

to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract” and a third-party claimant as “any individual ... asserting a claim against any individual ... insured under an insurance policy or insurance contract of an insurer.” W. Va. C.S.R. § 114-14-2.3 (2006); W. Va. C.S.R. § 114-14-2.8 (2006).

The court reasoned that under the Commissioner’s rule and the common law definition of third-party claimant, the Loudins could be characterized as either first-party or third-party claimants. Insofar as National took the position that William Loudin was a non-named insured or beneficiary under the policy when he caused injury to Thomas Loudin, the Loudins could be considered third-party claimants. However, there is no dispute that Thomas Loudin is the named insured on the policy in question and that he filed a claim under that policy. Thus, under the unique facts of this case, the Loudins’ bad faith cause of action has characteristics of both first-party and third-party bad faith claims.

To clear up the incongruity, the court looked to West Virginia public policy that the State should hold insurers accountable in a court of law when they wrongfully deny coverage to premium-paying insureds. “A policyholder buys an insurance contract for peace of mind and security, not financial gain, and certainly not to be embroiled in litigation. The goal is for all policyholders to get the benefit of their contractual bargain: they should get their policy proceeds promptly without having to pay litigation fees to vindicate their rights.”

In reversing the circuit court, the court held that the rejection of the Loudins as first-party claimants effectively terminated the Loudins’ right to seek legal redress for alleged improper handling of Thomas Loudin’s claim. The insurance policy at issue showed only the name of Thomas Loudin as the party procuring the policy. It was therefore unfair that Thomas Loudin was not owed a duty of good faith and fair dealing in resolving that claim as a first-party claimant after bringing a claim under the policy. Such an outcome essentially treated Thomas Loudin as a non-premium paying claimant seeking coverage under a third-party’s policy, when he, in fact, paid the premiums for the policy in question. Consequently, the court held that, “when a named policyholder files a claim with his/her insurer, alleging that a nonnamed

insured under the same policy caused him/her injury, the policyholder is a first-party claimant in any subsequent bad faith action against the insurer arising from the handling of the policyholder’s claim.” // Troy

Bad Faith/ Workers Compensation

Texas Supreme Court Limits Rights of Employees to Sue Their Employer’s Workers Compensation Insurers for Extracontractual Damages

1989 Reform of Texas Workers’ Compensation System Undermines Rationale for Bad Faith Cause of Action against Workers’ Compensation Carriers

Texas Mutual Insurance Company v. Ruttiger, __ S.W.3d __, 2011 WL 3796353 (Tex. Aug. 26, 2011)

Case at a Glance

Workers’ compensation claimants cannot sue under their employer’s workers’ compensation insurer for unfair claim adjustment practices under the Texas Insurance Code. The exclusive remedy for such claims is contained in the Texas Workers’ Compensation Act, which is part of the state’s Labor Code.

Workers’ compensation claimants may sue their employer’s workers’ compensation insurer for misrepresentation under the provision of the Texas Insurance Code prohibiting misrepresentation of policy terms. However, an insurer that merely disputes whether a claimant was injured in the course and scope of employment does not misrepresent the terms of a policy.

Four of the seven justices to address the question would have reversed *Aranda v. Insurance Co. of North America*, 748 S.W.2d 210 (Tex. 1988) and held that there should no longer be a common law cause of action for breach of the duty of good faith and fair dealing against a workers’ compensation insurance carrier. The remaining two justices voted to defer consideration of the claimant’s common law bad faith claim until the court of appeal has the opportunity to

consider it. The supreme court therefore remanded the issue of whether a cause of action for breach of the common law duty of good faith and fair dealing arising from an insurer's adjustment and handling of a workers' compensation claim survives the reform of the state's workers' compensation system.

Summary of Decision

Legal History. Before 1989 Texas had what many considered a dysfunctional workers' compensation system. The system had no organized administrative system; no mandatory evidentiary hearings, and no procedures to make sure that there was due process. The system even held "hearings" where the disputants were discouraged from even coming. Given the stumbling along quality and the irrationality of that system, the Texas Supreme Court, in *Aranda v. Insurance Co. of North America*, 748 S.W.2d 210 (Tex.1988), engrafted an extra-statutory cause of action for breach of the duty of good faith and fair dealing onto the workers' compensation system in order to discourage insurer misconduct and to protect employees. In recent years, the common law tort of insurance bad faith against workers' compensation carriers recognized in *Aranda* has been replaced by causes of action under the applicable portions of the Insurance Code, especially §§541-542. The elements of common law bad faith, for example, are found principally in §§541.060-.061.

It is no wonder that the idea of a new system was seriously considered and argued about during much of the 1980s, and a new law was finally passed in 1989, and codified in the Texas Labor Code §§ 401.001-506.002. The new statute set up stages in which an agreement can be sought (and is often, pragmatically achieved), stages in which there are actual, real hearings, and a process of administrative appeals, and a vigorous and relatively rigid set of schedules, where violations may lead penalties of various sorts. In addition, the new statute created an ombudsman program to provide assistance for injured workers who had disputes with insurers, and increasing sanctions for violations of the Act.

Issue. Do the 1989 reforms to the Texas workers' compensation system obviate the need for statutory and common law bad faith claims against workers' compensation? Can these remedies be reconciled with the sanctions for failure to pay workers'

compensation benefits contained in the Labor Code? The facts and processing in this case provided an almost perfect set of facts in which to consider these broad issues.

Case Facts. Ruttiger ("R") was the claimant. On June 21, 2004, R complained to his employer that he had sustained an injury that morning while working. He went to a nearby hospital and was diagnosed as having suffered a bilateral inguinal hernia. The proper applications and reports were filled out. The carrier began supplying temporary income benefits and began an investigation. Here is where problems began. Some of R's co-workers told stories that differed from R's. He had played softball over the preceding weekend. He complained of injury there. He limped away from the field. He limped onto the job. At some point, he bragged that although he was hurt on the field, he was going to get the comp insurer to pick up the tab. And the stories grow. An executive at the employer said that he never got a whole story from R. R had twice in the past been diagnosed as having the same problem, and there had been no surgery.

Facts Regarding Administrative and Judicial Procedure. In addition, according to the insurer's investigation, he was not able to reach R either by mail or by phone. Somewhat after the investigation the insurer, Texas Mutual Insurance Company (TMIC), filed a "Notice of Refused or Disputed Claim." Thereupon, it discontinued temporary income benefit checks. Within a few days, R hired a lawyer. Two months later, in September, the lawyer contacted the insurer and asked for a copy of its "Notice." Then another month went by and in late October he asked the Workers' Compensation Division for a Benefit Review Conference (BRC). This happened about four months after the accident was reported; that timing is not consistent with the intent of the "new law" system, and it is in fact rare. The BRC was held on December 2, 2004. The hearing then had to be put off for a month because of governmental error. Given R's injury and when it occurred, as these things go, without temporary benefits, June to December is quite a long time.

The case was resolved at the BRC. The insurer agreed that R has a compensable injury, that he had disability for part of the intervening time but not all of it, that he was entitled to weekly compensation from that time forward, and that the insurer would

pay relevant medical bills. The Workers' Compensation Commission approved the settlement. And TMIC paid in accordance with the agreement long before the approval was "published."

Several months after the comp case had been settled, R sued TMIC. Basically, the case was a bad faith case, with emphasis on statutory bad faith, and R sought the usual damages. The case was tried to a jury, and R prevailed. The intermediate appellate court affirmed. The case then went to the Texas Supreme Court, which reversed and remanded. In so doing, the majority opinion eliminated all but a sliver of bad faith from the workers compensation system—and that sliver probably will be eliminated in future cases.

The Texas Supreme Court's Opinion

Exhaustion of Remedies. Initially, the Texas Supreme Court rejected Texas Mutual's contention that R did not exhaust his administrative remedies by not continuing through all four possible dispute resolution steps under the Labor Code. The court noted that the parties had engaged in a BRC and entered into a Benefit Dispute Agreement that the WCD approved. Thus, there were no remaining disputed issues to be resolved. Nothing in the Texas Workers' Compensation Act, explained the court, requires a claimant to seek review of issues no longer in dispute.

Texas Insurance Code § 541.060. The court found that the Texas Legislature could not have intended private rights of action against workers' compensation insurers under Insurance Code § 541.060, which prohibits unfair claims handling, to survive the 1989 reform of the workers' compensation system, which "prescribes detailed, WCD-supervised, time compressed processes for carriers to handle claims for dispute resolution" and has "multiple, sometimes redundant but sometimes additive, penalty and sanction provisions for enforcing compliance with its requirements." The court explained that "[p]ermitt[ing] a workers' compensation claimant to additionally recover by simply suing under general provisions of Insurance Code section 541.060 would be inconsistent with the structure and detailed processes of the Act." In the court's view, "[i]t is conceptually untenable that the Legislature would have erected two alternative statutory remedies, one that enacts a structured scheme ... and carefully constructs rights,

remedies and procedures and one that would significantly undermine that scheme." The court added that allowing recovery under Insurance Code § 541.060 would reward an employee who delays in taking advantage of the Act's dispute resolution processes, such as in this case, where R contributed to his own damages by waiting over three months before contesting TMIC's denial of his claim. For the same reasons, the court held that workers' compensation claimants may not assert a cause of action under Insurance Code §§ 542.003(a) and (b)(3), which penalize carriers who fail to "adopt and implement reasonable standards for prompt investigation of claims arising under policies."

Texas Insurance Code § 541.061. Turning to Insurance Code § 541.061, which prohibits a carrier from making misrepresentations regarding its insurance policy, the court found no evidence of legislative "intent that it be applied in regard to settling claims," and therefore concluded, "it is not at odds with the dispute resolution process of the workers' compensation system." Although concluding that private rights of action for violations of § 541.061 survived the 1989 reform, the court insufficient evidence to support a finding that Texas Mutual misrepresented its policy. Instead, the parties' dispute centered on the threshold question of whether R was injured in the course of his employment.

Common Law Bad Faith. The court was unable to reach a consensus regarding the status of common law bad faith claims recognized in *Aranda* before the 1989 reforms, largely because the intermediate appellate court did not address the question. Two of the supreme court's nine justices voted to defer consideration of common law bad faith claims until the lower court first considers them. The remaining seven justices split 4-3 in favor of overruling *Aranda*. The plurality opinion joined by four of the justices stated that "[t]he *Aranda* cause of action operates outside the administrative processes and other remedies in the Act and is in tension with—and in many instances works in direct opposition to—the Act's goals and processes." The plurality went on to state that "[i]t was the Court's prerogative to recognize the need for and extend [the] extra-contractual common law cause of action when it decided *Aranda*; it is the Court's prerogative and responsibility to recognize if the cause of action is no

longer appropriate." In doing so, Texas would join the majority of other states in finding that workers' compensation statutes provide the exclusive remedy for bad faith claims handling by workers' compensation carriers.

Comment

The Texas Supreme Court's *not overbrowsing* the doctrines in *Aranda* in this case at this time was pointless adherence to the appellate principle against deciding issues not raised in the lower court. If the court of appeals decides anything, it is certain to follow the reasoning set forth in the supreme court's opinion. In all likelihood the case will now settle. // Quinn

Health Insurance

Health Insurance Policy Covers Non-cosmetic Breast Reduction Surgery

Cosmetic Procedures Exclusion did not Bar Coverage of Medically Necessary Surgery and Ensuing Complications

Shaffer v. WINhealth Partners, 261 P.3d 708 (Wyo. 2011)

Case at a Glance

Coverage for complications of medically necessary breast reduction surgery was not barred under contract that precluded coverage of cosmetic procedures but provided that reduction mammoplasty was either not covered or was "subject to limitations." Examining the contract as a whole, the two provisions allowed coverage of non-cosmetic breast surgery. A determination that the contract barred coverage of plaintiff's treatment for complications of breast reduction surgery was reversed.

Summary of Decision

Plaintiff underwent breast reduction surgery that was authorized as medically necessary by her

husband's employee health insurer at the time, Great West Healthcare. In 2006, the husband's health insurer changed to WINhealth Partners. Plaintiff was subsequently hospitalized for a staph infection of a type frequently contracted during surgery. WIN denied coverage for the treatment in part on the basis that the medical expenses arose from uncovered treatment to improve plaintiff's appearance. Plaintiff filed internal appeals but WIN refused to change its decision.

Plaintiff filed a complaint in a West Virginia trial court against WIN alleging that she suffered damages as a result of WIN's actions and omissions and that WIN breached its contract. The trial court concluded that the insurance contract clearly and unambiguously excluded coverage for plaintiff's breast reduction surgery. Because the contract also excluded coverage for treatment of complications arising from non-covered services, the court determined that plaintiff was not entitled to benefits for treatment of her infection and granted summary judgment in favor of WIN.

The Wyoming Supreme Court reversed, determining that based on the evidence in the record plaintiff was entitled to summary judgment on her claims for the treatment of her infection. The court observed that undisputed evidence established that plaintiff's breast reduction surgery was medically necessary and was not performed for cosmetic purposes. It was also clear that the infection was a complication of plaintiff's surgery.

Examining the contract, the state high court noted that one provision excluded coverage for cosmetic procedures and specifically referred to breast reductions. Separately, the Benefit Plan Exclusions and Limitations clause provided that "The following services are not covered or are subject to limitations: Reduction Mammoplasty." This "subject to limitations" language was not considered by the trial court.

Looking at the contract as whole, the supreme court reasoned that it could not ignore the contractual language that stated coverage for reduction mammoplasty may be subject to limitations, as opposed to excluded altogether. If, as WIN argued and the trial court decided, the exclusions and limitations provision excluded all reduction mammoplasty it would not be necessary to include the specific exclusion of cosmetic breast reductions. The only