The Weekly Update of Texas Insurance News

TEXAS INSURANCE LAW NEWSBRIEF

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FIFTH CIRCUIT HOLDS EXCESS LIABILITY COVERAGE WAS NOT TRIGGERED DESPITE PRIMARY CARRIER'S POLICY LIMITS TENDER

Recently, the Fifth Circuit evaluated a primary liability carrier's "tender" of its limits for covered claims and whether such a tender triggered the excess liability coverage. In *Service Corp. Int'l v. Great Am. Ins. Co. of New York*, 2008 WL 280900 (5th Cir. February 1, 2008), a funeral services company (SCI), with cemeteries throughout the United States, was sued by individual and class action plaintiffs for grave desecrations and improper burials at two specific cemeteries. Some, but not all, of the events underlying the lawsuits occurred between the policy period. SCI was covered by a $25 million primary liability insurance policy and a $50 million excess liability policy.

As the lawsuits were pending against SCI, the primary carrier determined that its covered claims would likely exceed its policy limit for the policy period. The carrier then tendered $25 million to SCI in exchange for an indemnity and hold harmless agreement as to the policy. The lawsuits settled for $100 million, but only $13.75 million was allocated to claims arising during the policy period.

SCI requested coverage from its excess liability carrier, but coverage was denied. The excess carrier argued since only $13.75 million was allocated to the policy period (and not the complete $25 million limit which had been tendered), the excess layer of coverage had not been triggered. In response, SCI filed suit against the excess carrier. The district court granted summary judgment in favor of the excess carrier.

On appeal, the Fifth Circuit noted the excess policy incorporated the primary policy's definition of "loss," which was "those sums actually paid *in the settlement or satisfaction of a claim* which the insured is legally obligated to pay as damages of injuries or offense." Thus, the Fifth Circuit concluded the parties intended any loss to be measured by the suns used for payment of covered claims during the policy period, not simply by the aggregate sums paid by the insureds. As such, the insured's own allocation was used by the Court to determine the excess liability policy had never been triggered.

APPELLATE COURT HOLDS LATE NOTICE OF OCCURRENCE DID NOT PREJUDICE INSURER AND BENEFITS WERE OWED

Last Thursday, the Houston First Court of Appeals ruled a claim which was filed nearly three years after the occurrence, although untimely, did not prejudice the carrier and triggered benefits under the policy. In

Nat. Family Care Life Ins. Co. v. Vann, 2008 WL 339686 (Tex. App.—Houston [1st Dist.] February 7, 2008), the insured purchased a "heart attack and cancer supplement" policy from the carrier. The insured did not tell anyone (including his spouse) about the policy and the carrier did not send any statements. After being hospitalized and diagnosed with cancer, the insured was unable to communicate and finally died leaving behind his 79 year old spouse.

After the insured's death, it was later discovered the carrier continued to collect premium payments for the policy. The deceased insured's family subsequently contacted the carrier to inquire about the premium payments and to submit a claim. The carrier immediately ceased its automatic withdrawals and ultimately denied the claim due to late notice.

Citing to a recent Texas Supreme Court case *PAJ, Inc. v. Hanover Ins. Co*., 2008 WL 109071 (Tex. January 11, 2008)(and reported in the *MDJW Insurance Newsbrief* on January 14, 2008), the Houston appellate court noted "an insured's failure to timely notify its insurer of a claim or suit does not defeat coverage if the insurer was not prejudiced by the delay." Here, the carrier did not present any evidence of prejudice to it due to the late notice and, therefore, the court held it was obligated to pay benefits to the insured's spouse under the policy.

CHANGES TO MEDICARE LAW COULD AFFECT PERSONAL INJURY CLAIM SETTLEMENT PRACTICES

Recently passed federal legislation (dealing in part with the Medicare Secondary Payer Act or MSPA) could impose civil fines up to $1,000 per day for businesses that do not report certain settlements with "Medicare beneficiaries." Starting July 1, 2009, general liability insurers (among others) will be required to provide the Secretary of Health and Human Services (HHS) with details of "any settlement" involving a Medicare recipient. HHS has been charged with working out the details for reporting requirements. There are still many questions that need to be answered about this new federal legislation, but it appears that general liability insurers will have no alternative but to also comply with the MSPA. Such compliance will create significant notice problems and compliance problems for litigants in any civil suit involving personal injuries and covered by certain types of liability insurance. The next 14 months will be very interesting as the interested parties try to work through the logistical problems created by this new federal legislation. We will continue to monitor and report on this new federal requirement impacting liability insurers.

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