineteen buildings in the complex had experienced plumbing leaks. Texas One admitted that it did not know when any of the leaks began. The parties agreed that the leaks existed continuously and repeatedly for more than 14 days prior to discovery of the damage. The parties also stipulated that the leaks under any particular building foundation at the property only affected the foundation of that particular building and did not contribute to the movement of any other building foundation at the property nor did they cause any other plumbing leaks.

In November 1999, Texas One filed suit in Texas state court against General Star and Fireman's Fund for breach of contract arising out of the insurers' refusal to pay on Texas One's claims. General Star and Fireman's Fund removed the case to federal court and moved for summary judgment, arguing, among other things, that each leak was a separate occurrence subject to a separate deductible. Agreeing with the defendants, the motions were granted.

HOLDING: Affirmed.

REASONING: Texas One contended that the district court erred in determining that the damage to each of the nineteen buildings is a separate occurrence under the Fireman's Fund excess coverage policy for which Texas One must pay nineteen deductibles. Texas One argued that although each building was damaged by different leaks, there is still only one occurrence for purposes of the Fireman's Fund policy. Texas One's argument rests upon its contention that all of the leaks can be traced back to defects in the materials and installation of the underground plumbing system.

The court noted that under Texas law, "the proper focus in interpreting 'occurrence' is on the events that cause the injuries and give rise to the insured's liability, rather than on the number of injurious effects." *Ran-Nan, Inc. v. General Accident Ins. Co.*, 252 F.3d 738, 740 (5th Cir. 2001) (quoting *H.E. Butt Grocery Co. v. Nat'l Union Fire Ins. Co.*, 150 F.3d 526, 530 (5th Cir. 1998). In applying this test, the court turned to the precedent set in *Goose Creek Consol. I.S.D. v. Cont'l Cas. Co.* 658 S.W.2d 338 (Tex. App—Houston [1st Dist.] 1983, no writ). The insurance policy in *Goose Creek* stated that a "loss occurrence" referred to "the total loss by perils insured against arising out of a single event." *Id.* at 340. The court held this was the same definition found in the Fireman's Fund policy. In *Goose Creek* the court held that regardless of the presence or absence of a single arsonist, there were two "occurrences" as a matter of law due to "the fact that two fires distinguishable in space and time occurred and that one did not cause the other." *Id.* at 341. Similarly, Texas One's property experienced multiple leaks distinguishable in space and time. It is true that the leaks, which independently damaged the nineteen buildings, arose from the same event. This does not, however, mean that each foundation movement was not a separate occurrence.

STATE LAW REQUIREMENTS THAT HMO OR INSURER ACCEPT OUT-OF-NETWORK HEALTH-CARE PROVIDERS IS NOT PRE-EMPTED BY ERISA

Ky. Ass'n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471 (2003).

FACTS: Plaintiff, health maintenance organizations, contracted with selected doctors, hospitals, and other health care providers to create exclusive "provider networks" in order to control the quality and cost of health-care delivery. Kentucky enacted two "Any Willing Provider" ("AWP") statutes, which required that HMOs or insurers accept out of network healthcare providers.

Plaintiff sued the Commissioner of Kentucky's Department of Insurance, claiming that the AWP statutes were trumped by the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA pre-empts all state laws relate to an employment benefit plan. Nevertheless, ERISA saves from pre-emption state laws that regulate insurance. The district court held that each of Kentucky's AWP laws regulates insurance and was, therefore, saved from pre-emption by § 514(b)(2)(A) of ERISA. The Sixth Circuit affirmed, holding that Kentucky's AWP laws regulated insurance as a matter of common sense, because they were specifically directed toward "insurers" and the insurance industry.

HOLDING: Affirmed.

REASONING: For a state law to be deemed a "law which regulates insurance," saved from preemption under ERISA, that law must be specifically directed toward entities engaged in insurance and it must substantially affect risk pooling arrangement between insurer and insured. Employee Retirement Income Security Act of 1974, § 514(b)(2)(A). Not all state laws "specifically directed toward" the insurance industry, however, will be covered by this provision, which saves laws that regulate insurance, not insurers. Rather, insurers must be regulated "with respect to their insurance practices." *Rush Prudential HMO, Inc. V. Moran*, 536 U.S. 355, 366 (2002).

Plaintiff argued that the Kentucky AWP statutes were not specifically directed toward insurers because they regulated not only the insurance industry but also doctors who sought to form and maintain limited provider networks with HMOs. The

Court disagreed with plaintiff, noting that neither of Kentucky's AWP statutes imposes any prohibitions or requirements on health-care providers. Kentucky health care providers are capable of entering into exclusive networks with insurers who are otherwise not covered by Kentucky's AWP statutes.

Plaintiff also argued that Kentucky's AWP laws fall outside section 514(b)(2)(A)'s scope because they do not regulate an insurance practice but focus upon the relationship between an insurer and third-party providers. Again, the Court disagreed with plaintiff, stating that state laws do not need to alter or control the actual terms of insurance policies to be deemed laws which regulate insurance under 514(b)(2)(A). It is sufficient that the laws substantially affect the risk pooling arrangement between insurer and insured. Because the AWP statutes had the effect of prohibiting Kentucky insurers from seeking insurance from a closed network of health-care providers in exchange for a lower premium, the statutes substantially affected the type of risk pooling arrangements that insurers could offer. Therefore, Kentucky's AWP statutes regulate insurance and are not preempted by ERISA.

AN AMBIGUITY DOES NOT ARISE IN A CONTRACT MERELY BECAUSE THE PARTIES ADVANCE CONFLICTING CONTRACTUAL INTERPRETATIONS

Phillips Petroleum Co. v. St. Paul Fire & Marine Ins. Co., 465 S.W.3d 933 (Tex. App.—Houston [1st Dist.] 2003).

FACTS: Phillips Petroleum Company contracted to hire H.B. Zachry Company to perform work at several Phillips facilities. Under the terms of the contract, Zachry agreed to obtain insurance coverage and to name Phillips as an additional insured on the policies. Zachry purchased an insurance policy from St. Paul Insurance Company, which carried a bodily-injury liability limit of $1 million per event.

Following an explosion at a Phillips's facility, injured Zachry employees and the estates of deceased employees sued Phillips. Phillips demanded that St. Paul provide Phillips with a defense, which St. Paul did until the $1 million limit had been spent. Phillips then sued St. Paul for breach of contract and sought a declaratory judgment that St. Paul owed Phillips an unlimited defense to the lawsuits and indemnity up to the liability limits of the policy.

St. Paul filed a motion for summary judgment, arguing that because the policy was a "fronting" policy, a policy in which the amount of deductible payable by the insured equals the amount of liability limits, and because Zachry was obligated to reimburse St. Paul for all expenses incurred in the defense of a claim, St. Paul owed no further obligation to Phillips once St. Paul expended $1 million. The trial court granted summary judgment in favor of St. Paul, and Phillips appealed.

HOLDING: Affirmed.

REASONING: Insurance contracts are subject to the same rules of construction as ordinary contracts. Potential ambiguity is a question of law for courts to decide by looking at a contract as a whole in light of the circumstances present when the contract was entered. An ambiguity does not arise merely because the parties advance conflicting contract interpretations. *Kelley-Coppedge, Inc. v. Highlands Ins. Co.*, 980 S.W.2d 462 (Tex. 1998). A contract term can be considered ambiguous only when, after applying the applicable rules of construction, the term is susceptible of two or more reasonable interpretations.

Phillips argued that because St. Paul did not indemnify Phillips for any "judgments, settlements, or medical expenses" in the initial $1 million expenditure, the policy's duty to defend language obligated St. Paul to continue to pay defense costs and indemnify. However, the court could not construe this term of the policy in isolation; rather, it considered all of the terms of the policy within the context of the entire policy and by referencing the original agreement between Phillips and Zachry.

A contract term can be considered ambiguous only when, after applying the applicable rules of construction, the term is susceptible of two or more reasonable interpretations.

The original Phillips/Zachry agreement did not specify the type of insurance Zachry was required to obtain, so Zachry's "fronting" policy sufficed. Moreover, even if the Phillips/Zachry agreement required 'traditional' general commercial liability insurance, St. Paul was not obligated to provide 'traditional' insurance by referring to the additional insured as one 'required by contract' in the policy.

The court was required to give effect to all provisions of the policy, so that none would be rendered meaningless. Had the court applied the construction of the policy terms as urged by Phillips, it would have rendered the terms of the deductible endorsement meaningless with regard to St. Paul's obligations to Phillips while simultaneously leaving them valid and enforceable with regard to St. Paul's obligations to Zachry.

To be legally binding, a contract must be sufficiently definite in its terms so that a court can understand the parties' obligations. The policy in question did not demonstrate that Phillips, as an additional insured, was owed an unlimited defense by St. Paul against the underlying lawsuits until St. Paul exhausted its policy liability limits by indemnifying Phillips for damage payments. The court found that because the policy was a "fronting" policy and Zachary was obligated to reimburse St. Paul for all claims expenses, St. Paul owed no further obligation to Phillips once St. Paul expended $1 million in defense.

COURT DID NOT ABUSE ITS DISCRETION IN CERTIFYING CLASS

INSURANCE CLASS DEFINITION MODIFIED BY APPELLATE COURT

Citizens Ins. Co. of America v. Daccach, 105 S.W.3d 712 (Tex. App.—Austin 2003).

FACTS: Plaintiff Dr. Fernando Hakim Daccach brought suit against Citizens Insurance Company ("Citizens") for selling securities from Texas without complying with the registration requirements of the Texas Securities Act. Citizens was in the business of selling life insurance policies to non-residents of the United States. These policies ("CICA policies") all allowed for dividend assignment to offshore trusts. The trusts used these dividends to buy common stock in Citizens Inc.

Daccach was designated a class plaintiff, based on allegations Citizens was liable for being an unregistered securities dealer and avoiding any regulation for the investment feature of the policies. The class members sought statutory rescission of the policy, or statutory damages, if they had already cancelled their policies. The trial court denied a summary judgment motion from Citizens, ruling that there was an issue of fact as to whether the CICA policies were securities under the Securities Act. The court granted Daccach's motion to certify the class after a four-day hearing. Citizens brought an interlocutory appeal arguing that the trial court abused its discretion in certifying the class because the court's definition failed to presently and precisely ascertain the proposed class. Citizens, further argued that certification should be reversed because none of the class certification requirements of Texas Rule of Civil Procedure 42 were met.

HOLDING: Affirmed.

REASONING: Rule 42 requires that members of a class be presently ascertainable by reference to objective criteria. *Intratex Gas Co. v. Beeson*, 22 S.W.3d 398, 408 (Tex. 2000). The certification at bar "specifically excluded from the Class" any persons that did not surrender their CICA policies or take other action to get court awarded relief within the time period established by the judgment. Citizens argued that this set up a fail-safe class, dependent upon a judgment in favor of the plaintiffs, and that those to be bound by the judgment would only be ascertainable following a favorable judgment to the plaintiff. The court held that the class included any person that assigned dividends and other benefits to the offshore trust, and these people could be objectively ascertainable from the records of the defendant.

On appeal, the court also held that in the event of a favorable plaintiff judgment, the exclusionary language would simply allow individual members of the class to keep their policies and not seek relief. In the event of a judgment favorable to the defendant, all class members would still be bound and could not assert a later individual action. The court noted an appellate court can redefine a class for clarity, so long as the previous class definition was not fundamentally flawed. The court altered the certification language to "specifically excluded from the remedy," rather than from the Class, to make it clear that this was not a post-judgment opportunity to opt out of the class.

Under Rule 42, for a class to be certified, it must meet certain requirements including numerosity, which means that the class is so numerous that the joinder of all members is impracticable. Requirements of predominance must also be met, which means that the common issues must predominate over individual ones. Citizens argued that in the event no member surrendered their policy after judgment, the class would fail the numerosity requirements. The court rejected this, noting that numerosity in the action was based on the number of members that had not opted out by the notice deadline, not after judgment. The court further held that the issue of whether the Securities Act was violated was a controversy and that this common issue predominated the class. Because the trial court followed the guidelines of Rule 42, the court held that the trial court did not abuse its discretion in certifying the class.

TEXAS SUPREME COURT HOLDS GENERALLY ACCEPTED MEANING OF "TEMPORARY SUBSTITUTE" VEHICLE DOES NOT INCLUDE TAKING A VEHICLE WITHOUT AT LEAST A REASONABLE BELIEF OF ENTITLEMENT TO ITS USE

Progressive County Mut. Ins. Co. v. Sink, ___S.W.3d ___ (Tex. 2003).

FACTS: Joshua McCauley's ("McCauley") pickup truck became disabled. McCauley borrowed a vehicle from his employer Alamo Rent-A-Car ("Alamo"), without obtaining prior permission to use the car and without any belief that he had permission to use the car he took. While using the vehicle, McCauley was involved in an accident with Paul Sink ("Sink").

Sink sued McCauley and obtained a judgment that was subsequently discharged in bankruptcy. Sink then commenced an action against Alamo, claiming he was a third-party beneficiary of the driver's policy and seeking benefits under that policy's liability coverage. The liability coverage section provided that Progressive would pay "damages for bodily injury or property damage for which any covered person became legally responsible because of an auto accident." The policy contained a broad exclusion that also precluded coverage for any person who used a vehicle without a reasonable belief that he had permission to do so but that exclusion did not apply to an insured or an insured's family member who used "your covered auto." The policy's definition of "your covered auto" referenced to a "substitute" vehicle.

Unlike the former standard form policy, the Texas Auto Policy ("TPAP") at issue adopted by the State Board of Insurance ("Board") did not expressly define "temporary substitute automobile" and did not say that any temporary substitute had to be used "with permission of the owner."

The trial court determined that the Alamo vehicle was not a covered vehicle under the policy because it was taken without permission. The court of appeals, however, concluded that a vehicle used by an insured or an insured's family member as a temporary substitute for another vehicle that is "out of normal use" is covered, even if used without permission of the owner.

HOLDING: Reversed.
REASONING: To determine whether the Board's deletion of a definition for "temporary substitute automobile" changed the scope of the coverage, a court must assess the ordinary meaning of the words to the general public, and, in light of this meaning, conduct an examination of the choice the purchaser had and the choice he made. The generally accepted meaning of "temporary substitute" vehicle is that it is a vehicle used with the owner's permission, or at least a reasonable belief that the owner consented. The Board's change in the exception paragraph was intended to "avoid 'proof problems' when a family member uses a covered auto without express permission," and not to "include stolen vehicles within the meaning of 'temporary substitute.'" The coverage exclusions evidenced the unwillingness of Progressive to cover a person driving a vehicle without a reasonable belief of entitlement.
DISSENT: The purpose of the new TPAP was to clarify and remove any permission requirement for an insured's "covered auto." "If an exclusionary clause in an insurance contract is ambiguous, a court must 'adopt the construction…urged by the insured as long as that construction is not unreasonable, even if the construction urged by the insurer appears to be more reasonable or a more accurate reflection of the parties' intent." Because under similar circumstances, courts have held that permission is not required under the insurance contract unless the insurance policy explicitly contained such a requirement, the interpretation urged by Sink was not unreasonable.

The Board's intent may have been to exempt all "covered autos," including temporary substitute autos, from the permission requirement to avoid proof problems for liability purposes. Coverage should have applied under the circumstances presented in this case.

MISCELLANEOUS

SUPREME COURT LIMITS PUNITIVE DAMAGES

COURT APPROVES SINGLE DIGIT MULTIPLES AS LIMITATION ON PUNITIVE DAMAGES

State Farm Mut. Auto. Ins. Co. v. Campbell, 123 S. Ct. 1513, 155 L. Ed. 2d 585 (2003).

FACTS: While driving, Campbell passed six vans traveling ahead of him on a two-lane highway by crossing into the opposite lane of traffic. An approaching motorist swerved onto the shoulder to avoid hitting Campbell's vehicle, lost control of the car, and collided with another vehicle. One motorist was killed and the other permanently disabled; Campbell was not injured.

In the ensuing wrongful death and tort action, Campbell's insurance provider, State Farm Mutual Auto Insurance Company, declined offers to settle within the $50,000 limit of Campbell's policy ($25,000 per claimant) and contested liability. State Farm ignored the advice of one of its investigators and assured Campbell that he would not be found liable for the accident. However, the jury found Campbell to be at fault and awarded a $185,849 judgment. State Farm initially refused to pay the excess liability, but relented five years later and agreed to pay the full judgment.

After State Farm relented, Campbell filed a complaint against State Farm, alleging bad faith, fraud, and intentional infliction of emotional distress. The trial court granted summary judgment for State Farm, but the appellate court reversed. On remand, the trial court denied State Farm's motion to exclude evidence of alleged conduct in unrelated cases that occurred outside of the state. State Farm requested a bifurcated trial and the court granted their request. In the first phase of the trial, the jury concluded that State Farm's decision not to settle the wrongful death and tort actions was unreasonable because there had been a substantial likelihood of a verdict in excess of the policy limit. In the second phase of the trial, the jury awarded Campbell $2.6 million in compensatory damages and $145 million in punitive damages, which the trial court reduced to $1 million and $25 million, respectively. Both parties appealed, and the Utah Supreme Court reinstated the $145 million punitive damage award. State Farm petitioned the United States Supreme Court for certiorari, and it was granted.
HOLDING: Reversed.
REASONING: Although States do possess discretion over the imposition of punitive damages, there are procedural and substantive constitutional limitations on these awards. *Cooper Industries, Inc. v. Leatherman Tool Group, Inc.*, 532 U.S. 424 (2001). For example, the Due Process Clause of the Fourteenth Amendment prohibits grossly excessive or arbitrary punishment of a tortfeasor. To determine what punishments are reasonable and proportionate to the wrong committed, courts must consider three guideposts: (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 awarded; and (3) the difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases. *BMW of North America v. Gore*, 517 U.S. 559 (1996).

The court clarified the first guidepost, stating that reprehensibility must be determined only from conduct that actually harmed the plaintiff. Therefore, a defendant should not be punished simply for being an unsavory individual or business. Furthermore, a state cannot award punitive damages to condemn a company for national deficiencies, nor punish a defendant for conduct that may have been lawful where it occurred.

Although the court declined to establish a bright-line ratio indicating the allowable extent of disparity between punitive and compensatory damages, it noted that few awards exceeding a single-digit ratio between the two are allowable. A punitive award of more than four times the amount of compensatory damages probably lies close to the line of constitutional impropriety. *Pacific Mut. Life Ins. Co. v. Haslip*,