EDITORS’ NOTEPAD

The Transportation Practice Group of ALFA International has published Transportation Update for about fifteen years. In response to the requests of clients we updated our extensive website at in 2005. We now have an archive of many recent issues of Transportation Update on the website including this one.

This issue of Transportation Update will only be published electronically. Our primary method of distribution will be by email, but this issue will simultaneously appear on our web site. Electronic publication also allows us to include hyperlinks for the use of our readers. If your first contact with Transportation Update is through our website, you can be added to our email distribution list by contacting us through Katherine Garcia. Please add Transportation Update to the subject line, and we will email the current issue and each subsequent issue to you as it is published. If you wish to receive Transportation Update in hard copy format, contact an ALFA attorney listed at the end of this newsletter, and they can provide this service for you.

In previous years Transportation Update primarily reported case, regulatory and statutory notes from around the country of general interest to the trucking community. In April 2005, we began to include reports from around the country of settlements and verdicts of particular interest. Any reader who learns of a settlement or verdict that they think would be of interest to the trucking community is encouraged to report that settlement or verdict to Michael K. Sheehy. Michael can be reached as follows:

Please see the Practice Tips section of this Update. This section features articles of medium length which cover practical questions of interest to both those who manage litigation for motor carriers and those who represent them. The Editors think that articles in this section have widespread application throughout the country.

The topic covered in this issue of Practice Tips is titled Medicare Set-Aside. The purpose of the article is to help defendants and their insurers understand that penalties and liabilities can be placed on defendants, just as on plaintiffs, if Medicare liens are left unsatisfied, and it addresses safe practices that should be implemented to avoid such penalties and liabilities. Richard W. Krieg and Jesse M. Hayes wrote this excellent article. If you have any questions or want additional information, please contact Dick at dkrieg@lewisking.com.

In this issue, we have an Article titled Money & Time: The Duty to the Insured to Promptly Settle with the Claimant. The article focuses upon the circumstances under which an insurer or an excess insurer may have a duty to settle a claim or suit. The issue is discussed in the context of a motor carrier continued on next page
EDITORS’ NOTEPAD (CONT.)

that has a substantial self insured retention (SIR) or similar contractual arrangement and retains the need to investigate and defend claims and suits. It also discusses the standards which will be applied in determining whether the duty to settle has been met in a fair and timely way. Will Futon (), Lee Rosenthal (), and Loren Prizant () have submitted this thorough study.

Please see below for a summary of an article of interest that will be published in the spring edition of the Update. We welcome comments, suggestions for improvement, and topics which you would like for us to address in future issues. It is our goal to provide timely relevant information to members of the trucking community. Our editors can be contacted as follows:

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FUTURE EVENTS

The Transportation Practice Group of ALFA International presents a multi-day seminar for members of the Trucking Industry each year. Our seminar this year was the presentation of several hypothetical exercises to focus groups. Focus on Trial: What Works at the Crossroads of Your Case was designed to let participants review for themselves the uses, benefits and limitations of focus groups in evaluating and preparing their serious cases.

The seminar next year is scheduled for April 25 – 27, 2007, at the Barton Creek Resort & Spa in Austin, Texas. The seminar is titled The Road to Resolution: Successfully Mediating Your Dispute, and the focus of this program is upon various approaches to effective alternative dispute resolution. Two mock mediations displaying contrasting mediation methods will be presented. A practical skills course involving a mock DOT level 1 inspection is part of the program. So this interesting program, the beautiful venue, great entertainment, excellent food, and this opportunity to meet and confer with your peer leaders in the industry all serve as good reasons to sign up now. You may do so on our website at www.alfainternational.com. The internet site for the Barton Creek venue is:

Barton Creek Resort and Spa.

Questions, comments and suggestions about this program can be directed to our program chair, Paul T. Yarbrough of the Albuquerque, N.M. firm of Butt, Thornton and Baer, P.C., at the number listed below, or by email at ptyarbrough@btblaw.com.

Logistical questions about the program can be directed to Katherine Garcia at the number listed below or by email at kgarcia@alfainternational.com.

The upcoming seminar is offered in response to requests from clients and from those who attended previous programs. Additional information about our 2007 seminar will be posted periodically on our website. www.alfainternational.com.

Please hold these dates (April 25-27, 2007) for this comprehensive program and plan to attend.

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In the spring issue of Transportation Update, we plan to publish an Article by Bob Corbin that deals with the Self Critical Analysis Privilege. If you want information about this issue, contact Bob at CORBINR@ggmfirm.com.

Connecticut

PROOF OF LOST WAGES AND LOSS OF EARNING CAPACITY IN CONNECTICUT THROUGH TESTIMONIAL EVIDENCE ALONE – CARRANO V. YALE NEW HAVEN HOSPITAL

In many cases, a given plaintiff will allege, in conjunction with certain non-economic damages, damages for loss of income and a loss of earning capacity. When faced with such damages claims, defense counsel will typically devote a significant amount of effort in the discovery process to obtaining documentary evidence from which counsel may assess the strength or weakness of such claims. Such documentary evidence may include such items as tax returns, W-2 forms, wage statements, pay stubs, and pay ledgers from a past or present employer. It would seem almost academic that in order to meet their burden of proof as to this type of damages claim, plaintiffs would likewise have to submit such documentary evidence to the trier of fact, during the case in chief. Following the Connecticut Supreme Court’s decision in Carrano v. Yale New Haven Hospital, the method of proving lost earnings and earning capacity may have become much less rigorous, yet the specific evidentiary requirements for proving such claims may have become more rigid. Thus, while a quick read of Carrano may lead to the conclusion that proving lost wages and loss of earning capacity just got easier for the plaintiff’s bar, a careful analysis reveals many ways for the defense to pick apart such claims.

Carrano was a wrongful death action in a medical malpractice context, brought after the plaintiff’s 37 year old husband died after being admitted to the hospital for an infection in one of his fingers. The decedent had a pre-existing condition of Crohn’s disease and developed significant complications while at the hospital. The complications included peripheral edema. Despite these obvious complications, the plaintiff was discharged. He died at home early the next morning from pulmonary edema. Under Connecticut’s wrongful death statute, the plaintiff was entitled to recover “just damages” for the death of her husband, to include such items as the value of the decedent’s destroyed earning capacity, less any necessary living expenses and income tax liability that would have been incurred on

3. Id. at 279 Conn. 626-27; 904 A.2d 155-56.
that future income.\textsuperscript{5}

For some years prior to his death, the plaintiff’s decedent had been on disability and social security due to his Crohn’s disease. He was thus on a fixed income at the time of his death. At trial, the plaintiff testified to the amount of net income her late husband received through disability from his employer and from social security. She presented no documentary evidence to corroborate her testimony, nor did she present any evidence regarding tax liability or living expenses. She did present expert testimony as to the decedent’s life expectancy. The trial court instructed the jury that any award of damages based on the decedent’s lost future disability income was to be adjusted to reflect the decedent’s income taxes and estimated living expenses, and any award was to be reduced to net present value. The jury found in favor of the plaintiff and awarded a total of $738,029.85 in economic damages.\textsuperscript{6} The defendants appealed, asserting various claims of error after their motions for a new trial and remittitur were denied. The Connecticut Appellate Court reversed the award, and the plaintiff appealed that decision to the Connecticut Supreme Court.\textsuperscript{7}

One of the defendants’ primary claims of error was that the evidence at trial was insufficient and that the trial court should not have denied their motion to set aside the verdict because the only evidence submitted was the plaintiff’s testimony. The Court flatly held that “testimonial evidence is sufficient to support an award of economic damages, provided the jury’s reliance on this evidence is reasonable.”\textsuperscript{8} Testimony as to economic damages, like any other testimony, is for the trier of fact to evaluate. The Court concluded that the lack of corroboration through nontestimonial evidence went to the weight of the claimant’s case and not to the claimant’s ability to bring that case before the trier.\textsuperscript{9} In sum, the Court “[saw] no reason why the traditional tests of credibility, testimony under oath and cross-examination, coupled with the claimant’s burden of proof, are insufficient to measure the accuracy and reliability of testimonial evidence concerning economic damages.”\textsuperscript{10} The Court went on to find that the plaintiff’s testimony was sufficient to enable the jury to determine the plaintiff’s economic damages to a reasonable certainty, even though there was some ambiguity in the plaintiff’s testimony as to what income her late husband received from disability benefits and social security.

Notably, the Court did not limit its holding regarding proof of economic damages by testimonial evidence alone to wrongful death cases. Rather, both the Court’s holding and the precedent upon which it is based appear to apply to any cases in which economic damages are claimed. It is up to the defendant, then, to test the credibility of the plaintiff’s testimonial evidence through documentary evidence, extrinsic evidence, or cross-examination.

The Carrano decision is quite helpful to defense counsel challenging a plaintiff’s evidence of economic damages insofar as the Court held that a plaintiff in a wrongful death action must introduce evidence from which the jury could determine the decedent’s personal living expenses or income taxes, and thus calculate the decedent’s net earnings to a reasonable certainty.\textsuperscript{11} In this case, the Court found that the plaintiff’s testimony afforded no evidence from which the jury could conclude that the plaintiff suffered any economic damage due to the loss of the decedent’s disability income because there was no evidence

\textsuperscript{5} Conn.Gen.Stat. 52-555(a); Floyd v. Fruit Industries, Inc., 144 Conn. 659, 671; 136 A.2d 918 (1957).

\textsuperscript{6} Carrano, 279 Conn. at 642-44, 904 A.2d at 165-66. The jury also awarded amounts for non-economic damages and loss of consortium.

\textsuperscript{7} The Appellate Court’s reversal was based upon the defendants’ claim of error that the trial court improperly awarded too many peremptory challenges to the plaintiff. It dealt with the claims of error related to damages only in a footnote and found that the proof of disability benefits, as a defined income stream, must be proved through non-testimonial evidence. Carrano v. Yale New Haven Hospital, 84 Conn.App. 656, 658, n.3, 854 A.2d 771 (2004).

\textsuperscript{8} Carrano, 279 Conn. at 647, 904 A.2d at 167-68.

\textsuperscript{9} Id.

\textsuperscript{10} Carrano, 279 Conn. at 647-48, 904 A.2d at 168 (Citations omitted; internal quotations omitted.).
from which the jury reasonably could find that the decedent’s income exceeded his income taxes and living expenses.12 And, while the Court’s holding in this regard does specifically address economic damages awards in wrongful death cases, it is certainly arguable that it does indeed extend to ordinary negligence cases, for example, a case in which a plaintiff alleges lost wages or loss of earning capacity. In such cases, a plaintiff must still prove his or her damages to a reasonable certainty, and any award for lost wages or loss of future income properly focuses on a plaintiff’s net income.

Following the Carrano decision, Connecticut defendants in all cases where economic damages are claimed must be prepared for the fact that a plaintiff may meet his burden of proof as to economic damages with testimonial evidence alone. Counsel must be prepared to challenge a plaintiff’s testimony through any number of means such as offering documentary evidence on cross or in the defense case-is-chief in order to rebut the plaintiff’s testimony and undermine its credibility. In wrongful death cases, it of course remains the plaintiff’s burden to prove economic damages, and defense counsel must be aware of the obligations Carrano places upon a claimant to offer evidence showing a decedent’s net income. And, because the Court did not address the issue of whether such evidence must come through expert testimony, counsel should still object to the admission of such evidence from any other source. Finally, even if expert testimony is offered, defense counsel should object to any evidence that is not specific to the decedent, particularly as to living expenses, as the Court clearly stressed that such evidence is unique as to a given decedent.

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INDIANA

WORKER’S COMP LIENS ARE FOR REAL

SCHNEIDER NATIONAL CARRIERS V. NATIONAL EMPLOYEE CARE SYSTEMS, INC., NO. 05-3184, 2006 WL 3392085 (7TH CIR., NOV. 27, 2006)

This case concerns the lien rights of a worker’s comp carrier under Indiana law in the trucking context. A trucker had a collision with another trucker, received worker’s comp, and then sued the tortfeasor’s employer. The work comp carrier sought to intervene in the lawsuit but withdrew after receiving assurances that the tortfeasor’s employer would assume responsibility for the lien. The matter was then settled without notifying or obtaining the consent of the worker’s comp carrier which was in violation of I.C. §22-3-2-13. The settlement agreement provided that the tortfeasor’s employer would assume responsibility and defend and indemnify the injured trucker against any liability for the missing work comp lien money.

A problem arose when the worker’s comp lien was $116,000 and the secret settlement was only $85,000. None of this was ever paid to the work comp carrier. There were some settlement negotiations, but negotiations broke down on the issue of whether the lien was reasonable and necessary and caused by the tortfeasor’s negligence. The district court

12 Id.
ordered judgment in favor of the work comp carrier and against the tortfeasor’s employer. The trial court was presented with cross motions for summary judgment, and the work comp carrier was awarded $56,666.66, which was $85,000 minus the one-third contingent fee. The Court of Appeals noted that the statute does not require an employer or its worker’s comp carrier to join or intervene in an action commenced by a third party. Whether or not they intervene, they still have the protection of the worker’s comp statute regarding the handling of their lien and the required consent to settlement. The comp carrier waived nothing by choosing not to intervene in the lawsuit that had been pending in Pennsylvania.

The Court of Appeals noted that the tortfeasor’s employer’s arguments were foreclosed by the fact that in settling the lawsuit they bound themselves not to assert the very position that they now took that they didn’t have to pay the work comp lien. In addition, they had an agreement with the injured party that they would settle any judgment for lien recovery. After a lengthy discussion of Indiana Worker’s Comp laws and settlement of litigation, the court found in favor of the worker’s comp carrier and against the tortfeasor’s employer. The court did note that the tortfeasor’s employer could not use its own non-compliance with the consent requirement of Indiana statute as a sword to defeat the liability to the worker’s comp carrier.

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MISSOURI

POTENTIAL LIABILITY FOR THIRD-PARTY LOGISTICS COMPANIES

In Schramm v. Foster, 341 F.Supp.2d 536 (D. of Md. 2004) the United States District Court for the District of Maryland found C.H. Robinson Worldwide, a third-party logistics company, liable for negligently selecting Groff Brothers Trucking, LLC as one of the many commercial carriers it maintained a relationship with in order to broker deals between those carriers and shippers needing products transported by truck. The parties settled following the court’s order, so the case never reached appeal. The decision was based on Maryland’s negligent hiring law, which is similar to that of most states, including Missouri. If this decision were followed by other courts, the potential liability for companies like C.H. Robinson would be greatly increased in cases arising out of motor vehicle accidents involving commercial carriers who obtain business from deals brokered by a third party logistics company.

In Schramm v. Foster Jasper Products, LLC contacted C.H. Robinson Worldwide to arrange for the shipment of some soy milk it had in a warehouse in Joplin, Missouri. C.H. Robinson contacted Groff Brothers Trucking, with whom it had a contract carrier agreement, to transport the soy milk to White Rose Food Corporation in Cateret, New Jersey. Groff then assigned the job to Brian Foster, one of its drivers. Schramm, 341 F.Supp.2d at 540. En route to New Jersey, while traveling eastbound on I-68, Foster exited onto Maryland Route 36, failed to stop or yield the right of way to oncoming traffic, and proceeded into the intersection. Id. at 541. A pick-up truck driven by Mitchell A. Thompson, and carrying as a passenger Tyler J. Schramm, a minor, collided with Foster’s truck. Id. Both Thompson and Schramm suffered serious injuries. Id.

Tyler Schramm’s parents brought a personal injury action against Brian Foster, Groff Brothers Trucking, and C.H. Robinson asserting state common law claims for negligence (under a respondeat superior theory), negligent entrustment, and negligent hiring and supervision, and federal claims under the Motor Carrier Act (“MCA”) and Federal Motor Carrier Safety Regulations (“FMCSR”). C.H. Robinson moved for summary judgment arguing that it could
not be found liable for the negligent acts of Groff Brothers Trucking or their driver because it was simply a third-party broker and not otherwise connected with Groff Brothers Trucking, nor did it maintain any control over the driver, Brian Foster.

The Court found that C.H. Robinson could not be found liable under a theory of respondeat superior because although it monitored Brian Foster’s progress in transporting the load from pick-up to delivery “there was no evidence that [C.H.] Robinson...had any control whatsoever of the manner in which Foster conducted his work.” Id. at 546. Likewise, the Court found that C.H. Robinson could not be held liable for negligent entrustment because it was not a supplier of chattel subject to liability for negligent entrustment. Id. at 547. C.H. Robinson was responsible only for brokering the deal between Groff Brothers Trucking and Jasper Products. In addition the Court ruled against the plaintiffs on their MCA and FMCSR claims because it held C.H. Robinson could not be deemed a “carrier” under federal law. Id. at 547-551.

The Court did find, however, that C.H. Robinson’s “self-proclaimed status as a third party logistics company providing one-point of contact service to its shipper clients is sufficient under Maryland law to require it to use reasonable care in selecting the truckers whom it maintains in its stable of carriers.” Id. at 551. The Court based this finding on the Maryland law of negligent hiring as it relates to the selection of an independent contractor. Under this law, “an employer may be held liable for negligence in selecting, instructing, or supervising an independent contractor.” Id. (internal citations omitted). The Court stated that for third party logistics companies such as C.H. Robinson Worldwide:

This duty to use reasonable care in the selection of carriers includes, at least, the subsidiary duties (1) to check the safety statistics and evaluations of the carriers with whom it contracts available on the SafeStat database maintained by FMSCA, and (2) to maintain internal records of the persons with whom it contracts to assure that they are not manipulating their business practices in order to avoid unsatisfactory SafeStat ratings....These obligations are not onerous, and I do not find that imposition of such common law duty would be incompatible with regulations promulgated by the FMCSR.

Id.

In this case, C.H. Robinson was aware that Groff Brothers Trucking had a marginal SafeStat rating. There was also evidence in the record which exposed the fact that Groff Brothers Trucking was formed upon the dissolution of RG Transportation, which experienced safety performance problems sufficient enough that its owner (Robert Groff, a co-owner of Groff Brothers) chose to dissolve it. The Court held that because C.H. Robinson was aware of this marginal rating it had a duty of further inquiry as to whether Groff Brothers was a suitable company to maintain in its stable of carriers. Id at 552. The Court even went so far as to say that C.H. Robinson increased the risk of harm to innocent third parties by its own actions:

When seeking business, Robinson advertises to shipper customers that “[i]n the rare event that the damage [caused in an accident] goes beyond the carrier’s insurance limits, CHRW maintains a liability insurance policy that pays the rest.” Robinson contends that because shippers cannot be held liable for personal injuries caused by a carrier’s driver and thus would not care about the existence of excess insurance coverage for such injuries, this promotional statement and ones like it are of no practical effect. I am not willing to take such a cynical view. Responsible shippers are entitled to receive from firms with which they contract honest and accurate information about the insurance available to compensate victims of catastrophic accidents, such as the one involved in this case....In the last analysis, this is a case in which the law may simply have to catch up with an obligation that Robinson has voluntarily assumed, presumably in response to the demands of the market.

Although strenuously contesting its liability in these proceedings, in conducting its everyday affairs Robinson apparently recognized the ambivalence of its position and purchased excess liability coverage, both to protect itself

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13 The law in Missouri is similar. See Lee v. Pulitzer Publishing Co., 81 S.W.3d 625, 634-35 (Mo. App. 2002).

14 49 C.F.R. § 355.25 prohibits any state law or regulation pertaining to commercial motor vehicle safety which is incompatible with the provisions of the FMCSR.
and to gain new customers. It has actively interjected itself into the relationship between shipper and carrier, and it has chosen to do business in a context heavily tinged with the public interest. I find the common law imposes upon it a duty commensurate with its undertakings.

*Id.* at 552-553 (emphasis added).

Thus, the Court held that a third-party logistics company that brokers deals between carriers and shippers owes a duty to use reasonable care in its selection of those carriers it plans to recommend to its clients in the shipping business who need goods transported by truck. The Court based its decision on the negligent hiring law of Maryland as it relates to the hiring of an independent contractor. Maryland’s law is similar, if not identical to that of most states, including Missouri. Should the reasoning adopted by this court be followed in other jurisdictions it would greatly increase the potential liability of third-party logistics companies like C.H. Robinson Worldwide when a motor vehicle accident occurs involving a trucking company with whom the third party broker maintains a relationship.

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**MISSOURI**  
AGGRAVATING CIRCUMSTANCES AWARDED AND UPHELD ON APPEAL

Company’s policy to leave the decision of whether to secure or tarp a load to driver’s sole discretion leads to punitive damages.

On August 20, 2001 Patricia Walker was driving along Interstate 70 in Independence, Missouri when she was struck and killed by a thirty-seven pound steel plate that flew through her windshield. It was later determined that the steel plate had fallen out of the truck carrying a load of scrap metal. The truck was owned by American Compressed Steel, Inc. (ACS) and driven by its employee, William Copeland. Copeland was charged and pled guilty to the misdemeanor offense of failure to sufficiently secure his transported load.

A wrongful death claim was filed on behalf of Ms. Walker by her father. It was later joined by Deric Lee Coon. Deric Coon was seven years old and claimed he had been equitably adopted by Ms. Walker. The trial court found that he was equitably adopted, and that decision was upheld on appeal.

The jury awarded two million dollars in compensatory damages and one million dollars for aggravating circumstances. Aggravating circumstances are awarded in wrongful death actions pursuant to Mo.Rev. Stat. §537.090 and are “akin” to punitive damages. See *Elliott v. Kesler*, 799 S.W.2d 97, 103 (Mo.App. 1990). The purpose of damages for aggravating circumstances is to punish the defendant and to deter future wrong doing.

The evidentiary burden for proving punitive damages is a clear and convincing standard. The clear and convincing standard requires evidence “which instantly tilts the scales in the affirmative when weighed against evidence in opposition; evidence which clearly convinces the fact finder of truth of the proposition to be proved.” See *Peters v. Gen. Motors Corp.*, 200 S.W.3d, 1, 25 (Mo.App. 2006).

The challenge on appeal was that ACS asserted the evidence was insufficient to show that it knew or had reason to know there was a high degree of probability that its conduct would result in injury to Ms. Walker or that it was completely indifferent or showed a conscious disregard to the safety of others.
The facts were that ACS employed Copeland as the driver of a “roll-up truck” that transported large containers of scrap metal. Typically, Mr. Copeland would drive to the site of an ACS customer, where the containers would be rolled onto the open truck bed. ACS truck drivers were responsible for inspecting the load to determine whether there was improper material, such as hazardous wastes, wood or refrigerators. Drivers had the discretion to refuse an improper load, request the customer to correct any problems with the load, or haul it away after tarping, strapping or chaining the load, if needed, to ensure that it was properly secured.

Mr. Copeland testified that he noticed that on the load in question that some of the scrap metal was piled such that it extended out of the container and about three feet above the sides and back gate of the truck bed. Copeland also noticed that other scrap items were scattered around the bottom of the container. He placed a canvas “diaper” near the bottom of the truck’s back gate to catch any loose items.

Witnesses testified that a metal plate flew out of the top of a truck around 2:00 p.m. One of the witnesses saw the name “American Steel” on the side of the truck. Later that day at approximately 5:45 p.m. other witnesses saw a semi-truck hit the metal plate in the roadway causing the metal plate to become airborne and crash through the window of Walker’s car, resulting in her death.

Several ACS management employees testified about the company’s policy for securing scrap metal loads. All the witnesses agreed that ACS had a duty to safely secure the loads because the failure to do so would create a high probability of serious injury or death to persons on the roadways. The transportation manager and assistant safety manager testified that ACS made a conscious business decision to allow its drivers to decide whether and how a particular load should be tarped, strapped, chained, or otherwise secured. The drivers were expected to consider several factors including the time it would take to tarp the load, the types of scrap metal involved and whether the truck would be traveling on highways (at higher speeds) or local streetways. Drivers were orally instructed about these considerations because ACS had no written policy regarding the proper security of loads. One week after the fatal incident involving Walker, ACS changed its policy and required drivers to place a tarp cover over all loads that would be hauled at highway speeds.

Jeffrey Ross, who was the president of ACS, testified there had been at least ten incidents of metal objects falling out of ACS trucks prior to Ms. Walker’s accident. The prior incidents resulted in property damage to other vehicles but no personal injuries.

Plaintiff’s then presented expert testimony from Arthur Atkinson. He testified that the fatal incident was foreseeable and preventable because the metal plate would not have escaped out and over the top of the ACS truck if it were loaded and properly covered with a tarp. Mr. Atkinson testified that Mr. Copeland’s conduct in failing to cover the load violated the Federal Motor Carriers’ Safety Regulations, Mo. Rev. Stat § 307.010 (requiring the covering of loads) and industry standards set forth in manuals for the Missouri Commercial Driver’s License, the American Trucking Association, Professional Truck Driver Institute of America, and the National Safety Council.

Mr. Atkinson opined that ACS had shown a conscious disregard for public safety in failing to comply with federal and state law industry standards. Plaintiff also presented the testimony of a private investigator who conducted surveillance of the ACS facility. The investigator observed that 62 percent of the incoming ACS trucks had scrap metal loads that were not tarped, chained or covered in any manner. Some of the loads were stacked over the top of the containers and hanging over the sides.

The appellate court held that the evidence was sufficient to show, by clear and convincing evidence, that ACS should have known that its failure to require drivers to secure loose pieces of scrap metal, by tarping or otherwise covering the loads, created a high probability of injury. The court also upheld the decision that ACS showed complete indifference to and a conscious disregard to the safety of others and upheld the award of damages for aggravating circumstances.
MISSISSIPPI


Elsie Etheridge filed a negligence action against Harold Case & Company, Inc. and its employee, Randy Parkman, seeking damages related to personal injuries she sustained on August 21, 1992. On that date, Etheridge was driving on Sartinville Road in Walthall County, Mississippi. She came to the intersection of Sartinville Road and Mississippi Highway 27. The intersection was controlled by a stop sign on Sartinville Road. The posted speed limit on Highway 27 was fifty-five miles an hour. A yellow double-diamond warning sign stood eight-hundred feet north of the intersection. The top diamond on the sign told drivers that an intersection lay ahead while the bottom diamond instructed drivers to “SLOW TO 45.” As Etheridge approached the intersection on Sartinville Road, Parkman, driving an eighteen-wheel tractor-trailer, approached it as he drove south on Highway 27. He passed the warning sign. When Etheridge pulled into the intersection, Parkman struck her.

During the trial, the jury heard conflicting testimony regarding whether Etheridge stopped at the Sartinville Road stop sign. The jury returned a defense verdict. On appeal, Etheridge argued that the trial court incorrectly concluded that the yellow double-diamond warning sign on Highway 27 was an advisory signal to drivers, not a mandatory traffic control device. On appeal, the Mississippi Court of Appeals ruled that although the warning sign was not a speed limit sign according to the Manual of Uniform Traffic Control Devices, it was an official traffic control device. The Court of Appeals also ruled that Miss. Code Ann. §63-3-313 required that drivers obey all traffic-control devices unless instructed otherwise by a police officer. Therefore, compliance with the yellow double-diamond warning sign was mandatory. However, because the weight of the evidence supported the conclusion that Etheridge pulled into the intersection at a point when Parkman could not avoid the accident, the trial court’s error was harmless.

COMMENT: Earlier decisions have found that violations of the state’s traffic laws are negligence per se. McClure v. Felts, 172 So. 2d 549 (Miss. 1965); Vaughn v. Lewis, 112 So. 2d. 247 (Miss. 1959). Applying Etheridge, it appears that a strong argument can now be made that any traffic control device placed by an appropriate governmental agency must be followed regardless of the device’s color.
Evidence that a passenger was not wearing a seat belt is admissible in some states with respect to both the issue of damages and the issue of proximate cause, that is, whether the sole proximate cause of the claimed injuries and/or death was the failure to wear the seat belt. In some jurisdictions, failure to use a seat belt may be admitted into evidence to support a defense of contributory negligence. Annot., 92 A.L.R.3d 9, “Automobile occupant’s failure to use seat belt as contributory negligence,” (2006 Thomson/West).

In accidents involving tractor-trailers, a passenger’s injuries may be caused or aggravated by the fact that he failed to wear a required safety harness. This situation most often arises when a co-driver or authorized rider is injured as a result of a fall from the sleeper berth. To avoid such injuries, section 393.76(h) of the Federal Motor Carrier Safety Regulations requires motor carriers to equip their sleeper berths with a safety harness. The regulations require that a sleeper berth be equipped with a means of preventing ejection of the occupant:

(h) Occupant restraint. A motor vehicle manufactured on or after July 1, 1971, and equipped with a sleeper berth must be equipped with a means of preventing ejection of the occupant of the sleeper berth during deceleration of the vehicle. The restraint system must be designed, installed, and maintained to withstand a minimum total force of 6,000 pounds applied toward the front of the vehicle and parallel to the longitudinal axis of the vehicle.

The regulations also require a driver to use a seat belt:

A commercial motor vehicle which has a seat belt assembly installed at the driver’s seat shall not be driven unless the driver has properly restrained himself/herself with the seat belt assembly.

49 C.F.R. § 392.16.

Whether contributory negligence is an appropriate defense depends on state law. Not every state recognizes contributory negligence as a total bar to a plaintiff’s claim, and not every state recognizes the doctrine of negligence per se.

Examples of cases where negligence per se barred a claim can be found with respect to the failure to observe federal regulations. See, e.g., Hageman v. TSI, Inc., 786 F.2d 452 (Colo. App. 1989) (federal regulations requiring interstate motor carriers to comply with safety standards were an appropriate basis for a negligence per se instruction); Wallace v. Ener, 521 F.2d 215 (Ga. 1975) (failure to use safety flags required by Motor Carrier Safety Regulations is negligence per se).

In Jenkins v. North American Van Lines, Inc., 46 F.3d 1124 (4th Cir. 1995), for example, a worker’s failure to wear an OSHA-required safety harness created a rebuttable presumption of negligence. Accordingly, the trial court did not err in instructing the jury on contributory negligence. Jenkins was decided under the law of the Commonwealth of Virginia, where contributory negligence is a complete bar to a negligence action, Jones v. Meat Packers Equipment Co., 723 F.2d 370, 373 (4th Cir.1983). Under Virginia law, the violation of any statute enacted to protect health, safety, and welfare, is negligence per se, MacCoy v. Colony House Builders, Inc., 239 Va. 64, 69, 387 S.E.2d 760, 763 (1990).

Depending on which state law applies, the violation of the Motor Carrier Safety Act in failing to wear a safety harness may constitute negligence per se and/or contributory negligence.
Pennsylvania Supreme Court Finally Resolves Joint and Several Liability Uncertainty

Prior to August 18, 2002, Pennsylvania, by common law, was a joint and several liability jurisdiction. Essentially, this meant that a tortfeasor found to be negligent was responsible for the entire amount of the judgment, even if other tortfeasors were also found to be at fault. Moreover, the person in whose favor a judgment was entered was entitled to collect the entire amount of the judgment from any of the defendants, i.e., each defendant’s responsibility was not limited to their individual share of the liability assessed by the jury.

On August 18, 2002, the “Fair Share” Act became effective for any cause of action accruing thereafter. Pennsylvania’s “Fair Share” Act abolished joint and several liability as it had previously existed, with certain limited exceptions for drunk drivers, environmental cases, and intentional acts, including fraud. Most importantly, the “Fair Share” Act provided that a tortfeasor found to be less than 60% liable was only responsible for its proportionate share of a verdict. A tortfeasor found to be 60% or more liable remained responsible for the full amount of the award.

On July 26, 2005, the Commonwealth Court of Pennsylvania declared the “Fair Share” Act unconstitutional. DeWeese v. Weaver, 880 A.2d 54 (Pa. Cmwlth., 2005). The Commonwealth Court held that the Act was unconstitutional because of the manner in which the law had been passed. In particular, the Commonwealth Court found that the Act violated at least one important provision of the Pennsylvania Constitution. Article 3, Section 3 of the Pennsylvania Constitution provides, in pertinent part, that “[N]o bill shall be passed containing more than one subject....” The Commonwealth Court held that the Bill in which the “Fair Share” Act was contained had more than one subject. The original Bill (which ultimately became the “Fair Share” Act) provided for DNA testing of certain alleged sexual and violent offenders and for the establishment of a state DNA data base. The Commonwealth Court held that the Bill contained two different subjects, and thus was in violation of this provision of the Pennsylvania Constitution. The Attorney General of the Commonwealth of Pennsylvania filed an appeal to the Pennsylvania Supreme Court from this decision of the Commonwealth Court. Because the Attorney General is a state official, the appeal was considered “of right” and acted as an automatic stay of the Commonwealth Court’s ruling. Thus, considerable uncertainty existed in the trial courts of Pennsylvania as to whether or not to apply the provisions of the “Fair Share” Act in cases involving multiple defendants.

The Pennsylvania Supreme Court recently resolved this uncertainty. On September 28, 2006, in a one sentence per curiam order, the Supreme Court affirmed the decision of the Commonwealth Court. In light of this ruling by the Supreme Court, the focus will now shift back to the Pennsylvania legislature. Earlier this year, the legislature had passed a Bill which was verbatim the original “Fair Share” Act but was without the additional provisions attached to the Bill. Unfortunately, Governor Rendell vetoed this legislation,
so the law of the Commonwealth of Pennsylvania has reverted to the common law rule of joint and several liability as it had existed prior to 2002 when the original “Fair Share” Act was adopted. Hopefully, there will be renewed efforts in the next legislative session to enact some modifications to the rule of joint and several liability in Pennsylvania.

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Pennsylvania

Computer Animations Approved by the Pennsylvania Supreme Court

In a case of first impression, the Pennsylvania Supreme Court recently held that computer generated animations (“CGA”) are admissible as demonstrative evidence of an expert’s findings and opinions.

The Supreme Court’s decision in Commonwealth v. Serge, 896 S.2d, 1170 (Pa., 2006) clearly sets forth the analysis that a trial court should undertake in determining the admissibility of the CGA, offers practical guidance for litigants who seek to use CGAs, and, finally, identifies several problem areas that could lead to exclusion of CGA evidence.

The bottom line is that the highest court in Pennsylvania has now made it clear that use of CGA evidence is appropriate in Pennsylvania courts. The ruling should encourage the increased use of CGAs by significantly reducing the likelihood that an expensive CGA will be inadmissible at trial.

A. The Standards for Admissibility of a CGA in Pennsylvania.

The Pennsylvania Supreme Court held that a CGA should be deemed admissible as demonstrative evidence if it: (a) is properly authenticated pursuant to Pennsylvania Rule of Evidence 901 as a fair and accurate representation of the evidence it purports to portray; (2) is relevant, pursuant to Pennsylvania Rules of Evidence 401 and 402; and (3) has a probative value that is not outweighed by the danger of unfair prejudice, pursuant to Pennsylvania Rule of Evidence 403.

In the Serge case, prosecutors used a CGA to aid the testimony of their expert forensic pathologist by visually demonstrating the expert’s view of how a husband murdered his wife. The court found the following evidence to be sufficient to properly authenticate the CGA: (1) the creator of the CGA explained the process by which the CGA was created, including its limitations; (2) police officers testified concerning the physical evidence at the crime scene, including various measurements taken at the scene; and (3) the forensic pathologist presented by the prosecution explained the existence of the facts relevant to his opinions, and stated his opinions about how the murder was carried out. The court found that the CGA was consistent with the foundation laid by these witnesses.

As to the issue of relevance, the Pennsylvania Supreme Court endorsed the conclusion that “the animation’s relevance under Pennsylvania Rule of Evidence 401 lay in its clear, concise, and accurate depiction of the Commonwealth’s theory of the case, which included the rebuttal of the appellant’s self-defense theory, without use of extraneous graphics or information.” Importantly, this language means that, assuming a proper foundation, CGA evidence will be found relevant in virtually every context in which it is offered as evidence. The animation will, in virtually every circumstance, offer a clearer, concise and arguably accurate depiction of the evidence offered.

Finally, the court ruled that the CGA’s probative value outweighed any danger of unfair prejudice. The court ruled that despite the potential power of CGAs to have a greater weight than other demonstrative evidence (due to its visual
nature), the court found that CGAs are nonetheless admissible if they are helpful to a jury’s understanding of the facts and the probative value outweighs any prejudicial effect. It found that under the circumstances of the Serge case, that the probative value of the CGA did in fact outweigh any prejudicial effect. It pointed to the facts that the CGA did not have any sound, did not depict blood coming from the victim’s wounds, did not display any facial expressions, and otherwise did not contain information aimed at inflaming the emotional passions of the jury.

B. Factors That Could Result in Exclusion of CGA Evidence.

The Pennsylvania Supreme Court offered the following as examples of possible unnecessary and prejudicial information that could be contained on a CGA: (1) sounds; (2) facial expressions; (3) evocative or even lifelike movements; (4) transition between the scenes to suggest a story line or add a subconscious prejudicial effect; or (5) evidence of injury such as blood or other wounds. The court found that no such evidence was presented in the Serge case. It made it clear, however, that if such evidence was contained on a CGA, it would likely determine that the CGA’s probative value was in fact outweighed by the prejudicial effect. Under such circumstances, the court would likely exclude the CGA evidence.

C. Practice Tips for Admission of CGA Evidence.

The Pennsylvania Supreme Court strongly approved of the Commonwealth’s and trial court’s handling of the CGA evidence in the Serge case prior to trial. In the pretrial phase of the case, the Commonwealth filed a motion in limine seeking admission of the CGA evidence. The court conducted a pretrial hearing with regard to the CGA evidence. The court heard testimony from the creator of the CGA as to the manner in which it was created and the purpose for which it was going to be offered at trial. The court permitted cross-examination of the expert animator with regard to these issues. The court ultimately determined that the CGA evidence was admissible. It is therefore urged that counsel seek a prior determination of admissibility of CGA evidence through the use of a motion in limine.

Another practice tip coming from the Serge case is that the trial court should give a limiting instruction both before the CGA evidence is presented and during the jury instructions. The Serge court strongly approved of the limiting instruction given by the trial court in that case. The limiting instruction is reproduced almost in its entirety in the Serge decision. The crux of the limiting instruction was to caution the jury that the CGA was demonstrative evidence like any other type of demonstrative evidence, that it should not be accepted by them as fact, that it merely depicts the expert opinion of one of the parties in the lawsuit, that the jury is free to accept or reject the animation as it is with any other type of evidence presented in the case, and that the jury should consider the limitations of the technology as testified to by the parties and in response to cross-examination.

D. Conclusion

Although the Serge decision is a criminal case, the Pennsylvania Supreme Court’s ruling regarding the admissibility of computer-generated animations has wide application in many cases, including civil actions. The case makes clear that the use of CGAs in Pennsylvania is appropriate. The case should help to alleviate concerns over investing significant amounts of money in the creation of CGAs because there is now clear case support for the admissibility of such evidence at trial. The evidence should be admissible as long as it complies with the rules of evidence as they apply to the admissibility of demonstrative evidence in general. This ruling should have particular usefulness for trucking companies and the insurers who defend trucking companies. Computer generated animations are particularly useful in trucking accident cases.
Rhode Island

STATION NIGHTCLUB FIRE LAWSUIT PROMPTS RHODE ISLAND’S LEGISLATURE TO AMEND THE JOINT TORTFEASOR ACT

On July 3, 2006, Rhode Island’s Joint Tortfeasor Act underwent a significant change by way of amendments to Sections 10-6-7 and 10-6-8 of the General Laws. Prior to amendment, these sections required that should an injured person release one joint tortfeasor, the amount recoverable against the remaining tortfeasors must be reduced by either the amount paid as consideration for the release by the settling tortfeasor or that settling tortfeasor’s pro rata share of fault, whichever is greater. In other words, if a settling tortfeasor paid $100,000 for a joint tortfeasor release but was found 75% responsible for the injury with $1,000,000 in damages awarded, the judgment for the remaining tortfeasors would be reduced by $750,000 to $250,000.

The amendments eliminate the non-settling tortfeasor’s ability to reduce liability by any amount other than the consideration paid for the release by the settling tortfeasor. In effect, the fault of a defendant is no longer a factor in reducing the verdict in cases where there are twenty-five or more deaths from a single occurrence. Going back to the previous example where the settling tortfeasor has paid $100,000 as consideration for a joint tortfeasor release, and the total damages awarded is $1,000,000, even though the settling tortfeasor was found to be 75% liable, the judgment for the remaining tortfeasors, collectively 25% liable, would be reduced by only $100,000 to $900,000.

The impetus behind this amendment is the civil lawsuit filed in the United States District Court for the District of Rhode Island subsequent to a fire in which 100 people died at the Station Nightclub in West Warwick, Rhode Island on February 20, 2003. Referred to as the “Station Fire Bill”, this amendment was intended to encourage prompt settlement by any of numerous defendants in the federal suit. Proponents of the amendment argued that these revisions to the joint tortfeasors act would benefit multi-party complex litigation by enabling tortfeasors to settle their claims in short time and remove the risk of claims for contribution asserted post-judgment. Under the new law, as soon as a plaintiff accepts the settlement amount, the settling joint tortfeasor makes payment and is out of the case regardless of his, her, or its actual responsibility for the injury.

Of course, this amendment is limited to lawsuits where there are twenty-five or more deaths from a single occurrence. Its applicability to civil litigation on the whole in Rhode Island is minimal, and it is largely viewed as strictly a vehicle for settlement of the Station Fire cases. There is, however, significant issue with the equity of these statutory amendments both in terms of its effect upon all of the defendants to the Station Fire case and in terms of any effect these amendments may have in the unforeseeable future of Rhode Island litigation.

South Carolina

“OWNER OPERATOR” AS EMPLOYEE VS. INDEPENDENT CONTRACTOR FOR PURPOSES OF WORKERS’ COMPENSATION CLAIM

In a quite recent case, the South Carolina Supreme Court re-confirmed its commitment to finding the existence of an
employment relationship for purposes of coverage under the South Carolina Workers’ Compensation Act. *Wilkinson v. Palmetto State Transport Co.*, Opinion No. 4179, South Carolina Supreme Court, decided in November 2006, involved the application of the Workers’ Compensation Act to a situation in which a driver, Scott Wilkinson, for Palmetto Transportation Company (“Palmetto”) was killed in a motor vehicle accident while hauling for the company in Virginia. In order to determine whether the driver’s family would receive benefits under the Workers’ Compensation Act as a result of the death, the Court had to resolve the question of whether Mr. Wilkinson was an employee or independent contractor of the company. Palmetto maintained that Mr. Wilkinson was an independent contractor, supporting its position largely with evidence that although the driver’s initial contract in 1998 described him as an employee, later contracts in 1999 and 2000 characterized his status as that of an independent contractor. However, the Court was quick to point out that “neither the descriptions of relationships as set forth in the parties’ contract, nor the language in the contract declaring the parties to be that of independent contractor/carrier is binding on this Court.” *Id.* (citing *Kilgore Group Inc. v. S.C. Employment Sec. Comm’n*, 313 S.C. 65, 437 S.E.2d 48, (1993)). “Rather, the determination of whether the worker is an employee or independent contractor is a fact-specific matter resolved by applying certain established principles.” *Id.* (citing *Nelson v. Yellow Cab Co.*, 349 S.C. 589, 564 S.E.2d, 110, (2002)).

This fact-specific determination involves an examination of four factors that are used to elucidate the right to and degree of control an employer has over the work of its laborers (whether employees or independent contractors). See, *S.C. Workers’ Comp. Comm’n v. Ray Covington Realtors, Inc.*, 318 S.C. 546, 459 S.E.2d 302 (1995); see also, Nelson. These factors are: (1) direct evidence of right to or exercise of control; (2) method of payment; (3) furnishing of equipment; and (4) right to fire. *Id.* While the presence of any one of the factors is sufficient to establish an employer-employee relationship, “the absence of any one of [them] is at most mild influential evidence of contractorship.” *Dawkins v. Jordan*, 341 S.C. 434, 439, 534 S.E.2d 700, 703 (2000).

With regard to the first issue of Palmetto’s right to control or actual exercise of control over how its driver was to accomplish his work, Palmetto pointed out that Mr. Wilkinson had the option to refuse loads and thus determined his own schedule. The Court was not persuaded by this argument and focused instead on Palmetto’s requirement that Mr. Wilkinson carry loads only for Palmetto while under contract with the company as well as the company’s instructions on when, where, and how to pick up and deliver loads. The sum of the Court’s analysis under this first factor weighed in favor of finding an employment as opposed to independent contractor relationship.

In contrast, the second factor—that of method of payment—suggested an independent contractor relationship rather than that of employer-employee. While Mr. Wilkinson was paid by the mile like employed drivers, his rate per mile was higher. Additionally, Mr. Wilkinson was responsible for various expenses, including fuel costs, service fees, and toll fees, unlike employed drivers, and Palmetto made no deductions for either social security or income taxes.

Interestingly, the Court found that the third consideration, which involves the furnishing of equipment, indicated that Mr. Wilkinson was an employee. The Court came to this conclusion despite the fact that Mr. Wilkinson owned his own tractor, though it is not clear who was responsible for maintenance and servicing of the tractor. The Court looked instead to Palmetto’s provision of the trailer and the Palmetto logo on Mr. Wilkinson’s tractor. Again, it was not clear how this logo was affixed (that is, whether it was removable or not), though the permanency of the logo might not have made a difference in the Court’s determination. The GPS system that Palmetto required its drivers to carry in their trucks further supported the Court’s finding that the company furnished equipment, though there was no discussion of whether the company simply required the system to be carried or in fact supplied all of the system equipment.

Finally, with regard to Palmetto’s right to fire Mr. Wilkinson, the Court pointed out that there
were many instances in which the company could fire the driver, and Mr. Wilkinson, in turn, could terminate his position with Palmetto at will. It would seem to this author that the consequences of such termination by either Palmetto or Mr. Wilkinson would be more indicative of whether the relationship between the two was an employment one, but the Court did not expound upon this question in this particular case.

In its conclusions, the Court emphasized (and it must be reiterated here) that “the Workers’ Compensation Act favors the inclusion of employers and employees and not their exclusion, and the presence of any one of the factors is sufficient proof of an employer/employee relationship.” In light of this preference and the facts of the situation, the Court concluded that the owner-operator was an employee and not an independent contractor for the purposes of the Workers’ Compensation Act.

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TENNESSEE

UNINSURED MOTORIST COVERAGE

In the case of Ragsdale v. Deering, No. M2004-00672-COA-R9CV, 2006 WL 2516391 (Tenn. Ct. App., Aug. 30, 2006), the Tennessee Court of Appeals considered an interlocutory appeal from the Circuit Court of Robertson County on the issue of whether an uninsured motorist insurer may deny coverage when damages arise from the intentional act of an uninsured motorist. In this case, the plaintiffs, Mr. Ragsdale and Mr. Hargrove, filed a lawsuit against a tortfeasor named Mr. Deering (and he had insurance coverage). Mr. Ragsdale served a copy of the Complaint upon his insurance carrier (Shelter Insurance Company) seeking coverage under the policy’s uninsured motorist provisions because Mr. Deering’s insurance carrier had denied coverage to him under the intentional acts provisions of the policy.

In support of its denial of uninsured motorist coverage and in support of its Motion for Summary Judgment, Shelter Insurance Company referenced the language of the policy which is substantially similar to most policies and reads as follows:

We will pay damages for bodily injury which an insured or the insured’s legal representative is legally entitled to recover from the owner or operator of an uninsured motor vehicle. The bodily injury must be caused by accident and arise out of the ownership, maintenance, or use of the uninsured motor vehicle.

(Emphasis added).

Shelter Insurance Company referenced the “by accident” language of the policy to argue that coverage would not be provided for injury sustained by an insured through the intentional acts of another.

At the trial level, the Circuit Court denied the uninsured motorist insurance carrier’s Motion for Summary Judgment finding that Shelter Insurance Company’s uninsured motorist policy provided coverage to its insured who sustained damages as a result of the intentional acts of the defendant whose coverage was rightfully denied under the intentional act policy provisions of his coverage. The Tennessee Court of Appeals affirmed the trial court’s decision.
In reaching its decision, the Court of Appeals referenced public policy arguments in support of Tennessee’s policy which requires insurance carriers to make available uninsured motorist coverage for the protection of persons who sustain damages by other owners or operators who are not adequately insured.

In further discussing the public policy arguments, the Court of Appeals noted that public policy supports the denial of insurance coverage by an insurer to one of its insureds who engage in intentional acts. After all, the underlying insured can control his or her own actions, and that person should not be able to insure himself or herself from the consequences of his or her own intentional actions.

With respect to uninsured motorist coverage, the Court of Appeals elected to view the definition of accident from the perspective of the insured victim. In following the majority of jurisdictions, the Court of Appeals interpreted the language of the UM policy to include the intentional acts of an uninsured motorist because from the insured victim’s standpoint the incident that caused the damages was unexpected and unintended.

In further construing the policy, the Court addressed Shelter’s argument that the damages sustained by the insured victim were caused by the uninsured motorist’s improper use of the vehicle. In support of its position, Shelter cited cases where coverage denials had been upheld by the Court. In specific, a case where trash was thrown from the window of a car and a case where someone shot a person from the window of a car. The Court stated in opposition to the argument of Shelter that the word “proper” was not used in the contract for uninsured/underinsured motorist carrier coverage. Furthermore, the Court differentiated the cases cited by Shelter to better define its rationale for prior denials of coverage. In doing so, the Court stated that if the vehicle was merely the “situs” of the action, then coverage may be denied if the damages arose from unlawful actions of the defendant/tortfeasor while in a vehicle when he or she caused damages that did not “originate from, flow from, or grow out of the actual use of the vehicle.”

In other words, the intentional ramming of the vehicle by the defendant/tortfeasor into the vehicle of the victim/insured caused the damages that reasonably flowed from, or originated from, or grew out of the use of the vehicle by the defendant/tortfeasor. The Court stated that such use was distinctly different from cases where coverage had been denied because damages were occasioned upon a plaintiff by the tortfeasor’s mere occupancy of a vehicle while engaging in unlawful conduct.

In the case of Wood v. U-Haul Company of Tennessee, No. M2005-00600-COA-R3-CV, 2006 W.L. 3071254 (Tenn. Ct. App., October 27, 2006), the Tennessee Court of Appeals considered an appeal by a plaintiff in a case that was tried before a jury in the Circuit Court of Davidson County. The plaintiff, Mark Wood, injured his back while allegedly assisting a U-Haul mechanic with the installation of a trailer hitch on the plaintiff’s truck. The plaintiff contended that the mechanic asked the plaintiff to hold the tailpipe of the truck out of the way with a pair of bolt cutters while the mechanic drilled holes for the installation of the trailer hitch. The plaintiff contended that the drilling of the holes

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TENNESSEE

COMPARATIVE FAULT

In the case of Wood v. U-Haul Company of Tennessee, No. M2005-00600-COA-R3-CV, 2006 W.L. 3071254 (Tenn. Ct. App., October 27, 2006), the Tennessee Court of Appeals considered an appeal by a plaintiff in a case that was tried before a jury in the Circuit Court of Davidson County. The plaintiff, Mark Wood, injured his back while allegedly assisting a U-Haul mechanic with the installation of a trailer hitch on the plaintiff’s truck. The plaintiff contended that the mechanic asked the plaintiff to hold the tailpipe of the truck out of the way with a pair of bolt cutters while the mechanic drilled holes for the installation of the trailer hitch. The plaintiff contended that the drilling of the holes
caused the truck to violently shake and caused the plaintiff to be thrown to the floor.

The interesting feature of the case is that the jury found that the plaintiff was 90% at fault and that the defendant U-Haul was only 10% at fault. The plaintiff had a long-standing history of low back problems and had been involved in an automobile accident nine months prior to the accident in question with aggravation of his low back problem. The jury concluded that the plaintiff was 90% negligent because the plaintiff knew that he had back problems and in light of such knowledge should not have been involved with the installation of a trailer hitch.

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TENNESSEE

LEGALLY DISABLED AND THE STATUTE OF LIMITATIONS

Those who are legally disabled due to unsound mind are protected by the statute of limitations for as long as the disability of unsound mind remains.

In the case of Abels ex rel. Hunt v. Genie Industries, Inc., 202 S.W.3d 99 (Tenn., 2006), the District Court for the Western District of Tennessee certified to the Tennessee Supreme Court the question of whether the Tennessee statute of limitations (Tenn Code Ann. § 28-3-104(a)(1) (2000)) “begins to run against the tort claims of a legally disabled individual once a legal guardian is appointed” or whether the Tennessee Legal Disability Statute (Tenn Code Ann. § 28-1-106 (2000)) tolls the statute of limitations for the legally disabled for as long as the person remains of unsound mind and regardless of whether that individual has a legal guardian who has been appointed to that person for the pursuit of claims.

In this case, the plaintiff, a disabled individual named Hunt, sustained severe brain injury in the course and scope of his employment while operating a Genie “Manlift.” The Circuit Court of Hardin County appointed Hunt’s uncle and supervisor (Abels) as “guardian ad litem.” The appointment order gave the guardian ad litem “full authority to handle Mr. Hunt’s financial affairs.”

Pursuant to such appointment, the guardian ad litem filed a products liability action against Genie on behalf of the disabled Hunt. The guardian ad litem filed the lawsuit within the 1-year statute of limitations because he believed it necessary to do so to toll the statute.

Approximately 18 months after the accident, the guardian ad litem sought leave of the court to amend the Complaint to add an additional party defendant, and that additional party defendant moved for summary judgment based upon the 1-year statute of limitations.

The District Court concluded that the Motion for Summary Judgment involved issues of state law without adequate controlling precedent and certified the issues for resolution by the Tennessee Supreme Court.

The Tennessee Supreme Court held as follows:

“The appointment of a guardian ad litem does not remove an injured person’s disability of ‘unsound mind’ under Tenn Code Ann. § 28-1-106, and ... the statute of limitations remains tolled so long as the injured person remains so disabled.”

With respect to the second issue of whether the disability of unsound mind is removed when the “injured person’s legal representative accepts responsibility for the injured person’s tort claims,” the court noted that Tenn Code Ann. § 28-1-106 states two very distinct conditions of disability – one being that of minority status and the other being that of unsound mind status. The statute “grants a grace period for minors and those of unsound mind during the disability and provides a maximum of three years in which to bring a claim after the disability is removed.”

The court went on to state that “the disability of a minority is removed when a minor attains the age of majority. The disability of unsound mind is removed when the individual is no longer of unsound mind due either to a change in the individual’s condition or the
individual’s death. The statute contains no language which would lead us to conclude that the legislature intended for removal of either of these two disabilities upon appointment of a guardian.”

Consequently, in Tennessee, the appointment of a guardian ad litem for a person who is a minor or who is of unsound mind does not negate the tolling of the statute of limitations.

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VERDICTS AND SETTLEMENTS

KENTUCKY

In October 2006, Lionel A. Hawse, Will H. Fulton and Lee A. Rosenthal of Woodward, Hobson & Fulton, in Louisville and Lexington, Kentucky, successfully defended PACCAR Inc in a wrongful death action brought by the parents of a deceased eleven year old boy. The product liability action asserted that the visibility of the Peterbilt cab chassis was inadequate causing the driver of the garbage truck to overlook the child. The Peterbilt cab chassis had four mirrors on the left side rather than the usual two mirrors. In addition the typical “California” mirror and attached square convex mirror were larger than required by Federal Regulation. The jury unanimously found that the product was not defective. The trial occurred in Fayette Circuit State Court in Lexington, Kentucky.

In July 2001 the driver of a right-hand steer automated garbage truck ran over an eleven year old as the driver negotiated a left turn into an intersecting street of a residential suburb of Lexington. The child was riding a “razor” scooter near the left curb heading in the same direction as the garbage truck. The scooter and the truck collided in the mouth of the intersecting street. Although the driver had previously seen the child in the neighborhood he momentarily “lost” him even though another child was seen in front of the truck before the attempted turn. The driver proceeded to turn anyway without locating the child and due to the “out-tracking” characteristic of straight trucks, the left rear tandems rolled over the child’s head and chest crushing him to death.

The product at issue was a 1993 PACCAR right hand drive cab & chassis equipped with an automated side loader body manufactured by Wayne Engineering. In addition to claims of inadequate off-side and rear visibility, plaintiff’s claimed that right-hand drive vehicles were unreasonably dangerous \textit{per se}, that they were too large for operation in residential neighborhoods (8 feet in width and 62,000 pound capacity, and that there were inadequate warnings regarding the out-tracking characteristics of straight trucks.

The incident created much publicity in Lexington including a comprehensive review of whether the government of the Lexington metropolitan area should abandon the automated side loaders which have been proven safer and more efficient than the 3 man rear loaders.

Plaintiff’s asserted that in addition to the four mirrors on the left side which came from Peterbilt as original equipment, the manufacturer should have included an aspherical mirror and a left hand video camera as well. Wayne had added a rear video camera at the time the garbage body was installed. Peterbilt established that aspherical mirrors have been criticized in such an application. The jury unanimously rejected (12-0) the need for an alternative design finding that there was no defect.
TEXAS

Deborah Dale was traveling westbound on IH-10 near Sonora, Texas at 9:00 PM. She was driving a 1992 Ford F-150 pulling a 19 foot camper trailer. She had just completed a series of uphill climbs which had slowed her speed to around 45 MPH. Explorer Trucking driver Tomasz Ruman was driving a tractor trailer at around 65 MPH in the same lane. After cresting the last hill, Ruman saw Ms. Dale, swerved left, and applied his brakes. Ruman's front right caught the left rear of Ms. Dale's camper. Both vehicles went off the road. Mr. Ruman reported no injuries. Ms. Dale reported cervical and lumbar pain and right shoulder pain and was transported to San Angelo Regional Hospital.

Ms. Dale was diagnosed with cervical and lumbar herniation and a right shoulder labrum tear. Surgery was recommended at all three levels, but none had been performed before trial. Past medical expenses totaled $34,000, and future medical expenses were presented totaling $105,000.

Ms. Dale contended that Ruman was negligent in the accident and also alleged negligent retention, training, supervision, and hiring as to Explorer Trucking. She claimed both defendants were grossly negligent. She sued for $3.5 million. Defendants contended the Ms. Dale was negligent for having failed to utilize her emergency flashers when she slowed down on the interstate. The topography of the hill was not an inhibiting factor to the visibility of the Dale vehicle, yet defendants contended they were still surprised by the slower moving vehicle with no emergency flashers. Defendants further argued that, with simply one more second of advanced warning from the flashers, the accident could have been avoided.

At the close of plaintiff’s case, the court granted judgment as a matter of law in favor of defendants on plaintiff’s claims of gross negligence, negligent retention, training, supervision, and hiring. After three days of trial, the jury returned a verdict finding both Ms. Dale and Mr. Ruman negligent and assessed each with 50% responsibility.

The jury awarded $74,000 in damages. Thus a judgment of $37,000 plus interest and taxable court costs was entered against Ruman. The damage aspect of the case was helped by video surveillance showing the plaintiff pruning shrubs and doing general yard work. The jury awarded no lost income or earning capacity after defendants introduced Ms. Dale’s social security disability application showing that one month before the accident she had filed a claim for benefits alleging she was totally disabled from a respiratory illness.

Explorer Trucking and Tomasz Ruman were represented by Larry D. Warren and Norma Herrera of the San Antonio ALFA firm, Ball & Weed, PC.
PRACTICE TIPS

MEDICARE SET-ASIDE

Introduction

One of your trucks is involved in a serious accident with a 65-year-old Medicare-eligible claimant. You want to settle the claim, including future medical expenses but are unsure how Medicare’s involvement might affect the settlement. Must Medicare’s interests be considered and evaluated during settlement negotiations? Even if the answer to that question is yes, do you, the defendant, have an obligation to ensure that any existing Medicare liens are satisfied by the settlement?

The purpose of this article is to help defendants and their insurers understand that penalties and liabilities can be placed on defendants, just as on plaintiffs, if Medicare liens are left unsatisfied. Quite simply, an uninformed, unprepared defendant might overlook Medicare’s rights in a settlement and could get stuck footing the same bill twice. It is important, therefore, that you give proper consideration to Medicare’s interests before entering into any settlement agreements.

Medicare

The Medicare program was established in 1965 as a “coordinated and comprehensive approach to federal health insurance and medical care for the aged” and disabled\(^{16}\). Medicare is administered by the Centers for Medicare & Medicaid Services (“CMS”), which was formerly known as the Health Care Financing Administration. CMS is a division of the Department of Health and Human Services. From its inception until 1980, Medicare typically paid for medical services regardless of whether the beneficiary was covered by another health plan.\(^{17}\) However, in an effort “to curb skyrocketing health costs and preserve the fiscal integrity of the Medicare system,”\(^{18}\) Congress enacted a “series of cost cutting amendments to the Medicare program . . . known as the Medicare Secondary Payer (MSP) statute.”\(^{19}\)

MSP Statute

Codified in 42 U.S.C. § 1395y(b), the MSP statute has existed for over 25 years. For most of that time, the statute has been limited to the workers’ compensation realm of civil litigation. Since the time of its enactment, however, “Congress has expanded its reach several times, making Medicare secondary to a greater array of primary coverage sources, and creating a larger spectrum of beneficiaries who no longer may look to Medicare as their primary source of coverage.”\(^{20}\) As a consequence, knowing the MSP statute has become a must for lawyers and others working in the personal injury liability field.

\(^{16}\) Turecamo v. Commissioner, 554 F.2d 564, 571 (1977); see HR. Rep. No. 213, 89th Cong., 1st Sess. 2 (1965)


\(^{18}\) Id.at 1071.

\(^{19}\) Id.

The purpose of the MSP statute is to make certain that Medicare is only secondarily responsible for payment of medical expenses by assigning “primary responsibility for medical bills of Medicare recipients to private health plans when a Medicare recipient is also covered by private insurance.” To this end, the MSP statute has two main features. First, the statute prohibits Medicare from making any payments where “payment has already been made or can reasonably be expected to be made promptly” by a primary plan. The statute defines a “primary plan” as: a group health plan or large group health plan, a workmen’s compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance... An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

The federal regulations further explain what is meant by “automobile or liability insurance” and “no-fault insurance”:

Liability insurance means insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners’ liability insurance, malpractice insurance, product liability insurance, and general casualty insurance.

Liability insurance payment means a payment by a liability insurer, or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurance policy, by any individual or other entity that carries liability insurance or is covered by a self-insured plan.

No-fault insurance means insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It is sometimes called “medical payments coverage”, “personal injury protection”, or “medical expense coverage.”

When a Medicare beneficiary requires treatment as a result of an injury caused by a responsible third party, Medicare will defer to one of these plans as the “primary” payer for all injury-related expenses. The goal is to shift the cost of treatment back to the responsible party.

In the real world, however, “prompt” payment by a “primary” payer does not always happen. Frequently in personal injury litigation, a primary plan has a legitimate basis for denying medical benefits while the parties dispute liability, causal relationship, and the need for treatment. During the course of litigation a beneficiary may still require treatment, and so the second essential feature of the MSP statute grants Medicare the authority to make payments when a primary plan “has not made or cannot reasonably be expected to make payment with respect to such item or service promptly.” These payments are called “conditional payments,” because Medicare is only allowed to make them on the condition that Medicare is promptly reimbursed by the primary plan after a settlement is reached or after the plan is adjudicated liability.

**Past Medical Expenses (Conditional Payments)**

Situations where Medicare has made payments prior to a settlement require that the injured party already be a Medicare beneficiary. In these situations, it is essential that these “conditional payments” are properly investigated prior to the resolution of the claim and that the amounts owed to Medicare are factored into the settlement agreement. If the primary plan is responsible it will have to reimburse Medicare. CMS cannot issue a formal demand for recovery until after

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22 42 U.S.C. § 1395y(b)(2)(A)(ii). “Prompt or promptly, when used in connection with payment by a liability insurer means payment within 120 days after the earlier of the following: (1) The date a claim is filed with an insurer or a lien is filed against a potential liability settlement. (2) The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.” 42 C.F.R. § 411.50.
24 42 C.F.R § 411.50
26 See 42 U.S.C § 1395y(b)(2)(B)(ii).
payment has been made; however, attorneys can obtain an estimate of Medicare’s claim by contacting CMS’s Coordination of Benefits Contractor. This is helpful both for ensuring that there are no inappropriate claims and for determining a final amount to be included in the settlement.

If Medicare’s interests are overlooked, all parties in the litigation could face significant exposure. The MSP statute grants Medicare both a direct right of action and subrogation rights in order to recover amounts paid that should have been paid by a primary payer. As soon as CMS discovers that payment has been made or could be made under workers’ compensation, liability, no-fault insurance, or group health plan, it has the right to initiate recovery. This means that CMS has a direct right of action to recover twice the amount of the Medicare primary payment. Furthermore, the regulations state that in cases of “liability insurance settlements and disputed claims under employer group health plans, workers’ compensation insurance or plan, and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required... the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.”

Reimbursement must be made to Medicare within 60 days. After that time, interest will begin to accrue until reimbursement is made. If done properly, once Medicare receives the appropriate reimbursement the case will be closed. If Medicare’s interests are overlooked, you open yourself up to a number of unwanted liabilities ranging from the insurance carrier or self-insured being exposed to double damages, the government pursuing a right of recovery against the attorney, or the claimant bringing a malpractice claim against the attorney post settlement.

**Future Medical Expenses**

With regard to future medical expenses in liability cases, CMS currently has no formal policy on how to consider Medicare’s interests. Medicare set-aside professionals and others in the industry predict that CMS will soon require Medicare beneficiaries to follow a course of action similar to the one in place for workers’ compensation claims and settlements. A look at what is required in a workers’ compensation claim is helpful. In a workers’ compensation case, if you are seeking to close out future medical expenses you are required to get approval from CMS before proceeding. In those cases, if you omit this step, and CMS decides that your settlement is an attempt to shift the burden of future medical expenses onto Medicare, it will not recognize the terms of the settlement. Furthermore, it could result in the beneficiary losing future Medicare coverage, or CMS bringing suit to recover the entire amount (or double the amount) from the attorney or the carrier.

You should consider Medicare’s interests whenever you are seeking to close out future medical benefits and either of the following conditions applies:

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27 CMS has instructed parties seeking to obtain information regarding past Medicare expenses as follows:

Any question (that an attorney may have) about potential liens should be directed to CMS’s Coordination of Benefits (COB) Contractor promptly upon entering into an agreement to represent a Medicare beneficiary for an accident or injury that may involve health care claims. The COB Contractor can be reached Monday through Friday, 8am-8pm Eastern Time (except holidays); the toll-free number is 1-800999-1118.

The COB Contractor will send the attorney a “Medicare right of recovery” letter and a “release of information” form for beneficiary signature. The COB Contractor will advise the attorney as to the lead Medicare recovery contractor and create a Medicare Secondary Payer record in the CMS database used in the claims adjudication process to prevent mistaken Medicare primary payment for affected claims.

28 See 42 U.S.C. § 1395y(b)(2)(B)(i) and (iii).

29 See 42 C.F.R § 411.24(b).

30 See 42 C.F.R § 411.24(e).

31 See 42 C.F.R § 411.24(g).

32 See 42 C.F.R § 411.24(c)(2).

33 42 C.F.R § 411.24(i).

34 See 42 C.F.R § 411.24(h).

35 See 42 C.F.R § 411.24(m)(2)(ii).
1. The petitioner is already a Medicare beneficiary or is Medicare eligible.\(^{36}\)

2. The petitioner has a “reasonable expectation” of becoming a Medicare beneficiary within 30 months of the date of the settlement and the anticipated amount of the settlement exceeds $250,000.\(^{37}\)

The most preferred method by CMS when closing out

\(^{36}\) “The Medicare program encompasses four basic groups: (1) Persons who have reached age 65 and are entitled to receive either Social Security, widows or Railroad Retirement benefits; (2) Disabled persons of any age who have received Social Security, widows or Railroad disability benefits for 25 months; (3) Persons with end-stage renal disease (“ESRD”) who require dialysis treatment or a kidney transplant; and (4) Persons over age 65 who are not eligible for either Social Security or Railroad Retirement Benefits who purchase Medicare coverage by payment of a monthly payment. The “working aged” are those Medicare beneficiaries who are also active employees working for an employer of 20 or more employees. 42 C.F.R. §§ 405.340-341. See Cooper v. Blue Cross and Blue Shield, 19 F.3d 562 (11th Cir. 1994). Froze, v. Transcon. Ins. Co., 374 F. Supp. 2d 1067, 1071 (2004). Approval of a Medicare Set-Aside arrangement for current Medicare beneficiaries need only be obtained when the settlement exceeds $25,000.

\(^{37}\) Situations where an individual has a “reasonable expectation” of Medicare enrollment for any reason include but are not limited to:

   a) The individual has applied for Social Security Disability Benefits;
   b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;
   c) The individual is in the process of appealing an/or re-filing for Social Security Disability Benefits;
   d) The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or
   e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based on ESRD.

Thomas L. Grisson, Director of CMS, Medicare Secondary Payer-Worker’s Compensation (WC) Frequently Asked 4-22-2003 (CMS memorandum to All Regional Administrators).

future medical costs is to establish a Medicare Set-Aside arrangement (MSA). A MSA can be either professionally or self-administered. The purpose of a MSA is to set aside a portion of the settlement for payment of future medical expenses. If done properly, once the fund is depleted, the beneficiary remains eligible for future medical treatment by Medicare.

The parties must estimate what the future medical expenses will be for the injury.

The parties typically have an attorney or attorneys who specialize in this field perform these calculations for them. They then submit to CMS all the relevant information about the claim and future medical expenses for approval of the arrangement and the amount. The following information should be provided to CMS to allow for proper consideration of the adequacy of the funds and to make sure that the burden is not being shifted to Medicare.

1. Date of entitlement to Medicare.
2. Basis for Medicare entitlement (disability, ESRD or age).
3. Type and severity of injury or illness. Is full or partial recovery expected? What is the projected time frame if partial or full recovery is anticipated? As a result of the accident is the individual an amputee, paraplegic or quadriplegic? Is the beneficiary’s condition stable or is there a possibility of medical deterioration?
4. Age of beneficiary.
5. Amount of lump sum or amount of structured settlement.
6. Is the commutation for the beneficiary’s lifetime or for a specific time period?
7. Is the beneficiary living at home, in a nursing home, or receiving assisted living care, etc.?
8. Are the expected expenses for Medicare covered items and services appropriate in light of the beneficiary’s condition?\(^{38}\)

It should be noted that CMS does not use any specific form or calculation to approve the arrangement. Approval is granted on a case-by-case basis after numerous factors are considered and negotiated. Again, failure to comply with the MSP statute can result in exposure to liabilities and penalties for both parties and attorneys involved.

While the procedure for establishing a MSA arrangement in workers’ compensation claims is informative and may very well become the standard protocol in liability settlements, that is not yet the case. Conceivably, a Medicare beneficiary could establish a MSA arrangement and submit it to CMS for approval just as in a workers’ compensation settlement, but there is no guarantee that CMS will approve it, or even review it, as there is currently no review procedure in place for liability claims. Until MSA arrangements

\(^{38}\) Parashar B. Patel, Deputy Director of CMS, Workers’ Compensation: Commutation of Future Benefits 7-23-2001 (CMS Memorandum to All Regional Administrators).
Until MSA arrangements or their equivalent become commonplace in liability cases, there are some precautionary measures that can be taken to ensure that Medicare’s interests are being considered. First, before ever entering settlement discussions, go through the process of obtaining projections of future medical expenses. Secure documentation from professionals, including physicians, about what costs will be involved in the future care of the beneficiary. It may even be helpful to have a Life Care Plan created. This would be similar to setting up a MSA, except that there would be no need to submit the plan to CMS for approval.

Next, the language in the settlement documentation should be carefully prepared so that it is abundantly clear that Medicare’s interests have been considered in reaching the settlement. This may involve demonstrating an understanding of the MSP statute and addressing the various Medicare interests, such as the appropriate procedure that will be followed for any conditional payment reimbursements coming out of the settlement as discussed above.

Finally, plainly identify the amount “set aside” for compensation of future medical expenses. Ensure that the Plaintiff and his or her attorney are made aware of the amount and of its intended purpose. Encourage the Plaintiff to keep receipts for, or otherwise document, any treatment or costs associated with the claim. Make sure that the Plaintiff understands that those funds are to be spent on medical treatment related to the claim before any injury-related claims can be submitted to Medicare.

In the end, because CMS currently has no formal process for reviewing or approving set-aside arrangements in liability cases, there is always the risk that if CMS seeks reimbursement after the settlement is final and the claimant does not reimburse Medicare, CMS would still have a right of action against the primary payer. Until CMS provides further guidance, however, careful and thorough preparation of a settlement could save you from paying twice.

**Conclusion**

The MSP statute may seem like a minefield that you must negotiate when working out the details of a liability settlement. Indeed, failure to properly consider Medicare’s interests when doing so could have a damaging effect on the resolution of the claim. Both parties could be faced with additional costs, delay, duplicative payments, and monetary penalties. The recent changes to the MSP statute grant CMS substantial recovery rights and place a greater burden of reporting and compliance on the litigating parties. The practitioner who has taken the time to become familiar with the MSP statute and guidelines, however, can safely navigate this rapidly developing and largely uncharted area of law. Being thoroughly informed and well prepared will put you in a stronger position to protect yourself, your client, and your clients’ interests by giving proper consideration to Medicare’s rights in your liability settlement.
**ARTICLES**

**MONEY AND TIME: THE DUTY TO THE INSURED TO PROMPTLY SETTLE WITH THE CLAIMANT**

**INTRODUCTION**

The focus of this article will be a discussion of the circumstances under which an insurer or an excess insurer may have a duty to settle a claim or suit. We will discuss primarily the context in which a motor carrier has a substantial self insured retention (SIR) or similar contractual arrangement in which a motor carrier retains the need to investigate and defend claims and suits. We will also discuss the standards which will be applied in determining whether the duty to settle has been met in a fair and timely way. An in-depth review of the Texas Supreme Court case *Rocor International, Inc. v. National Union Fire Insurance Co.*, 77 S.W.3d 253 (Tex. 2002) will illustrate how one court wrestled with these issues. Before delving into this topic, we will discuss briefly the various types of insurance which come into play when the courts consider these issues and several problems which have arisen where a motor carrier has a significant deductible or a large SIR.

**I. THE INSURANCE RELATIONSHIP FOR THE MOTOR CARRIER**

There are three common forms of insurance for the motor carrier. Primary policy coverage serves as the most common form of basic insurance. This is almost exclusively the type of insurance purchased by automobile owners. Douglas R. Richmond, *Rights and Responsibilities of Excess Insurers*, 78 Denv. U.L. Rev. 29, 29 (2000). An umbrella policy often covers claims not encompassed by the primary policy and can essentially stand alone in the defense of those claims because the lack of coverage by the primary insurer. *Id.* at 31. Finally, excess insurance covers claims that exceed the underlying limit of a primary policy. By working in tandem, all assist in benefiting the insured by protecting against varying levels of damages and claims. In these typical policies the obligation to investigate and defend the insured falls by contract on the insurance carrier.

Primary liability insurance is the most familiar form of insurance with most motor carriers. Douglas R. Richmond, *Rights and Responsibilities of Excess Insurers*, 78 Denv. U.L. Rev. 29, 30 (2000). The policy covers the second risk by requiring the company to indemnify the insured for judgments or settlements, but only up to a specified amount. *Id.* at 1304.

Some insureds may also choose to purchase an umbrella policy, a policy which would cover different types of claims than those risks covered by the primary policy. *See Am. States Ins. Co. v. Md. Cas. Co.*, 628 A.2d 880, 886 (Pa. Super. Ct. 1993). In other words, an umbrella policy serves as an additional primary insurance that exists to cover claims not covered and/or specifically excluded by the basic primary policy. Douglas R. Richmond, *Rights and Responsibilities of Excess Insurers*, 78 Denv. U.L. Rev. 29, 30 (2000).

Insurance Law and Practice § 4682, 28 (1979)). The policy may also be applicable in lawsuits where it is very clear that the primary policy limits will be exceeded and the excess carrier chooses to be active (in a variety of different ways) in the case to protect its interests. Thus, while the primary policy has not yet been depleted, the risk of that occurrence is great, encouraging the excess carrier to join the defense.

Self-Insured Retention plans (SIRs) are generally similar to a primary liability policy; however, the insured has determined to manage the risk on its own in a particular way. A SIR almost always retains with the insured motor carrier the duty to defend as well as the duty to pay claims and judgments up to a specified amount. Each of these main types of insurance arrangements for motor carriers (and the others that exist) have varying risks to the contracting parties which are impacted in claims and litigation as possible settlements with a claimant or plaintiff are considered. We will discuss these various considerations where appropriate.

II. THE DUTY OF GOOD FAITH AND FAIR DEALING

All contracts, including these types of insurance contracts, contain the implied “duty to perform with care, skill, reasonable expedition and faithfulness the thing agreed to be done.” Apodaca v. Aetna Cas. & Sur. Co., 1998 WL 808622, 4 (Tex. App. 1998) quoting Montgomery Ward Co. v. Scharrenbeck, 204 S.W.2d 508, 510 (Tex. 1947). “[T]he issue in a breach of good faith and fair dealing claim does not focus on whether the underlying claim was valid, but on the reasonableness of the insurer’s conduct in rejecting the claim.” Id. at 5, citing Lyons v. Millers Casualty Ins. Co. of Tex., 866 S.W.2d 597, 601 (Tex. 1993) (as discussed below, bad faith claims are also brought when an insurer fails to settle). When an insured believes that its insurer has violated the duty of good faith and fair dealing, the insured may bring a claim for “bad faith.”

It should also be noted that in some jurisdictions the claimant also has a right to bring a “bad faith” claim against an insurance carrier. These claims are generically called “third party bad faith claims.” Plaintiffs often attempt to join third party bad faith claims with a suit directly against the motor carrier and its driver. Most courts hold bad faith claims in abeyance until the underlying claim is resolved.

The issue of bad faith is complicated by the fact that an insurer’s duties are evaluated under different standards by different courts. Many jurisdictions have created statutes imposing the duty of good faith and fair dealing. See, e.g., Tex. Ins. Code Article 21.21 (ensuring a cause of action against an insurance company that has used “unfair methods of competition or unfair or deceptive trade practices.”) The relationship between insurer and insured has also been described as “fiduciary” by courts, see, e.g., Mowry v. Badger State Mut. Cas. Co., 385 N.W.2d 171 (Wis. 1986) (citing, implicating a more stringent set of obligations given the heightened duty associated with the fiduciary duty standard in its most general sense than the court would impose on “ordinary” contracting parties.

Other jurisdictions view the claim as either contractual, see Michael Sean Quinn, The Defending Liability Insurer’s Duty to Settle: A Meditation Upon Some First Principles, 35 Tort & Ins. L.J. 929, 933-938 (Summer 2000), or extra-contractual, applying different negligence standards. Id. In these courts, a breach of the implied warranty of good faith in an insurance policy is treated as a tort. Id. Conversely, the express warranty set forth in the policy is viewed as a contract and thus a contractual breach. Id. This characterization can significantly impact the statutes of limitation governing when suit must be brought as well as the measure of damages for first party bad faith claims. Counsel for motor carriers must be intimately familiar with these jurisdictional variations to adequately advise the motor carriers of their rights.

Most jurisdictions provide a combination of these theories. See, e.g., Egan v. Mutual of Omaha Ins. Co., 620 P.2d 141, 145 (Cal. 1979) (en banc) (noting that the relevant standard was “whether a prudent insurer would have accepted the settlement offer if it alone were to be liable for the entire judgment” thereby implicating both the “prudent insurer and a reasonable man standard, as in one who is “liable for the entire judgment”).
The duty of the primary insurer to defend against claims is well accepted, see Fireman’s Fund, 65 Cal. App. 4th at 1305, but the issue becomes more muddled when excess insurance or umbrella policies exist. For example, an excess policy provider would not have an interest in defense if the claim was clearly covered by the primary policy. However, when the claim potentially or definitively exceeds the policy coverage of the primary insurer, the excess carrier has an interest, however personal to protect itself (as opposed to protection of the insured) in the outcome and, hence, defense of the case. Douglas R. Richmond, Rights and Responsibilities of Excess Insurers, 78 Denv. U.L. Rev. 29, 44-45 (2000).

The potential conflicts within this situation abound. Though the primary insurer has the duty to defend the insured, see Fireman’s Fund, 65 Cal. App. 4th at 1305, a primary insurer would not like to carry the full cost of the defense, especially with the critical knowledge that their policy limit will likely be exceeded, Douglas R. Richmond, Rights and Responsibilities of Excess Insurers, 78 Denv. U.L. Rev. 29, 45 (2000), and defense costs are not typically included in excess policies. Michael Sean Quinn, The Defending Liability Insurer’s Duty to Settle: A Meditation Upon Some First Principles, 35 Tort & Ins. L.J. 929, 931, 933-938 (Summer 2000).

This contradicts the excess carrier’s ability to recoup defense cost when the excess carrier chooses, not required by duty, to assume “it’s insured’s defense because the primary insurer fails to do so.” Douglas R. Richmond, Rights and Responsibilities of Excess Insurers, 78 Denv. U.L. Rev. 29, 45 (2000) citing Kitchnefsky v. Nat’l Rent-A-Fence of Am., Inc., 88 F.Supp.2d 360, 370-71 & n.16 (D.N.J. 2000). This reinforces the principle that defense costs rest primarily on the primary insurer who also retains the first duty to defend. Considering these conflicts, the incentive for the insurer to strongly defend the excess carrier’s financial interests may be lacking. Both insurers may therefore have an interest in defense of the case, though both may not have a duty to defend the case. Thus, excess carriers can be prompted to join a lawsuit earlier than their specific duty requires in many situations.

The duty for an excess carrier to defend exists only when the primary policy limit has been truly spent; Fireman’s Fund Ins. Co., 65 Cal. App. 4th at 1304 (citing Olympic Ins. Co. v. Employers Surplus Lines Ins. Co., 126 Cal. App. 3d 593, 597 (Cal. Ct. App. 1981)), however, at their choice, the excess carrier may include (as is routinely the case) the right to participate in defense of a case in their contract. Douglas R. Richmond, Rights and Responsibilities of Excess Insurers, 78 Denv. U.L. Rev. 29, 44-45 (2000). If an excess carrier asserts this contractual right and accepts this duty, the corresponding liability to defend with good faith and fair dealing may apply. The excess carrier may, under certain highly specific circumstances, be able to sue the primary carrier for the costs of defense. Such a suit would be viable when the excess carrier was forced to accept the defense because of the refusal of the primary carrier to fulfill this duty. Nat’l Union Fire Ins. Co. v. Travelers Ins. Co., 214 F.3d 1269, 1272-73 (11th Cir. 2000); Hartford Accident & Indem. Co. v. Super. Ct., 23 Cal. App. 4th 1774, 1779 (Cal. Ct. App. 1994). A primary insurer may officially relinquish this duty through a declaration that this duty has been fulfilled, see Hartford Accident & Indem. Co. v. Super. Ct., 23 Cal. App. 4th 1774, 1779-80 (Cal. Ct. App. 1994). At this point, the duty falls to the excess carrier as well as the corresponding liability for good faith and fair dealing.

Courts include the duty to settle within the duty of good faith and fair dealing. Douglas R. Richmond, Bad Insurance Bad Faith Law, 39 Tort Trial & Ins. Prac. L.J. 1, 4-5 (2003); Asermerly v. Allstate Insurance Co., 728 A.2d 461 (R.I. 1999) (an insurance company’s fiduciary obligations include a duty to consider seriously a plaintiff’s reasonable offer to settle within policy limits.) One explanation offered for inferring a duty to settle is based on conceptualizing the insurer–insured relationship as a fiduciary one. Mowry, 385 N.W.2d at 179. Because the insured may not control the defense of the claim against them, they rely on the insurer to keep their best interests in mind in strategizing and carrying out the defense. See Michael Sean Quinn, The Defending Liability Insurer’s Duty to Settle: A Meditation Upon
Some First Principles, 35 Tort & Ins. L.J. 929, 931-32 (Summer 2000). At times, settlement is a better option for the insured than litigation, and therefore, settlement may be seen as part of the defense strategy. Thus, insurers are required to consider and execute settlement, if appropriate, or a potential breach of good faith and fair dealing may arise. Id. at 929.

When an insured claims that the insurer did not fulfill its duty to settle, courts must interpret the actions of the insurer within the confines of the relationship of insurer-insured. Courts have utilized different standards in determining whether the insurer fulfilled their duty, mainly that of a “reasonable man,” a “reasonable insurer,” or some combination thereof. Certainly this distinction can significantly impact jury deliberations if the instructions are followed. Jurisdictions differ both in their description of the standard and which standard they choose to apply. The standards typically include an analysis of whether, “in light of the victim’s injuries and the probable liability of the insured, an ultimate judgment is likely to exceed the amount of the settlement offer.” Johansen v. California State Auto Assn. Inter-Ins. Bureau, 538 P.2d 744, 748 (Cal. 1975).


In Florida, the Supreme Court explicitly established a reasonable person standard in holding “[a]n insurer...has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business.” Gutierrez, 386 So.2d at 785. (Emphasis added). Furthermore, negligence should be considered because the insurer should “investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so.” Id. at 464.

A reasonable person standard was also articulated in a ruling from the Rhode Island Supreme Court. Asermely, 728 A.2d at 461. This holding requires the finding of reasonableness to imitate the fiduciary obligations implicitly included in the relationship between the insurance company and the insurer. Id. at 464. In conducting its business under the fiduciary duty obligation, the insurer is required to act in the “best interest of its insured in order to protect the insured from excess liability.” Id. (citing Medical Malpractice Joint Underwriting Association of Rhode Island v. Rhode Insurers’ Insolvency Fund, 703 A.2d 1097, 1102 (R.I. 1997).

With a standard of this kind, the court apparently gives jurors an open invitation to put themselves in the position of the insured in making the determination. When this perspective is coupled with the potential for hindsight bias (as these cases always arise when an excess verdict has already been given) this would appear to provide a practical standard which is heavily weighted in favor of the insured.

Other jurisdictions consider the insurer’s actions under a “reasonable insurer” standard. See, e.g., Hartford Case Ins. Co. v. N. H. Ins. Co., 628 N.E.2d 14, 18 (Mass. 1994); Goodson v. American Standard Ins. Co. of Wis., 89 P.3d 409 (Colo. 2004); Cotton States Mutual Ins. Co. v. Brightman, 580 S.E.2d 519 (Ga. 2003). These courts choose to judge the reasonableness of the actions “from the viewpoint of one who is exposed to the entire risk.” Johnson v. American Family Mutual Insurance Co., 674 N.W.2d 88, 91 (Iowa 2004). Courts rationalize this standard again using the fiduciary duty standard by asking what would the insurer do if they could be liable for the full settlement, as the insured could be without the insurance policy.

In Johnson, the Iowa Supreme Court held that in insurance actions, a plaintiff claiming bad-faith must show there existed no reasonable basis for rejection. Id. This standard should be analyzed from the insurer’s standing. Id. Thus, the benchmark for establishing reasonableness hinges on the finding of good faith and honest belief that “the action could be defeated or the judgment held within the policy limits.” Id. at 90. This jurisdiction represents...
the other end of the spectrum from jurisdictions like Rhode Island.

The practical rationale for the Iowa approach is that the insured in these situations will **always** have the possibility of an excess verdict regardless of the amount of coverage they purchase. In the real world, many motor carriers either choose not to buy a realistic amount of coverage or simply can not afford to do so. If the standard for imposing bad faith is too liberal, it in effect simply extends an unspecified amount of additional coverage to the insured for which they did not pay a fair premium. In addition, it is often the case that motor carriers without sufficient coverage often have the worst accident records in the industry. Accordingly, the standard chosen by the courts in this area can have a real impact on the safety of the public.

California courts have also adopted the reasonable insurer standard. *Johansen*, 538 P.2d at 744. If a “prudent insurer would have accepted the settlement offer if it alone were to be liable for the entire judgment” serves as the standard for judging reasonableness. *Egan v. Mutual of Omaha Insurance Co.*, 620 P.2d 141, 145 (Cal. 1979).

Additionally, the reasonable insurer standard expands into the third-party claim cases. When confronted with a third-party in lawsuits, it is important to note that the insurer’s good faith requirement extends **only** to the insured. *Goodson v. Am. Standard Insurance Co. of Wis.*, 89 P.3d 409, 414 (Co. 2004). Therefore, in a third-party context, “the insured must show that a reasonable insurer under the circumstances would have paid or otherwise settled the third-party claim.” *Id.* at 415. The duty to settle, which surfaces in the relationship established between the primary insurer and excess carrier while in a lawsuit, can be breached in some jurisdictions by leaving the settlement negotiations to the insured. *Am. Centennial Ins. Co. v. Warner-Lambert Co.*, 681 A.2d 1241, 1248 (N.J. Super. Ct. Law Div. 1995). However, a suit for breach of this duty by the excess carrier requires a showing that the primary insurer breached a duty to the insured. Douglas R. Richmond, *Rights and Responsibilities of Excess Insurers*, 78 Denv. U.L. Rev. 29, 72-73 (2000). Again, this emphasizes that the principle of the duty of good faith extends to the insured and is to be viewed from a reasonable insurer’s position.

Beyond a reasonable person standard and a reasonable insurer standard, some jurisdictions have created a blend of both standards. While this sometimes complicates the issue, the cases are typically fact-specific and should be seen as such. Nonetheless, these decisions can be extended to other cases by analogy for a complete understanding of the many standards of reasonableness.

Indeed, it is difficult to fashion a clear-cut standard in this area of the law as all the cases tend to be fact specific. Many cases present facts which are “on the bubble,” and reasonable attorneys and insurance professionals can differ widely over whether or not it is unreasonable to not settle a case within the contractual coverage limits.

It is axiomatic that when purchasing insurance motor carrier’s want reasonable premiums that are **not** based on inflated settlements which did not really need to be made. Conversely, all motor carriers want every case that is on the bubble settled within the policy limits. Occasionally insurance companies even get mixed signals from different people within the motor carrier’s operation about whether or not a specific case should be settled. Those charged with overseeing the operational costs of a motor carrier often do not want a case settled even when others in the trucking company want the risk off the books.

One blended standard requires the insurer to “place itself in the shoes of the insured and conduct itself as though it alone were liable for the entire amount of the judgment.” *Dairyland Insurance Co. v. Herman*, 954 P.2d 56, 61 (N.M. 1997) quoting *Johansen v. California State Auto Assn. Inter-Ins. Bureau*, 538 P.2d 744, 748 (Cal. 1975). This echoes the standard of a reasonable person in that it requires a person to act as one would in conducting her own business; however, it specifically requires the determination to be from the viewpoint of a reasonable insured. The facts of this case can lend reasoning to the decision
- one insurance company was seeking reimbursement from another insurance company. Id. Therefore, should this ruling be applied to other facts, the court would probably implement the reasonable person standard.

The duty to settle can apply to both primary and excess carriers. Rocor Int’l, Inc. v. Nat’l Union Fire Ins. Co., 77 S.W.3d 253 (Tex. 2000). However, the duty to settle typically applies to excess carriers only once their policy is implicated, Douglas R. Richmond, Rights and Responsibilities of Excess Insurers, 78 Denv. U.L. Rev. 29, 44-45 (2000), i.e. when the primary policy is exhausted. An excess insurer could also be held responsible for the consequences of delayed settlement, as seen in the detailed discussion of the Rocor decisions below in both the Texas intermediate Court of Appeals and ultimately in the Texas Supreme Court. Id. In other words, once the excess insurer has the duty to defend, whether they accepted that duty or whether it transferred to them, they also have the duty to settle. Id. at 66. Without this transfer of duty, the primary insurer would continue to be responsible for settlement as the excess carrier is responsible for the defense, which would create a situation fraught with conflict. Because of the sometimes competing interests of the insurers both as to each other and the insured, notice of a lawsuit in its early stages to all those involved is encouraged. Douglas R. Richmond, Rights and Responsibilities of Excess Insurers, 78 Denv. U.L. Rev. 29, 38 (2000). This alerts the excess carrier from the beginning of the lawsuit of the possibility of their involvement in the action. Notice of the initiation of claims and suits to all insurance carriers by motor carriers also meets the “duty to cooperate,” which is virtually always a contractual obligation of the insurance policy. Motor carriers with SIR policies should require that their counsel keep all carriers advised of the course of the investigation and defense of each claim and suit.

The duty to settle is likewise complicated by the co-existence of primary and excess insurance. Because primary insurers are responsible for defense until the case settles, the primary insurer’s “policy limits are exhausted, or until there is otherwise no potential for coverage under its policy,” Id. at 45, settlement could realistically be discussed without the input of the excess carrier despite the implication of the excess policy. The conflict of interests between the insurers is easily illustrated in a case where the liability would be obviously above the limits of the primary policy.

Because of the desire to keep defense costs low and the knowledge that the primary insurer will pay their full policy, the incentive for the primary insurer to drive as low a settlement as possible in the excess layer may be lacking. Douglas R. Richmond, Rights and Responsibilities of Excess Insurers, 78 Denv. U.L. Rev. 29, 38 (2000). Instead, the primary policy would rather settle at whatever costs, since they would be paying out their full policy regardless of the actual settlement. By settling early, the primary policy insurer would both save money and time on reaching a more favorable settlement. To avoid this problematic situation, excess carriers may include a requirement within their contract that notice be given about settlement discussions. Douglas R. Richmond, Rights and Responsibilities of Excess Insurers, 78 Denv. U.L. Rev. 29, 33-34 (2000). In fact, at least one court has found that primary insurers have a duty of notice to the excess carrier even in the absence of language in the policy requiring such notice. See Am. Centennial, 681 A.2d 1241, 1245-46 (N.J. Super. Ct. Law Div. 1995).

In summary, the duty to settle is complicated by both the varying standards used to evaluate the behavior of the various parties and the existence of competing interests between the primary and excess insurers. A tendency may exist in a variety of situations to gamble with another contractual party’s money in the settlement context, and each party must be aware of their rights and responsibilities in the entire settlement process. The transfer of the duty to defend between the primary carrier and the excess carrier essentially defers some of this conflict, as does the expectant notice option. However, much conflict remains between the two insurance carriers embroiled in a lawsuit with claims involving the monetary commitments of both carriers. This can also be significantly complicated where the motor carrier’s own money (in the form of a SIR or deductible) is also at risk in the fashioning of the settlement of a claim or suit.
III. SPECIAL CHALLENGES OF THE SELF-INSURED RETENTION

Large self-insured retentions and large deductibles present a variety of unusual problems for the motor carrier and the insurance company as well. This section discusses several of the types of problems that can arise from this relationship. These cases generally arise from the fact that motor carriers with large self-insured retentions and large deductions do not typically insure the risks associated with the investigation and defense of claims and suits. The following cases turn almost exclusively on the language of the policy under consideration. Consequently, motor carriers considering the SIR approach should discuss in detail how they wish to proceed with their broker and their carrier so that they will in fact buy the type of policy they really want.

No motor carrier should seriously consider a SIR policy unless they are working with a broker who is intimately familiar with this form of coverage. Similarly motor carriers considering a SIR policy should only consider an insurer who is willing to educate them about the intricacies of the policy.

Where a motor carrier chooses to self-insure these costs, it needs to develop a network of excellent investigators and local and/or regional lawyers. There are several nationwide investigators who specialize in trucks and other commercial vehicles. Most motor carriers who self insure the duty to investigate and defend claims and suits go to these specialists. Similarly, there are many attorneys throughout the country who heavily specialize in the defense of claims and suits against motor carriers. As the regulations of the federal government and federal statutes impact significantly on motor carriers’ operations, it is preferable to seek out lawyers who have significant experience in defending motor carriers for this reason. Ideally, these investigative specialists and attorneys can assist the motor carrier in avoiding the types of situations reflected in this group of cases.

A. Can an Excess Carrier Have a Claim Against a Partially Self-Insured Motor Carrier for Bad Faith if the Motor Carrier Fails to Settle Within the SIR?

In International Ins. Co. v. Dresser Industries, Inc., 841 S.W.2d 437, 444-445 (Tex. App. 1992), the intermediate Texas Court of Appeals held that a policy providing for excess insurance coverage imposes no duty upon the insured to accept a settlement offer that would avoid exposing the excess insurer to liability. Dresser was a self-insured manufacturer who retained complete control of the handling and defense of all claims and lawsuits made or brought against it. Id. at 440. Dresser’s excess carrier, International, did not approve of the manner in which Dresser handled and defended the underlying lawsuit, and claimed that Dresser owed International a contractual and a common law duty to make reasonable attempts to settle within the SIR. Id. With respect to the contractual duty, the Court rejected International’s argument because the policy contained a provision which read: “[The excess insurer] shall never make formal demand upon a primary insurer that the latter settle a claim within its policy limit.” Id. at 443. Similarly, the Court also rejected International’s argument that there exists a common law duty to make “reasonable” attempts to settle. Because this was an issue of first impression in Texas, the Court looked to, the only published appellate court opinion at that time which dealt with this question. In Safeway Stores, the California Supreme Court expressly rejected the invitation to find that the insured owed an excess carrier any duty “which would require an insured contemplating settlement to put the excess carrier’s financial interests on at least an equal footing with his own.” Id. at 1043. Thus, while an excess carrier may be able to sue a primary insurer for bad faith if it fails to settle a case within its policy limits, Dresser stands for the proposition that an excess carrier may not sue a self-insured policyholder for bad faith in failing to settle within its SIR.

The Southern District Court of NY later agreed in Employers Mutual Casualty Co. v. Key Pharmaceuticals, Inc., 871 F.Supp. 657, 666 (S.D.N.Y 1994), where it said that “recognizing a tort cause of action by an excess carrier against its insured would substantially increase the duty and potential liability of the insured.” (Emphasis added.) The Court in Employers Mutual noted that policyholders pay premiums to excess carriers to guard against the risk of
litigation, and it would not make sense for the insured to bear that risk which the excess carrier collects a premium to cover. The District Court continued, “Indeed, we have no idea what the basis for a fiduciary duty running from insured to insurer would be, independent of the terms of the contract of insurance itself.” Id. Similarly, the Court in Dresser noted that International knowingly accepted the risk of insuring exposure beyond the primary coverage in return for the premium it received from Dresser. Dresser, 841 S.W.2d at 444.

Distinguishing Dresser, in Clarendon Nat’l. Ins. Co. v. FFE Transportation Services, Inc., Not Reported in F.Supp.2d, 2004 WL 3210604 (N.D. Tex. 2004) the Northern District Court of Texas allowed the excess carrier’s claim against the self-insured for failure to settle because the terms of the policy explicitly granted the excess carrier the right to investigate and settle any claim or suit as it sees fit. Id. at 4-5. Whereas the policy in Dresser gave the insured the right to investigate and settle, the Clarendon policy’s language was different. Clarendon indicates that whether an excess carrier has a cause of action against the insured for failure to settle depends largely on the terms of the policy. However, in the absence of clear terms in the policy granting the excess carrier the right to investigate and settle claims, the insured owes no common law duty to the excess carrier to settle within the SIR. See Employers Mutual, 871 F.Supp. at 666.

While there is a monetary savings to a motor carrier when it chooses not to insure the cost of the investigation and defense of claims and suits, most motor carriers pursue this option because they feel they are in the best position to evaluate exactly what their needs are in this process. In a pure insurance context, the insured has no control over which cases get settled and which do not. This lack of control can be detrimental to a motor carrier’s best interests. Allowing a contractual provision where the “excess carrier” gets to dictate whether or not a case is settled within the SIR is totally inconsistent with the reasons motor carriers wish to retain the duty to defend. Motor carriers who choose the SIR approach usually want to determine themselves (without the threat of compulsion) whether they wish to try cases, for example, where the Plaintiff has significant injuries but a low chance of prevailing on liability.

There is good reason to allow an excess carrier to sue the primary insurer for bad faith while not allowing the excess carrier to sue the self-insured policyholder. If an excess insurer could not sue the primary insurer for bad faith in failure to settle a claim, the primary insurer would have every incentive to drag its feet in settling claims. Western Alliance Ins. Co. v. Norhem Ins. Co. of New York, 968 F.Supp. 1162, 1169 (N.D. Tex. 1997) (citing). If the existence of excess insurance relieved a primary insurer of its responsibility to negotiate and settle up to its policy limits in good faith, then the primary insurer would have a disincentive to settlement. Id. Moreover, if during settlement negotiations the primary insurer is allowed to force the excess insurer to cover part of the primary’s insurance exposure, the coverages and rate structures of the two different types of insurance—primary and excess—would be distorted, and excess insurance premiums would have to be adjusted. Id. On the other hand, allowing an excess insurer to enforce a primary carrier’s duty to negotiate and settle in good faith to the full limits of the primary carrier’s policy does not add to or change that carrier’s duties. Id.

There is also good reason to reject the argument that the duty of good faith between insured and insurer is reciprocal. In Twin City Fire Ins. Co. v. Country Mut. Ins. Co., 23 F.3d 1175 (7th Cir. 1994), the Seventh Circuit Court of Appeals determined that the Dresser Court was obtuse in not recognizing that the duty of good faith between insured and insurer is a reciprocal one. Id. at 1180. However, in reaching that conclusion, the Court erroneously assumed that every policy would automatically grant the excess carrier the right to investigate and settle. Id. at 1179. The Court stated, “If the insured was acting irresponsibly in pressing the case to trial, the excess insurer, depending on the terms of the policy, would have a contract defense to the insured’s claim against it.” Id. at 1180 (emphasis added). While the policy at issue in Clarendon may have contained language to this effect, the excess carrier would have no contract claim or defense if the policy did not
explicitly reserve the right to investigate and settle for the excess carrier, as is often the case. As the Court in Employers Mutual stated:

Policyholders, even partially self-insured policyholders, are not primary carriers. Policyholders pay premiums to excess carriers in order to have protection against the risks of litigation (which risks include that of guessing wrong in settlement negotiations); primary carriers do not, and therefore must be careful as to how they balance their own interests with the competing interests of the excess carriers in any given claim instance. We have found no basis in the law, nor have we been pointed to any, for concluding that, apart from the premiums it pays, an insured also assumes a fiduciary duty of care toward its insurer in the context of settlements. Employers Mutual, 871, F.Supp. at 666.

**Conclusion**

If an excess carrier wishes to impose a duty to make reasonable attempts to settle within the limits of the SIR, it should include language in the policy to that effect. In Clarendon, a Texas District Court allowed the excess carrier to maintain such a suit against the self-insured where the policy included language reserving to the excess carrier the right to investigate and settle all claims as it sees fit. Clarendon, 2004 WL 3210604 at 4-5. Even the Seventh Circuit’s opinion in Twin City, holding that the self-insured does owe a duty of good faith to his insurer, was based on the assumption that the terms of the policy provided as such. See Twin City, 23 F.3d at 1180. The central proposition that each opinion confirms is that, **absent clear terms in the policy** granting the excess carrier the right to investigate and settle claims, the insured owes no common law duty to the excess carrier to make reasonable attempts to settle within its SIR. The clear message from this group of cases to motor carriers operating with a SIR (and retaining the duty to defend) is that if they wish to have the untrammeled right to decide which cases to try they need to check their policy language extremely carefully.

**B. Can an Excess Carrier Have a Duty to Defend in the Self Insured Retention Contractual Relationship?**

In *City of Oxnard v. Twin City Fire Ins. Co.*, 44 Cal. Rptr. 2d 177 (Cal. App. 1995), the Court of Appeals held that a self-insurer is solely liable for its defense costs attributable to the extent of its SIR, just as a primary insurer is responsible for defense expenses attributable to the extent of its coverage. The Court noted, “The distinction between excess and primary insurers is important because excess insurers have no duty to participate in the insured’s defense until the primary coverage is exhausted.” *Id.* at 179-180. When an SIR is in place, the insured acts as its own primary insurer. *Id.* at 180. The SIR endorsement “effectively transforms the policy from a primary policy into an excess policy” covering only amounts in excess of the self-insured retention. As the Court noted in *Garamendi v. Mission Ins. Co.*, Not Reported in Cal. Rptr. 3d, 2005 WL 1140705 (Cal. App. 2005), a self-insured can not reasonably expect to receive the benefit of coverage for a period for which the insurer explicitly opted not to pay. *RLI Ins. Co. v. Superior Court of Ventura County*, Not Reported in Cal. Rptr. 3d, 2004 WL 1171649 (Cal. App. 2004), quotes *Oxnard*, asserting that, “There is no equitable reason for shifting to the excess carrier defense costs which the primary insurer incurred to discharge the contractual obligations it freely assumed. . . As a matter of policy, respondents cannot be held liable for defense costs they were not contractually obligated to pay.” 44 Cal. Rptr. 2d at 180.

In *Montgomery Ward & Company, Inc. v. Imperial Cas. & Indem. Co.*, 97 Cal. Rptr. 2d 44, 56 (Cal. App. 2000), the Court distinguished Oxnard by the terms of its policy. Again, the Court relied primarily on the language in the policy, and the policy in *Montgomery Ward* explicitly placed the duty to defend on the excess carrier. The Court explained, “Here - in contrast to express policy provision in Oxnard - the duty to defend is explicitly stated, and the existence of a retained limit or SIR is not inconsistent with a first dollar duty to defend if the policy so provides.” *Id.* (Emphasis added).
**In Home Ins. Co. v. Superior Court, 54 Cal. Rptr. 2d 292, 295-296 (Cal. App. 1996),** the insured claimed that the Oxnard interpretation of the policies ought to be rejected because it “causes the unfavorable result of discouraging the insured from negotiating a favorable settlement, and instead encourages him to litigate the suit to judgment in order to recoup all defense expenses.” While the ruling in Oxnard may **theoretically** encourage the self-insured to reject some settlement offers within their retention, it does not justify altering the agreement between the insurer and the insured. As the Court in Home Ins. Co. explained, “Whatever abstract merit there may be to the arguments in favor of the confidentiality of settlements,” Oxnard “teach[es] that those considerations are secondary to enforcement of the parties’ contractual rights to pay and be paid only on the terms and conditions to which they agreed.” Id. at 296.

**Conclusion**

Absent an **express** provision in the policy placing the duty to defend on the excess carrier, a self-insurer is solely liable for its defense costs attributable to the extent of its SIR. As Oxnard, Home Ins. Co., and RLI Ins. Co. noted, there is no good reason to force the excess carrier to bear the burden of defense costs which the self-insured freely assumed. Courts should -- and consistently do -- interpret policies by their explicit terms.

**C. When is the Excess Carrier’s Duty to Indemnify Triggered?**

In *Missouri Pacific R.R. Co. v. International Insurance Co.*, 679 N.E.2d 801 (Ill. App. Ct. 1997), the Illinois Appellate Court held that Missouri Pacific, the insured, must exhaust all its SIRs for each period of insurance before looking to the excess insurers for coverage. *Id.* at 808. Hundreds of current and former Missouri Pacific employees brought claims against the company for hearing loss and asbestos-related injuries allegedly caused by continuous and repeated on-the-job exposure to unsafe levels of noise and unsafe levels of asbestos. *Id.* Mo. Pac. maintained SIRs between 1937 and 1986 totaling $67 million, and bought other insurance policies between 1957 and 1986. Under these policies, the insurers agreed to indemnify Missouri Pacific for “all sums” caused by an “occurrence,” where “occurrence” is defined as: “(a) an accident, or (b) a continuous or repeated exposure to conditions which result in personal injury or property damage which is neither expected nor intended from the standpoint of [Missouri Pacific], if such accident or such personal injury or property damage occurs while this policy is in force.” *Id.* The employees’ NIHL claims and the asbestos-exposure claims spanned several different periods of coverage with different SIR amounts. *Id.*

In reaching its holding, the Court determined that principles of horizontal exhaustion were more appropriate than vertical exhaustion. Horizontal exhaustion means that the primary insurance must be exhausted across all of the triggered policy periods before the next layer of coverage must respond to a continuous loss. Douglas R. Richmond, *Rights and Responsibilities of Excess Insurers*, 78 Denv. U.L. Rev. 29, 79 (2000). Vertical exhaustion allows an insured to select policy periods triggered by a continuous loss. The first-in-time primary and excess policies will be exhausted before the next-in-time primary and excess policies are tapped. *Id.* Vertical exhaustion principles allow the self-insured to receive the benefit of coverage for a period for which he paid no premiums. (See *Mo. Pac.*, 679 N.E.2d at 808, *citing* (Ill. App. Ct. 1996), “A firm that fails to purchase insurance for a period is self-insuring for all the risk incurred in that period; otherwise it would be receiving coverage for a period for which it paid no premium.”). Generally, all primary insurers must exhaust their policy limits before an excess insurer has any obligation to the insured. In *Mo. Pac.*, the Court decided that the SIRs were the equivalent of primary insurance, and therefore, *Mo. Pac.* must exhaust the SIRs before looking to the insurer for coverage. *Mo. Pac.*, 679 N.E.2d at 808 (*But see In re Vanderveer Estates Holding, LLC*, 328 B.R. 18 Bkrtcy. (E.D.N.Y. 2005), where the Court held that while an insured must generally exhaust all its SIRs before looking to the insurers for coverage, that principle does not apply when the insured is in bankruptcy.)

In *Mo. Pac.*, the claims for noise-induced hearing loss and
asbestos exposure involved damage continuously caused and continuously sustained. Because both the damage-causing agency and the damages the agency caused occurred continuously in each policy period, a rule which required the policy in effect when the first damage occurred to cover damages caused in that and successive policy periods would make no sense. Great Lakes Dredge & Dock Co. v. Commercial Union Assur. Co., 57 F.Supp.2d 525 (N.D. Ill. 1999). The sensible rule, as the appellate court held, is to attempt to make each policy respond to the damage that occurred during its policy period. Id. The pro rata, time-on-the-risk approach taken by the Mo. Pac. Court solved the problem of how to allocate damages among the policies, but it is only appropriate where “a single continuous occurrence results in an un-allocable loss implicating successive policy periods.” See Mo. Pac., 697 N.E.2d at 808.

Other courts have distinguished Mo. Pac. on the basis of the policy language and its particular definition of a single continuous occurrence. The policy language in Mo. Pac. limited the amount of coverage to property damage that occurred during the policy period. In Chicago Bridge & Iron Co. v. Certain Underwriters at Lloyd’s, London, 797 N.E.2d 434, 442-443 (Mass. App. Ct. 2003), that limiting language was absent, and in fact, the policy’s definition of “occurrence” provided that the duty to indemnify is triggered even if only some of the property damage occurs during the policy period. (See also Krusinski Const. Co. v. Northbrook Property and Cas. Ins. Co., 326 Ill.App.3d 210, 221 (Ill. App. Ct. 2001).

Therefore, there was no reason to use a pro-rata allocation of damages, and the Court held each insurer on the risk jointly and severally liable. Chicago Bridge, 797 N.E.2d at 445.

In Commonwealth Edison Co. v. National Union Fire Ins. Co. of Pittsburgh, PA., 752 N.E.2d 555, 569 (Ill. App. Ct. 2001), the Court did not consider Edison’s SIR as primary insurance included within the “other insurance” clause of the policy, despite the contrary holding in Mo. Pac. that SIRs may constitute primary insurance. In Mo. Pac., the issue was whether the insured’s SIR constituted primary insurance where he owned no other primary insurance policies. Id. However, in Edison, the policy language made no mention of SIRs or self-insurance in the “other insurance” clause as did the policy in Mo. Pac. Additionally, Edison’s SIRs supplemented other primary insurance policies, whereas Mo. Pac. held only its own SIRs and its excess policies. Id. These differences allowed the Court to avoid the principle of horizontal exhaustion that was addressed in Mo. Pac.

Conclusion

The language of the particular insurance policy is central to determining whether vertical or horizontal exhaustion principles apply, and also whether a pro-rata, time-on-the-risk allocation of liability is preferable to joint and several liability. Unless the excess policy provides that it shall only be excess to a specific underlying policy, horizontal exhaustion is generally preferred. Horizontal exhaustion represents the reality that the insured pays a smaller premium to the excess insurer because both parties know the excess carrier will only be triggered after the primary carriers or SIRs have exhausted their limits. To force the excess carrier to indemnify the insured for losses which occurred during a period for which it has other policies or SIRs that are not yet exhausted would negate the reason for the excess carrier’s lower premiums.

It also makes sense that a self-insured should have to exhaust its retention before looking to the excess carrier for coverage. To allow otherwise would blur the line between primary carriers and excess carriers. Mo. Pac., 679 N.E.2d at 809. Additionally, courts should not allow self-insured policyholders to manipulate their coverage to avoid absorbing the cost resulting from its position as a self-insurer. Id. While this issue may not often face motor carriers, the approach of the courts which fall back on contractual language is instructive for motor carriers as well. The Missouri Pacific court assumed that the insured had a high degree of sophistication as indicated by the emphasis on the SIR arrangement. The message here to motor carriers is that they must thoroughly investigate all the details of a SIR contract before undertaking it.
D. Whether the Excess Insurer May Maintain a Malpractice Claim Against the Insured’s Attorney.

In *Am. Continental Ins. Co. v. Weber & Rose*, the Kentucky Court of Appeals decided whether an excess insurer could be subrogated to the insured’s right to assert a malpractice action against the law firm representing the insured, and alternatively, whether the excess insurer falls within the class of persons whom the services of the insured’s law firm are intended to benefit, such that the excess insurer may bring the claim directly. The law firm defending the self-insured failed to plead as an affirmative defense the exclusive remedy provision of the Worker’s Compensation Act, and the plaintiff won a 2.9 million dollar verdict which exceeded the self-insured’s 2 million dollar retention. American Continental urged the Court to follow the lead of Texas courts, which have *allowed* the excess insurer to sue law firms employed by primary carriers on behalf of the insured. *Am. Continental*, 997 S.W.2d at 14 (Ky. App. 1998). Am. Continental argued that to do otherwise discourages an insured from demanding competent counsel, while simultaneously both imposing a burden on the primary insurer and relieving the insured’s counsel of liability for legal malpractice. Id. However, the Kentucky court rejected that argument, ruling that “adopting such a rule would be inimical to the preservation of traditional and longstanding concepts associated with attorney-client relationship, as recognized by Kentucky law.” Id.

The Kentucky court also rejected Am. Continental’s argument that it was an intended and foreseeable beneficiary of the legal services rendered to the insured, and that the law firm therefore owed a duty of care to Am. Continental. Id. The Court held that Am. Continental had no contractual relationship with the law firm, the firm was retained by the insured, and nothing in the record indicated that the insured was obligated to provide an attorney to represent Am. Continental’s interest. Id. Because Am. Continental was at most an incidental beneficiary of the insured’s contract with the law firm, they were owed no legal duty by the firm. Id.

The basic holding in *Am. Continental* is that the law requires privity of contract in legal malpractice cases unless the plaintiff was an intended beneficiary of the lawyer’s contract. Courts do not want the lawyer’s loyalty to be divided between the insured and the insurer. Id. Courts cite the personal nature of both legal services and the attorney-client relationship, as well as the preservation of the attorney-client privilege, as justifications for disallowing assignments of such claims. *Mallios v. Baker*, 11 S.W.3d 157 (Tex. 2000). Courts have also expressed concern that assignments will lead to commercial marketing of claims and increased litigation, resulting in increased costs of malpractice insurance and increased costs in legal services. Id. However, some other courts have allowed an excess insurer’s right of subrogation to the primary insurer’s legal malpractice action against its own attorney. *Charter Oak Fire Ins. Co. v. State Farm Mut. Auto. Ins. Co.*, 344 N.J. Super. 408, 782 (N.J. Super. 2001) (See, permitting the cause of action.)

**Conclusion**

If an excess insurer wants to maintain the right to sue for legal malpractice on behalf of its insured, the excess carrier must be in control of the insured’s defense and must have been a party to the contract with the law firm. Allowing such a claim by the insurer against the insured’s lawyer would divide the lawyer’s loyalty and do damage to the special attorney-client relationship. See *Am. Continental*, 997 S.W.2d at 14. While it is true, as Am. Continental argued, that prohibiting the insurer’s claim encourages the insured to accept less than competent counsel, this risk is outweighed by the potential for damage to the attorney-client relationship, especially where an insurer could have guarded against the risk of incompetent counsel by accepting responsibility for the defense in the policy. See *Charter Oak*, 344 N.J. Super. at 782. It should be noted that in Kentucky the courts hold that counsel employed by an insurance carrier to defend an insured represent both the insurance carrier and the insured. Not all states follow this analysis. Nevertheless the Kentucky decision seems to ignore the real nature of a SIR contract where a motor carrier
is involved. The very nature of this relationship is a partnership and in this context the decision in *Am. Continental Ins. Co. v. Weber & Rose* does not seem to ring true. In such a partnership the motor carrier does have a legitimate desire to “have their own counsel”, but the authors have difficulty seeing how a decision in the case for the insurance company would really threaten that relationship.

**IV. FACTUAL SCENARIO:**


In May 1989, a truck driver employed by Rocor International, Inc. (“Rocor”) struck and killed two Texas highway patrol officers who were stopped on the side of the road dealing with a drunk driver. See *Rocor International, Inc. v. National Union Fire Insurance Co.*, 995 S.W.2d 804 (Tex. App. 1999); *Rocor International, Inc. v. National Union Fire Insurance Co.*, 77 S.W.3d 253 (Tex. 2002). Having consumed four or five scotch and waters himself, Rocor’s driver was also intoxicated at the time of the accident.

Rocor immediately launched an investigation. Within a month Rocor was able to determine that it was a clear case of liability. It also determined that the verdict could be in the millions. In January 1990, Rocor contacted the plaintiffs to set up mediation.

Rocor had three sources of insurance. First, it carried a $1 million primary policy with a $1 million self-insured retention endorsement (SIR), under which it had the right to defend itself. It also carried an $8,000,000 excess policy, under which the excess carrier had no duty to defend. The excess policy did require Rocor to cooperate with its excess carrier in settling claims. Prior to mediation, Rocor’s excess carrier determined that the liability could reach their coverage and took over control of the settlement discussions.

The excess carrier made the first settlement offer, $2.8 million, in April 1990. The offer did not include any of the excess carrier’s own funds, but instead was made up of the $1,000,000 deductible, the $1,000,000 in primary coverage, and contributions from the driver’s bobtail carrier and the bar that served the scotch and waters.

The plaintiffs responded with a $6.3 million demand. Of import, counsel for Rocor and the excess carrier both agreed that the value of the case was between $6 and $6.5 million. Thus, the plaintiffs’ demand was within the range. Plaintiffs’ counsel made a separate demand to settle the troopers’ children’s claims for $400,000. Rocor’s attorney was not made aware of the children’s demand.

In May 1990, Rocor’s attorney put the excess carrier on notice that it should settle the case or assume defense costs. In September 1990, counsel for Rocor learned for the first time of the children’s settlement demand. The settlement of the children’s claims, which was to come from the deductible and primary coverage, was completed the following month.

In March 1991, more than a year after the excess carrier assumed control of negotiations and a year after the plaintiffs’ $6.3 million demand, the entire case settled for $6.4 million. During the interim between the plaintiffs’ $6.3 million demand and settlement, Rocor’s counsel prudently continued to prepare the case for trial. Rocor brought suit against its excess carrier for the expenses it incurred preparing a defense.

Rocor claimed that its excess carrier engaged in unfair insurance practices under article 21.21 of the Texas Insurance Code and the Texas Deceptive Trade Practices Act as well as having made misrepresentations regarding the settlement. The trial court granted a directed verdict on the Deceptive Trade Practices claim because Rocor was not a consumer, but the rest of the case went to the jury. The jury found that the excess carrier’s negligence caused Rocor’s damages and that they had engaged in deceptive acts or practices.

The excess carrier moved for a judgment notwithstanding the verdict and argued that Rocor could not maintain negligence or article 21.21 cause of action. The trial court granted the motion. A split intermediate Texas Court of Appeals reversed the trial court’s decision. Five justices concluded that Rocor could assert a common-law negligence claim while three concluded it could put forth an article 21.21 claim. Thus, the Court of Appeals rendered a judgment for Rocor on its common-law negligence claim.
The decision was appealed to the Supreme Court of Texas. The Rocor case provides a good backdrop for a discussion of the duty an insurer owes to its insured to settle claims with third parties.

V. BASIS FOR THE DUTY TO PROMPTLY SETTLE: STATUTORY V. NEGLIGENCE

A. Negligence

Back in May 1990, almost a year prior to their $6.3 million demand, the plaintiffs’ attorney sent a letter demanding that the case be settled for policy limits, $10 million. Attorneys for Rocor and the excess carrier did not view this as a serious demand, but as an attempt to “Stowerize” them into giving a high offer. Texas has long standing law, pursuant to the case of G.A. Stowers Furniture Co. v. American Indem Co., 15 S.W. 2d 544 (Tex. Comm’n App. 1929), hence the term “Stowerize”. Stowers addressed an insurer’s duty to settle once presented with a settlement demand within the policy limits.

Stowers, which was decided in 1929, involved an indemnity policy issued to Stowers furniture company with limits of $5,000. On a January night, a truck owned by Stowers became disabled and was left on the side of the road. The plaintiff’s vehicle collided with the disabled vehicle, and the plaintiff sued Stowers for $20,000.

The terms of the policy allowed the indemnity company to take control of the defense. Stowers was only allowed to settle at its own expense and could not interfere with the indemnity company’s settlement negotiations.

The case went to trial and a verdict was returned in the amount $12,207. After a failed appeal, Stowers paid $14,000 to the plaintiff. During litigation the plaintiff demanded $4,000, but the insurance company’s top offer was $2,500. Stowers brought suit against its indemnity company alleging that a person of ordinary prudence would have settled the case for $4,000 and that the indemnity company did not act in good faith. The trial court directed a verdict to the indemnity company.

The appeals Court analogized the relationship between Stowers and the indemnity company to that of agent and principal. Pursuant to the agreement, the indemnity company was acting on behalf of Stowers and should be held to a standard of care that Stowers would have exercised on its own behalf. If the indemnity company failed to exercise that standard of care, then it would be liable for Stowers’ damages. In sum, the provisions of the policy that provided the indemnity company with the power to control the litigation came with a duty to exercise ordinary care in using that power.

The Court was troubled by the notion that an indemnity company had an absolute right to refuse settlement regardless of reason. Thus, the Court held the indemnity company to a degree of care “which a man of ordinary care and prudence would exercise in the management of his own business.” This became known as an insurer’s “Stowers” duty to settle.

Reaching back to the Stowers case, the excess carrier in Rocor argued that there could be no Stowers liability without an excess judgment against its insured. Rocor counter-argued that Stowers was a special subset of ordinary negligence which did not preclude recovery of damages caused by its insured’s failure to settle.

Unfortunately for this discussion, the Court did not reach the issue because it was not established that the excess carrier received a proper settlement demand within limits that an ordinarily prudent company would have accepted. As discussed below, that is one of the triggering factors for a duty to settle. Regardless, ordinary negligence can serve as a basis in suit for failure to settle with a third-party. A statutory basis is not required.

B. Statutory

Rocor brought suit pursuant to Texas Insurance Code Article 21.21 which stated:

Any person who has sustained actual damages as a result of another’s engaging in an act or practice declared in Section 4 of this Article or in rules or regulations lawfully adopted by the Board under this Article to be unfair methods of competition or unfair or deceptive acts or practices in the business of

39 Since this case the article has been amended to allow for insured to bring unfair settlement practices claims.
insurance . . . may maintain an action against the person or person engaging in such acts or practices.

Article 21.21-2 defines an unfair practice as “not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.”

The law had previously and clearly established that an insured may sue its insurer under Article 21.21 for not attempting in good faith to promptly, fairly, and equitably settle a claim with its own insured. Vail v. Texas Farm Bureau Mutual Insurance Co., 754 S.W.2d 129 (Tex. 1988). It was not clear whether an insured could sue its insurer for not promptly settling with a third party.

The Texas Supreme Court had previously refused to allow a cause of action brought by a third-party claimant against the defendant’s insurer for failing to settle a claim against its insured. Allstate Ins. Co. v. Watson, 876 S.W.2d 145 (Tex. 1994). The basis for the ruling was that the third-party was not a party to the insurance contract and did not have the same rights as an insured. The factual scenario was different in Rocor because the suit was brought by the insured, who was a party to the insurance contract. The reasoning for the dismissal of the Watson case was not present.

The Texas Supreme Court held that Rocor did have a cause of action against its excess carrier. The Court was unable to find any language in the statute or intent on the part of the legislature to limit an insurer’s duty to promptly settle only to first-party claims. The only requirement is that the insured would have to sustain actual damages. In many cases, the insured is covered by a primary policy and its defense is assumed and paid for by its primary carrier. In those cases, arguably, an insured would have a difficult time proving actual damages. It certainly could not claim that it incurred defense costs as a result of the carrier’s failure to promptly settle.

VI. COMMENCING OF THE DUTY AND THE IMPACT OF UNDERLYING LIABILITY

Article 21.21 states that an insurer can be liable if it does not attempt a prompt, fair and equitable settlement when liability has become reasonably clear. In relying on Stowers, the Court unified the common-law and statutory standard. The duty to promptly settle arises when there is coverage, liability is reasonably clear, and the insurer is presented with a proper settlement demand within the policy’s limits that an ordinarily prudent insurer would have accepted.

Absent some mitigating circumstances such as failure to pay premiums, coverage is usually not an issue, but what exactly rises to the level of “reasonably clear”? A rear-end accident comes to mind. What if an insured pulls out in front of a claimant, but claims that the claimant had plenty of time and the claimant simply rear-ended the insured? That would seem not to be reasonably clear. Two of the authors tried such a case earlier this year and obtained a defense verdict for the motor carrier.

Pursuant to the triggering elements, the insurance company does not have to solicit demands. In American Physicians Insurance Exchange v. Garcia, 876 S.W.2d 842 (Tex. 1994), the Court had held that placing a duty on the insured to solicit demands and bid against itself would be counter productive and would not encourage settlement. Further, a demand in excess of limits, although reasonable, does not trigger the duty to settle in Texas.

Rocor’s excess carrier argued that Garcia precluded Rocor from its action. In Garcia, a doctor had several coverages, including a “claims-made” policy, which required the injury to have been caused by an occurrence within the policy period. The estate of a former patient filed suit against the doctor for medical malpractice that occurred over a period of two years. The claims-made carrier instructed the doctor that only one of the patient’s treatments took place within the policy period and that coverage would turn solely on that visit.

The claims-made carrier and the doctor’s primary carrier agreed to share in settlement and judgment on a pro-rata basis. The primary carrier took the lead in the defense. The plaintiff filed multiple complaints, all of which involved events that occurred prior to the doctor’s coverage with the claims-made carrier. Therefore, the claims-made carrier informed the doctor that
Before trial, the doctor and the plaintiffs entered an agreement whereby the plaintiffs would only seek satisfaction for a judgment from the insurance carriers. The doctor assigned all of his claims against his insurance company to the plaintiffs. On the day of trial, the plaintiffs, for the first time, alleged malpractice that took place within the policy period for the claims-made policy.

The plaintiffs sued the claims-made carrier, pursuant to the agreement with the doctor, alleging that the failure to settle violated article 21.21 and the Deceptive Practices Act. The jury found that the claims-made carrier was negligent in not settling the case and engaged in an unfair practice. The Supreme Court reversed.

The Supreme Court held that the evidence established that the claims-made carrier discharged its duty to defend and did not breach its Stowers duties because it never received a settlement demand within policy limits.

The carrier, although agreeing to share the defense costs, had assigned control of the defense over to the doctor’s other carrier. As to the duty to settle, no duty arose until the day of trial, when plaintiffs amended their complaint to include an occurrence within the policy period. Once that amended complaint was filed, the carrier had a duty to exercise ordinary care. However, no demand was ever made within policy limits and, therefore, the duty to settle never was triggered. This raises another important point -- cover yourself in paper.

**VII. COVERING YOURSELF IN PAPER**

As always, it is important to document your file in settlement negotiations particularly with a SIR policy and an “excess carrier”. In the case of the duty to promptly settle, it is not only important to document the offers, but also the demands. As discussed above, one of the triggering factors for the duty to settle is receiving a proper settlement demand from the claimant. In Rocor, confusion and lack of documentation helped Rocor’s excess carrier.

Rocor did not base its suit on its excess carrier’s failure to accept the $10 million demand that was made early on. Instead, Rocor relied on an oral offer that was highly disputed by all sides. Correspondence proved that the parties’ did not have equal understanding of the settlement demands. The Court found that an “insurer should not be held liable for failing to accept an offer when the offer’s terms and scope are unclear and are the subject of dispute.” This illustrates the importance of documentation of all settlement discussions by both the insurer and the insured.

**VIII. THE IMPACT OF RESISTANCE FROM THE INSURED**

In certain cases, an insured may object to an insurer settling a case with a claimant, regardless of whether it is within policy limits. If an “insured consent” provision is present in the policy, then the insurer must abide by the insured’s decision. In the absence of such a consent provision, the insurer is placed in an interesting position. On the one hand, it has been presented with a settlement demand within its policy limits. Under the law discussed above, the insurer would have the duty to act reasonably once it has been presented with the demand. On the other hand, is there a duty to justify the settlement to the insured? The Court in Dear v. Scottsdale Insurance Co., 947 S.W.2d 908 (Tex. App. 1997) answered “no” to this question.

The court in Dear was a private investigator who had been sued by one of his clients who claimed that she had been overcharged for a fraudulent investigation. The investigator, obviously concerned about his future business, did not want the case settled. The insurance company was presented with an offer within limits and settled the case. The insured brought suit against the insurance company claiming that the claim was negligently investigated, handled and settled causing him loss of business and reputation. The Court found no cause of action. The policy gave the insurer the absolute right to settle the claims within the policy limits. Lacking any contractual language, the Court was unwilling to allow any extra-contractual theories of recovery such as negligent settling. The Court likewise found that the insured was not owed a duty of good faith and fair dealing in investigating the claims.
The insured had brought suit based on the case of Ranger County Mutual Insurance Co. v. Guin, 723 S.W.2d 656 (Tex. 1987). In that case, the Court had given a broad definition of the duties of an insurer who had undertaken the duty to defend. The Court stated that the agency relationship extends the full range of agency, including investigation. Id. at 659. Even with the statement, Ranger County hinged on the attorney’s failure to offer policy limits. There were no allegations of negligent investigation. The Court in Dear was not willing to give substance to the dicta in Ranger and find a duty where an insurer settles within policy limits.

Seemingly, the insured in Dear was putting forth a case based on the opposite of a Stowers duty. Because of that, the Court was not willing to throw out the insurer’s contractual right to settlement to create a theory of recovery for the insured. The only duty that was owed to the insured was the duty to accept a settlement offer that any reasonably prudent person would. See also Ford v. Cimarron Insurance Co., Inc., 230 F.3d 828 (5th Cir. Tex. 2000.)

IX. THE RELATIONSHIP OF DUTY TO DEFEND TO DUTY TO SETTLE

As in the Rocor case, an excess policy does not usually contain a duty to defend clause. It was the excess carrier’s position that since it did not have a duty to defend, it could not be liable for defense costs. The excess carrier again relied on Stowers arguing that a Stowers duty is based upon the insured’s control of the defense. The Court disagreed stating that Stowers was based not only on a duty to act prudently in defense of an insured, but to also act prudently in settlement.

As spelled out in the policy, the excess carrier voluntarily assumed control over the settlement negotiations. It therefore assumed a duty to act prudently. Of more importance was that Rocor’s claim was not of a contractual nature, but was based in torts, rendering the lack of a contractual duty to defend irrelevant.

A duty to defend and the duty to promptly settle a case are exclusive concepts that are not necessarily reliant upon one another. Once a carrier exercises its right to enter into the settlement negotiations, they must do so in a reasonable and prudent nature. The fact that they have not been previously involved in the defense of the claim (or have a contractual obligation to do so) is irrelevant.

X. DAMAGES

As illustrated in Rocor, damages incurred by the insured in litigating the case after a proper settlement demand has been made and the case is settled are recoverable as damages in a failure to properly settle the case in a timely fashion. Since the underlying suit never went to trial in Rocor, the insured was never exposed to the possibility of personal liability for a judgment. When the underlying case does go to trial, exposure is created and different damages are recoverable.

In Convalescent Services, Inc. v. St. Paul Fire and Marine Insurance Co., 1999 WL 33918572 (5th Cir. Tex. 1999) the Fifth Circuit reviewed the aftermath of a failure to promptly settle suit where the underlying suit did go to trial. The plaintiff sued the insurer for injuries which resulted in $80,000 in medical expenses. The plaintiff made a demand of $250,000, which was within the policy limits. Most of the exposure in the underlying suit was punitive in nature, which was not covered by the policy. St. Paul offered $35,000 and the case went to trial. The jury awarded $350,000 in compensatory damages and $850,000 in punitive damages, for which the insured was personally liable. St. Paul filed a motion for declaratory judgment that it was not liable for the punitive award against its insured based on Stowers or any other doctrine. The insured counterclaimed.

According to the Court of Appeals, the District Court wrongfully applied a fourth Stowers element in ruling for St. Paul, that “an insurer is liable for the amount of the judgment only if the insured is found liable in a covered claim in an amount exceed policy limits.” Id. at 7. The District Court cited Rocor in support of the fourth element. The Court of Appeals could find no support for a fourth element. St. Paul had argued that since punitive damages were not covered in the policy, it was not liable to the insured for those damages.

The Court of Appeals found that the punitive damage award was
a result of St. Paul’s failure to settle with the plaintiff. Since the insured brought the action in tort, the limiting language of the policy was irrelevant. An insured can recover “all reasonably foreseeable damages which would not exist but for the violation, including punitive damages which could not have been assessed had there been a settlement.” Id. at 9. The duty to act reasonably in settlement does not end when a non-covered damage is demanded. The decision of the Court of Appeals that there would have been no punitive damages if the case had been settled is one which may be subject to criticism, but as a practical matter it does seem to track the underlying facts of this particular case.

XI. CONCLUSION

The cases discussed in this paper reflect breakdowns which can occur in the relationship of the insured motor carrier with a large self-insured retention and the “excess” carrier for that trucking company. That relationship cannot be successful in either the short or long term without trust and communication on both sides. Many of these cases reflect a lack of education on the part of the motor carrier concerning the nature and details of the contract of insurance they have purchased. It is incumbent on both the motor carrier with a large SIR and the “excess” carrier to discuss the kinds of details which come up in these cases at the initiation of their relationship.

Truly outstanding insurance carriers are those who regularly write policies of this kind and whose brokers take the time to be certain that the products that they are selling actually meet the detailed needs of motor carriers who chose the self-insured retention package of coverage.

There is an extremely large body of law that has developed on the interpretation of insurance policies of the various types that motor carriers typically purchase in today’s market. This is the case for both straight insurance and policies with large self-insured retentions or deductibles. Motor carriers, in particular who choose large deductibles or large self-insured retentions, need the guidance at the outset from specialized brokers. In addition, they have to develop a network of experienced local attorneys where they have chosen not to insure the duty to defend.

Motor carriers with large deductibles and self-insured retentions have special problems which do not frequently arise in “insurance defense” contracts. Because of these concerns, it is important to communicate carefully with local counsel about what is expected from them, for example, when settlement discussions begin. The Rocor case is a perfect example of this type of situation. Many settlement discussions in cases of this kind traditionally begin as oral discussions. In the Rocor case, it is quite possible that a different result would have occurred if the initial oral discussions had been memorialized in writing. Consequently, local counsel in situations of this kind need to keep up not only with the law of the jurisdiction in which they are practicing, but also with nationwide trends which may identify issues which have not otherwise presented themselves in their own jurisdictions.

Certainly, the Rocor decision suggests that motor carriers with larger deductibles and SIRs should insist that their counsel get comprehensive written demands at some point in the settlement negotiations.

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