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TEXAS INSURANCE LAW NEWSBRIEF

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TEXAS SUPREME COURT PREVENTS UIM INSURER FROM ENFORCING A SETTLEMENT MADE ON JURY VERDICT WITH NO JUDGMENT

In a potentially important underinsured motorist (UIM) decision issued last Friday, the Supreme Court of Texas held a UIM insurer may not enforce a jury verdict that is not reduced to judgment, but is instead settled after the verdict and disposed of without rendition of a final judgment. *In Re USAA General Indem. Co*., --- S.W.3d ---, No. 20-0075, 2021 WL 1822944 (Tex. May 7, 2021) involved an auto accident in which the injured claimant sued both the defendant driver and his own UIM insurer, seeking damages far in excess of the defendant's liability insurance limits. USAA demanded its own separate trial on its liability under the UIM coverage, and the UIM claim was bifurcated from the tort claim and abated. After trial, the jury found the defendant 100% responsible for the accident and awarded damages in excess of the defendant's liability insurance (but less than the claimant was seeking). They then settled for roughly the amount of the jury award and dismissed the tort portion of the case without a final judgment.

After the settlement and dismissal of the tort portion of the case, USAA consented in writing to the settlement. Then, with the abatement lifted on the UIM portion of the case, USAA immediately moved for summary judgment and contended a trial on the UIM claim was no longer necessary because the jury verdict and subsequent settlement conclusively established both liability and damages. The claimant argued USAA had consented too late and was not now entitled to claim its contract damages were limited to the underlying jury verdict and settlement.

In a seven-justice majority opinion, the court declined to apply the doctrine of collateral estoppel to prevent the negligence and damages issues from being re-litigated because collateral estoppel, by its own terms, applies only to final judgments, and the post-verdict dismissal was not a final judgment. Additionally, a UIM insurer's contractual liability depends on the damages the insured is "legally entitled to recover" from the underinsured motorist. And only a judgment, not merely a jury verdict, establishes the amount the plaintiff in any lawsuit is legally entitled to recover. Finally, the court pointed out that piecemeal consent cannot be given – the insurer either consents or refuses to consent to the outcome as a whole, and may not consent only to the parts it likes. Because USAA consented to the outcome, it also implicitly consented to the verdict's lack of enforceability without a final judgment. Therefore, the court reasoned, the parties had to start over and conduct a separate trial, as USAA had originally demanded, to determine its insured's legal entitlement to recover damages from the underinsured motorist.

Because the majority held the lack of a judgment prevented USAA from enforcing the jury verdict at all, it did not address the question of whether USAA's post-verdict, post-settlement consent was timely.

Two justices dissented, focusing in part on the fact that for unknown reasons, the defendant's liability insurer funded the entire settlement of $160,000, rather than merely paying its $30,000 limit. Because the claimant was fully compensated by the defendant's liability insurer, the defendant did not meet the definition of an "underinsured motorist" and there could be no possible UIM exposure.

They also found it significant that USAA had participated in post-verdict hearings, sought judgment on the verdict at that time, and opposed dismissal of the case. Thus, the dissent expressed concern that the outcome created an opportunity for a claimant to obtain one jury verdict, collude with the defendant to dismiss the suit without judgment if he is not happy with the number (even over his UIM insurer's objection, which happened here) and then try liability and damages a second time against the UIM insurer, hoping for a larger number the second time around. The dissent likened this situation to *Gandy* in its potential for collusive fraud and public policy concerns.

Finally, the dissent cited existing supreme court precedent holding that a dismissal with prejudice is tantamount to a final judgment on the merits. While the dissent agreed collateral estoppel only applies to final judgments when a third party attempts to relitigate them in a later suit, they pointed out that here, USAA was not a third party, and these events all took place within the confines of a single lawsuit. Therefore, traditional notions of collateral estoppel did not apply anyway.

The dissent concluded the trial court had abused its discretion by refusing to enter a judgment on the verdict as USAA had requested, and argued mandamus should have been granted to prevent a second lengthy and expensive trial on fact issues that already been decided by one jury.

Editor's note: This outcome highlights the importance of concluding a settled case, particularly a UIM case, with a final judgment rather than a mere dismissal, so that the judgment will create collateral estoppel, preventing key issues in the case from being re-litigated later. However, when an insurer declines to participate in the litigation, it often loses the ability to control the ultimate disposition of the case, which can lead to adverse results such as this one. This is true for liability insurers generally, as well as UIM

insurers. The majority appeared to view this result as simply the risk a UIM insurer must take when it either consents or refuses to consent to be bound by the as-yet-unknown outcome of the tort claim, while the dissent read the policy's consent clause as entitling the UIM insurer to the precise kind of hindsight the majority refused to allow.

TEXAS SUPREME COURT CLARIFIES STANDARDS FOR PROVING AND CHALLENGING MEDICAL BILLS

Last Friday, the Supreme Court of Texas issued an important evidentiary decision which has particular significance in the realm of third-party defense of injury cases, upholding the right of litigants to challenge the reasonableness of potentially inflated medical expenses offered by injured claimants. *In Re Allstate Indem. Co.*, --- S.W.3d ---, No. 20-0071, 2021 WL 1822946 (Tex. May 7, 2021) involved an auto accident and subsequent UIM case in which the insured submitted $41,000 in medical bills supported by an affidavit under Texas Civil Remedies & Practices Code § 18.001. Allstate retained an expert with a nursing degree and extensive experience in medical coding and auditing, who reviewed the bills and timely submitted a counter-affidavit challenging their reasonableness.

The insured moved to strike the counter-affidavit on the ground that the nurse auditor was not qualified to challenge medical bills, essentially arguing that a doctor's bills may only be challenged by another doctor in the same field. The trial court struck the counter-affidavit and prohibited the expert from offering any testimony on the reasonableness or necessity of the medical bills. This mandamus proceeding ensued.

The court first traced the history of Tex. Civ. Prac. & Rem. Code Chapter 18, which governs the use of affidavits to prove medical expenses and is designed to streamline the process of proving medical expenses without requiring the use of formally designated experts and extensive expert testimony.

The supreme court concluded the nurse auditor was highly qualified to review billing codes, compare them to national databases of prices for medical services with the same or similar billing codes to which she had access, determine the median prices for those services, and give expert opinion on whether the bills being offered were reasonable relative to median prices for those services.

The supreme court agreed with prior opinions holding that credentials in a particular field of medicine do not necessarily qualify any medical practitioner to testify on every medical matter, but rejected the notion that this principle requires a wholesale rule that only someone who practices in the same field can ever give qualified rebuttal testimony. The court observed that given the current landscape of medical coding and billing, there may be many doctors who have no particular expertise in medical coding and billing. Here, there was evidence the nurse auditor had extensive experience in the precise area on which her affidavit gave testimony – medical coding, billing, and price auditing.

The insured also challenged whether the counter-affidavit gave reasonable notice of the opinions being given, and here again, supreme court upheld the counter-affidavit, noting the counter-affidavit itemized each charge that was being challenged and explained the bases for the nurse auditor's opinions and the methodology she used to arrive at her conclusions.

The insured also argued the nurse auditor's opinions were unreliable, attempting to convert the examination of the counter-affidavit into a traditional expert testimony gatekeeping function under *Daubert*. The supreme court rejected this notion as well, and declined to subject a medical billing affiant or counter-affiant to the full reliability inquiry required of traditional expert testimony under *Daubert*.

Finally, the supreme court held the trial court had abused its discretion by not only striking the counter-affidavit, but also prohibiting Allstate from doing anything else to challenge the reasonableness of the medical bills, such as cross-examining the original affiant or bringing additional witnesses. While Chapter 18 is designed to set minimum standards that are *sufficient* to prove medical bills, the court concluded nothing in it makes the initial affidavit *conclusive*, even in the absence of a compliant counter-affidavit. The court rejected any reading of Chapter 18 that suggests it imposes a waiver of the right to contest the reasonableness of medical bills, and disapproved several other Texas court opinions following that reading.

FIFTH CIRCUIT UPHOLDS NO-DEFENSE EXCESS LIABILITY POLICY

Last week, the Fifth Circuit examined the defense obligations of excess carriers, affirming summary judgment for an excess insurer whose policy included a right, but not a duty, to defend the insured after exhaustion of the underlying policy limits. *Tex. Disposal Systems, Inc. v. FCCI Ins. Co.*, ---F.3d ---, No. 20-50274, 2021 WL 1805865 (5th Cir. May 5, 2021) involved an insured who had four stacked insurance policies providing a total tower of $17 million. FCCI, the primary carrier, defended the insured against a wrongful death case. At the top of the four-insurer tower sat Arch. Like many excess policies, Arch's policy did not impose a duty to defend the insured, while the three policies below it included a duty to defend.

Ultimately, the first three insurers reached partial settlements with various plaintiffs that exhausted their limits. Once the settlements were paid, they tendered the remaining unsettled claims to Arch, and FCCI terminated its defense. Arch declined to assume the defense, pointing out its policy did not require it to do so. The insured defended itself through the conclusion of trial and then sued both FCCI and Arch for the disputed defense costs and extra-contractual damages.

In the ensuing coverage lawsuit, the insured contended Arch either modified the policy by agreeing to defend it, or had already assumed the defense and was prevented from withdrawing it. The Fifth Circuit rejected the notion that a contract could be modified by the unilateral acts of one party without a clear meeting of the minds reaching a new agreement supported by consideration. There was no evidence that any such agreed modification had occurred here. The court also reasoned that the policy terms actually

prevented Arch from assuming the insured's defense until the underlying policies had been exhausted by payment of judgment or settlements, which protects the underlying insurers from having their defense of the insured interfered with by a meddling excess carrier. Arch told the insured it would not be assuming the defense before the partial settlements were finalized and thus before the underlying policies were exhausted, and therefore Arch could not have already assumed the defense. While there was evidence Arch had retained an attorney who may have represented the insured, there was no evidence he ever took over the role of lead counsel from the attorney hired by FCCI – thus Arch did not "assume" the defense, but at most merely associated with the defense being conducted by FCCU.

Having concluded Arch did not breach its contract, the court summarily upheld summary judgment in Arch's favor on all extra-contractual claims that had been asserted.

Editor's Note: Although this case resulted in a win for the excess carrier, the court's discussion of the evidence suggests this coverage lawsuit might have been avoided if there had been clearer and earlier communication of Arch's intention not to assume the insured's defense, which it had the right but not the duty to do. However, that same clarity of communication might have prevented the partial settlements from ever being achieved, as the insured argued it would not have agreed to them if it had known it would lose its defense. The trial of the remaining unsettled claims resulted in an additional $1.1 million judgment against the insured, which was within the remaining available policy limit. It is not clear how much the insured incurred in defense costs after FCCI terminated its defense.