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, Suite 1800 Houston, Texas 77002 713.632.1700 FAX 713.222.0101
111 Congress Avenue, Suite 1070 Austin, Texas 78701 512.610.4400 FAX 512.610.4401
900 Jackson Street, Suite 710 Dallas, Texas 75202 214.420.5500 FAX 214.420.5501

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TEXARKANA COURT FINDS THAT PLAINTIFF SUFFFERED NO DAMAGES AND REVERSES $350,000 JUDGMENT AGAINST MEDICAL MALPRACTICE INSURER FOR NOT RENEWING A POLICY

Last Wednesday, the Texarkana Court of Appeals reversed a trial court judgment against a medical malpractice insurer, finding that the insured surgeon suffered no damages as a result of the non-renewal of his policy. In *The Medical Protective Company v. Herrin*, 2007 WL 2848856 (Tex. App.—Texarkana, October 03, 2007), The Medical Protective Company appealed from a trial court judgment awarding its former insured Dr. Bob J. Herrin $350,000 in damages plus attorneys' fees. The Medical Protective Company was Dr. Herrin's former medical malpractice carrier. The company settled a malpractice case against Dr. Herrin in 1996 for $300,000. Herrin alleged that the company promised the settlement would not cause cancellation or non-renewal of his policy. The company renewed Herrin's policy in 1997, but did not renew the policy in 1998 due to the high frequency and severity of claims against his policy. Herrin was able to find replacement coverage with Frontier Insurance for the next three years. However, Frontier then left the Texas market and Herrin was unable to find adequate coverage, forcing him to retire. Herrin alleged that The Medical Protective Company's non-renewal in 1998 caused him to retire prematurely and thus suffer damages.

The Texarkana Court determined that even assuming the jury correctly decided that The Medical Protective Company violated the Texas Deceptive Trade Practices Act ("DTPA") and defrauded Dr. Herrin, the judgment was in error because Herrin suffered no damages. With regard to the DTPA claim, the court found that Herrin's claim for mental anguish was not supported by legally sufficient evidence. Herrin had testified at trial that the 1998 non-renewal made him feel "terrible" and "tremendously upset" and that after the non-renewal, he could no longer get his work done as easily and the work was no longer pleasant. However, he admitted that he did not seek professional psychiatric assistance or receive any medication for his alleged mental anguish. The court found that this testimony could not support an award for mental anguish because it showed "nothing more than mere worry, anxiety, vexation, embarrassment, or anger." Similarly, with respect to Herrin's fraud claim, the appellate court also found that the award was not supported by the evidence. The Texarkana court noted that there was no evidence that Herrin suffered any injury as a result of relying on The Medical Protective Company's alleged promise that his assent to the settlement of the malpractice lawsuit would not cause cancellation or non-renewal of his policy.

FEDERAL DISTRICT COURT IN DALLAS DECLINES TO ABSTAIN FROM DECIDING DECLARATORY ACTION, DENIES MOTION FOR MORE DEFINITE STATEMENT, AND DENIES MOTION TO JOIN INSURANCE AGENT IN COVERAGE SUIT.

Recently, a Federal District Court in Dallas declined to abstain from deciding a declaratory action brought by Employers Mutual Casualty Company ("EMC") and EMCASCO Insurance Company ("EMCASCO") to determine coverage for a third party claim brought against its insured, Juan Miguel Bonilla ("Bonilla"). The Court also denied the defendants' motion for more definite statement and motion to compel joinder of the insurance agent. In *Employers Mut. Cas. Co. v. Bonilla*, 2007 WL 2809905 (N.D. Tex. September 27, 2007), EMC and EMCASCO brought a declaratory action to determine coverage for a lawsuit filed by an employee against their insured for injuries she sustained when a mobile kitchen in which she was working caught on fire. While the declaratory action was pending, a state court entered judgment in favor of the employee in the amount of $1,832,933.58. Before the judgment, the state court had severed the employer's case (Bonilla) against the owner of the mobile kitchen (Jolly Chef). Moreover, after the judgment, Bonilla added EMC and EMCASCO to the severed action. Then, Jolly Chef filed for bankruptcy and the state court abated the closed the case pending the outcome of the bankruptcy.

With regard to the defendants' motion to abstain the coverage declaratory action, the Dallas federal court declined to abstain because (1) the declaratory action was justiciable; (2) the court had the authority to grant declaratory relief; and (3) a balancing of the factors weighed in favor of exercising jurisdiction to decide the action. It appears this was an easy decision for the court due to the abatement of the state court action due to the bankruptcy filing of one of the parties in that case. Furthermore, in denying the defendants' motion for a more definite statement, the court determined that the insurance carriers had adequately outlined the various policy provisions showing that no coverage existed and thus satisfied Rule 8's requirement of "a short and plain statement of the claim showing that the pleader is entitled to relief." Additionally, the court noted that the motion for more definite statement should be denied because the additional information requested could be obtained through discovery. Finally, the court declined to grant the defendants' motion to join the in state insurance agent in an effort to prevent diversity jurisdiction. The court found that the insurance agent was not a necessary party because the issue to be decided in the case rested solely on the contractual language in the policies.

FIFTH CIRCUIT AFFIRMS TRIAL COURT'S SUMMARY JUDGMENT FOR HEALTH INSURER REGARDING INSURERED'S EXTRA CONTRACTUAL CLAIMS BECAUSE THERE WAS A *BONA FIDE* DISPUTE AS TO COVERAGE

Last Friday, the Fifth Circuit affirmed a district court's summary judgment in favor of a health insurer regarding an insured's extra-contractual claims. In *Henry v. Mutual of Omaha Insurance Company*, 2007 WL 2897966 (5th Cir. October 05, 2007), the plaintiffs, on behalf of their deceased son, filed suit against Mutual of Omaha Insurance Company ("MOIC"), the issuer of their son's health insurance coverage, alleging that MOIC's denial of coverage for intravenous immunoglobulin ("IVIG") replacement therapy caused their son to commit suicide. The federal district court granted MOIC's motion for summary judgment and the Fifth Circuit affirmed.

The plaintiffs' extra contractual claims were the sole subject of the appeal. The Fifth Circuit explained the plaintiffs' claims under the DTPA, Insurance Code, and for common law bad faith all failed because MOIC had a reasonable basis for its decision to deny coverage. The court explained: "[p]lainly put, an insurer will not be faced with a tort suit for challenging a claim of coverage if there was any reasonable basis for denial of that coverage." The Fifth Circuit found MOIC's reliance upon the proffered opinions of several board-certified doctors who reviewed the insured's claim demonstrated good faith. The court rejected the insured's argument that the reports prepared by MOIC's in-house and independent physicians were not objective, because these physicians were paid by MOIC. The court noted that the doctors were not "patently off-base in their analysis and conclusions" and their professional justifications were not "illegitimate or specious." The court concluded by explaining: "[t]he question is not whether in the end MOIC's doctors were right or wrong in their diagnosis of [the insured's] condition and medical needs; the question is whether their methods and conclusions were reasonable, and whether MOIC was reasonable in relying on these conclusions." The Fifth Circuit affirmed because it was satisfied that MOIC did not breach its duty of good faith and fair dealing, stating that MOIC clearly had a reasonable basis on which to deny coverage of its insured's IVIG treatment for lack of medical necessity.

Editor's Note: Although this case arises out of a health insurance context, the Fifth Circuit's broad pronouncements about the standards applicable to determine whether an insurer's reliance on experts in evaluating claims is proper will have applicability to *any* first party insurance claim where the insurer retains one or more expert consultants to evaluate some aspect of the submitted claim.

CHRIS MARTIN NAMED ONE OF TEXAS' "GO TO" INSURANCE LAWYERS

The October 8, 2007 issue of *The Texas Lawyer* named founding partner Chris Martin as one of the five "Go To" insurance lawyers in Texas. The "Go To" Guide is an independent research and resource guide of American Lawyer Media (the publisher of *The Texas Lawyer*) designed to identify those lawyers whom other Texas lawyers and Texas business leaders consider the "best of the best" in 30 different practice areas. Chris also received this prestigious "Go To" designation in the field of insurance law in 2001 when *The Texas Lawyer* published its first "Go To" Guide of Texas Top Lawyers.