

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION**

HEALTHTRACKRX INDIANA, INC.	§	
	§	
	§	
v.	§	NO. 4:23-CV-01063-ALM-BD
	§	
RSUI INDEMNITY COMPANY	§	

**REPORT AND RECOMMENDATION
OF UNITED STATES MAGISTRATE JUDGE**

In this diversity suit, HealthTrackRx Indiana, Inc., sued its insurer, RSUI Indemnity Company, for breach of contract. Dkt. 1. The parties disagree about the applicability of a retention provision and a limit on RSUI’s liability for HealthTrackRx’s claims. *See* Dkt. 21 at 1–2. Each party moved for judgment on the pleadings regarding HealthTrackRx’s request for declaratory relief. Dkts. 14, 15. The court denied HealthTrackRx’s motion, denied RSUI’s motion in part and granted it in part, and directed further consideration after full briefing of one issue. Dkt. 25. Having received that briefing, Dkts. 27, 28, the court recommends that RSUI’s motion be granted in full.

BACKGROUND

The court previously recounted the background of this case. Dkts. 21 at 1–2, 25 at 2–9. In brief, HealthTrackRx bought an insurance policy from RSUI under which RSUI agreed to pay for HealthTrackRx’s defense costs in the event that HealthTrackRx was the target of one or more regulatory claims. Dkt. 1 at 1. When HealthTrackRx reported two such claims, RSUI agreed to pay for its defense but asserted that the policy required HealthTrackRx to pay the first \$250,000 of its defense costs as a “retention” and was also subject to a \$250,000 limit on liability. *Id.* at 3.

HealthTrackRx requested a declaration that “RSUI is obligated to provide defense coverage, not subject to a retention and not subject to a policy limit for HealthTrackRx’s incurred and future defense costs.” Dkt. 1 at 9. Each party moved for judgment on the pleadings with respect to that request. Dkts. 14, 15. The court concluded that HealthTrackRx’s claims were subject to the

retention, but it did not decide whether they were subject to the limit on liability. Dkt. 25. It instead ordered and received supplemental briefing on that issue. Dkts. 26 (order), 27 (RSUI’s supplemental brief), 28 (HealthTrackRx’s supplemental brief).

RSUI argues that the policy contains a “mere punctuation error” that the court can disregard and that, without that error, the policy unambiguously subjects HealthTrackRx’s claims to the limit on liability. Dkt. 27; *see* Dkts. 21 at 11–13 (describing and discussing the claimed punctuation error), 25 at 21–34 (same). HealthTrackRx argues that the limit on liability is not susceptible to any clear meaning and is unenforceable under Indiana law. Dkt. 28; *see* Dkt. 21 at 3 (unchallenged conclusion that Indiana law governs the parties’ dispute). Neither party has offered any extrinsic evidence regarding the meaning of the challenged language. *See* Dkts. 27 at 3 (stating that “RSUI is not currently aware of any extrinsic evidence that should be considered”), 28 at 6–8 (arguing that extrinsic evidence would be irrelevant).

STANDARD OF REVIEW

Federal Rule of Civil Procedure 12(c) provides that, “[a]fter the pleadings are closed—but early enough not to delay trial—a party may move for judgment on the pleadings.” Rule 12(c) motions, which are commonly used to determine questions of law related to insurance coverage, *see, e.g., In re Katrina Canal Breaches Litig.*, 495 F.3d 191, 224 (5th Cir. 2007); *Cinemark Holdings, Inc. v. Factory Mut. Ins. Co.*, 500 F. Supp. 3d 565, 569 (E.D. Tex. 2021), are “designed to dispose of cases where the material facts are not in dispute and . . . judgment[s] on the merits can be rendered by looking to the substance of the pleadings,” *Great Plains Tr. Co. v. Morgan Stanley Dean Witter & Co.*, 313 F.3d 305, 312–13 (5th Cir. 2002). “Pleadings should be construed liberally, and judgment on the pleadings is appropriate only if there are no disputed issues of fact and only questions of law remain.” *Id.* at 312.

The Rule 12(c) standard is the Rule 12(b)(6) standard. *Johnson v. Teva Pharms. USA, Inc.*, 758 F.3d 605, 610 (5th Cir. 2014). “The central issue is whether, in the light most favorable to the plaintiff, the complaint states a valid claim for relief.” *Hughes v. Tobacco Inst., Inc.*, 278 F.3d 417,

420 (5th Cir. 2001). A claim will be dismissed when the plaintiff has not alleged enough facts to state a claim to relief that is plausible on its face or has failed to “raise [its] right to relief above the speculative level, . . . on the assumption that all the allegations in the complaint are true (even if doubtful in fact).” *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007).

DISCUSSION

I. The Relevant Policy Language and the Interpretive Problems It Creates

The policy provision at issue reads:

The **Insurer’s** maximum aggregate Limit of Liability for **Loss** under this policy in connection with **Regulatory Claims** made against all **Insured’s** shall be \$250,000. This sublimit shall be part of and not in addition to the amount set forth in Item 2.A of the Directors and Officers Liability Declarations Page.

Dkt. 14-1 at 53 (boldface omitted going forward); *see id.* (defining “Regulatory Claim”); *id.* at 19 (defining “Insurer” as RSUI), 44 (defining “Insured” as “any Insured Organization and/or any Insured Person,” where the “Insured Organization” is HealthTrackRx and its parent company and an “Insured Person” is “[a]ny past, present or future director, officer, or Employee, management committee members or members of the Board of Managers of the Insured Organization”); Dkt. 21 at 5–9 (discussing the meaning of “Loss”).

Neither party disputes that the claims against HealthTrackRx are regulatory claims, and the court already determined that RSUI’s liability to pay defense expenses for those claims qualifies as “Loss.” Dkt. 25 at 10–21. So whether the limit on liability applies in this case depends on whether the regulatory claims against HealthTrackRx are “made against all Insured’s.” Dkt. 14-1 at 53.

That flawed language is susceptible to at least two readings. One is that the apostrophe was added by mistake, such that the provision should read: “Regulatory Claims made against all Insureds.” That interpretation is problematic because “Insureds” is defined to include a group of unknown, and potentially numerous, people and entities, some of which may not yet exist or exist any longer; it is hard to imagine how claims could be made against “all” of those people and entities. *See* Dkt. 14-1 at 44.

Another possibility is that a word was omitted after “Insured’s,” such that the provision should read: “Regulatory Claims made against all Insured’s _____,” where the blank might be filled with “agents,” “employees,” or “properties,” to theorize just a few possibilities. That interpretation has its own problems. If a word is missing, there is no indication of what it might be. And that reading is possible only if there is a second mistake: either the apostrophe was misplaced, and should have appeared after the “s” to yield the plural possessive “Insureds’,” or the singular “Insured” should not have been preceded by “all.”

II. Recommendation for Resolution of the Parties’ Dispute

Neither party’s motion addressed the difficulties arising from the provision’s language, so the court initially recommended granting RSUI’s motion only in part. Having now received and considered the parties’ supplemental briefing under the governing law, the court will recommend a finding that the provision is not ambiguous in the applicable sense of that word and that RSUI’s motion be granted in full.

A. Lack of ambiguity

Under Indiana law, “[a]n insurance policy is a contract like any other” and is “governed by the same rules of construction as other contracts.” *Justice v. Am. Fam. Mut. Ins. Co.*, 4 N.E.3d 1171, 1175–76 (Ind. 2014). “When confronted with a dispute over the meaning of insurance policy terms,” courts applying Indiana law “afford clear and unambiguous policy language its plain, ordinary meaning.” *Erie Indem. Co. v. Est. of Harris*, 99 N.E.3d 625, 630 (Ind. 2018). The court’s interpretation of an insurance policy should “harmonize its provisions, rather than place the provisions in conflict.” *Allgood v. Meridian Sec. Ins. Co.*, 836 N.E.2d 243, 247 (Ind. 2005).

But Indiana courts also apply some special rules of construction to insurance policies. *G&G Oil Co. of Ind., Inc. v. Cont’l W. Ins. Co.*, 165 N.E.3d 82, 87 (Ind. 2021). One of them is that an ambiguity in an insurance policy is construed against the policy drafter and in favor of the insured. *Id.* But that rule does not suggest that a policy term is ambiguous just because the parties dispute its meaning. *Erie Indem. Co.*, 99 N.E.3d at 630. Ambiguity, in the relevant sense, exists only if “reasonably intelligent policyholders would honestly disagree on the policy language’s meaning.”

Id. Otherwise, the policy “must be enforced according to its terms, even those terms that limit an insurer’s liability.” *Haag v. Castro*, 959 N.E.2d 819, 824 (Ind. 2012) (quoting *Prop.-Owners Ins. Co. v. Ted’s Tavern, Inc.*, 853 N.E.2d 973, 978 (Ind. Ct. App. 2006)).

HealthTrackRx asked the court to declare that the defense expenses RSUI is liable for, which the court already found to be “Loss,” are not subject to the \$250,000 limit on liability. Dkt. 1 at 9. RSUI’s motion for judgment on the pleadings asks the court to deny that request. Dkt. 14 at 15. RSUI has the better of imperfect arguments. The phrase “Regulatory Claims made against all Insured’s,” Dkt. 14-1 at 53, is not properly viewed as ambiguous under Indiana law, and it is best understood as containing a misplaced apostrophe and applying to the claims made against HealthTrackRx.

1. Misplaced apostrophe

RSUI argues that, under Indiana law, the apostrophe in the word “Insured’s” is a typographical error that the court can ignore. Dkt. 27 at 6–8. It notes that courts in Indiana and elsewhere have disregarded errant apostrophes. *Id.* at 6–7 (collecting cases). And indeed, Indiana law allows for those kinds of reformations, *see State v. Bd. of Comm’rs of Carroll Cnty.*, 178 N.E. 563, 568–69 (Ind. 1931); *Schiller v. Knigge*, 575 N.E.2d 704, 707 (Ind. Ct. App. 1991), but only if the contract itself or parol evidence shows that the error does not reflect the intent of the parties, *see White Truck Sales of Indianapolis, Inc. v. Shelby Nat’l Bank of Shelbyville*, 420 N.E.2d 1266, 1269 (Ind. Ct. App. 1981).

Here, two aspects of the policy suggest that the parties intended to write “Insureds” instead of “Insured’s.” For one, “Insured’s” is preceded by “all.” Whatever interpretive issues “all” might bring, *see infra* Part II.A.2, that word strongly suggests that a plural word will follow, *see Bogi v. Citizens Ins. Co. of the Midwest*, 427 F. Supp. 3d 954, 961 (W.D. Mich. 2019); *Powers v. Weitzl*, 2023 IL App (4th) 230104-U, ¶ 5, 2023 WL 6993120; *Aetna Ins. Co. v. N.Y. Cent. R. R.*, 17 Ohio Supp. 169, 172 (Ohio Com. Pl. 1946). That is to say, a reasonable reader of the policy would not expect the provision to refer to “all Insured.”

Context also suggests the plural because a limit of liability for loss “in connection with Regulatory Claims made against all Insured’s _____” would be ineffectual. As defined by the policy, an “Insured” is either HealthTrackRx, its parent company, or any one of several types of people and entities related to either of them. Dkt. 14-1 at 44. In other words, an Insured might be one of HealthTrackRx’s or its parent company’s directors, officers, employees, management-committee members, or members of its board of managers. *Id.* The policy makes RSUI liable for loss that “any Insured” is “legally obligated to pay on account of any covered Regulatory Claim.” *Id.* at 54. But it does not cover loss arising from a claim made against an Insured’s employee, an Insured’s agent, an Insured’s subsidiary, an Insured’s property, or anything else along those lines. So if a claim were made against HealthTrackRx, the policy would cover loss that results from that claim. And if a claim were made against one of HealthTrackRx’s employees, the policy would cover loss from that claim as well because HealthTrackRx’s employees are Insureds. But if that employee had an employee of his or her own and a claim were made against the employee’s employee, the policy would not cover loss arising from that claim. The only coverage the policy provides for the object of a possessive is coverage of the Insured Organization’s employees, subsidiaries, &c., because they are themselves Insureds. RSUI would not be liable to cover claims against anything that could follow “Insured’s” at all, so a limit on its liability for such claims would have no effect. That indicates that the parties intended for the relevant regulatory claims to be those “against all Insureds.” *See Walb Constr. Co. v. Chipman*, 175 N.E. 132, 135 (Ind. 1931) (stating that “[n]o part of a contract will be treated as redundant or as surplusage if a meaning reasonable and consistent with other parts of the contract can be given it”); *Barker v. Price*, 48 N.E.3d 367, 370 (Ind. Ct. App. 2015) (explaining that a contract should be read “as a whole, attempting to ascertain the parties’ intent and making every attempt to construe the contract’s language ‘so as not to render any words, phrases, or terms ineffective or meaningless’” (quoting *Four Seasons Mfg., Inc. v. 1001 Coliseum, LLC*, 870 N.E.2d 494, 501 (Ind. Ct. App. 2007))).

HealthTrackRx argues that the court cannot reform the policy because the errant apostrophe was a unilateral mistake, not a mutual one. Dkt. 28 at 4. As HealthTrackRx notes, for the court to

correct a typographical error, the error must be a “mutual mistake” that “does not express what the parties actually intended.” *Plumlee v. Monroe Guar. Ins. Co.*, 655 N.E.2d 350, 356 (Ind. Ct. App. 1995). According to HealthTrackRx, there can be no mutual mistake in an insurance contract because there is no “meeting of the minds.” Dkt. 28 at 4–5. “The insurance companies write the policies; we buy their forms or we do not buy insurance.” *Id.* at 4 (quoting *Bradshaw v. Chandler*, 916 N.E.2d 163, 166 (Ind. 2009)).

But it is incorrect to say that, just because one party drafted a contract, the other had no agency. *Lysheh v. Cellular Sales of Tenn., LLC*, No. 3:17-cv-542, 2018 WL 2207122, at *4–5 (E.D. Tenn. May 14, 2018) (explaining that parties can still mutually assent to a standardized, “take it or leave it” contract); see *Payless Shoesource, Inc. v. Travelers Cos., Inc.*, 585 F.3d 1366, 1367–68 (10th Cir. 2009) (Gorsuch, J.) (holding that the court could disregard a grammatical mistake in an insurance contract). In any event, the argument proves too much. If HealthTrackRx were right that there was never a “meeting of the minds,” there would be no contract at all and RSUI would not be liable to cover any of HealthTrackRx’s loss, see *Homer v. Burman*, 743 N.E.2d 1144, 1146–47 (Ind. Ct. App. 2001), an outcome it would surely oppose. There would also be obvious implications for the broader insurance industry, or at least the portion of it governed by Indiana law.

The court may excuse a typographical error, even when it appears in a standardized contract. See *Peterson v. First State Bank*, 737 N.E.2d 1226, 1229–30 (Ind. Ct. App. 2000); see also *Bradshaw*, 916 N.E.2d at 166 (explaining that, although courts construe ambiguities strictly against the insurer, they “enforce limits on coverage where the policy unambiguously favors the insurer’s interpretation”). Here, every indication is that neither party intended to render “Insured” (or “Insureds”) possessive. Indeed, HealthTrackRx, which now objects to that conclusion, appeared to acknowledge as much before the court noted the implications of that error. Dkt. 16 at 17 (adding a “[sic]” after “Insured’s” when quoting the provision). The court will not presume that the parties intended to be bound by a provision that does not make sense.

2. The scope of “all”

Having reached that conclusion, the court must also address an issue that, despite its invitation, Dkt. 26 at 1, neither party’s supplemental brief addressed: the meaning of “all” in the disputed provision. As the court has noted, “the phrase ‘all Insured[]s’ . . . is unusual in the broader context of the policy,” which more often uses the phrase “any Insured”—or, in one instance, “any Insureds.” Dkt. 26 (citing 32 pages of the policy).

Indiana courts have given the word “all” “various definitions dependent upon the usage in each particular case.” *Town of Kewanna Water Works v. Ind. Emp. Sec. Bd.*, 171 N.E.2d 262, 266 (Ind. App. 1961). It can mean “every” or “the entire or total number, amount or quantity.” *Rogier v. Am. Testing & Eng’g Corp.*, 734 N.E.2d 606, 616 (Ind. Ct. App. 2000) (brackets omitted). But it can also mean “any whatsoever.” *Id.* (brackets omitted); see Merriam–Webster’s Collegiate Dictionary 31 (11th ed. 2020) (defining “all” to include “every member or individual component of,” “the whole number or sum of,” or “any whatever”). In some instances, “all” means every member of a class collectively and without exception. See *Balagtas v. Bishop*, 910 N.E.2d 789, 795 (Ind. Ct. App. 2009) (holding that a statute permitting an insured to reject coverage “on behalf of all named insureds and other insureds” “must apply to all insureds” as opposed to “some but not all of the named insureds or other insureds”). But in other contexts, “all” can refer to a single person or entity. See *Gardner v. State Farm Mut. Ins. Co.*, 589 N.E.2d 278, 282 (Ind. Ct. App. 1992) (holding that a limit of liability calculated by “the amount paid *all* insureds by or for any person or organization who is or may be held legally liable for the bodily injury” included any “payments to *an* insured by another person or organization responsible for the bodily injury” (emphasis added)).

That leaves two potential meanings. The aggregate limit of liability applies to loss in connection with regulatory claims that name as respondents either:

- 1) HealthTrackRx, its parent company, *and* every “past, present or future director, officer, [and] Employee,” *and* every “management committee member[] [and] member[] of the Board of Managers of,” Dkt. 14-1 at 44, HealthTrackRx *and* its parent company; or

- 2) HealthTrackRx, its parent company, *or* any “past, present or future director, officer, or Employee, management committee member[] or member[] of the Board of Managers of,” *id.*, HealthTrackRx *or* its parent company.

But just because the court can discern two potential meanings of that phrase is not enough to create an ambiguity under Indiana law. *USA Life One Ins. Co. of Ind. v. Nuckolls*, 682 N.E.2d 534, 538 (Ind. 1997). Ambiguity would exist only if each interpretation were reasonable. *Id.*

The first potential meaning is not reasonable. The disputed provision describes an aggregate; it contemplates a sum of multiple claims made against multiple insureds. *See* Bryan A. Garner, *A Dictionary of Modern Legal Usage* 39 (2d ed. 1995) (explaining that an “aggregate” is “a mass of discrete things or individuals taken as a whole”); *see also Allstate Ins. Co. v. Dana Corp.*, 737 N.E.2d 1177, 1194 (Ind. Ct. App. 2000) (describing an aggregate limit on liability as “the maximum liability of the insurer where there are multiple occurrences, each of which creates liability for the insurer”). That is consistent with the rest of the policy. Although in most places it uses the phrase “any Insured,” the provision at issue here is the only instance in which “any” or “all” is both preceded by and (after the errant apostrophe is removed) followed by a plural noun. It seems that the parties contemplated that multiple claims could be filed against one or a few insureds.

The alternative—that the parties contemplated that the claims would be filed against each and every insured—would be absurd, given the policy’s expansive definition of “Insured.” Under that reading, the provision would apply when claims are filed against a potentially changing group of parties of unknown identity and number, some of which may no longer exist, others of which may not yet exist. Dkt. 14-1 at 44 (defining “Insured,” “Insured Organization,” and “Insured Person”); Dkt. 21 at 5–9 (discussing the meaning of “Loss”). It is not reasonable to conclude, and HealthTrackRx does not argue, that the parties contemplated that claims could be brought against all of HealthTrackRx; its parent company; every member of each of their management committees and boards of managers; and every director, officer, and employee that either of them had at the time of contracting, has ever had, and ever will have. And Indiana courts do not read contract provisions to create absurd results. *Nuckolls*, 682 N.E.2d at 539.

* * *

Flawed though it is, the disputed provision is not ambiguous under Indiana law. There is just one reasonable interpretation of it: the \$250,000 aggregate limit on liability applies to the sum of each regulatory claim made against any insured, including HealthTrackRx.

B. RSUI’s entitlement to judgment

HealthTrackRx’s complaint seeks a declaration that (1) the policy’s coverage for defense expenses incurred as a result of regulatory claims is not subject to a \$250,000 retention amount and (2) those expenses do not count toward the \$250,000 liability limit. Dkt. 1 at 9. The court has already determined that HealthTrackRx is not entitled to the first declaration. Dkt. 25 at 10–21. It found that defense expenses for regulatory claims fell within the meaning of “Loss.” Dkt. 25 at 11–17. And as HealthTrackRx conceded, that conclusion means that those expenses “would be subject to the retention and erode limits [on liability].” Dkt. 16 at 16 (emphasis omitted). Neither party disputes that the regulatory claims against HealthTrackRx are regulatory claims against an insured. The court’s earlier determination that RSUI’s liability to pay defense expenses is within the definition of “Loss” is dispositive. Loss accrued in connection with regulatory claims made against an insured—what HealthTrackRx’s claim is for—is subject to the limit on liability. RSUI’s motion for judgment on the pleadings should therefore be granted in full.

RECOMMENDATION

It is **RECOMMENDED** that RSUI’s motion for judgment on the pleadings, Dkt. 14, be **GRANTED**.

* * *

Within 14 days after service of this report, any party may serve and file written objections to the findings and recommendations of the magistrate judge. 28 U.S.C. § 636(b)(1).

A party is entitled to a de novo review by the district court of the findings and conclusions contained in this report only if specific objections are made. *Id.* § 636(b)(1). Failure to timely file written objections to any proposed findings, conclusions, and recommendations contained in this

report will bar an aggrieved party from appellate review of those factual findings and legal conclusions accepted by the district court, except on grounds of plain error, provided that the party has been served with notice that such consequences will result from a failure to object. *Id.*; *Thomas v. Arn*, 474 U.S. 140, 155 (1985); *Douglass v. United Servs. Auto Ass'n*, 79 F.3d 1415, 1417 (5th Cir. 1996) (en banc), *superseded by statute on other grounds*; 28 U.S.C. § 636(b)(1) (extending the time to file objections from 10 to 14 days).

So **ORDERED** and **SIGNED** this 29th day of April, 2026.



Bill Davis
United States Magistrate Judge