Texas federal court explores parameters of “sophisticated insured” doctrine to defeat application of *contra proferentum* in construing ambiguities in policy

*Vought Aircraft Industries, Inc. v. Falvey Cargo Underwriting, Ltd. (June 25, 2010 N.D. Texas).*

In this litigation, Vought Aircraft Industries, Inc. (“Vought”) sought to recover the costs of repairing a horizontal stabilizer — a horizontal wing atop an airplane’s tail fin that helps maintain level flight — from its insurer Falvey Cargo Underwriting, Inc. (“Falvey”) which had, in turn, placed the risk in the London market. Upon determining certain of the provisions of the marine cargo policy at issue were ambiguous, the court then needed to consider whether to apply the general rule, and resolve the ambiguity in favor of coverage. In reviewing the issue, the court noted an exception to the general rule “when corporate insureds with bargaining power equal to the insurer participate in drafting insurance coverage.” Because there was a factual issue as to the extent that Vought or its broker negotiated and drafted the marine cargo policy at issue, this issue would ultimately have to be resolved by the jury.

To the insured’s concern that the “sophisticated insured” rule would create an exception to the general rule for all large corporations — and create different interpretations of the same policy language based upon the status of the insured — the court saw that concern as unfounded because the exception would apply only where the policies were drafted at least in part by the corporations. In conclusion the court found it significant that evidence showed Vought was sophisticated, had equal bargaining power with the insurer, and had — through its broker — crafted various parts of the insurance contract.

In addition, the court found that Falvey’s employment of an outside accounting firm and the existence of a good faith dispute as to the amount owed under the policy precluded, as a matter of law, recovery for a breach of the duty of good faith and fair dealing or of a duty created under the misrepresentation provisions of the unfair insurance practice sections of the Texas Insurance Code.
In Harper, the insured failed to disclose or otherwise misrepresented several health issues when he applied for his life insurance policy, including the fact that he was morbidly obese, and had previously been treated for both liver disease and a stroke. When he died of a heart attack 50 days after the policy was issued, his widow attempted to collect the insurance benefits. When the carrier not only denied coverage, but rescinded the policy based on the insured’s misrepresentations, his widow sued, alleging breach of contract, reasonable expectations, promissory estoppel and breach of the covenant of good faith and fair dealing. The court granted the carrier’s summary judgment motion as to all claims.

The Wyoming Supreme Court upheld the ruling. In so doing it rejected the argument that the carrier had a duty to independently investigate the truthfulness of the representations the insured made on the application, holding that no such duty arises in the absence of some notice to the carrier that the application might contain inaccurate or untruthful information. The court also rejected arguments that the carrier had engaged in “post-claim underwriting,” the court noting that such a practice had been held by at least one court to constitute per se evidence of bad faith, but there was simply no evidence that it had occurred with respect to the insured. The court applied the fairly-debatable standard to the bad faith claims, analyzing whether a reasonable insurer would have denied the claim under the facts presented. As the court believed the carrier had acted reasonably under the circumstances, it held that no bad faith had occurred.

Under similar facts, the Adam court also rejected a bad faith claim arising out of the life insurer’s denial of a claim and rescission of the policy in light of material misrepresentations made in the policy application. There, the insured failed to disclose that he had been diagnosed as bipolar. When he was killed in a car accident several months after the policy was issued, his estate sought to collect under the policy. The carrier denied coverage, and rescinded the policy based on the misrepresentation. The estate sued for breach of contract and bad faith. The trial court granted the carrier’s summary judgment motion. The Eighth Circuit upheld the trial court.

As in Harper, the Adam court applied the “fairly debatable” standard to the bad faith claim. The court explained that whether a claim is fairly debatable is generally a question of law. Under this standard, the court found that the insured’s misrepresentation provided a reasonable basis to deny the claim, and thus, there was no bad faith as a matter of law. The insured’s estate argued that the carrier had a duty to investigate the statements made on the insurance application where it was aware that one source of the insured’s income was Social Security, which raised a red flag as to the reason why the insured was eligible to receive Social Security payments. The court was not persuaded by this argument.

One interesting note from the two cases is that while the misrepresentation in the Harper case arguably related to the insured’s cause of death, in Adam the cause of death was an automobile accident, wholly unrelated to the insured’s undisclosed diagnosis of bipolar disorder. In both cases, however, the court found the misrepresentations to be material and a sufficient basis to support not only the denial of coverage but a rescission of the policy altogether.
Texas Court denies bifurcation of bad faith case from UIM contract action, instead ordering the matters be severed entirely


After Juan Garcia was involved in a motor vehicle accident with Ramon Valverde, he sued for UIM benefits under his employer’s insurance policy. He later added claims for bad faith based on an alleged failure to properly investigate his claim and alleged unfair settlement practices, both of which alleged actions ran afoul of Texas statutes. The carrier, United Fire, filed a motion for severance of the bad faith case from the contract action, arguing that the introduction of a settlement offer it had made, the policy limits and the facts regarding how it had handled the claim would prejudice it in the UIM case and would cause confusion in the trial. In support, United Fire emphasized that a UIM claim is different from other types of insurance claims in that there is no contractual duty to pay any benefits until the insured obtains a judgment establishing both liability and the underinsured status of the other driver.

Garcia opposed severance, arguing instead that bifurcation would adequately address United Fire’s concerns. The court rejected Garcia’s position, and agreed that severance of the bad faith claims was appropriate. In so doing, the court noted that since United Fire was under no obligation to pay UIM benefits until Garcia could establish the liability and underinsured status of the other driver, the bad faith claims could be rendered entirely moot by the outcome of the UIM portion of the case. Accordingly, the court held United Fire should not be required to conduct discovery and prepare for trial on a bad faith claim that may not even survive the UIM portion of the trial. A reading of the case strongly suggests that the outcome may well have been different if the severance versus bifurcation issue had not arisen in the context of a UIM claim.

Federal district court refuses to dismiss class action claims against insurance holding company


In Johnson, the plaintiffs had filed a class action against a number of GEICO entities for, among other things, bad faith breach of contract and breach of the duty of fair dealing. The defendants filed a motion to dismiss GEICO Corporation based on an alleged lack of standing, arguing that while certain of the putative class members were named insureds of one GEICO entity or another, GEICO Corporation was merely a holding company that did not issue any policies or handle any PIP claims in Delaware. They argued that the plaintiffs’ alleged injuries were thus not traceable to GEICO Corporation and that it should be dismissed as a defendant in the lawsuit.

In response, the plaintiffs argued that the allegations and evidence in the record demonstrated their standing, in that GEICO Corporation actively participated in and/or controlled the management and strategies employed by its insurer subsidiaries. Plaintiffs further noted that GEICO Corporation received regular management reports that documented the claims handling systems and cost-containment efforts of its subsidiaries. They also pointed to statements made by Berkshire Hathaway, Inc., GEICO Corporation’s parent company, establishing the holding company provided “advisory services” to its subsidiary insurance companies.
The court relied on these arguments, and the plaintiffs’ allegation that the various GEICO entities operate “jointly, collectively and interchangeably” to find plaintiffs’ claims against GEICO Corporation could survive the motion to dismiss for want of standing. In so holding, it noted that taking the allegations as true, as it was required to do in considering the motion to dismiss, it was apparent that plaintiffs had stated claims against GEICO Corporation for at least fraud and tortious interference with contact. However, the court emphasized it could revisit the standing issue as to the holding company at a later time, after the facts regarding the relationship between GEICO Corporation and its subsidiaries were better developed through discovery.