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I. DUTY OF GOOD FAITH AND FAIR DEALING

A. ELEMENTS OF BREACH OF DUTY

DURING the Survey period the Texas Supreme Court decided five significant cases further defining and narrowing the common law duty of good faith and fair dealing. The two most important of these cases were *Lyons v. Millers Casualty Insurance Co.*[1] and *Transportation Insurance Co. v. Moriel.*[2] Both of these cases had an immediate impact in the trial courts and courts of appeals on litigation involving this common law duty. The other three cases are *National Union Fire Insurance Co. v. Dominguez*,[3] *Natividad v. Alexsis, Inc.*,[4] and *Texas Farmers Insurance Co. v. Soriano.*[5] Additionally, the court decided to hear three other cases that will likely be used to further define the duty of good faith. These cases are *Nicolau v. State Farm Lloyds*,[6] *Republic Insurance Co. v. Stoker*,[7] and *Davis v. Twin City Fire Insurance Co.*[8]

Lyons is the most significant decision penned by the Texas Supreme Court concerning the duty of good faith and fair dealing since *Arnold*[9] and *Aranda.*[10] In *Arnold*, the court first recognized an insurer's duty to deal fairly and act in good faith towards its insured in the context of a first party claim, holding that a breach of this duty "is stated when it is alleged that there is no reasonable basis for denial of a claim or delay in payment or a failure on the part of the insurer to determine whether there is any reasonable basis for the denial or delay."[11] About a year later in *Aranda*, the court refined the standard of care required of the insurer and required an insured to prove "(1) the absence of a reasonable basis for denying or delaying payment of the benefits of the policy and (2) that the carrier knew or should have known that there was not a reasonable basis for denying the claim or delaying payment of the claim."[12]

1. 866 S.W.2d 597 (Tex. 1993).
2. 879 S.W.2d 10 (Tex. 1994).
3. 873 S.W.2d 373 (Tex. 1994).
4. 875 S.W.2d 695 (Tex. 1994).
5. 881 S.W.2d 312 (Tex. 1994).
6. 869 S.W.2d 543 (Tex. App.—Corpus Christi 1993, writ granted).
7. 867 S.W.2d 74 (Tex. App.—El Paso 1993, writ granted).
8. 865 S.W.2d 231 (Tex. App.—Texarkana 1993, writ granted).
9. Arnold v. National County Mut. Fire Ins. Co., 725 S.W.2d 165 (Tex. 1987).
10. Aranda v. Insurance Co. of N. Am., 748 S.W.2d 210 (Tex. 1988).
11. *Arnold*, 725 S.W.2d at 167.
12. *Aranda*, 748 S.W.2d at 213.

The court explained in *Aranda* that there is an objective and a subjective element to proving a breach of this duty. The objective element requires a showing that a reasonable insurer under similar circumstances would have paid the claim.[13] The subjective element requires a showing that the defendant insurer knew there was no reasonable basis to deny or delay the claim or, based on its duty to investigate, should have known there was no reasonable basis for denial or delay.[14] The court felt the subjective element was necessary to balance the insurer's right to deny invalid claims with its duty to investigate and pay valid claims.[15]

As was discussed in last year's Annual Survey[16] a disagreement arose among the courts of appeals in 1992 and 1993 about the standard by which a jury's finding of a breach of the duty of good faith and fair dealing should be reviewed in light of the two *Aranda* elements. According to one view, exemplified by *State Farm Lloyds, Inc. v. Polasek*,[17] the court does not apply the traditional standard of review—that is, looking only at the evidence supporting the verdict and disregarding the evidence to the contrary. Instead, the court looks only at the evidence relied upon by the insurer in denying the claim. If this evidence presents a reasonable basis for the insurer's conduct, then there is no breach as a matter of law. The competing view, best discussed in *State Farm Fire & Casualty Co. v. Simmons*,[18] applies the traditional standard of review and allows the jury to weigh all the evidence and decide whether the insurer acted in a reasonable manner when it denied or delayed the claim.

Interestingly, the Texas Supreme Court used neither *Polasek* nor *Simmons* to resolve this dispute, denying the applications for writ of error in each case.[19] Instead, the court used *Lyons* to try to explain the standard of review and the proof requirements for establishing a breach of the duty of good faith and fair dealing. According to the court, a no-evidence review of a bad faith finding must determine whether "[t]he evidence presented, viewed in the light most favorable to the prevailing party, [permits] the logical inference that the insurer had no reasonable basis to delay or deny payment of the claim, and that it knew or should have known it had no reasonable basis for its action."[20]

The court further determined that "[t]he evidence must relate to the tort issue of no reasonable basis, not just to the contract issue of coverage."[21] This is so, said the court, because the issue of bad faith does not

13. *Id.*
14. *Id.*
15. *Id.*
16. *See* Philip K. Maxwell and Tim Labadie, *Insurance Law, Annual Survey of Texas Law*, 47 SMU L. REV. 1227, 1296-1304 (1994).
17. 847 S.W.2d 279 (Tex. App.—San Antonio 1992, writ denied).
18. 857 S.W.2d 126 (Tex. App.—Beaumont 1993, writ denied).
19. The supreme court still has not acted on State Farm's motion for rehearing in the *Simmons* case.
20. *Lyons*, 866 S.W.2d at 600.
21. *Id.*

focus on whether the claim was valid, but on whether the insurer acted reasonably in denying the claim.[22]

The court claimed that it was not abolishing the traditional no-evidence standard of review in bad faith cases but that it was utilizing a "particularized application of our traditional no evidence review."[23] As applied to this case, the court found that Lyons had presented no evidence that Millers Casualty had breached its duty of good faith and fair dealing.[24]

The evidence showed that Ms. Lyons submitted a claim for damage to her home, contending the damage was caused by a windstorm. Millers sent an adjuster and two experts to investigate the loss, all of whom concluded the damage was from settling and cracking, which were excluded causes. Lyons hired an engineer who concluded that a tree struck the house during the storm, causing the damages. The jury determined that one-quarter of the damage was attributable to the windstorm, with the rest attributable to foundation settlement.

The court noted that the evidence offered by Lyons to prove Millers' bad faith included an expert's opinion that the wind caused the damage and the testimony of Lyons and her neighbors that the house was visibly damaged after the storm. The court viewed this evidence as supporting contractual liability, but did not consider it in connection with the bad faith claim. Instead, the court found that Lyons offered no evidence that the reports of Millers' experts were not objectively prepared or that Millers' reliance on them was unreasonable, or any other evidence that showed that Millers acted without a reasonable basis. According to the court, the insurer will not be liable for breach of the duty of good faith and fair dealing if it reasonably relied on expert reports indicating that the loss was not a covered peril, even though liability on the policy is ultimately established.[25]

The court's opinion was not unanimous; Justice Doggett (joined by Justices Gammage and Hightower), dissented, accusing the majority of engaging in a factual sufficiency review of the evidence which is prohibited by the Texas Constitution. According to the dissent, under a legal sufficiency review the court must consider only the evidence supporting the jury's finding, viewed most favorably in support of the finding, and must disregard all contrary evidence and inferences.[26] Justice Doggett believed that the majority had discounted Lyons' expert witness, thereby evaluating the credibility, sufficiency, and weight of Millers' experts in order to find that their investigation was adequate and factually constituted a reasonable basis for the denial of the claim.[27] As such, the court

22. *Id.* at 601.
23. *Id.* at 600.
24. *Id.* at 601.
25. *Lyons*, 866 S.W.2d at 601.
26. *Id.* at 602 (Doggett, J., dissenting).
27. *Id.* at 604. Justice Doggett also claimed that the majority ignored evidence that supported the jury's verdict: Lyons' and her neighbors' testimony about the damage to the home immediately after the windstorm; expert testimony that the wind had caused the

engaged in a factual sufficiency review rather than a legal sufficiency review.

Within a month after deciding *Lyons*, the court wrote again on this same subject in *National Union Fire Insurance Co. v. Dominguez*.[28] In this case, Dominguez filed a worker's compensation claim for repetitious, traumatic injury to his back. National Union, the worker's compensation carrier, denied the claim based on Dominguez's alleged failure to report the injury as an on-the-job injury and his failure to report the injury within thirty days. The doctor who had initially seen Dominguez diagnosed his back pain as stemming from a degenerative condition rather than being work-related. However, a second physician diagnosed Dominguez's condition as work-related. Soon after National Union and Dominguez settled the worker's compensation claim, Dominguez filed this suit for breach of the duty of good faith and fair dealing. The jury concluded that National Union breached the duty of good faith and fair dealing with conscious indifference to Dominguez's rights. Thus, the trial court rendered judgment for past and future mental anguish damages and punitive damages.

The court of appeals reversed the award of punitive damages because of lack of evidence of National Union's conscious indifference. It also reversed the award of future mental anguish damages on a no-evidence point. However, the court of appeals affirmed the judgment for breach of the duty of good faith and fair dealing and the past mental anguish damages.[29]

The Texas Supreme Court reversed the judgment of the court of appeals and rendered judgment that Dominguez take nothing. According to the Texas Supreme Court, a claimant alleging breach of the duty of good faith and fair dealing has the burden of proving a negative proposition, the absence of a reasonable basis for denying the claim of which the carrier knew or should have known.[30] In conducting a no-evidence review of the jury's finding of a breach of the duty of good faith and fair dealing, a court may consider only the evidence supporting the finding and must disregard all evidence and inferences to the contrary.[31]

The court, reiterating its conclusion reached in *Lyons*, held that a legal sufficiency review of a bad faith finding requires that the evidence relied on by the insured as evidence of bad faith "must be such as to permit the logical inference that the insurer had no reasonable basis to delay or deny

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damage to the home; Millers' denial of the claim within a month of its receipt based solely on a three sentence report; Millers' claims adjuster's refusal to talk to Lyons, hanging up when she called with inquiries; and its investigators' conscious choice not to interview any independent eyewitnesses until Lyons filed suit almost two years after making her claim.

28. 873 S.W.2d 373 (Tex. 1994).

29. National Union Fire Ins. Co. v. Dominguez, 793 S.W.2d 66 (Tex. App.—El Paso 1990), *rev'd*, 873 S.W.2d 373 (Tex. 1994).

30. *Id.*, 873 S.W.2d at 376.

31. *Id.* (citing Garza v. Alvin, 395 S.W.2d 821, 823 (Tex. 1965)).

payment of the claim, and that it knew, or should have known it had no reasonable basis for its actions."[32]

The court then explained that while a court must give weight only to evidence supporting the judgment for the insured, rejecting all evidence to the contrary, it is "only after an appellate court has determined what potential basis an insurance company may have had for denying a claim [that] the court [can] conduct a meaningful review of whether the insured has presented evidence that the insurer lacked a reasonable basis for denying or delaying the claim."[33]

According to the majority, the only evidence offered by Dominguez establishing bad faith was a letter sent by a doctor to Dominguez's attorney, stating his opinion that the injury was work-related. The court viewed this letter only as evidence of coverage, and as such, it could not serve as evidence of an absence of a reasonable basis for denying the claim.[34] The court further held that Dominguez presented no evidence that cast doubt on National Union's reliance on the medical professionals who diagnosed the condition as a degenerative disease or on Dominguez's own statements on insurance forms that his condition was not work-related.[35] Accordingly, the court concluded that there was no evidence of a breach of the duty of good faith and fair dealing.

Justice Doggett, joined by Justice Gammage, dissented, once again condemning the court for failing to make a proper no-evidence review of the jury findings and improperly engaging in fact-finding.[36] Justice Doggett accused the majority of misleading the reader concerning the evidence presented by Dominguez to support the jury's finding of bad faith. According to Justice Doggett, the letter by the doctor mentioned by the majority was not the only evidence of bad faith.[37]

Justice Doggett further noted that there was a dispute in the evidence as to whether Dominguez had promptly notified his employer that his injury was work-related. Dominguez testified that he had in fact done so. The majority, however, chose to believe the evidence contradicting Dominguez's testimony, even though the jury seemed to resolve the dispute in favor of Dominguez. Justice Doggett found that there was some evidence of bad faith to justify the jury's finding. Seemingly exasperated,

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32. *Id.* (citing *Lyons*, 866 S.W.2d at 600).
33. *Id.*
34. *Dominguez* at 376-77.
35. *Id.*, 873 S.W.2d at 377.
36. *Id.* at 377 (Doggett, J., dissenting).
37. *Id.* at 378 (Doggett, J., dissenting). The other evidence included National Union's denial of Dominguez's claim on the basis that his injury was not reported within thirty days or reported as an on-the-job injury; the fact that the decision resulted from the recommendation of an investigator who, apparently, never interviewed Dominguez's managing supervisor; National Union's investigator's complete misrepresentation of Dominguez's post-injury health care; the investigator's false report indicating that Dominguez did not seek immediate medical treatment and that the doctor found no physical impairment; and the incorrect statement in the report that Dominguez had only seen the doctor who concluded that the injury was job-related once, when in fact, he had been treated on numerous occasions by that doctor.

Justice Doggett wrote "[t]he majority continue[d] its practice of wearing blinders when evaluating facts not helpful to insurance companies while violating the constitutional mandate that review by this Court is limited to legal, not factual, sufficiency."[38]

Following closely after *Dominguez* was *Texas Farmers Insurance Co. v. Soriano*.[39] This case dealt with the dual issues of an insurer's duty of good faith and fair dealing and duty to settle under *Stowers*[40] when there are competing claims for a limited amount of insurance proceeds under an automobile liability policy. Soriano was the driver of a car that collided head-on with a car driven by Medina. Mr. Medina was severely injured, Mrs. Medina was killed, and their two children were injured in the accident. Lopez, a passenger riding with Soriano, was also killed. Soriano had only minimum insurance coverage through his parents' policy with Texas Farmers Insurance Group, which provided for limits of $10,000 per person and $20,000 per occurrence.

Farmers offered to settle with the Medinas for the $20,000 policy limits, but the Medinas refused, desiring to determine whether Soriano had any assets. The Medinas and Lopez's parents then sued Soriano. Farmers settled with the Lopez family for $5000 and offered the remaining $15,000 to the Medinas. They rejected the offer, demanding the $20,000 policy limit. The case then proceeded to trial, and the jury found Soriano negligent. Consequently, the trial court rendered judgment for about $172,000 in damages.

Soriano then assigned his rights against Farmers to the Medinas, who thereafter sued for negligence, gross negligence, and breach of the duty of good faith and fair dealing. The jury found Farmers negligent and grossly negligent in their handling of the Medinas' claims. The jury also found that Farmers breached a duty of good faith and fair dealing to Soriano by failing to settle with the Medinas. The trial court awarded about $520,000 in actual damages and prejudgment interest, and $5 million in exemplary damages. The court of appeals affirmed, and the Texas Supreme Court reversed, holding that Soriano take nothing.[41]

In addressing the bad faith issue, the court first noted that it has never recognized a cause of action for breach of the duty of good faith and fair dealing where an insurer failed to settle third-party claims against its insured.[42] However, since Farmers did not challenge whether Soriano had a claim for breach of the duty of good faith and fair dealing, the court determined that it should review the evidence relating to this jury finding. Farmers asserted only that there was no evidence that it breached a duty

38. *Id.* at 379.

39. 881 S.W.2d 312 (Tex. 1994).

40. G. A. Stowers Furniture Co. v. American Indem. Co., 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved).

41. 844 S.W.2d 808 (Tex. App.—San Antonio 1993), *rev'd*, 881 S.W.2d 312 (Tex. 1994).

42. *Soriano*, 881 S.W.2d at 317. The court's opinion on the *Stowers* claim is discussed *supra* at note 36 and accompanying text.

of good faith and fair dealing because it had a reasonable basis for not settling with the Medinas.

The court again applied the standard of review described in *Lyons*. That is, the evidence, viewed in the light most favorable to the insured, must at least permit the logical inference that the insurer had no reasonable basis to delay or deny payment of the claim. In addition, the court held that the evidence must relate to the tort issue of the reasonableness of denying or delaying payment, and not just the contract issue of coverage.[43]

According to the court, Farmers had no duty to pay the Medinas the full policy limits before the Lopez settlement. Farmers made an offer, which the Medinas rejected. Only after the Lopez settlement did the Medinas demand full payment and, at that time, Farmers was under no obligation to settle for more than the remaining $15,000. As such, Farmers had a reasonable basis for refusing to pay the Medinas more than the remaining $15,000, and, therefore, it did not breach a duty of good faith and fair dealing.[44]

The court of appeals and the trial courts were not long in responding to *Lyons* and *Dominguez*. Some courts, however, rather than relying on *Lyons*, resorted to *Polasek*, concluding that *Lyons* adopted the approach taken by *Polasek*.[45] This is a serious error because *Polasek* is much more extreme than *Lyons*. Even though it is not clearly articulated in *Lyons*, the Texas Supreme Court seems to require the insured to prove that the evidence relied on by the insurance company to deny or delay the claim did not provide a reasonable basis for such denial or delay. Thus, the court found significant the fact that the insureds in *Lyons* and *Dominguez* failed to show that the insurers' reliance on their experts' opinions was unreasonable.[46] The *Polasek* approach, however, would seem to rule out a breach of the duty even when it is shown that an insurer's reliance on an expert's opinion was unreasonable.

Early in its opinion, the *Polasek* court stated that "the insured must prove that there were no facts before the insurer which, if believed, would justify denial of the claim."[47] Then the court stated, "In a bad-faith action, the issue is whether there was evidence in existence before [the insurer]; the issue is not whether [the insurer] correctly evaluated the evidence before it."[48] Along these same lines, the court also stated, "The issue in the bad faith case is not whether the factfinder believes the evidence that [the insurer] believed when it denied the claim; the issue is whether such evidence existed."[49] There is no requirement that the insurer's belief in the information it uses to deny a claim be reasonable.

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43. *Id.*
44. *Id.* at 318.
45. *See supra* note 17 and accompanying text.
46. *Lyons*, 866 S.W.2d at 601; *Dominguez*, 873 S.W.2d at 377.
47. *Polasek*, 847 S.W.2d at 284.
48. *Id.* at 285.
49. *Id.* at 286.

The *Polasek* court did pay homage to the requirement of *Arnold* and *Aranda* that the basis for the denial be reasonable, but effectively eliminated the objective test of bad faith announced in *Aranda*. The court held that in a case where the insurer's denial of a claim is based upon the contention that the insureds burned their own house, "the issue in the bad faith suit is not whether the [insureds] set the fire, or whether a reasonable insurer would have decided that they did nor did not set it."[50] Moreover, the court held that "[a] bad faith cause of action is not satisfied by proof . . . that [the insurer] acted unreasonably in denying [the] claim."[51] The focus for this court was whether the insurer discovered information which, *if believed*, served as a reasonable basis for denial of the claim. Thus, the court held that it is not up to the "trier of fact to second-guess the insurer about reasonableness" or "to decide whether the insurer acted reasonably,"[52] a far more narrow view of the duty of good faith than that taken by the supreme court in *Lyons*.

Even though the *Polasek* test is much more strict than *Lyons*, it is unquestionably easier to apply, which may be the reason some courts of appeals are looking to *Polasek* rather than *Lyons* for guidance. For example, in *Rogers v. CIGNA Insurance Co. of Texas*,[53] the court relied heavily upon *Polasek* to affirm a directed verdict in favor of the insurer on the issue of good faith and fair dealing.

While driving a car provided by his employer, Rogers collided with a train and suffered injuries. After the accident, CIGNA, his employer's workers' compensation insurer, began paying indemnity and medical benefits for total incapacity. Rogers returned to work three months after the accident, and CIGNA stopped paying the benefits after about six months. Rogers then filed a claim with the Industrial Accident Board, asking that he be given indemnity benefits for total and permanent incapacity. After the Industrial Accident Board awarded Rogers partial incapacity, CIGNA filed suit to set aside the award. The jury found total and permanent incapacity. The parties settled while the appeal was pending. Rogers then filed this suit claiming that CIGNA breached its duty of good faith and fair dealing when it denied his claim. After Rogers rested during the trial of this matter, the court granted CIGNA's motion for a directed verdict. In affirming, the court of appeals first noted that the traditional standard for reviewing directed verdicts would require that it disregard evidence favoring CIGNA and consider only the evidence favorable to Rogers. The court, however, held that this traditional standard of review was altered by *Polasek* and, thus, could not be used in a bad faith case.[54]

50. *Id.*

51. *Id.* at 283.

52. *Polasek*, 847 S.W.2d at 287. As one might expect, one of the Beaumont court's main criticisms of *Polasek* was that it took away from the jury the determination of whether the insurer's conduct was reasonable and allowed the insurer to be the arbiter of its own conduct. *Simmons*, 857 S.W.2d at 136.

53. 881 S.W.2d 177 (Tex. App.—Houston [1st Dist.] 1994, no writ).

54. *Id.* at 183.

Instead, the court must determine whether there was any evidence before CIGNA that gave it a reasonable basis to deny Rogers' claim. If any such evidence is found by the court, the directed verdict must be affirmed.

The court relied upon the statement in *Polasek* that the issue in such a bad faith case is "whether there was evidence in existence before [the insurer]; . . . not whether [the insurer] correctly evaluated the evidence before it."[55] Thus, the court felt that it could not disregard the evidence supporting the insurer's denial, but rather, the court held that it must disregard the evidence favoring the insured because, again quoting *Polasek*, "Courts and juries do not weigh the conflicting evidence that was before the insurer; they decide whether evidence existed to justify denial of the claim."[56]

Consequently, the court of appeals considered only the evidence supporting CIGNA's decision to deny Rogers' claim, concluding that there was a reasonable basis for doing so as a matter of law. The court noted that before Rogers would be entitled to payments for total incapacity, he would have to be unable to secure and hold the type of employment at which he was making a living before his injury.[57] CIGNA, however, had reports from four doctors, all of whom concluded that Rogers could return to the same work he had been doing before the accident. The court held that, based on the reports, CIGNA had a reasonable basis to conclude that Rogers was not totally incapacitated.[58]

The court also found that CIGNA had a reasonable basis not to make payments for partial incapacity. To be entitled to payments for partial incapacity, an employee must suffer a reduction in earning capacity. Rogers, however, returned to work in the same job he held before the accident making the same amount of money. In fact, his earnings had increased annually since the accident. The court held that this was some evidence that CIGNA had a reasonable basis to dispute Rogers' claim for payments for partial incapacity.[59]

Rogers argued that the directed verdict was improper because one of his witnesses testified that CIGNA had no reasonable basis for the handling of his claim. This witness testified that it was unreasonable for CIGNA to appeal the Board's award. The court determined that this testimony did not preclude the directed verdict because there was other undisputed evidence that CIGNA did have a reasonable basis.[60]

Another case relying more on *Polasek* than *Lyons* is *Cortez v. Liberty Mutual Fire Insurance Co.*[61] After receiving workers' compensation benefits for almost two years, Cortez saw Dr. Capen, an independent medical

55. *Id.* (quoting *Polasek*, 847 S.W.2d at 281).
56. *Id.* (quoting *Polasek*, 847 S.W.2d at 281).
57. *Id.* at 184 (citing Trinity Universal Ins. Co. v. Rose, 217 S.W.2d 425, 426 (Tex. Civ. App.—Texarkana 1949, writ ref'd n.r.e.)).
58. *Rogers*, 881 S.W.2d at 184.
59. *Id.* at 185.
60. *Id.*
61. 885 S.W.2d 466 (Tex. App.—El Paso 1994, writ denied).

evaluation doctor, who concluded that Cortez could return to work. Relying on this medical evaluation, Liberty Mutual requested a prehearing conference to determine if there was a reasonable medical basis for suspending Cortez's weekly benefits. The benefits were suspended after the conference, and Cortez filed suit for breach of the duty of good faith and fair dealing and continuation of workers' compensation benefits. Cortez settled his workers' compensation suit in October 1992.

Liberty Mutual then filed a motion for summary judgment in the bad faith case, arguing that: (1) a reasonable basis for suspension of benefits was shown as a matter of law; (2) collateral estoppel barred the bad faith action; and (3) judicial admission barred the bad faith action. The trial court granted summary judgment. The court of appeals affirmed.

After quoting the *Aranda* elements of bad faith, the court noted that carriers can deny invalid or questionable claims without being subject to liability for an erroneous denial. In considering the propriety of a summary judgment on a bad faith claim, the court held that if there was conflicting evidence as to whether there was reasonable basis for the carrier's action, a jury issue existed and summary judgment should not be granted. If, however, uncontroverted evidence of a reasonable basis is present, the bad faith claim is defeated.[62]

Relying on *T.E.I.A. v. Puckett*,[63] Cortez argued that Liberty Mutual had no reasonable basis for suspending benefits because it violated Industrial Accident Board Rules by acting on an independent medical evaluation rather than a release by his treating physician. The court, however, distinguished Puckett because in that case the carrier unilaterally discontinued benefits without a medical release from any source.[64]

Under the circumstances of this case, the court held that Dr. Capen's opinion stating Cortez could return to work, although not a release from Cortez's treating physician, constituted a reasonable basis for suspending the benefits as a matter of law.[65] According to the court, Dr. Capen's opinion was not controverted by the treating physician. Furthermore, Liberty Mutual did not immediately stop making payments but waited until a prehearing conference was held.

Several other courts after *Lyons* granted summary judgment in favor of the insurer on the issue of good faith and fair dealing, finding that as a matter of law the insurer had a reasonable basis for denying the claim. These cases include *Ramirez v. Transcontinental Insurance Co.*,[66] *Packer v. Travelers Indemnity Co. of Rhode Island*,[67] *Emmert v. Progressive County Mutual Insurance Co.*,[68] *Emscor Manufacturing, Inc. v. Alliance*

62. *Id.* at 469.
63. 822 S.W.2d 133 (Tex. App.—Houston [1st Dist.] 1991, writ denied).
64. *Cortez*, 885 S.W.2d at 470 n.1.
65. *Id.* at 470-71.
66. 881 S.W.2d 818 (Tex. App.—Houston [14th Dist.] 1994, writ denied).
67. 881 S.W.2d 172 (Tex. App.—Houston [1st Dist.] 1994, no writ).
68. 882 S.W.2d 32 (Tex. App.—Tyler 1994, writ denied).

Insurance Group,[69] and *Pioneer Chlor Alkali Co., Inc. v. Royal Indemnity Co.*[70]

In *Packer*, the court affirmed the summary judgment that the insurer had established a reasonable basis for denying the workers' compensation claim based on the evidence that three out of four doctors who treated Packer's back injury recommended against surgery.[71] Moreover, there was no evidence that Travelers' reliance on the opinions of these three doctors was unreasonable or that their opinions were not objective.[72] According to the *Packer* court, when a bona fide controversy exists as to coverage, an insurer should be free to deny the claim and have the question of coverage litigated without being subjected to tort liability.[73]

The *Ramirez* court also focused on the notion of a bona fide controversy to affirm a summary judgment in favor of a workers' compensation carrier.[74] Ramirez claimed that his existing temporomandibular joint syndrome (TMJ) was aggravated by an on-the-job accident and filed for workers' compensation benefits. Transcontinental refused to pay benefits. The Texas Workers' Compensation Commission found that Ramirez suffered an injury in the course and scope of his employment and awarded him $15,590. Transcontinental appealed the award to the district court and eventually settled this claim with Ramirez. Soon thereafter, Ramirez filed suit against Transcontinental for breach of the duty of good faith and fair dealing. Transcontinental responded by filing a motion for summary judgment, claiming that it had a reasonable basis to deny Ramirez's claim. The trial court granted this motion. The court of appeals affirmed. In reviewing the summary judgment, the court set aside the traditional standard of review, opting for the "particularized application of [the] traditional no evidence review" set forth in *Dominguez* and *Lyons*.[75] Ramirez, relying on *Guajardo v. Liberty Mutual Insurance Co.*,[76] argued that the summary judgment was improper because Transcontinental's reliance on Dr. Rejaie's opinions was unreasonable in light of reports from his dentist, who presented a contrary opinion. The court, while agreeing that situations may arise where a contrary medical opinion will cast doubt on the reliability of the insurer's expert's opinion, disagreed with Ramirez's position that summary judgment is improper any time conflicting medical opinions exist. The court held that Ramirez did not present evidence to show that Transcontinental's reliance on its expert was unreasonable.[77]

69. 879 S.W.2d 894 (Tex. App.—Houston [14th Dist.] 1994, writ denied).
70. 879 S.W.2d 920 (Tex. App.—Houston [14th Dist.] 1994, no writ).
71. *Packer*, 881 S.W.2d at 175-76.
72. *Id.* at 176.
73. *Id.*
74. *Ramirez*, 881 S.W.2d at 822.
75. *Id.*
76. 831 S.W.2d 358 (Tex. App.—Corpus Christi 1992, writ denied).
77. *Ramirez*, 881 S.W.2d at 826.

Ramirez claimed that evidence of Transcontinental's unreasonable reliance on Dr. Rejaie's opinions included an entry in the claim file that he referred Ramirez to a Dr. Morgan because he, Dr. Rejaie, "was not an expert." The court dismissed this statement because while Dr. Rejaie admitted that he did not normally treat TMJ, he never said he was not an expert in diagnosing TMJ. The court also found important the fact that Ramirez, not Transcontinental, chose Dr. Rejaie and that Dr. Phillips did not dispute or criticize Dr. Rejaie's conclusions or attack his credentials or impartiality.[78]

Ramirez next argued that Transcontinental did not have a reasonable basis for denying the claim because its denial was based solely on evidence that Ramirez had a preexisting condition and preexisting conditions are compensable if an on-the-job injury aggravates that condition. Ramirez relied on *Nationwide Mutual Insurance Co. v. Crowe*.[79] The court distinguished *Crowe* because the carrier in that case denied the claim based on a preexisting condition without conducting any investigation into whether the condition was aggravated by an on-the-job injury.[80] According to the court, Transcontinental did conduct an investigation by obtaining statements from five of Ramirez's co-workers, which conflicted with Dr. Phillips conclusions.[81]

Relying on *State Farm Fire & Casualty Co. v. Simmons*[82] and *Commonwealth Lloyds Insurance Co. v. Thomas*,[83] Ramirez argued that the Transcontinental investigation was outcome-oriented. The court, however, distinguished those cases as ones where a carrier ignored investigative leads. According to the court, there was no evidence that Transcontinental ignored any information in its investigation.[84]

Ramirez was not a unanimous decision. Justice Ellis, in his dissent, urged that Dr. Phillips' medical opinion was sufficient to raise a fact issue on reasonable basis and that the issue should have been submitted to a jury. According to Justice Ellis, a dispute about whether there is a reasonable basis to support the denial of a claim is a fact issue for the jury.[85] If the court were to truly indulge every reasonable inference and resolve any doubts in favor of Ramirez, wrote Justice Ellis, there would be sufficient evidence to raise a fact issue on reasonable basis. Specifically, Justice Ellis pointed to the evidence of Dr. Phillips' opinion that Ramirez's TMJ was aggravated by an on-the-job injury. Moreover, Transcontinental received this opinion shortly after September 15, 1989, the date of Dr. Phillips' report. However, an October 27, 1989 entry to the claim file

78. *Id.*
79. 857 S.W.2d 644 (Tex. App.—Houston [14th Dist.]), *writ dism'd*, 863 S.W.2d 462 (Tex. 1993).
80. *Ramirez*, 881 S.W.2d at 826-27.
81. *Id.* at 827.
82. 857 S.W.2d 126 (Tex. App.—Beaumont 1993, writ denied).
83. 825 S.W.2d 135 (Tex. App.—Dallas 1992), *writ dism'd*, 843 S.W.2d 486 (Tex. 1993).
84. *Ramirez*, 881 S.W.2d at 827-28.
85. *Id.* at 829.

noted that Transcontinental told Ramirez's attorney that it did not have medical information to support Ramirez's non-work status.

At that time Transcontinental had only a verbal report from Dr. Rejaie that Ramirez's condition was probably not work-related. However, there was a notation in the file that the doctor was not an expert, and the file was referred to Dr. Morgan. Justice Ellis questioned the majority's dismissal of Dr. Rejaie's lack of expertise by drawing a distinction between diagnosing and treating. Justice Ellis felt that the ability to diagnose TMJ did not conclusively establish that Transcontinental's reliance on Dr. Rejaie's opinion was a reasonable basis. Additionally, Justice Ellis pointed out that Dr. Phillips, who worked with Dr. Morgan and who was this physician to whom Ramirez was referred, had concluded that the TMJ was work-related.[86]

Emmert, *Emscor*, and *Pioneer Chlor* are similar in that in each case the court found that the insurer, in the face of an ambiguous policy provision, acted in good faith by construing the provision in such a way to deny coverage. Although the court in *Emmert* did not specifically address the issue, the Fourteenth Court of Appeals in *Emscor* and *Pioneer Chlor* concluded that since a provision is ambiguous only if there are two or more reasonable interpretations, the insurer's interpretation must be a reasonable basis for denying the claim.[87] The fallacy of equating a reasonable interpretation with a reasonable basis for denying a claim is that the law, which insurers are presumed to know, demands an insurer to construe an ambiguous provision in favor of the insured and in favor of coverage.[88] If, as a matter of contract law, the insurer cannot construe an ambiguous provision in its favor, reliance on its own interpretation cannot, as a matter of law, serve as a reasonable basis for a denial.

Likewise, exclusionary clauses must be strictly construed in favor of the insured and against the insurer. In *Emmert*, the court, while recognizing that the exclusions in Emmert's policy (along with the exception to the exclusions) were at best unclear and ambiguous, held that, while there was coverage, Progressive did not breach its duty of good faith and fair dealing by construing the exclusion against *Emmert*.[89] This result simply is not consistent with basic contract law.

Some courts, while following the precedent of *Lyons*, clearly have rejected the extreme approach devised by Justice Peeples in *Polasek*, including other panels of the San Antonio court on which Justice Peeples sits. One such case is *Southern Life & Health Insurance Co. v. Alfaro*.[90]

86. *Id.* at 830.

87. *Emscor*, 879 S.W.2d at 910; *Pioneer Chlor*, 879 S.W.2d at 939-40.

88. National Union Fire Ins. Co. v. Hudson Energy Co., 811 S.W.2d 552, 555 (Tex. 1991).

89. 882 S.W.2d at 34, 36.

90. 875 S.W.2d 740 (Tex. App.—San Antonio 1994, no writ). The court originally issued its opinion on February 26, 1993, which is mentioned in last year's Annual Survey. *See* Maxwell, *supra* note 16, at 1304. While the case was on rehearing, the Texas Supreme Court decided *Lyons* and *Dominguez*. Upon rehearing, the court incorporated the *Lyons* standard of review and still found sufficient evidence to support the finding of bad faith.

In this case, Tony Alfaro was shot and killed by Castillo. Tony was the named insured in a $10,000 term life insurance policy issued by Southern Life & Health Insurance Company (SL&H). The policy had a $10,000 accidental indemnity rider. Antonio Alfaro, Tony's uncle and primary beneficiary, was paid the $10,000 face amount, but was denied the accidental double indemnity claim because, according to SL&H, Tony's death resulted, directly or indirectly, from the commission or attempted commission of an assault or felony.

Antonio sued SL&H claiming violations of the Texas Insurance Code. Based on the jury's verdict, the trial court rendered judgment for Alfaro for the double indemnity accidental death benefit, additional damages, prejudgment interest and attorney's fees.

SL&H argued that there was no evidence that it did not attempt a good faith settlement after liability had become reasonably clear, because a bona fide controversy is sufficient reason for an insurer not to pay a claim. In deciding whether SL&H acted in bad faith, the court noted that the appropriate no evidence standard of review under *Lyons* requires the court to focus:

> on the relationship of the evidence arguably supporting the bad faith finding to the elements of bad faith. The evidence presented, viewed in the light most favorable to the prevailing party, must be such as to permit the logical inference that the insurer had no reasonable basis to delay or deny payment of the claim, and that it knew or should have known it had no reasonable basis for its actions.[91]

Upon reviewing the evidence, the court found that both elements of bad faith were proven by Alfaro. There was some evidence that Tony was not attempting to commit an assault or any other felony at the time Castillo shot him. Furthermore, there was evidence that SL&H did not conduct a thorough investigation of the claim, as it failed to interview two women who were present at the murder scene and to review Castillo's written confession until three months after the claim was denied. Additionally, the jury was presented with evidence that SL&H postponed its decision regarding the claim until the end of Castillo's trial. According to the court, SL&H should have known there was no reasonable basis for denial or delay. Thus, the court held that the jury's finding was not so contrary to the overwhelming weight of evidence as to be clearly wrong and unjust.[92]

The San Antonio Court of Appeals, sitting en banc, has also rejected Justice Peeples' opinion in *Polasek*. In *Employers National Insurance Co. v. Dalros*[93] the court affirmed a judgment based on the insurer's breach of

91. *Id.* at 742 (quoting Lyons v. Millers Cas. Ins. Co., 866 S.W.2d 597, 598 (Tex. 1993)).
92. *Id.* at 744-46.
93. No. 04-92-00078-CV, 1994 WL 81435 (Tex. App.—San Antonio, Mar. 14, 1994, n.w.h.) (en banc) (Chief Justice Chapa wrote the majority opinion, and Justices Peeples and Rickhofff wrote dissenting opinions). After this case was decided, the insurer was placed in receivership, and an injunction was issued preventing any action against the insurer. Thus, the case has been abated pending the outcome of the receivership.

the duty of good faith and fair dealing even in light of *Lyons*. In this case, Dalros submitted a claim to Employers for damage to his pool. Several days later, without any investigation, Employers informed Dalros over the phone that the claim had been denied due to flooding. A couple of weeks later, the pool cracked and Dalros again called Employers. Later, an adjuster was sent out by Employers to inspect the pool. The adjuster suggested that the claim be denied because the loss was caused by cracking, an exclusion under the policy.

Approximately one year later, an attorney hired by Dalros sent a demand letter to Employers. Within two months Employers sent Dalros a $10,000 check, representing the policy limits. Dalros later filed suit, alleging that Employers breached its duty of good faith and fair dealing. The jury found against Employers and awarded $12,500 in damages for mental anguish and $250,000 in exemplary damages. The court of appeals, relying on *Polasek*, originally reversed and rendered judgment that Dalros take nothing, holding that Dalros did not prove that there was no evidence, supporting Employers' initial denial leading to the delay in order to establish a breach of the duty of good faith and fair dealing. On a motion for rehearing *en banc*, the court affirmed the judgment for actual damages caused by the insurer's bad faith but reversed the judgment as to exemplary damages.

The court first considered whether there was sufficient evidence to support the jury's finding that Employers breached its duty of good faith and fair dealing. In making this legal sufficiency review, the court relied upon the standard set forth in *Lyons*.[94] The Texas Supreme Court in *Lyons* stated that the evidence must relate to the issue of no reasonable basis, not just to the contract issue of coverage.[95] The San Antonio court interpreted this to mean that the evidence could not relate just to the issue of coverage.[96] That is not to say, however, that any evidence relating to coverage is automatically unrelated to the bad faith claim.

Turning to the evidence, the court noted that Employers, without conducting an investigation, initially denied the claim based on an exclusion for flooding. As Employers later conceded, the flooding exclusion had no application to Dalros' claim. Thus, the court concluded that Employers had no reasonable basis for denying the claim on this basis. Employers later denied the claim based on an exclusion for losses caused by "cracking." The court held, however, that the cracking did not occur until fourteen to eighteen days after the claim was made. Moreover, there was evidence that, had the pool been examined when the claim was first made, no cracking would have been found. Additionally, there was evidence that, if the claim had been paid when it was first submitted, the cracking could have been minimized or prevented by repair work. Therefore, the court held that it was unreasonable to deny the claim based on

94. Lyons v. Millers Cas. Ins. Co., 866 S.W.2d 597 (Tex. 1993).
95. *Lyons*, 866 S.W.2d at 606.
96. *Dalros*, 1994 WL 81435 at *3-4.

an exclusion that only became applicable due to the insurer's delay in investigating the claim.[97] Employers also complained that the trial court refused to instruct the jury on the existence of a "bona fide controversy." The court held this was not necessary in light of the reaffirmation in *Lyons* of the no evidence test in bad faith cases.

Justice Rickhoff dissented, claiming that Dalros offered no evidence that Employers did not have a reasonable basis for denying the claim.[98] According to Justice Rickhoff, the loss to Dalros' pool was caused by cracking, which was specifically excluded from coverage. Because there was no contractual liability, Justice Rickhoff argued there should be no bad faith liability. Justice Rickhoff also called for the elimination of the duty of good faith and fair dealing in the first party insurance context. He claimed that this common law action is unnecessary because insureds have at their disposal causes of action for breach of contract, fraud, negligence, and violations of the DTPA and Insurance Code. Moreover, insurance companies are subject to intense state regulation and can be severely reprimanded by the Insurance Board if too many complaints are made. Justice Rickhoff also suggested that, contrary to what the Texas Supreme Court thought in *Arnold*, there is no unequal bargaining power in favor of the insurer. According to Justice Rickhoff, the insured holds the advantage because insurance policies are to be construed in favor of the insured, not the insurer.[99]

Another case after *Lyons* to affirm a judgment based on breach of the duty of good faith and fair dealing is *Universe Life Insurance Co. v. Giles*.[100] Universe Life denied Giles' health insurance claims for her hospitalization and subsequent bypass operation several months later. The insurer contended that the claims had arisen as the result of preexisting conditions. Universe Life's conclusion was based upon a prescription Giles had been given to decrease her cholesterol levels. Universe Life equated the prescription to treatment for heart disease. Additionally, the medical records of Dr. Sanford, one of Giles' physicians, reflected that she had experienced chest pain and hypertension for two to three years. Dr. Sanford corrected his statement and informed Universe Life that the chest pain had only been experienced for two to three weeks with no hypertension. Universe Life, however, continued to deny the claim. The jury found that Universe Life breached its duty of good faith and fair dealing to Giles. The court of appeals affirmed the judgment based on this finding, in light of the evidence that Universe Life had continued to deny Giles' claims based on Dr. Sanford's records even after he corrected his records.[101] Universe Life even sued Dr. Sanford, claiming that he caused the denial of the claim. That suit was dismissed. Additionally, for a

97. *Dalros*, 1994 WL 81435, at *4.
98. *Id.* at *6 (Rickhoff, J., dissenting).
99. *Id.* at *6-7.
100. 881 S.W.2d 44 (Tex. App.—Texarkana 1994, writ requested).
101. *Giles*, 881 S.W.2d at 49.

substantial length of time Universe Life had refused to tell Giles the reasons for denying her claim.

Before *Lyons* was decided, the El Paso Court of Appeals, in *Republic Insurance Co. v. Stoker*,[102] concluded that an insurer can be liable for breach of the duty of good faith and fair dealing even in the absence of contractual liability. In this case, Stoker came suddenly upon a traffic jam caused by a delivery truck that had lost some of its furniture. Stoker, unable to stop, rear-ended Templeton. Stoker did not hit any of the furniture or the delivery truck. Stoker submitted a claim to Republic under her uninsured motorist coverage. Without doing much investigation, Republic denied the claim after concluding that Stoker was more than fifty percent at fault in causing the accident.

The trial court granted Republic a summary judgment on the contract finding no coverage because there was no physical contact between Stoker and the pickup truck that dropped furniture onto the highway. The "no physical contact" reason was not asserted by Republic until litigation ensued. However, judgment was rendered in favor of Stoker based on the jury's finding that Republic had breached its duty of good faith and fair dealing, had engaged in unfair or deceptive acts, and had committed unconscionable conduct. The court of appeals affirmed. Republic argued that Stoker, because there was no coverage under the policy, could not recover for breach of the duty of good faith and fair dealing. According to Republic, its refusal to pay the claim, no matter how wrong the reason, could not cause any harm to Stoker because there was no contractual liability. The court disagreed.

Relying on *Viles v. Security National Insurance Co.*,[103] the court concluded that an insurer can breach its duty of good faith and fair dealing even in the absence of contractual liability.[104] In *Viles*, the court held that the breach of the duty of good faith and fair dealing is a tort, separate and distinct from a cause of action for breach of contract.[105] Accordingly, the Texas Supreme Court permitted Viles to recover for the insurer's bad faith even though he had not submitted a proof of loss, which was a contractual condition precedent. Moreover, the supreme court held that the special relationship which gives rise to the duty of good faith and fair dealing also imposes on the insurer "a duty to investigate claims thoroughly and in good faith, and to deny those claims only after an investigation reveals there is a reasonable basis to do so."[106]

Republic denied Stoker's claim without reviewing the police report, without viewing the accident scene or the photographs of it, and without interviewing witnesses. Moreover, prior to suit being filed, Republic only asserted as the basis of denying the claim that Stoker was more than fifty

102. 867 S.W.2d 74 (Tex. App.—El Paso 1993, writ granted).
103. 788 S.W.2d 566 (Tex. 1990).
104. *Stoker*, 867 S.W.2d at 78.
105. *Viles*, 788 S.W.2d at 567.
106. *Id.* at 568.

percent at fault and not that there had been a lack of physical contact. Thus, according to the court, Stoker could assert a cause of action for breach of the duty of good faith and fair dealing.[107]

The court further held that an insured is entitled to rely upon the insurer's stated grounds for denying a claim so she can make reasoned decisions about pursuing claims in court. To hold otherwise would allow the insurer to escape liability under any theory that allows it to avoid payment, no matter how late the theory is advanced and no matter how weak the earlier theory.[108]

Justice Koehler dissented, arguing that there can be no liability for breach of the duty of good faith and fair dealing when the insurer has no contractual duty to pay the claim.[109] According to the dissent, a breach of the duty of good faith and fair dealing is established by showing the absence of a reasonable basis for denying the claim. Thus, if there exists a reasonable basis for denying the claim, it should not matter whether the insurer conducted a thorough investigation or whether the reason given was valid. Justice Koehler felt that Republic had a reasonable basis for denying the claim because there was no physical contact with the uninsured motorist.[110]

The Texas Supreme Court granted writ on May 11, 1994 on five points of error, one of which was that the insurer could not be liable in tort for improperly investigating a claim if there was a valid reason to deny the claim (even though not discovered by insurer until much later).[111] A foreshadowing of the court's resolution of this case in favor of the insurer may be seen in the supreme court's statement in *Transportation Insurance Co. v. Moriel*[112] that "[t]he threshold of bad faith is reached when a breach of contract is accompanied by an independent tort."[113]

Another case decided before *Lyons* that the court decided to hear is *Nicolau v. State Farm Lloyds*.[114] One of the main issues in this case asked when an insurer's reliance on its expert's opinions could be considered unreasonable so as to subject the insurer to liability for bad faith. The Nicolaus sued State Farm after it denied their claim made under a homeowners policy for repairs to correct damage caused by movement of their homes' foundation. State Farm denied the claim, contending that the damage was caused by an inherent vice or settling, both of which were excluded under the policy. The jury found that State Farm breached its contract, breached its duty of good faith and fair dealing, and engaged in an unconscionable action or course of action as prohibited by the DTPA. The jury awarded $102,200 as policy benefits for the necessary repairs,

107. *Stoker*, 867 S.W.2d at 79.
108. *Id.* at 80.
109. *Id.* at 80-81 (Koehler, J., dissenting).
110. *Id.* at 81.
111. 37 Tex. Sup. Ct. J. 774 (May 111, 1994).
112. 879 S.W.2d 10 (Tex. 1994).
113. *Id.* at 17.
114. 869 S.W.2d 543 (Tex. App.—Corpus Christi 1993, writ granted).

$50,000 for mental anguish, and $300,000 as exemplary damages for State Farm's malicious breach of its duty of good faith and fair dealing. The trial court rendered a judgment n.o.v. on the extra-contractual claims and rendered judgment only on the breach of contract claim. The court of appeals affirmed in part and reversed and rendered in part.

The court held that an insurer's reliance on an expert to provide technical assistance in determining whether the particular loss is covered under the policy must be reasonable.[115] In order to prove that the insurer acted in bad faith because its reliance upon the expert was unreasonable, the insured can attack the expert's opinion in two ways. First, according to the court, the insured can present contrary expert opinion. Whether this evidence destroys the insurer's reasonable basis is a fact question for the jury.[116] Second, held the court, the insured can attack the credibility of the expert and show that the insurer's expert's opinion was questionable and the insurer knew or should have known the opinion was questionable.[117]

The dispute between the Nicolaus and State Farm focused on the cause of the damage to their home. State Farm contended that foundation movement was the cause, which was excluded by the policy from coverage. The Nicolaus, while admitting that there was foundation movement, asserted that a leaking pipe caused this problem, which was a covered event. In order to determine that nature of the loss, State Farm hired Haag Engineering to inspect the house. Haag Engineering concluded that the leak did not contribute to the foundation movement. However, the Nicolaus presented evidence that State Farm knew that Haag Engineering rarely, if ever, determined that a localized leak beneath the house caused foundation movement. They also presented evidence that despite its awareness of a plumbing leak beneath the house, Haag concluded that there was no relationship between the plumbing leak and the foundation damage without even isolating the leak, determining its severity, or taking soil samples.

Moreover, Haag did not reconsider its opinion, even after soil borings were performed indicating that the moisture content of the clay under the Nicolau home was high.[118] Based on this evidence, the court concluded that there was more than enough evidence for a jury to determine that a reasonable insurer under similar circumstances would not have denied the Nicolaus' claim.[119] Additionally, the jury could have inferred that State Farm's reliance on its experts was not reasonable.

State Farm complained to the Texas Supreme Court about many rulings made by the court of appeals. The supreme court granted State Farm's application for writ of error on several points, two of which as-

115. *Id.* at 551.
116. *Id.*
117. *Id.*
118. *Id.* at 551.
119. *Nicolau*, 879 S.W.2d at 551.

serted that the court of appeals erred by not applying the no evidence review as stated in *Lyons*.[120] However, if *Lyons* stands for the proposition that an insured must present evidence that the information used by the insurer did not form a reasonable basis for denying the claim, it seems that the Nicolaus met this burden by showing that State Farm knew that the results of its engineer's inspection would support noncoverage since he did not believe that a plumbing leak such as experienced by the Nicolaus could ever be the cause of foundation movement.

B. Damages for Breach of the Duty

1. Punitive Damages

Whereas *Lyons* was the most significant decision concerning the evidence necessary to establish a breach of the insurer's duty of good faith, the most significant concerning the recovery of exemplary damages was *Transportation Insurance Co. v. Moriel*.[121] While at work, Juan Moriel suffered injuries initially requiring twelve days of hospitalization. Transportation, the workers' compensation carrier, paid for the hospitalization costs. After being released from the hospital, Moriel began experiencing a loss of movement in one leg and impotence. Moriel was referred to the Baylor College of Medicine Sleep Disorders and Research Center in Houston after his doctors could not find a physical cause for the impotence. Transportation eventually indicated that it would cover the tests at Baylor, but not Moriel's expenses in traveling to Houston from El Paso, where Moriel lived. Moriel agreed to these terms and underwent tests at Baylor. The tests indicated that Moriel's impotence was caused in part by a physical problem.

Although Transportation had authorized the testing at Baylor in advance, it took Transportation more than two years to pay for the tests. Transportation claimed that it delayed payment because it did not promptly receive the Baylor medical report, although Moriel testified that he personally delivered it to the claim adjuster shortly after the tests were completed. Transportation's explanation of why it continued to delay payment, even after the date it conceded the report was received, was that it did not think the impotence was related to Moriel's on-the-job injury. Several other medical bills were submitted to Transportation for payment, all of which Transportation delayed payment for more than one year.

Moriel filed a workers' compensation claim against Transportation and obtained an award from the Industrial Accident Board in excess of $30,000. After Transportation appealed that award to the district court, Moriel added a claim for breach of the duty of good faith and fair dealing based on Transportation's unreasonable delay in paying the claims. The

120. 37 Tex. Sup. Ct. J. 965 (June 15, 1994). The two other points of error granted related to the findings of unconscionable conduct and punitive damages.

121. 879 S.W.2d 10 (Tex. 1994).

workers' compensation claim was settled and the bad faith claim was tried to a jury, which found that Transportation acted with heedless and reckless disregard of Moriel's rights when it delayed payment of the claims without a reasonable basis for doing so. The jury awarded $101,000 in actual damages and $1 million in punitive damages. The trial court entered judgment based on the verdict and the court of appeals affirmed. The Texas Supreme Court reversed and remanded for a new trial.

Because Transportation did not challenge the jury's finding of bad faith, the only issue before the court was the propriety of the punitive damages. The end result was the creation of a new standard for proving gross negligence as a prerequisite for recovering punitive damages for breach of the duty of good faith and fair dealing. The court's first step was to reevaluate the definition of gross negligence because, at least, this degree of conduct must be proven to recover punitive damages. The court first looked to the definition of gross negligence found in *Burk Royalty Co. v. Walls*:[122] "Gross negligence . . . should be that entire want of care which would raise the belief that the act or omission complained of was the result of a conscious indifference to the right or welfare of the person or persons to be affected by it."[123]

The court noted that before *Burk Royalty* the courts focused on the component of "entire want of care" and reasoned that if some care were shown there could not be any gross negligence.[124] The *Burk Royalty* court changed this emphasis by admonishing courts to look for evidence of the defendant's mental state rather than the exercise of care.

The court criticized *Burk Royalty* for eroding the distinction between negligence and gross negligence by permitting an inference of the defendant's mental state from surrounding circumstances.[125] The court complained that after *Burk Royalty* a jury could infer gross negligence from evidence of some carelessness, thereby failing to consider the definition of "gross negligence" as a whole. Thus, the court, rather than utilizing the *Burk Royalty* definition, looked to the statutory definition of "gross negligence," which is: "such an entire want of care as to establish that the act or omission was the result of actual conscious indifference to the rights, safety, or welfare of the person affected."[126]

From this definition the court concluded that the are two components of gross negligence: 1) the defendant's act or omission, and 2) the defendant's mental state.[127] The first component is objective in nature. That is, "[o]bjectively, the defendant's conduct must involve an 'extreme

122. 616 S.W.2d 911, 920 (Tex. 1981).

123. *Moriel*, 879 S.W.2d at 19 (citing Mission Pac. Ry. v. Shuford, 72 Tex. 165, 171, 10 S.W. 408, 411 (1988)).

124. *Moriel*, 879 S.W.2d at 20.

125. *Id.* at 21.

126. TEX. CIV. PRAC. & REM. CODE § 41.001 (5) (Vernon Supp. 1994).

127. *Moriel*, 879 S.W.2d at 21-22.

degree of risk' . . . ."[128] The requirement that there be an extreme degree of risk "is not satisfied by a remote possibility of injury or even a high probability of minor harm, but rather 'the likelihood of serious injury' to the plaintiff."[129]

Additionally, the court held that whether an extreme risk is created by a defendant's conduct requires "an examination of the events and circumstances from the viewpoint of the defendant at the time the events occurred, without viewing the matter in hindsight."[130] The second component is described by the court as subjective in nature. That is, "the defendant must have actual awareness of the extreme risk created by his or her conduct."[131] While reaffirming that this subjective mental state can be proven by circumstantial evidence, the court rejected, as misleading, the holding in *Williams v. Steves Industries, Inc.*[132] that gross negligence could be proven if, under the surrounding circumstances, a reasonable person would have realized that his conduct created an extreme degree of risk to the safety of others.[133] Thus, the court held that to prove gross negligence one must show that the act was likely to result in serious harm and that the defendant (rather than a reasonable person) was consciously indifferent to the risk of harm.[134]

Applying these same principles to the bad faith context, the court found an insurer will be liable for punitive damages for its bad faith only when its conduct creates a risk of serious harm to the insured and the insurer is aware that the insured would probably suffer serious injury because of the conduct.[135] The harm or injury that the insured must suffer, according to the court, must be "independent and qualitatively different" from the damages resulting from a breach of contract and from the insurer's bad faith.[136] Mental anguish, mere inconvenience, annoyance or delay do not satisfy this requirement.[137] Instead, the court held that "an insurance carrier's refusal to pay a claim cannot justify punishment unless the insurer was actually aware that its action would probably result in extraordinary harm not ordinarily associated with breach of contract or bad faith denial of a claim—such as death, grievous physical injury, or financial ruin."[138]

Just as *Lyons* greatly narrowed the conduct of insurers which will amount to a breach of the duty of good faith and fair dealing, *Moriel* all but eliminated the possibility that an insurer will be liable for punitive

128. *Id.* at 22 (citing Wal-Mart Stores, Inc. v. Alexander, 868 S.W.2d 322, 326 (Tex. 1993)).
129. *Id.* (quoting *Wal-Mart*, 868 S.W.2d at 327).
130. *Id.* at 23.
131. *Id.* at 22 (citing *Wal-Mart*, 868 S.W.2d at 326).
132. 699 S.W.2d 570, 579 (Tex. 1985).
133. *Moriel*, 879 S.W.2d at 22-23.
134. *Id.* at 22.
135. *Id.* at 23-24.
136. *Id.* at 24.
137. *Id.*
138. *Moriel*, 879 S.W.2d at 24.

damages if by some chance it breaches this duty. It will be extremely rare that the denial or delay of an insurance claim will cause the death, grievous physical injury, or financial ruin of the insured *and* even if such occurred, that the insurer was actually aware that its action would probably result in such devastation to the life of the insured. In redefining the gross negligence standard for punitive damages in a bad faith case, the court comes close to equating gross negligence to the statutory definition of malice. One of the definitions of malice is "an act that is carried out by the defendant with a flagrant disregard for the rights of others and with actual awareness on the part of the defendant that the act will, in reasonable probability, result in human death, great bodily harm, or property damage."[139] To equate these terms would be improper since each has different elements and typically malice is thought of as involving a higher, more culpable mental state than gross negligence.[140]

Arguably, the gross negligence requirements of *Moriel* would not need to be proven if punitive damages were sought because a breach of the duty of good faith and fair dealing was accompanied by intentional conduct, fraud or malice rather than gross negligence. This is so because the court specifically recognized that punitive damages might be proper in such circumstances and that it was writing only about the elements required to prove gross negligence.[141]

The Texas Supreme Court reversed the judgment for punitive damages against Transportation because there was no evidence that Moriel had suffered any harm other than "anxiety and embarrassment" because of Transportation's unreasonable delay in paying his claims.[142] Additionally, the court did not find any evidence that Transportation was aware that its delay would probably cause Moriel any extraordinary harm. Rather than render a take-nothing judgment, the court remanded for a new trial because of its significant change in the gross negligence standard.[143]

The court also adopted procedural standards in *Moriel* for assessing and reviewing punitive damage awards to "ensure against excessive or otherwise inappropriate awards."[144] While the court noted that the current Texas procedures were inadequate to guard against disproportionate punitive damages in relation to the offense, a jury instruction incorporating the *Kraus* factors[145] is the one procedure that does pass constitutional scrutiny.[146] In fact, the jury instruction in this case was cited with approval by the court.[147]

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139. TEX. CIV. PRAC. & REM. CODE § 41.001(6)(B) (Vernon Supp. 1994).
140. *See* Luna v. North Star Dodge Sales, Inc., 667 S.W.2d 115 (Tex. 1984).
141. *Moriel*, 879 S.W.2d at 23 n.16.
142. *Id.* at 26.
143. *Id.*
144. *Id.* at 29.
145. *See* Alamo Nat'l Bank v. Kraus, 616 S.W.2d 908 (Tex. 1981).
146. *Id.* at 29 n.26.
147. The jury instruction read as follows:

The first procedure adopted was the bifurcation of the amount of punitive damages from all other issues.[148] If a timely motion to bifurcate is made, the first trial involves the issues of liability for actual damages, the amount of actual damages, and liability for punitive damages.[149] If the jury finds that the defendant is liable for punitive damages, a second trial with the same jury is had to determine the amount of punitive damages.[150] It is only at this point that evidence is presented to the jury on the net worth of the defendant.[151]

The next procedure adopted by the court[152] was to require the courts of appeals, when conducting a factual sufficiency review of a punitive damages award, to detail the relevant evidence and explain why the evidence supports or does not support the punitive damages in light of the factors announced in *Alamo National Bank v. Kraus*.[153] The court was also asked to change the burden of proof required for the recovery of punitive damages from preponderance of the evidence to clear and convincing. The court refused to do so in light of the legislature's recent rejection of this standard.[154] The court also refused to require trial courts to articulate their reasons for refusing to disturb a punitive damage award because trial courts are already overworked and understaffed.[155] However, the court did urge the trial courts to make such findings to the extent practicable.[156]

Although Transportation did not challenge the jury's finding that it had no reasonable basis for delaying payment of Moriel's claims, the court did discuss the nature of the duty of good faith and fair dealing. Reaffirming *Viles v. Security National Insurance Co.*,[157] the court held that a bad faith claim is separate and distinct from a breach of contract claim and the resolution of one does not determine the other.[158] According to the

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The term "punitive damages" is an amount which you may, in your discretion, award as an example to others and as a penalty or by way of punishment, in addition to any amount you may have found as actual damages. In determining that amount, you may consider—

1. the nature of the wrong,
2. the frequency of the wrongs committed,
3. the character of the conduct involved,
4. the degree of culpability of the wrongdoer,
5. the situation and sensibilities of the parties concerned,
6. the extent to which such conduct offends a public sense of justice and propriety, and
7. the size of the award needed to deter similar wrongs in the future.

Moriel, 879 S.W.2d at 27 n.22.

148. *Id.* at 30.
149. *Id.*
150. *Id.*
151. *Id.* at 30.
152. *Moriel*, 879 S.W.2d at 31.
153. 616 S.W.2d 908 (Tex. 1981).
154. *Id.* at 32.
155. *Id.* at 33.
156. *Id.*
157. 788 S.W.2d 566 (Tex. 1990).
158. *Moriel*, 879 S.W.2d at 17.

court, bad faith involves a breach of contract accompanied by an independent tort.[159] Bad faith, wrote the court, is not merely a bona fide dispute regarding coverage, a determination that the insurer was simply wrong in denying the claim, nor a "simple disagreement" between experts regarding coverage.[160] Bad faith, instead, is when the insurer has "no reasonable basis for denying or delaying payment of the claim, and . . . it knew or should have known that fact."[161]

Justice Doggett, joined by Justice Gammage, concurred in the judgment to the extent that the system governing punitive damages needs improvement but disagreed with the majority's attempt to improve the system.[162] Justice Doggett agreed with the procedures adopted by the majority to ensure fairness in the awards of punitive damages and would have gone further to require the trial courts to articulate the reasons for overruling a motion for new trial challenging punitive damages.[163]

Justice Doggett, however, opposed and disagreed with the majority's standard of gross negligence. First, Justice Doggett criticized the requirement that the insurer's conduct result in an injury "independent and qualitatively different" from injury resulting from breach of contract and bad faith before punitive damages can be recovered.[164] Justice Doggett could find no Texas authority for this proposition, which he viewed as an attempt to make it virtually impossible to recover punitive damages from insurance companies.[165]

Justice Doggett also disapproved of the majority's decision to abolish the ability to prove gross negligence with evidence of circumstances that show the awareness of an extreme risk by a reasonable person rather than just through evidence of the specific defendant's awareness.[166] Justice Doggett felt that doing away with this element of gross negligence protects "those who choose not to be aware of the consequences of their [conduct]."[167]

After deciding *Moriel*, the court granted an insurer's application for writ of error in *Davis v. Twin City Fire Insurance Co.*[168] Davis sued Twin City for breach of contract, breach of the duty of good faith and fair dealing, and violations of article 21.21 and the DTPA because Twin City failed to pay for a hot tub prescribed to her by her doctor. The jury found that Twin City breached its duty of good faith and fair dealing, but did not award any damages for mental anguish. The jury awarded $100,000 in

159. *Id.*
160. *Id.* at 17-18.
161. *Id.* at 18 (Doggett, J., concurring) (citing Arnold v. National County Mut. Fire Ins. Co., 725 S.W.2d 165, 167 (Tex. 1987) and Aranda v. Insurance Co. of N. Am., 748 S.W.2d 210, 213 (Tex. 1988)).
162. *Id.* at 47.
163. *Moriel*, 879 S.W.2d at 34-35.
164. *Id.* at 40.
165. *Id.* at 40-41.
166. *Id.* at 41-44.
167. *Id.* at 44.
168. 865 S.W.2d 231 (Tex. App.—Texarkana 1993, writ granted).

exemplary damages, but the trial court rendered judgment only for the cost of the hot tub. The court of appeals modified the judgment to include the award of exemplary damages.[169]

Twin City argued that Davis was not entitled to recover exemplary damages because she recovered only insurance benefits, which are contract damages. Before Davis could recover exemplary damages, asserted Twin City, she had to recover damages resulting from the tort of bad faith. The court held Davis did recover damages for Twin City's bad faith since the supreme court in *Vail*[170] held that the amount of benefits wrongfully withheld are damages, as a matter of law, flowing from an insurer's breach of the duty of good faith and fair dealing.[171]

The Texas Supreme Court granted Twin City's application for writ of error on two points.[172] One claimed that the court of appeals erred in awarding exemplary damages when the only actual damages recovered were the wrongfully withheld insurance benefits. The other point of error asserted that the court of appeals did not detail the relevant evidence and explain why the evidence supported the punitive damages as required by *Moriel*.

The court also granted writ in *Nicolau*[173] on whether State Farm should be liable for punitive damages.[174] The jury found that State Farm maliciously breached the duty of good faith and fair dealing. On appeal, State Farm argued that the evidence was insufficient to support this finding. The court disagreed with State Farm because the evidence revealed that when it hired Haag Engineering, State Farm was fully aware of Haag's predisposition not to link foundation damage with plumbing leaks. There was also evidence that State Farm was not interested in hearing about the home's foundation problems when its representative was at the scene overseeing the plumber hired by State Farm to determine whether a leak existed. Furthermore, State Farm admitted that it never told Nicolau about the additional living expense provision in the policy that would have reimbursed him for living expenses caused by the home becoming partially unlivable after the leak was discovered.[175]

Interestingly, the jury was not asked whether State Farm was grossly negligent when it acted in bad faith, but whether it maliciously breached its duty. Malice was defined in accordance with section 41.001(6)(B) of the Civil Practice & Remedies Code.[176] State Farm's point of error, how-

169. *Id.* at 237.
170. Vail v. Texas Farm Bureau Mut. Ins. Co., 754 S.W.2d 129, 136 (Tex. 1988).
171. *Davis*, 865 S.W.2d at 236.
172. 37 Tex. Sup. Ct. J. 1207 (Sept. 17, 1994).
173. Nicolau v. State Farm Lloyds, 869 S.W.2d 543 (Tex. App.—Corpus Christi, 1993, writ granted).
174. 37 Tex. Sup. Ct. J. 965 (June 15, 1994).
175. *Nicolau*, 869 S.W.2d at 553.
176. "Malice" means "(B) an act that is carried out by the defendant with a flagrant disregard for the rights of others and with actual awareness on the part of the defendant that the act will, in reasonable probability, result in human death, great bodily harm, or property damage." TEX. CIV. PRAC. & REM. CODE § 41.001(6)(B) (Vernon Supp. 1994).

ever, asserts that punitive damages were improper because there was no evidence that State Farm's conduct created an extreme risk of harm for the Nicolaus.[177] However, "extreme risk of harm" is an element of gross negligence, not malice. Moreover, as mentioned above, the supreme court's opinion in *Moriel* dealt only with the elements of gross negligence, not malice. Thus, this case presents the court an opportunity to explain the elements of malice and how they differ from the Moriel elements of gross negligence, if they do.

C. Scope of the Duty

1. *No Duty*

As mentioned above, although the Texas Supreme Court has never recognized a cause of action for breach of the duty of good faith and fair dealing when an insurer fails to settle third-party claims against its insured, the court in *Soriano*,[178] without resolving this issue, held that even if there is such a duty, Texas Farmers did not breach it.[179] Justice Cornyn, however, wrote a concurring opinion in *Soriano* urging the court to directly hold that an insurer does not have a duty of good faith and fair dealing to settle third-party claims.[180] According to Justice Cornyn, the standard that has been adopted in this context is negligence, not the "no reasonable basis" standard of good faith.[181] The good faith standard applies only to first-party claims, and to impose such a standard on third-party claims "would result in the insured having to prove a higher level of culpability than would be required to prove negligence."[182]

In *Natividad v. Alexsis, Inc.*[183] the court was faced with the issue of whether an independent adjuster firm hired by the insurer to handle its claims owed the insured the same duty of good faith and fair dealing owed by the insurer. Natividad sustained accidental injuries in the course of her employment with Revco. Revco had workers' compensation insurance with National Union, which had hired Alexsis to investigate, adjust, and handle all claims of Revco employees. Because her claims were not being timely paid, Natividad sued National Union, Alexsis, its adjuster Steen, and Revco. After Natividad settled with National Union and Revco, Alexsis and Steen moved for a summary judgment, claiming that they did not owe Natividad a duty of good faith and fair dealing. The trial court rendered a summary judgment in favor of the defendants.

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177. 37 Tex. Sup. Ct. J. 965 (June 15, 1994).

178. Texas Farmers Ins. Co. v. Soriano, 881 S.W.2d 312 (Tex. 1994). Since the initial draft of this Article was written, the supreme court resolved this issue, holding that an insurer does not owe a duty of good faith and fair dealing to a third-party claimant. Transport Ins. Co. v. Faircloth, 38 Tex. Sup. Ct. J. 424 (Mar. 30, 1995).

179. *Id.* at 317.

180. *Id.* at 318-19 (Cornyn, J., concurring).

181. *Id.* at 319.

182. *Id.*

183. 875 S.W.2d 695 (Tex. 1994).

According to the court, an insurer's duty of good faith and fair dealing emanates from the special relationship between the insured and the insurer, which exists only because the insured and insurer are parties to a contract.[184] "Without such a contract[,] there would be no 'special relationship' and[,] hence, no duty of good faith and fair dealing."[185] Thus, the court concluded that those not in contractual privity with the insured owe no duty of good faith and fair dealing to the insured.[186] In this case, Natividad was not a party to a contract with Alexsis, but had contractual privity with only her employer and National Union.[187] There was a contract between Alexsis and National Union, but because Natividad was not a party to that contract, the court determined that there was no special relationship between Natividad and Alexsis so as to create a duty of good faith on the part of Alexsis to Natividad.[188]

The court further held that National Union's duty of good faith and fair dealing was non-delegable.[189] Consequently, if an insurer contracts with agents or contractors for the performance of claim handling services, "the [insurer will be] liable for actions by those agents or contractors that breach the duty of good faith and fair dealing owed to the insured by the [insurer]."[190]

Justice Gammage, joined by Justices Hightower, Doggett, and Spector, disagreed with the majority, arguing that contractual privity between the parties is not required to give rise to the duty of good faith and fair dealing.[191] According to Justice Gammage, "[t]he duty of good faith and fair dealing 'emanates not from the terms of the insurance contract, but from an obligation imposed in law as a result of a special relationship between the parties governed or created by a contract.' "[192] Although there was no contract between Natividad and Alexsis, there was a contract whereby Alexsis promised to handle the claims of the Revco employees in accordance with the terms of the National Union policy.[193] Thus, when Alexsis dealt with Natividad, the relationship was governed by the workers' compensation insurance contract.[194]

Justice Gammage also felt that Natividad was a beneficiary under the contract between Alexsis and National Union.[195] But, even if she were not a beneficiary under the contract, Justice Gammage felt that there was a special relationship between Alexsis and National Union because the

184. *Id.* at 697-98.
185. *Id.*
186. *Id.* at 698.
187. *Id.*
188. *Natividad*, 875 S.W.2d at 698.
189. *Id.*
190. *Id.*
191. *Id.* at 700 (Gammage, J., dissenting).
192. *Id.* at 700 (quoting Viles v. Security Nat'l Ins. Co., 788 S.W.2d 566, 567 (Tex. 1990)).
193. *Natividad*, 875 S.W.2d at 700.
194. *Id.*
195. *Id.* at 701.

latter delegated to Alexsis the sole authority to evaluate, process, and deny Natividad's claims.[196] Justice Gammage wrote that "[t]he reasoning for recognizing the duty to the covered employee from the employer's [insurer] extends as well to the [insurer's] agent, the adjusting company [that] deals directly with the employee."[197]

Justice Gammage also criticized the majority's conclusion that "because [the insurer can] be held liable for its agent's actions, no cause of action is necessary against the agents themselves."[198] Justice Gammage felt that the actual wrongdoer must be punished in order to put an end to the wrongdoing.[199]

The Fourteenth Court of Appeals in *Emscor Manufacturing, Inc. v. Alliance Insurance Group*[200] held that an excess liability insurer does not owe the insured a duty of good faith and fair dealing because the excess insurer had no duty under the policy to handle the liability claims made against the insured.[201] In a similar vein, the court in *Texas Employers Insurance Association v. Underwriting Members of Lloyds*[202] held, with little discussion, that the excess insurer does not owe a duty of good faith to the primary insurer.

2. *Existence of Duty*

In *Union Bankers Insurance Co. v. Shelton*[203] the court held that an insurer's duty of good faith and fair dealing extends to the cancellation of insurance policies. Thus, a cause of action for breach of this duty exists when the insurer wrongfully cancels an insurance policy without a reasonable basis and the insurer knew, or should have known, about that fact.[204] The court noted that the same reasons for imposing this duty on insurers in the context of claims handling demanded that the duty extend to cancellation of policies.[205] Just as the insurer has exclusive control over the evaluation, processing, and denial of claims, so too is the insured at the insurer's mercy for the continuation of coverage.[206] According to the court, there is unequal bargaining power between insurer and insured regarding the payment of claims and the continuation of coverage.[207] Moreover, if the duty of good faith did not extend to the cancellation of policies insurers could "avoid bad faith liability by cancelling the entire policy rather than denying a single claim."[208]

196. *Id.*
197. *Id.*
198. *Id.*
199. *Natividad*, 875 S.W.2d at 701.
200. 879 S.W.2d 894 (Tex. App.—Houston [14th Dist.] 1994, writ denied).
201. *Id.* at 912-13.
202. 836 F. Supp. 398 (S.D. Tex. 1993).
203. 37 Tex. Sup. Ct. J. 1138, 1142 (June 22, 1994).
204. *Id.* at 1143.
205. *Id.*
206. *Id.*
207. *Id.*
208. *Union Bankers*, 37 Tex. Sup. Ct. J. at 1143.

In *E-Z Mart Stores, Inc. v. Hale*[209] the court held that an employer administering a self-insured plan assumed the role of an insurer and thus owed the employees a duty of good faith and fair dealing in handling claims under the plan.[210] In this case, Hale was injured while working as an E-Z Mart store manager. E-Z Mart had previously posted a notice that it was changing to a self-insurance program for workers' compensation benefits. E-Z Mart paid Hale's benefits and began paying her expenses. Later Hale was notified that E-Z Mart had stopped paying her expenses because it had determined that her injury had not occurred in the manner she had stated.

Hale sued E-Z Mart for, among other things, breach of the duty of good faith and fair dealing. The trial court entered judgment based on the jury verdict awarding Hale $254,686.27, fifty weeks of compensation benefits, and pre- and post-judgment interest. The court of appeals affirmed.

E-Z Mart asserted that the duty of good faith and fair dealing imposed on insurers did not apply to it. According to the court, a duty of good faith and fair dealing arises when a contract between parties expressly provides the duty or when a special relationship exists between the parties.[211] Texas law recognizes such a duty in an insured-insurer relationship.[212] As such, the question before the court was whether E-Z Mart, through its self-insurance program, came under the same duty.[213]

According to the court, when E-Z Mart disposed of its insurance coverage for employees, it expressly assumed the role as its employees' workers' compensation carrier.[214] The court held, therefore, that E-Z Mart placed itself in the position as insurer and thus owed a duty of good faith and fair dealing to Hale and the other employees.[215]

D. Standard of Care (Nature of the Duty)

Texas courts are not unanimous in their understanding of the precise standard of care required by an insurer in order to fulfill its duty of good faith. Some courts liken the duty of good faith to a negligence concept, while others contend that it is different and requires less of the insurer than the duty not to act negligently. For example, as mentioned above, Justice Cornyn, in his concurring opinion in *Soriano*, drew a distinction between the negligence standard applied to third-party duty to settle cases (*Stowers*) and the no reasonable basis standard of bad faith.[216] According to Justice Cornyn the negligence standard applies only to *Stowers*

209. 883 S.W.2d 695 (Tex. App.—Texarkana 1994, writ requested).
210. *Id.* at 700.
211. *Id.* at 699.
212. *Id.*
213. *Id.* at 700.
214. *E-Z Mart*, 883 S.W.2d at 700.
215. *Id.*
216. Texas Farmers Ins. Co. v. Soriano, 881 S.W.2d 312, 319 (Tex. 1994) (Cornyn, J., concurring).

claims, while the no reasonable basis standard applies to first-party insurance claims.[217] Justice Cornyn resisted applying a no reasonable basis standard to third-party claims as this "would presumably supplant the negligence standard recognized in *Stowers*, and would result in the insured having to prove a higher level of culpability than would be required to prove negligence."[218]

The Corpus Christi Court in *Nicolau*[219] implicitly recognized this distinction when it held that the limits on punitive damages found in the Tort Reform Act[220] do not apply to a cause of action for breach of the duty of good faith and fair dealing. Although the court did not expound on the reasons for its conclusion, the reasoning becomes apparent when looking at the Act. Section 41.002 provides that chapter 41, dealing with exemplary damages, applies only to the causes of action which are the subject matter of section 33.001.[221] Section 33.001 details the rules of comparative responsibility in negligence, strict tort liability, strict products liability, and breach of warranty cases.[222] If bad faith is not a negligence action, then it does not fall within the causes of action mentioned in section 33.001, and thus the punitive damage caps in chapter 41 do not apply. While the Corpus Christi court did not state this as the reason for its conclusion, this was the reasoning employed by the Houston court in *Nationwide Mutual Insurance Co. v. Crowe*.[223]

The Texarkana court, however, in *Universe Life Insurance Co. v. Giles*[224] reached a contrary conclusion, deciding that chapter 41 did apply to punitive damage awards for breach of the duty of good faith and fair dealing as this, according to the court, "is a negligent act."[225] The Texarkana court, like the Corpus Christi court, provided no analysis or reasoning to support its conclusion.

Each of these courts assumed either that bad faith is or is not a negligent act and proceeded from that point. The only court to provide a basis for such a position, either way, was the El Paso court in *Brotherhood's Relief and Compensation Fund v. Cawthorn*.[226] That court concluded that a breach of the duty of good faith and fair dealing is not an act of negligence since the Texas Supreme Court has never spoken of the duty in terms of negligence whenever it has discussed the elements of this duty.[227] The court did note that in *Arnold* the court, when first recogniz-

217. *Id.*
218. *Id.*
219. Nicolau v. State Farm Lloyds, 869 S.W.2d 543, 553 (Tex. App.—Corpus Christi 1993, writ granted).
220. TEX. CIV. PRAC. & REM. CODE § 41.007 (Vernon Supp. 1994) (exemplary damages cannot exceed four times actual damages or $200,000, whichever is greater).
221. TEX. CIV. PRAC. & REM. CODE § 41.002(a) (Vernon Supp. 1994).
222. TEX. CIV. PRAC. & REM. CODE § 33.001 (Vernon Supp. 1994).
223. 857 S.W.2d 644 (Tex. App.—Houston [14th Dist.]), *writ dism'd*, 863 S.W.2d 462 (Tex. 1993).
224. 881 S.W.2d 44, 52 (Tex. App.—Texarkana 1994, writ requested).
225. *Id.* at 52.
226. 815 S.W.2d 254 (Tex. App.—El Paso 1991, writ denied).
227. *Id.* at 258-59.

ing the duty of good faith, relied on *Stowers*, which, of course, imposed upon the insurer the duty not to negligently settle claims made against the insured by third parties.[228] Yet, the *Arnold* court did not use terms of negligence to describe a cause of action for breach of the duty of good faith and fair dealing.[229] Additionally, the court noted that the supreme court in *Aranda* relied upon *Montgomery Ward & Co. v. Scharrenbeck*,[230] which held that the common law imposes a duty to perform a contract in a non-negligent manner.[231] Moreover, *Aranda* held that this same duty of care applies to insurance contracts.[232] Yet again, the *Aranda* court did not use the term "negligence" to formulate the duty of good faith.[233] Thus, the El Paso court concluded that "the decision to pay or deny the claim does not involve negligence."[234]

The distinction between a negligence standard in third-party claims and a no reasonable basis standard in first-party insurance, if one truly exists, makes little sense. There is no rationale in requiring less of the insurer when handling claims submitted by its own insured than when handling claims made against its insured. Both the *Stowers* duty and the duty of good faith and fair dealing were imposed by law because of the special relationship that exists between the insurer and the insured that arises out of the insurer's unequal bargaining power over the insured. The foundation of the court's decisions in *Stowers* and *Arnold* was that the respective duties are required to prevent the insurer from abusing its exclusive control over the handling of claims, whether they be first or third-party claims.[235] The similarities between *Stowers* and *Arnold* are obvious from the following quotes from each case. *Stowers* states:

> [I]t would certainly be a very harsh rule to say that the indemnity company, in a case such as this, owed no duty whatever to the insured further than the face of the policy, regardless of whether it was negligent in discharging its duties as the sole and exclusive agent of the assured, in full and complete control. Such exclusive authority to act in a case of this kind does not necessarily carry with it the right to act arbitrarily.[236]

Similarly, the *Arnold* court states:

> In the insurance context a special relationship arises out of the parties' unequal bargaining power and the nature of insurance contracts which would allow unscrupulous insurers to take advantage of their insureds' misfortunes in bargaining for settlement or resolution of claims. In addition, without such a cause of action insurers can arbitrarily deny coverage and delay payment of a claim with no more

228. *Id.*
229. *Id.*
230. 204 S.W.2d 508 (1947).
231. *Cawthorn*, 815 S.W.2d at 259.
232. *Id.*
233. *Id.*
234. *Id.*
235. *Stowers*, 15 S.W.2d at 547; *Arnold*, 725 S.W.2d at 167.
236. *Stowers*, 15 S.W.2d at 547.

> penalty than interest on the amount owed. An insurance company has exclusive control over the evaluation, processing and denial of claims.[237]

In *Stowers*, the court concluded that an insurer will be "held to that degree of care and diligence which a man of ordinary care and prudence would exercise in the management of his own business" when it came to settle claims made against the insured.[238] Similarly, the court in *Aranda* held that one element of whether an insurer has breached the duty of good faith "requires an objective determination of whether a reasonable insurer under similar circumstances would have delayed or denied the claimant's benefits."[239] Although the court did not mention the word "negligence," this element clearly incorporates a negligence standard into the duty of good faith.

There is, of course, a second, subjective element to bad faith which requires the insured to prove that the insurer knew or, based on its duty to investigate, should have known that there was no reasonable basis for the delay or denial.[240] Whatever this element adds to the negligence standard of the first element, it clearly is not a requirement to prove intentional or even grossly negligent conduct, since the court in *Moriel* held that the insurer, when it denies a claim without a reasonable basis, engages in bad faith and more must be shown to prove gross negligence, malice or intentional conduct.[241]

Many of the difficulties facing the courts concerning the duty of good faith could be resolved by treating them as the *Stowers* duty; that is, applying a negligence standard of care. This would eliminate the problem the courts are having in analyzing whether the insured has proven a negative proposition: "no reasonable basis." It would also harmonize the duties owed by the insurer to its insured regardless of the type of claim being submitted. Adoption of the negligence standard for bad faith would also subject this cause of action to tort reform, thereby limiting the amount of punitive damages that could be recovered against the insurer and permitting the insurer to submit to the jury an issue on comparative causation. If bad faith is treated as something distinct from negligence, there is no basis for an insurer to plead or submit to the jury the insured's percentage fault (or comparative bad faith). Chapter 33 of the Texas Civil Practices and Remedies Code clearly would exclude this cause of action from its application.[242] Even so, many insurers are claiming that the insured has a corresponding duty of good faith. This has no support in Texas jurisprudence and, in fact, collides with *Arnold* and all subsequent cases which have imposed the duty only on the insurer.

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237. *Arnold*, 725 S.W.2d at 167.
238. *Stowers*, 15 S.W.2d at 548.
239. Aranda v. Insurance Co. of N. Am., 748 S.W.2d 210, 213 (Tex. 1988).
240. *Id.*
241. Transportation Ins. Co. v. Moriel, 879 S.W.2d 10, 23 n.16 (Tex. 1994).
242. TEX. CIV. PRAC. & REM. CODE ANN. § 33.001 (Vernon Supp. 1994).

II. DUTY TO SETTLE THIRD-PARTY CLAIMS (STOWERS DUTY)

A. ELEMENTS OF A STOWERS CAUSE OF ACTION

Soon after the court decided *American Physicians Insurance Exchange v. Garcia*,[243] where the court held that the *Stowers* duty is not triggered unless a settlement demand is within policy limits, the court decided *Texas Farmers Insurance Co. v. Soriano*.[244] One of the issues in this case was whether the insurer breached its *Stowers* duty when it refused to settle with one claimant for the $20,000 policy limits after it had already settled with another claimant for $5000. In addressing this issue, the court reiterated the three elements of a *Stowers* cause of action stated in *American Physicians*: (1) a claim against an insured is within the scope of coverage; (2) there is a demand within policy limits; and (3) the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood of an excess judgment.[245]

The court concluded that, when faced with a settlement demand arising out of multiple claims and inadequate proceeds, an insurer may enter into a reasonable settlement with one of the several claimants, even if the settlement decreases the amount available to satisfy other claims.[246] The court believed that this approach will "promote[ ] settlement of lawsuits and encourage[ ] claimants to make their claims promptly."[247]

Farmers left $15,000 in available limits to satisfy the Medinas' claims after settling the Lopez claim. The court listed two reasons it might possibly find that Farmers negligently failed to settle the Medinas' claim: (1) Farmers negligently rejected a demand from the Medinas within policy limits; or (2) the Lopez settlement was unreasonable.[248] According to the court, there was no evidence to reach either conclusion.[249]

Although the evidence indicated that Farmers might have been able to settle the Medinas' claims for $20,000 prior to the Lopez settlement, there was no evidence that the Medinas ever demanded $20,000 before the Lopez settlement.[250] Without evidence of a demand within the policy limits prior to the Lopez settlement, Farmers had no duty to settle the Medinas' claims for $20,000, or for greater than $15,000 after the Lopez settlement.[251] Therefore, the court held that Farmers did not negligently reject a demand within policy limits.[252]

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243. 876 S.W.2d 842 (Tex. 1994). *American Physicians* was discussed in last year's annual review. *See* Maxwell, *supra* note 16, at 1404.
244. 881 S.W.2d 312 (Tex. 1994).
245. *Id.* at 314.
246. *Id.* at 315.
247. *Id.*
248. *Id.*
249. *Soriano*, 881 S.W.2d at 315.
250. *Id.*
251. *Id.* at 315-16.
252. *Id.* at 316.

The court further held that there was no evidence that the Lopez settlement was unreasonable.[253] Soriano claimed that the Lopez settlement was unreasonable when compared to the more serious Medina claims. However, said the court, the fact that the Medinas' claims might have been more serious was not evidence that the Lopez claim was unreasonable.[254] According to the court, Soriano must have shown "that a reasonably prudent insurer would not have settled the Lopez claim when considering solely the merits of [that] claim and the potential liability of its insured on the claim."[255] The court concluded that there was no evidence that Farmers' decision to settle the Lopez wrongful death claim for $5000 was unreasonable.[256]

Justice Hightower concurred in the judgment but disagreed with the court's analysis of an insurer's duty to settle for the same reasons he gave in his dissent in *American Physicians*.[257] In *American Physicians*, Justice Hightower wrote that the *Stowers* duty includes the duty to explore settlement possibilities and thus, an insurer should not be allowed to wait until a demand within policy limits is made before engaging in reasonable attempts to settle.[258]

B. Covenant Not to Execute

Although Soriano assigned his rights to the Medinas in exchange for a covenant not to execute, Farmers did not raise an issue concerning the affects of such covenant upon Soriano's damages. One might recall that this was an issue written on by the Texas Supreme Court in its first opinion in *American Physicians*. Justice Hightower, writing the majority opinion, found that the American Physicians Insurance Exchange (APIE) breached its *Stowers* duty and that a covenant not to execute did not negate Garcia's damages.[259] On rehearing, a majority of the court found that APIE did not breach its *Stowers* duty and thus did not reach the issue of the covenant not to execute. Justice Hightower, however, in his now dissenting opinion incorporated his discussion regarding the covenant not to execute from the first opinion.[260] This issue may soon be resolved as the court has granted the application for writ of error in *State Farm Fire & Casualty Co. v. Gandy*.[261]

One of State Farm's points of error upon which the application for writ was granted was that the lower courts erred in rendering judgment against State Farm because the person who obtained a judgment against State Farm's insured agreed to a covenant not to execute in exchange for

253. *Id.* at 316.
254. *Soriano*, 881 S.W.2d at 316.
255. *Id.*
256. *Id.*
257. *Id.* at 318 (Hightower, J., concurring in judgment only).
258. *American Physicians*, 876 S.W.2d at 863-64.
259. American Physicians Ins. Exch. v. Garcia, 36 Tex. Sup. Ct. J. 406 (Dec. 31, 1992).
260. *American Physicians*, 876 S.W.2d at 867-72 (Hightower, J., dissenting).
261. 880 S.W.2d 129 (Tex. App.—Texarkana 1994, writ granted).

the insured's rights against State Farm. In this case, Julie Gandy sued Pearce, her stepfather, alleging that he had repeatedly abused her sexually. Pearce requested that State Farm defend him. State Farm provided homeowner's insurance to Pearce, and Gandy alleged that some of the sexual abuse occurred at his home. State Farm eventually decided to defend Pierce, but reserved its right to deny coverage based on the policy exclusion for intentional conduct.

Gandy brought this lawsuit against State Farm, as assignee of Pearce, on the basis that State Farm had failed to provide Pearce an adequate defense. Gandy obtained favorable jury findings and a judgment was rendered against State Farm. State Farm argued to the court of appeals that Gandy failed to prove that its conduct proximately caused Pearce damage. Gandy's theory was that the amount of the agreed judgment that she took against Pearce, which amounted to about $6 million, constituted actual damages to Pearce. The court questioned whether Pearce suffered any damages from the judgment because of Gandy's covenant not to execute.[262] However, the court deferred to the supreme court's first opinion in *Garcia*, which held that a covenant not to execute does not eliminate the judgment debtor's damages.[263]

C. TURNOVER

In *Charles v. Tamez*[264] the court held that unasserted, denied *Stowers* causes of action are not assets subject to turnover. Gilberto and Gloria Charles sued Raul Tamez after Mr. Charles was paralyzed from an automobile accident. Mr. Charles was a passenger in a car driven by Tamez, who negligently turned left into the path of an on-coming truck. Tamez was insured by Farmers Texas County Mutual Insurance Company. Farmers hired the law firm of Adams & Graham to represent and defend Tamez against the Charles suit.

Little more than one month after suit was filed, Mr. Charles died from his injuries. On March 25, 1991, Mrs. Charles's attorneys hand-delivered a *Stowers* letter to Adams & Graham offering to settle all claims brought personally and on behalf of her deceased husband against Tamez for Tamez's policy limits of $20,000. Adams & Graham did not accept Mrs. Charles's offer within the allotted time and the case went to trial. Judgment was rendered on the jury verdict in favor of Mrs. Charles, individually and on behalf of her husband's estate, against Tamez for over $180,000. No appeal was perfected and the judgment became final. The judgment amount in excess of the policy limits remains unsatisfied.

Postjudgment discovery indicated that Tamez had no nonexempt assets subject to execution other than the causes of action Tamez possessed against Farmers and other persons responsible for the *Stowers* breach, such as the law firm of Adams & Graham. Mrs. Charles sought to reach

262. *Id.* at 137-38.
263. *Id.* at 138.
264. 878 S.W.2d 201 (Tex.—Corpus Christi 1994, writ denied).

those assets by initiating the proceeding for a court-ordered turnover. Adams & Graham continued to represent Tamez on the turnover motion and opposed the requested turnover. In connection with this motion, Tamez testified by affidavit that he was not dissatisfied with Farmers's or Adams & Graham's representation of him. Tamez also testified that he would not have permitted Farmers to settle for policy limits if such settlement left him exposed to liens by the hospitals. The court granted turnover to Mrs. Charles of Tamez's claims against Farmers and other parties liable for the manner in which Farmers oversaw Tamez's defense. Tamez moved for a new trial.

At a hearing on the motion for a new trial, the court modified the turnover order requiring an accounting to Tamez only of the excess proceeds from the sale, not of any excess from the suits; otherwise the court continued to order a sheriff's sale of the causes of action. Adams & Graham moved to intervene and to quash the sale. Tamez, now represented by another attorney, also moved to quash the sale. Mrs. Charles moved to strike the intervention of Adams & Graham, contending that it came after the final judgment and, was thus too late. The court allowed Adams & Graham to intervene, quashed the sale of the causes of action against both Farmers and Adams & Graham, and denied the turnover. The court of appeals affirmed.

The court of appeals recognized that a cause of action is a property right and can be subject to turnover under the turnover statute.[265] Under the statute, Mrs. Charles had only to show that Tamez owned the causes of action, which were not exempt or susceptible to normal attachment or levy to justify turnover.[266] The court, in affirming the denial of the turnover, did not conclude that Mrs. Charles had failed to meet this burden of proof, but that public policy barred the turnover of the causes of action in this case because Tamez did not want to assert, and in fact, denied that he had a cause of action against his attorneys for legal malpractice or against his insurer for failure to settle the lawsuit.[267] The court concluded that Tamez must first decide that his lawyers acted contrary to his interest before deciding whether to sue for any malpractice.[268] According to Tamez's testimony, his attorneys acted according to his wishes. The court held, therefore, that unless Tamez was proven incompetent, he alone could determine if he believed that his counsel misrepresented him.[269] Thus, the court held that "unasserted, denied causes of action for legal malpractice for failure to settle under the *Stowers* doctrine are not assets subject to turnover."[270] According to the court, "allowing a party to force a suit for malpractice on behalf of a satisfied opponent does not

265. *Charles*, 878 S.W.2d at 205; *see* TEX. CIV. PRAC. & REM. CODE § 31.002 (Vernon 1986 & Supp. 1994).
266. *Id.*
267. *Charles*, 878 S.W.2d at 208.
268. *Id.* at 207.
269. *Id.*
270. *Charles*, 878 S.W.2d at 208.

promote the specific purpose of the turnover statute or the overall purpose of the Texas legal system."[271]

The court recognized that an insured's right to sue his insurer for failure to settle under *Stowers* is subject to both equitable subrogation and assignment.[272] But, it is not subject to involuntary assertion.[273] Again, Tamez testified that he had no complaint regarding Farmers.[274] As with the attorneys, the court held that public policy bars turnover of unasserted, denied causes of action against insurers for failure to settle lawsuits.[275] The court affirmed the trial court's denial of turnover, reasoning that Tamez had not been shown to be incompetent, and Tamez's cause of action would wither into an "insubstantial illusion," a "hollow lawsuit," in the face of his state satisfaction with his representatives.[276] The effect of that reasoning is to place a greater burden of proof upon a similarly-situated turnover applicant than Texas law demands, that is, the applicant must: (1) show the judgment debtor to be incompetent; and (2) prove the merits of the action in the turnover proceeding.

The turnover statute, and all Texas cases discussing burden of proof in a turnover proceeding, requires only slight evidentiary showing—merely "some evidence" of possession or control of the subject asset.[277] A turnover order can issue even when no evidence has been presented.[278] At most, a judgment creditor should show: (1) that the judgment debtor owns the subject property; (2) that the property cannot readily be attached; and (3) that the property is not exempt from attachment, execution, and other seizure.[279] In seeking turnover of a chose in action, a judgment creditor only has to show that the judgment debtor owns it.[280] The applicant has no duty to prove its merits or lack of defenses[281] or its value.[282] The purpose of the turnover proceeding is merely to ascertain whether or not an asset is in the possession of the judgment debtor or subject to the debtor's control.[283] Moreover, once a judgment creditor presents evidence tracing the assets to the judgment debtor, a presump-

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271. *Id.*

272. *Id.*

273. *Charles*, 878 S.W.2d at 208.

274. *Id.*

275. *Id.*

276. *Id.* at 209.

277. Brink v. Ayre, 855 S.W.2d 44, 46 (Tex. App.—Houston [14th Dist.] 1993, no writ).

278. *See* Beaumont Bank, N.A. v. Buller, 806 S.W.2d 223, 226 (Tex. 1991) (the lack of any evidence is only a relevant consideration in determining whether the trial court should not have granted turnover).

279. *Brink*, 855 S.W.2d at 45; *see also* TEX. CIV. PRAC. & REM. CODE ANN. § 31.002 (Vernon 1986 & Supp. 1994).

280. *Brink*, 855 S.W.2d at 45.

281. Renger Memorial Hospital v. State, 674 S.W.2d 828, 831 (Tex. App.—Austin 1984, no writ).

282. Associated Ready Mix, Inc. v. Douglas, 843 S.W.2d 758, 762 (Tex. App.—Waco 1992, orig. proceeding).

283. *Buller*, 806 S.W.2d at 227.

tion arises that those assets are in the debtor's possession and the burden then shifts to him to account for the assets.[284]

The effect of this court's opinion, whenever a judgment debtor decides to oppose turnover of his chose in action by denying that it exists or refusing to assert it, is to force the turnover applicant to further prove the merit of the action and that the judgment debtor is incompetent. The court's pronouncement is wrong because it conflicts with the established case law and because the holding changes the purely procedural nature of the turnover statute, intended to assist judgment creditors in the collection of their judgment debts, into a complex, substantive procedure. In a case such as this, the burden of production of the asset improperly shifts from the judgment debtor to the judgment creditor, who must prove to the trial court a great likelihood the action will succeed.

The foundation of the court's opinion is that Raul Tamez, the insured, stated in affidavit that he had no complaints against Farmers and his lawyers for the way they handled his case. Such claims by a judgment debtor should never be the basis for denying turnover of his choses in action. One obvious reason is that any judgment debtor desiring to avenge his judgment creditor can simply feign a desire not to press a lawsuit, so that the creditor is unable to obtain the same on turnover.

The court of appeals has incorrectly, and without precedent, held that a judgment creditor may not use the turnover statute to reach the judgment debtor's *Stowers* action if the judgment debtor does not want to bring the action himself. Holding that a lawsuit under the *Stowers* doctrine is "essentially personal"[285] and not subject to involuntary assertion by turnover, the court legislated a novel, unprecedented class of exempt property—"unasserted, denied causes of action for failure to settle [lawsuit]."[286] This holding conflicts with the sole authority of the Legislature to create property exemptions. This holding will also invite inevitable abuse. Any insurance company whose negligence has caused an excess judgment to be entered against the insured can rely on this case and do what was apparently done here—somehow make the insured happy with the insurer and then thwart any turnover attempts to reach the insured's causes of action. This holding exempting "unasserted, denied" causes of action from turnover may endanger our settled public policy goals of protecting insureds.

It is true that after *Charles* was decided, the Texas Supreme Court refused an application for writ of error in *Zuniga v. Groce, Locke & Hebdon*,[287] and thus adopted the holding that a client may not assign a cause of action against his or her attorney for legal malpractice. However, the same concerns that prevented such an assignment cannot impact the assignability of a *Stowers* action or its acquisition through turnover.

284. *Id.* at 226.
285. *Charles*, 878 S.W.2d at 208.
286. *Id.*
287. 878 S.W.2d 313 (Tex. App.—San Antonio 1994, writ ref'd).

In *Zuniga*, the court concluded that an assignment of a legal malpractice cause of action will not be permitted because it would cause "a demeaning reversal of roles."[288] After the client, now a judgment debtor, assigned his legal malpractice cause of action to his opponent, now a judgment creditor, the client would have to take the position that but for his attorney's negligence, he would have successfully prevailed against the allegations being made against him.[289] The judgment creditor, on the other hand, would have to abandon any notion that the merits of his case were strong enough to win on and instead argue that he would have lost except for the defendant's attorney's negligence.[290] According to the court, allowing such conduct to occur solely to find a party with sufficient assets to pay a judgment would demean the legal profession by giving the public the idea that lawyers "will take any position, depending upon where the money lies, and that litigation is a mere game and not a search for the truth."[291] Allowing a judgment creditor like Mrs. Charles to obtain by turnover causes of action belonging to her judgment debtor would not demean the legal profession as feared by the San Antonio court. Mrs. Charles tried to obtain by turnover Mr. Tamez's cause of action against his insurer for its negligent failure to settle the personal injury and wrongful death claims brought against him by Mr. & Mrs. Charles. As it so happened, the reason Farmers did not respond to the *Stowers* demand was because of Adams & Graham's negligence in not timely communicating the offer. Thus, this case focuses on acquiring a *Stowers* cause of action. Consequently, Mrs. Charles did not have to take a position contrary to the one she took in the underlying lawsuit. That is, she does not have to allege that she would not have been successful in obtaining a judgment against Mr. Tamez but for the negligence of Adams & Graham. Instead, she only had to agree with Mr. Tamez that but for the negligence of Farmers and Adams & Graham, she would have settled the underlying lawsuit for Farmers's policy limits of $20,000. This is not contrary to any position Mrs. Charles took in the underlying lawsuit since she did, in fact, attempt to settle with Mr. Tamez for that amount. Thus, the public policy reasons stated in Zuniga and adopted by this Court had no impact on Mrs. Charles's ability to acquire Mr. Tamez's *Stowers* cause of action, whether by assignment or by turnover.

III. UNFAIR OR DECEPTIVE ACTS (ARTICLE 21.21 & THE DTPA)

A. STANDING TO SUE

As discussed in detail in last year's Annual Survey, the Texas Supreme Court in *Allstate Insurance Co. v. Watson*[292] determined that a third-party

288. *Id.* at 318.
289. *Id.*
290. *Id.*
291. *Id.*
292. 876 S.W.2d 145 (Tex. 1994).

claimant cannot assert a cause of action for unfair claim settlement practices under article 21.21 of the DTPA against the alleged wrongdoer's insurer.[293] In addressing this issue, the court noted to maintain an action under section 16 of article 21.21, the conduct must be:

1. declared to be unfair or deceptive in section 4 of article 21.21;
2. defined in the rules and regulations adopted by the State Board of Insurance to be unfair or deceptive; or
3. defined by DTPA section 17.46 as an unlawful deceptive trade practice.[294]

The court first concluded that unfair claims settlement practices are not declared to be unfair or deceptive by section 4.[295] Next, the court determined that Board Order 18663, which was promulgated under article 21.21, does not specifically address unfair claims settlement practices.[296] The court did note that Board Order 41454 does define conduct that constitutes unfair claims settlement practices, but this was promulgated under article 21.21-2, not article 21.21.[297] The court, therefore, concluded that it could not form the basis of an article 21.21 cause of action.[298] The court also mentioned that article 21.21-2, itself, defines and prohibits unfair claims settlement practices.[299] However, article 21.21-2 does not provide a private cause of action.[300]

As to the final possible cause of action under article 21.21, conduct defined by DTPA section 17.46 as deceptive trade practices, the court held that since unfair claims settlement practices are not listed in section 17.46(b), they are not actionable under article 21.21 through the DTPA.[301] Thus, the court eliminated the possibility of maintaining a cause of action under section 17.46(a) for unlisted deceptive trade practices.

Significantly, the court was careful to limit its opinion to claims being asserted by third-party claimants and indicated that it was not disturbing the law regarding the causes of action an insured can maintain against his or her insurer. According to the court, Ms. Watson was required to assert her cause of action "through the reasoning of *Vail*."[302] The court explained:

> *Vail* thus presented the question of construction of art. 21.21, section 16 in the context of an insured-insurer relationship and in light of the preexisting common law duty of good faith and fair dealing recognized in *Arnold*. In reaching our decision today, we are particularly mindful of the duties imposed on insurers as to their insureds. . . .

293. *Id.* at 150.
294. *Id.* at 147 (quoting TEX. INS. CODE ANN. art. 21.21, § 16 (Vernon Supp. 1994)).
295. *Id.* at 147.
296. *Id.* at 148.
297. *Allstate*, 876 S.W.2d at 148.
298. *Id.*
299. *Id.*
300. *Id.* at 148-49.
301. *Id.* at 149.
302. *Allstate*, 876 S.W.2d at 149.

> *Vail* is predicated upon this Court's expressed belief that a special relationship exists between an insured and the insurer. . . . *Vail* remains the law as to claims for alleged unfair claim settlement practices brought by insureds against their insurers.[303]

The court in *Vail*[304] held that there are several possible avenues for an insured to maintain a cause of action against his or her insurer for unfair claims settlement practices under article 21.21, section 16, either directly or by its incorporation through DTPA section 17.50(a)(4):

1. By Board Order 18663's[305] incorporation of article 21.21-2's prohibition of unfair claims settlement practices;
2. By Board Order 18663's incorporation of Board Order 41454's[306] prohibition of unfair claims settlement practices;
3. By Board Order 18663's incorporation of a breach of the common law duty of good faith and fair dealing; and
4. By article 21.21, section 16's incorporation of unlisted deceptive trade practices prohibited by DTPA section 17.46(a).[307]

In *Wheelways Insurance Co. v. Hodges*,[308] the court relied on *Watson* to deny relief under article 21.21 to a judgment creditor and assignee of the insured. Hodges was injured in a car accident caused by Harvey, who was driving a rental car owned by Capps Rent-A-Car. Wheelways provided primary coverage to Capps, authorized users of Capps's vehicles, and those vicariously liable for the acts or omissions of Capps or its authorized users. Wheelways, however, refused to provide coverage under this policy for Hodges' injuries, and she sued Harvey. Hodges obtained a default judgment against Harvey in the amount of $250,000. Harvey then assigned his rights against Wheelways to Hodges and she proceeded to file suit against it alleging breach of contract, breach of the duty of good faith and fair dealing, negligence, and violations of the DTPA and the Insurance Code.

The jury found for Hodges on theories of negligence and violations of the DTPA and the Insurance Code. The jury also awarded Hodges $200,000 damages for her mental anguish, punitive damages, and attorney's fees. The court of appeals reversed and remanded for a new trial.

Concerning the issue of whether Hodges could recover damages for her mental anguish under article 21.21, the court simply dismissed this claim as one being asserted by a third-party claimant who, according to *Watson*, does not have "standing to sue to enforce the extracontractual obligations, rights, and remedies imposed by Article 21.21."[309] The supreme court's holding in *Watson* was not so expansive, but was limited to refusing to allow third-party claimants to sue another person's insurer for unfair claims settlement practices. The supreme court did not rule the

303. *Id.* (citations omitted).
304. Vail v. Texas Farm Bureau Mut. Ins. Co., 754 S.W.2d 129 (Tex. 1988).
305. Codified at 28 TEX. ADMIN. CODE § 21.3 (West 1994).
306. Codified at 28 TEX. ADMIN. CODE § 21.203 (West 1994).
307. *Vail*, 754 S.W.2d at 136.
308. 872 S.W.2d 776 (Tex. App.—Texarkana 1994, no writ).
309. *Id.* at 782.

possibility of a third-party claimant suing the insurer for violations of section 4 of article 21.21, Board Order 18663 or DTPA section 17.46(b).

Moreover, Hodges's status was not identical to Watson's. Ms. Watson sued Townsley's insurer before she had litigated the issue of his negligence or obtained a judgment against him. Hodges did obtain a judgment establishing Harvey's negligence and the damages resulting therefrom. Thus, as a judgment creditor, Hodges stepped into Harvey's shoes. Additionally, Harvey assigned his causes of action against Wheelways to Hodges.

A similar situation was presented in *Emscor Manufacturing, Inc. v. Alliance Insurance Group*.[310] Alliance provided excess liability coverage to Emscor, which was facing a claim by the families of two employees who died on the job (the Ketcher plaintiffs). After Emscor's primary carrier became insolvent, Emscor demanded that Alliance tender its policy limits to settle with the Ketcher plaintiffs. Alliance refused and Emscor and the Ketcher plaintiffs entered into an agreed judgment.

After suing Alliance for its refusal to settle, Emscor assigned seventy-five percent of any recovery it might obtain to the Ketcher plaintiffs and they joined the lawsuit as plaintiffs. Alliance moved for summary judgment, asserting that Emscor failed to meet the conditions of coverage under the policy. The trial court granted this motion and the court of appeals affirmed the summary judgment.

The majority of the court, in one sentence found in a footnote, concluded that the Ketcher plaintiffs had no standing to sue Alliance under article 21.21 based on *Watson*.[311] The dissent, however, argued that the Ketcher plaintiffs were not third-party claimants per se because Emscor had assigned some of its contractual rights to them.[312] "As Emscor's assignees, the Ketcher plaintiffs can enforce the obligations and duties that Alliance owed to Emscor under the excess coverage policy."[313]

Another case extending *Watson* beyond its narrow holding is *Hancock v. Walker*.[314] This mandamus proceeding was brought by Risk Managers International to compel the trial court to vacate or stay his order requiring it to post a $2 million bond. In the underlying lawsuit, the Trans sued Morgan and his employer after the Trans' sons were killed in an automobile accident. The Trans added Risk Managers and Corporate Underwriters alleging violations of article 21.21 and the DTPA, and breached the duty of good faith and fair dealing. Upon the Trans request, the trial court required Risk Managers, as an unauthorized insurer, to post a bond pursuant to article 1.14-1 section 6(a) and article 1.36 section 11(a) of the Insurance Code.

310. 879 S.W.2d 894 (Tex. App.—Houston [14th Dist.] 1994, writ denied).
311. *Id.* at 910 n.6.
312. *Id.* at 919.
313. *Id.* at 919-20.
314. 873 S.W.2d 422 (Tex. App.—Fort Worth 1994, orig. proceeding).

The court of appeals granted the writ of mandamus, holding that the Trans lacked standing to invoke the bond requirements of the Texas Insurance Code.[315] According to the court, the Trans, as third-party claimants, have standing under the Insurance Code, only if they allege acts or practices enumerated in article 21.21 section 16 and demonstrates reliance on those acts.[316] Unlike Ms. Watson, who asserted a claim for unfair claims settlement practices, which is not specifically enumerated in article 21.21 section 16, the Trans alleged that Risk Managers engaged in conduct declared unfair in section 4 of article 21.21, a claim specifically enumerated in section 16.[317] However, the court determined that the Trans could not show damage from relying on Risk Managers' representations, "because the underlying claim arose in tort."[318]

The same attempt to impose a reliance element onto the DTPA failed when it was first tried almost ten years ago in *Weitzel v. Barnes*[319] and when it was tried in 1994 in *Celtic Life Insurance Co. v. Coats*.[320] In *Weitzel*, the defendant argued that a consumer had to prove reliance on a misrepresentation before there could be recovery under the DTPA. The court, looking to the language of the statute, disagreed. The court noted that the DTPA allows recovery when there is proof of a deceptive act or practice that is a producing cause of the consumer's actual damages.[321] Producing cause does not contain an element of reliance and, in fact, the Legislature rejected a reliance standard in favor of a producing cause standard.[322] Thus, the court held that courts should not impose requirements rejected by the Legislature.[323] When the same argument was made to the supreme court last year in *Celtic Life*, the court reaffirmed its decision in *Weitzel* that reliance is not an element of recovery under the DTPA.[324]

In *Hart v. Berko, Inc.*,[325] the El Paso Court of Appeals took the holding of *Watson* that article 21.21, section 16 makes actionable conduct that is defined as an unlawful deceptive trade practice in DTPA section 17.46, which implicitly rejected the holding in *Vail*, that unlisted practices under DTPA section 17.46(a) are actionable under article 21.21, and applied it to an action brought by an insured against an insurance agent for alleged misrepresentations. The court thus concluded that only the conduct prohibited by DTPA section 17.46(b) is actionable under article 21.21, section 16.[326] The court seemingly recognized the internal inconsistency of

315. *Id.* at 424.
316. *Id.*
317. *Id.*
318. *Id.* at 424.
319. 691 S.W.2d 598 (Tex. 1985).
320. 885 S.W.2d 96 (Tex. 1994).
321. *Weitzel*, 691 S.W.2d at 600.
322. *Id.*
323. *Id.*
324. *Celtic Life*, 885 S.W.2d at 99.
325. 881 S.W.2d 502 (Tex. App.—El Paso 1994, writ denied).
326. *Id.* at 509.

Watson in eliminating a cause of action under article 21.21 for unlisted practices under DTPA section 17.46(a), which *Vail* permitted, and the holding that "*Vail* remains the law as to claims for alleged unfair claim settlement practices brought by insureds against their insurers."[327] The El Paso court's resolution of this inconsistency was to view *Watson* as modifying *Vail* rather than allowing *Vail* to remain intact for insureds.[328]

Tri-Legends Corp. v. Ticor Title Insurance Co.[329] and *Crum & Forster, Inc. v. Monsanto Co.*,[330] present opposing views on the extent of the application of *Watson* to claims brought by an insured against his or her insurer. Tri-Legends sued Ticor for an alleged misrepresentation in a title commitment. The commitment stated that record title of property Tri-Legends wanted to purchase appeared to be vested in Allied Bank, the entity offering to sell the property to Tri-Legends. The actual record title owner of the tract when it was purchased by Tri-Legends was actually the Russell King Development Corporation. Tri-Legends claimed that this title defect thwarted its attempts to develop and market condominiums on the tract of land, which was the reason for purchasing the property.

In affirming a summary judgment in favor of Ticor, the court of appeals held that Tri-Legends had not alleged any viable causes of action under article 21.21 or the DTPA. Taking its cue from *Watson*, the court held that conduct actionable under article 21.21, section 16 are those acts declared unfair or deceptive in section 4 of article 21.21 and the rules and regulations of the State Board of Insurance promulgated under article 21.21, or those acts defined by DTPA section 17.46 as being false, misleading or deceptive.

In *Watson*, the court held that section 4 of article 21.21 "is an exclusive list of statutory unfair or deceptive acts or practices in the business of insurance."[331] The *Tri-Legends* court concluded from that statement that since section 4 does not mention misrepresentations in title commitments that Tri-Legends had not alleged any violations of section 4.[332]

Tri-Legends also sought damages for Ticor's alleged violation of Board Order 41060,[333] which prohibits misrepresentations of insurance policies. The court held that this Board Order does not prohibit any conduct in addition to the conduct prohibited in article 21.21 or other rules and regulations, and thus does not make actionable misrepresentations in a title commitment.[334] Such an interpretation of this Board Order renders it meaningless.

The court next concluded that Tri-Legends could not recover under the DTPA because section 17.46(b) does not specifically state that a misrep-

327. *Watson*, 876 S.W.2d at 149.
328. *Hart*, 881 S.W.2d at 508-09.
329. 889 S.W.2d 432 (Tex. App.—Houston [14th Dist.] 1994, writ denied).
330. 887 S.W.2d 103 (Tex.App.—Texarkana 1994, writ requested).
331. *Watson*, 876 S.W.2d at 147.
332. *Tri-Legends*, 889 S.W.2d at 440.
333. Codified at 28 TEX. ADMIN. CODE § 21.3 (West 1994).
334. *Tri-Legends*, 889 S.W.2d at 440.

resentation in a title commitment is a prohibited false, misleading, or deceptive act or practice.[335] The court misunderstands the purpose and intent of the laundry list items in section 17.46(b). They are designed to be broad and categorical rather than referring to specific acts and must be liberally construed "due to human inventiveness in engaging in deceptive or misleading conduct."[336] This court, by applying a narrow, tortured construction to the DTPA, circumvents the legislature's intent of protecting consumers by allowing unwarranted loopholes in the statute.

The Texarkana court in *Monsanto*, on the other hand, refused to impose such a narrow construction on these statutes, holding that *Watson* is applicable only to those claims for unfair claim settlement practices asserted by third-party claimants and that *Vail* still governs causes of action brought by insureds against their insurers.[337] Consequently, the court held that an insured still has a cause of action under article 21.21 for unlisted deceptive trade practices under DTPA section 17.46(a).[338]

B. Jury Questions

In *Spencer v. Eagle Star Insurance Co. of America*,[339] the court was faced with the issue of how to properly submit to the jury an insurer's liability under article 21.21 and the DTPA. Charles and Sharon Spencer sued Eagle Star for delaying payment of benefits owed under business interruption coverage. The Spencers suffered a fire loss at their business on February 19, 1986, but Eagle Star did not unconditionally tender payment of the benefits until March 10, 1987.

Eagle Star's liability was submitted in the following question:

> Was the handling of the Spencers' claim for loss of earnings by Eagle Star an unfair practice in the business of insurance? "Unfair practice" means any act, or series of acts which is arbitrary, without justification, or takes advantage of a person to the extent that an unjust or inequitable result is obtained.[340]

The jury answered this question in the affirmative but the trial court granted Eagle Star's post-verdict motion for judgment or for judgment n.o.v., on the basis that the question " 'does not support a judgment against the Defendant under our law,' and rendered a take-nothing judgment."[341] The Spencers appealed. The court of appeals affirmed, holding that the question was immaterial and defective.[342] The Texas Supreme Court reversed and remanded for a new trial.[343]

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335. *Id.* at 441-42.
336. Pennington v. Singleton, 606 S.W.2d 682, 688 (Tex. 1980).
337. *Monsanto*, 887 S.W.2d at 117-18 n.10.
338. *Id.* at 118.
339. 876 S.W.2d 154 (Tex. 1994).
340. Spencer v. Eagle Star Ins. Co. of Am., 780 S.W.2d 837, 838 (Tex. App.—Austin 1989), *rev'd*, 876 S.W.2d 154 (Tex. 1994).
341. *Id.* at 839.
342. *Id.* at 843-44.
343. *Spencer*, 876 S.W.2d at 155.

The supreme court agreed with the lower courts that the question and instruction were defective because the instruction did not specify the conduct made unlawful.[344] Citing *Brown v. American Transfer & Storage Co.*,[345] the court held that "[w]hen liability is asserted based upon a provision of a statute or regulation, a jury charge should track the language of the provision as closely as possible."[346]

Accordingly, the court found the instruction was too broad and ill-defined as it allowed the jury to find an unfair insurance practice based on conduct that took advantage of the Spencers and resulted in an inequitable result.[347] The court noted that article 21.21, section 16, "does not refer to every [unfair or deceptive] practice imagined but only to those specified by other statutes and regulations."[348] Even so, the court concluded that the question was not immaterial, as it submitted liability under article 21.21—the heart of the Spencers' case.[349] Accordingly, the supreme court held that the trial court should have granted a new trial, rather than disregarding the jury's answer to the question and rendering a judgment n.o.v.[350]

On rehearing, Eagle Star argued that just as in *State Department of Highways v. Payne*,[351] the Spencers were not entitled to a new trial because they failed to properly submit their theory of liability. The court distinguished *Payne* because the plaintiffs there had abandoned one basis of liability by refusing to submit it over defendant's objection.[352] The Spencers, however, did not abandon their claim under article 21.21 but instead requested an improper submission of it to the jury.[353]

Eagle Star also complained that a new trial would give the Spencers "a second bite at the apple."[354] This, the insurer asserted, would encourage plaintiffs to request the submission of an erroneous question, knowing that the only risk is a new trial. The court rejected this argument, holding that the trial court had the responsibility to submit the proper questions to the jury and the consequences of the trial court's error should not fall upon the plaintiffs.[355] Moreover, the court recognized that the prospect

344. *Id.* at 157.
345. 601 S.W.2d 931, 937 (Tex.), *cert. denied*, 449 U.S. 1015 (1980).
346. 876 S.W.2d at 157.
347. *Id.*
348. *Id.* at 157.
349. *Id.*
350. *Id.*
351. 838 S.W.2d 235 (Tex. 1992).
352. *Spencer*, 876 S.W.2d at 157.
353. *Id.* at 158.
354. *Id.*
355. *Id.* This poignant statement rings even truer in this case than most, since the question submitted to the jury was actually composed by the trial court. The Spencers submitted several questions at the charge conference tracking the language of article 21.21, the DTPA, and the Board Orders. The court, after considering all the questions, came back with one liability question, feeling that it would submit the essence of the Spencers' case. Imagine the surprise of the Spencers when that same judge granted a judgment n.o.v. saying that the jury's affirmative finding to his question does not support a judgment under Texas law!

of a new trial is usually a disincentive, rather than an incentive, to request submission of improper jury questions.[356]

In *Hart v. Berko, Inc.*[357] the trial court submitted Hart's liability to the jury in a broad form submission. The jury was asked whether Hart engaged in any of the following conduct:

a. Making or causing to be made any statement misrepresenting the terms, benefits, or advantages of an insurance policy; or
b. Making, or directly or indirectly causing to be made, any assertion, representation, or statement with respect to insurance that was untrue, deceptive or misleading; or
c. Representing that an agreement confers or involves rights, remedies, or obligations which it does not have or involve; or
d. Engaging in any false, misleading or deceptive act or practice.[358]

Because the court determined that unlisted practices under DTPA section 17.46(a) were no longer actionable after *Watson*, it held that the trial court erred in submitting subsection d.[359] Hart complained that an improper judgment was rendered because the jury, which was not required to provide an answer as to each subsection, could have based its affirmative finding on subsection d. However, because there was evidence to support an affirmative finding on the other subsections, the court concluded that the inclusion of subsection d did not cause the rendition of an improper judgment.[360]

C. Actionable Conduct

The issue in *Chicago Title Insurance Co. v. McDaniel*[361] revolved around the types of representations made by title insurers that are subject to liability under the DTPA. At the time McDaniel purchased a house from Couch Mortgage Company, he also purchased a title insurance policy to be issued by Chicago Title. The policy provided that Chicago Title, "for value does hereby guarantee to the Insured . . . that as of the date hereof, the Insured has good and indefeasible title to the estate or interest in the land described or referred to in this policy."[362]

About five years later, McDaniel received a notice from the bankruptcy trustee of Couch Mortgage that the property was subject to a preexisting lien that had been properly filed and recorded. McDaniel

356. *Id.*
357. 882 S.W.2d 502 (Tex. App.—El Paso 1994, writ denied).
358. *Id.* at 508 n.2. The language found in subsection a of the jury instruction is taken from section 4(1) of article 21.21. *See* 4 State Bar of Texas, Texas Pattern Jury Charges PJC 102.16 (1990). The language in subsection b is taken from section 4(2) of article 21.21. *See* 4 State Bar of Texas, Texas Pattern Jury Charges PJC 102.17 (1990). Subsection c of the jury instruction can be found in DTPA § 17.46(b)(12). The language in subsection d, along with a definition of "false, misleading or deceptive," which was provided to the jury, submits an unlisted practice under DTPA § 17.46(a). *See* 4 State Bar of Texas, Texas Pattern Jury Charges PJC 102.15 (1990).
359. *Hart*, 881 S.W.2d at 508-09.
360. *Id.* at 511.
361. 875 S.W.2d 310 (Tex. 1994).
362. *Id.*

abandoned the property about a year later. Three months later, a federal bankruptcy court ruled that McDaniel's purchase money lien on the property was superior to the preexisting lien.

McDaniel brought this suit seeking damages under the DTPA based on Chicago Title's representations. After suit was filed, Chicago Title secured the release of the preexisting lien. Thus, Chicago Title argued that it discharged its obligations under the title insurance policy and could not be liable under the DTPA because it made no representations regarding the status of the title to McDaniel's property. The trial court granted summary judgment in favor of Chicago Title, which was reversed by the court of appeals.[363] The supreme court concluded "that there was no genuine issue of fact concerning any misrepresentations by [Chicago Title]" and reversed the judgment of the court of appeals.[364]

According to the court, a title policy is a contract of indemnity and a title insurer only has the duty to indemnify the insured against losses caused by defects in title.[365] Thus, Chicago Title's issuance of a policy did not constitute a representation regarding the status of the property's title. Rather, it constituted an agreement to indemnify McDaniel against losses caused by any defects in the title. The court, while recognizing that a title insurer may be held liable under the DTPA for an affirmative representation, could find no allegation of any such representation, nor was there any allegation that Chicago Title breached its duty under the contract.[366] Thus, the court could find no genuine issue of material fact regarding representations made in the title insurance policy.[367]

The Fourteenth Court of Appeals, in two cases decided on the same day, relied upon *McDaniel* to deny recovery against a title insurer under the DTPA. The first case is *Commonwealth Land Title Co. of Houston, Inc. v. Nelson*.[368] Nelson sold some property to Graphic Investments for $250,000—$100,000 in cash and the remaining $150,000 in a note. The note was to be secured by a first lien in favor of Nelson. However, immediately after the closing, Graphic resold the property to Allied and, because of a forged subordination agreement, First Bank, Allied's lender, believed it obtained a first lien on the property. First Bank later foreclosed on the property after Allied defaulted on its note. The FDIC eventually took over First Bank and sold the property to Bonner.

After all this came to Nelson's attention, he sent Commonwealth a demand letter, to which it responded by saying that because the subordination agreement was forged, the Nelsons had a superior lien to First Bank. Thus, according to Commonwealth, the sale from the FDIC to Bonner was ineffective to disturb the Nelsons' lien. Consequently, Common-

363. *Id.*
364. *Id.*
365. *Id.* at 311.
366. *McDaniel*, 875 S.W.2d at 311.
367. *Id.* at 310.
368. 889 S.W.2d 312 (Tex. App.—Houston [14th Dist.] 1994, writ requested).

wealth told the Nelsons that they had suffered no damage and could seek foreclosure.

The Nelsons did not attempt to foreclose on the property. Instead, they filed suit against Commonwealth Title, Commonwealth Insurance, and others alleging, among other things, negligence, fraud, violations of the DTPA and Insurance Code, and breach of contract. At judgment, the trial court ruled that the Nelsons had a good and valid first lien on the property and awarded them actual damages, additional damages under the DTPA, attorney's fees, and exemplary damages. The court of appeals reversed and rendered judgment in favor of Commonwealth.

The court first concluded that the trial court was correct in its decision that Nelson had a first lien on the property.[369] Consequently, relying on *McDaniel*, the court concluded that the Nelsons could not recover any damages from Commonwealth.[370] The court of appeals found the Nelsons' situation identical to that of the McDaniels.[371] Because the Nelsons had a valid first lien, there was no title defect that required Commonwealth to indemnify the Nelsons.[372]

The second case decided by the Fourteenth Court of Appeals is *Tri-Legends Corp. v. Ticor Title Insurance Co.*[373] Tri-Legends alleged that Ticor misrepresented the status of the title of property it purchased from Allied Bank. Ticor's title commitment stated that record title appeared to be vested in Allied Bank, when in fact it was in the Russell King Development Corporation. The trial court granted a summary judgment in favor of Ticor and the court of appeals affirmed.

The court held that even if there was a title defect, Tri-Legends could not recover any damages from Ticor because Ticor's only duty to Tri-Legends was to indemnify it against losses caused by defects in the title.[374] The court reached its conclusion based on the holding in *McDaniel* that a title insurance policy is a contract of indemnity and the issuance of such a policy does not constitute a representation regarding the status of the property's title.[375]

The court noted that Tri-Legends was not suing under a title insurance policy, but because of an alleged misrepresentation made in a title commitment.[376] However, it did not find this of significance so as to fall outside *McDaniel*.[377] The court reasoned that a title commitment is "nothing more than a document used by a title insurance company as a precursor to the issuance of the title insurance policy itself."[378] Because Ticor indemnified Tri-Legends by successfully defending its title, the

369. *Id.* at 323.
370. *Id.*
371. *Id.* at 324.
372. *Id.*
373. 889 S.W.2d 432 (Tex. App.—Houston [14th Dist.] 1994, writ requested).
374. *Id.* at 443.
375. *Id.*
376. *Id.*
377. *Tri-Legends*, 889 S.W.2d at 444.
378. *Id.*

court held that Ticor had fulfilled its duty under the title insurance policy.[379] Tri-Legends argued that this case was similar to *First Title Co. of Waco v. Garrett*[380] rather than *McDaniel*. In *Garrett*, the title insurance company was held liable under the DTPA for misrepresentations made in a title commitment.[381] The court distinguished *Garrett*, saying that liability there was based on an "affirmative" representation in the title commitment that there were no restrictive covenants of record.[382] The court held that the statement that record title appeared to be vested in Allied was not an actionable affirmative representation.[383]

One of the issues in *Celestino v. Mid-American Indemnity Insurance Co.*,[384] was when can a provision in an insurance policy be an actionable misrepresentation. Arturo Celestino was killed while working at Sebastian Cotton & Grain (Sebastian). Celestino's family sued Sebastian for exemplary damages alleging gross negligence, their only extrastatutory recourse under the Workers' Compensation law. About two months before Celestino's death Sebastian purchased an umbrella policy that provided $1 million in excess employer's liability coverage from Mid-American. Sebastian had primary coverage through Houston General. Therefore, when it was sued by Celestino, Sebastian made claims on Houston General and Mid-American to settle the lawsuit for $1,950,000. Houston General tendered its policy limits of $1 million, but Mid-American denied coverage claiming that its policy "[did] not cover punitive or exemplary damages, which are the only damages alleged against the insured or even that can be alleged."[385]

Sebastian then settled with Celestino for $8,000,000 plus a conditional assignment of Sebastian's claims against Mid-American. Sebastian and Celestino later filed this lawsuit asserting causes of action for breach of contract, unconscionable conduct, misrepresentations under the DTPA and Insurance Code, fraud, and negligence based on Mid-American selling a policy of excess employer's liability and accepting premiums, but providing absolutely no coverage. The policy excluded coverage for exemplary damages—the only type of damages a Sebastian employee could seek because workers' compensation coverage was also provided.

The trial court granted Mid-American's motion for summary judgment on all causes of action.[386] The court of appeals reversed as to the breach of contract and unconscionable conduct actions, but affirmed as to the remaining claims.[387]

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379. *Id.*
380. 860 S.W.2d 74 (Tex. 1993).
381. *Id.* at 75.
382. *Tri-Legends*, 889 S.W.2d at 444.
383. *Id.*
384. 883 S.W.2d 310 (Tex. App.—Corpus Christi 1994, writ requested).
385. *Id.* at 312.
386. *Id.* at 311.
387. *Id.*

The common law fraud and DTPA misrepresentation causes of action were based on allegations that Mid-American made a material misrepresentation in the declaration page of the policy that said the policy conferred $1 million in excess employer's liability coverage. In order to determine whether this statement was actionable as a misrepresentation, the court held that it must be read in the context of the whole policy.[388] A general provision within a contract, held the court, cannot be isolated and labeled a misrepresentation because subsequent provisions preclude the effect of the general provision.[389] The court emphasized that a provision in an insurance policy could be an actionable misrepresentation if it was the sole representation made to the insured.[390]

Here, however, the declaration page on which the general coverage provision was found, warned the reader to review the entire policy carefully because it was a nonstandard policy and might differ from over policies. Additionally, the general provisions on the first page of a four-page policy contained clearly worded limitations of coverage. Thus, the court held the general provision of coverage did not amount to an actionable material misrepresentation.[391]

Celestino also asserted a DTPA unconscionable conduct cause of action, which was also dismissed by summary judgment. The court, even though it affirmed the summary judgment on the causes of action based on alleged misrepresentations, reversed it as to unconscionable conduct because the unconscionability claim was not based on alleged misrepresentations but on the gross disparity between the coverage provided by the policy (none) and the premiums paid by Sebastian.[392] According to the court, any remedy Celestino may have had "must emanate from the discrepancy between the lack of coverage and the promise of insurance for which Mid-American accepted premiums."[393]

An agent's alleged misrepresentation was the subject of *Hart v. Berko, Inc.*[394] When Berko's vice-president, Blaugrund, inquired about increasing the amount of Berko's coverage with its fire insurance carrier, D.J. Enterprises, Hart, a D.J. Enterprises employee, allegedly told Blaugrund that the coverage would increase from $242,000 to $600,000. After Berko's building was destroyed on February 27th, Hart notified Blaugrund that it was only covered for $242,000.

D.J. Enterprises argued that Berko had not provided enough evidence to factually and legally support a finding that Hart's representations were a producing cause of damages. D.J. Enterprises contended that Blaugrund's testimony, that even if she had known Hart had not obtained

388. *Id.* at 314.
389. *Celestino*, 883 S.W.2d at 214.
390. *Id.* at 315.
391. *Id.*
392. *Id.* at 314.
393. *Id.* at 314.
394. 881 S.W.2d 502 (Tex. App.—El Paso 1994, writ denied).

the insurance on February 21st, she would not have looked for another carrier, established that she had not relied on the misrepresentations.

The court held, however, that reliance is not an element of proof under the DTPA or article 21.21.[395] Instead, what must be shown is that the wrongful conduct was a producing cause of damages.[396] "Producing cause," which means "an efficient, exciting or contributing cause"[397] does not contain elements of reliance or foreseeability.[398] In the context of misrepresentations made by Hart, the court held that producing cause was proven by evidence that Berko believed it was covered when it was not.[399] The court held that there is no requirement to prove that Berko would have taken other action if it had known it was not covered.[400]

D. Authority of State Board of Insurance to Make Rules Prohibiting Unfair Practices in the Business of Insurance

In *National Association of Independent Insurers v. Texas Department of Insurance*[401] a group of insurers filed suit challenging the validity of two rules promulgated by the State Board of Insurance. The first, Rule 1000, prohibits "insurance companies from 'blacklisting' consumers merely because they previously had been rejected by another [insurance company]."[402] The second, Rule 1003, "prohibits insurers from refusing to sell insurance or denying a preferred rate to a consumer because the consumer owns only one automobile."[403] The trial court upheld both rules.[404] The court of appeals affirmed.[405]

Article 21.21, section 13 gives the Board the authority to promulgate and enforce reasonable rules and regulations as is necessary to accomplish the purpose of article 21.21 The purpose of article 21.21 is "to regulate trade practices in the business of insurance by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices. . . ."[406]

The insurers argued that the Board exceeded its authority in promulgating these rules because article 21.21 does not give the Board authority to define as "unfair" conduct other than that enumerated in the statute.

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395. *Id.* at 507.
396. *Id.*
397. *Id.* at 506 (citing Rourke v. Garza, 530 S.W.2d 794, 801 (Tex. 1975)).
398. *Hart*, 881 S.W.2d at 506.
399. *Id.* at 506.
400. *Id. See also* State Farm Fire & Casualty Co. v. Gros, 818 S.W.2d 908 (Tex. App.—Austin 1991, no writ).
401. 888 S.W.2d 198 (Tex. App.—Austin 1994, writ requested).
402. *Id.* at 202. This rule is codified at 28 Tex. Admin. Code § 21.1000 (West 1994).
403. *NAII*, 888 S.W.2d at 202. This rule is codified at 28 Tex. Admin. Code § 21.1003 (West 1994).
404. *NAII*, 888 S.W.2d at 202.
405. *Id.*
406. Tex. Ins. Code Ann. art. 21.21, § 1(a) (Vernon Supp. 1994).

The insurers asserted that such a conclusion follows from the holding in *Allstate Insurance Co. v. Watson*[407] that section 4 of article 21.21 is an "exclusive list of statutory unfair or deceptive acts or practices in the business of insurance."[408]

The court of appeals disagreed, noting that the supreme court in *Watson* also wrote that for conduct to be actionable under article 21.21 it must be declared unfair or deceptive in section 4 or "the rules and regulations of the State Board of Insurance adopted under art. 21.21 . . ."[409] The court of appeals concluded that, by this statement, the supreme court impliedly recognized the Board's power to determine and prohibit unfair practices.[410]

Moreover, held the court, the same power is acknowledged by section 16 of article 21.21, which gives a private cause of action based on conduct "declared . . . in rules and regulations lawfully adopted by the Board under this article to be unfair methods of competition and unfair or deceptive acts. . . ."[411]

Even assuming the Board has the authority to define which conduct is unfair, the insurers argued that Rules 1000 and 1003 exceeded its authority because the Board did not adopt any rules or criteria by which it determines whether an act is unfair. The court held that section 13(f) of article 21.21 "provides the standards and criteria with which the Board must comply [when promulgating rules]," and that the Board need not promulgate additional standards before issuing rules under article 21.21.[412]

The insurers responded that, because the Board is not required to develop standards or criteria for determining when a practice is unfair, article 21.21 is unconstitutionally vague. According to the court, the Legislature can delegate rule-making authority to an agency if this grant of authority is in a statute that declares the public policy of the state and the primary standards the agency must observe.[413] The court noted that the supreme court has held that the phrase "not worthy of public confidence" is a sufficient standard[414] and that the Legislature acted within constitutional constraints when it delegated authority to prohibit insurance policy forms that are "unjust, unfair, inequitable, misleading, [or] deceptive."[415] Based on these two cases, the court held that the standard of "unfairness" utilized by article 21.21 is constitutionally sufficient to guide the Board in the exercise of its authority.[416]

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407. 876 S.W.2d 145 (Tex. 1994).
408. *Id.* at 147.
409. *NAII*, 888 S.W.2d at 203 (quoting *Watson*, 876 S.W.2d at 147).
410. *Id.*
411. TEX. INS. CODE ANN. art. 21.21, § 16 (Vernon Supp. 1994).
412. *NAII*, 888 S.W.2d at 204.
413. *Id.*
414. *Id.* (citing Jordan v. State Bd. of Ins., 334 S.W.2d 278, 280 (Tex. 1960)).
415. *Id.* at 205 (citing Key Western Life Ins. Co. v. State Bd. of Ins., 350 S.W.2d 839, 848-50 (Tex. 1961) (emphasis added by the court of appeals)).
416. *NAII*, 888 S.W.2d at 205.

The insurers also argued that Rules 1000 and 1003 are invalid because they are "unnecessary, unreasonable, arbitrary, and capricious"—the circumstances under which a rule can be invalidated as provided in article 21.21, section 13(f).[417] First, the insurers argued that "the Board failed to produce any evidence of the blacklisting that Rule 1000 prohibits," or how "the practice of refusing to issue preferred rates to single-car owners" injured consumers.[418] Initially, the court held that it was the Insurers burden to prove that the rules were invalid because there was a presumption of validity.[419] The court found that the Insurers had not met their burden.[420]

Moreover, the court held that the Board does not need to wait until consumers have been harmed before promulgating a rule that prohibits unfair practices in the business of insurance.[421] Thus, the Board can take prophylactic measures to prevent such practices.[422]

The insurers also argued that during the process of promulgating Rules 1000 and 1003, the Board did not comply with various provisions of the Administrative Procedure Act (APA), thus making the rules invalid. First, asserted the insurers, the Board did not give adequate notice of the proposed rules. The APA requires an agency to publish notice of a proposed rule and to include within the notice "a concise explanation of the particular statutory or other provisions under which the rule is proposed. . . ."[423] The insurers contended that the notice pertaining to Rule 1000 was invalid because it contained eleven in applicable statutes that the Board claimed authorized the rule. The court found irrelevant the inclusion of these statutes because the notice did indicate that the rule was being promulgated under article 21.21. The court held that the notice was sufficient to put the public on notice of the statutory basis for the rule.[424]

The APA also requires that an agency order adopting a rule include the factual bases for the rule's adoption, a summary of comments from interested parties, and the reasons why the agency disagrees with those comments. The insurers complained that the Board's order relating to Rule 1000 did not meet those requirements because it provided no factual basis for the rule and did not explain why the prohibited activities are unfair. The court disagreed because the order states that declining to write insurance based on the actions of another insurer "is anti-competitive and results in the blacklisting of some consumers from the insurance market.

417. *Id.*
418. *Id.*
419. *Id.*
420. *Id.*
421. *NAII*, 888 S.W.2d at 205.
422. *Id.*
423. TEX. GOV'T CODE ANN. § 2001.124(3)(A) (Vernon Pamph. 1994).
424. *NAII*, 888 S.W.2d at 208-09.

This section will ensure that the possibility of unfair competition and unfair practices do not occur in the marketplace."[425]

IV. LIABILITY OF INSURERS FOR AGENT MISREPRESENTATIONS

One of the most horrendous opinions of 1993, in terms of deviating from long-established Texas law as well as the law of every other state, was recanted when, in 1994, the supreme court issued a new opinion in *Celtic Life Insurance Co. v. Coats*.[426] The issue before the court was when will an insurer be held vicariously liable for the misrepresentations of its agent. Harrell, appointed by Celtic to be its agent for selling insurance in Texas, told Coats that the Celtic policy provided a $1,000,000 limit on benefits for in-hospital psychiatric care while only providing a $10,000 limit for out-patient psychiatric care benefits. The jury found that Harrell misrepresented the benefits of the policy and that such representation was a producing cause of damages to Coats. Because the jury also found that Harrell had authority to explain, on Celtic's behalf, the trial court rendered judgment against Celtic for Harrell's misrepresentation. The court of appeals affirmed.[427]

Originally, the supreme court, led by Justice Enoch, reversed the judgment, holding that before an insurer can be vicariously liable for its agent's misrepresentations, it must have authorized the agent's authority to make representations "outside the scope of the written document."[428] Justice Spector, heading up a three member dissent, claimed that by its holding, the court was requiring an insurer to authorize the agent to make misrepresentations before it could be held vicariously liable for its agent's conduct. Justice Spector claimed that the proper holding should be that an insurer will be liable for the acts of its agent done in the scope of his authority, even though the insurer has not authorized the specific act. Fortunately, on hearing, the court rejected Justice Enoch's views and opted to return to the long-established law.

Celtic first argued to the court that it should not be liable for Harrell's representations because he was a soliciting agent not a recording agent. The court rejected this argument because the Insurance Code does not make a distinction between the two types of agents in the context of life, health, and accident insurance.[429] Accordingly, the court looked to article 21.02, which defines who are agents.[430] This statute provides in part:

> Any person who solicits insurance on behalf of any insurance company, . . . or who takes or transmits other than for himself any application for insurance or any policy of insurance to or from such

425. *Id.* at 209.
426. 885 S.W.2d 96 (Tex. 1994).
427. 831 S.W.2d 592 (Tex. App.—Austin 1992), *aff'd*, 885 S.W.2d 96 (Tex. 1994).
428. *See* 36 Tex. Sup. Ct. J. 1259 (Sept. 10, 1993). *See also* Maxwell, *supra* note 16, at 1328-35.
429. *Celtic Life*, 885 S.W.2d at 98.
430. *Id.*

> company, . . . or who shall receive or deliver a policy of insurance of any such company, . . . or receive, or collect, or transmit any premium of insurance, . . . or do or perform any other act or thing in the making or consummating of any contract of insurance for or with any such insurance company other than for himself, . . . shall be held to be the agent of the company for which the act is done, or the risk is taken, as far as relates to all the liabilities, duties, requirements, and penalties set forth in this chapter.[431]

The court held that Harrell was clearly Celtic's agent because he performed some of these acts on behalf of Celtic.[432] Chief Justice Phillips wrote a concurring opinion addressing Celtic's argument that imposing liability on it for Harrell's misrepresentation amounts to allowing the agent to change the terms of the policy, an act he had no authority to do and which is specifically prohibited by article 21.02 and article 21.04.[433] These statutory provisions state that article 21 does not authorize the agent who solicits insurance to "alter, amend, modify, waive, or change a term or condition of an insurance policy or application for an insurance policy."[434] Chief Justice Phillips saw no conflict in holding Celtic liable under article 21.21 for Harrell's misrepresentations and the language of articles 21.02 and 21.04 because Celtic was not held contractually liable but vicariously liable under article 21.21 and the DTPA.[435]

After determining that Harrell was Celtic's agent in light of article 21.02, the court looked to the rule of law that an insurance company is generally liable for any misconduct by an agent that is within the actual or apparent scope of the agent's authority. Reiterating what it said in *Royal Globe Insurance Co. v. Bar Consultants, Inc.*,[436] the court held that it is more fair to place the risk on the insurer, which chooses the agent, than on the insured.[437]

Celtic argued that it should not be liable for Harrell's misrepresentations because the jury found that Harrell did not have authority to make representations "outside the scope of the written document."[438] According to the court, this finding had no bearing on Celtic's liability because the inquiry was not whether the principal authorized the specific wrongful act, but whether the agent was acting within the scope of the agency relationship at the time the wrongful act was committed.[439] Thus, the court held that the jury's finding that Harrell had the authority to "explain," on behalf of Celtic, the benefits of the policy was sufficient to render Celtic liable for Harrell's misrepresentation of the benefits.[440]

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431. TEX. INS. CODE ANN. art. 21.02 (Vernon Supp. 1994).
432. *Celtic Life*, 885 S.W.2d at 98.
433. *Id.* at 101.
434. TEX. INS. CODE ANN. art. 21.02 (Vernon Supp. 1994). *See also* TEX. INS. CODE ANN. art. 21.04 (Vernon Supp. 1994).
435. *Celtic Life*, 885 S.W.2d at 98.
436. 577 S.W.2d 688, 694 (Tex. 1979).
437. *Celtic Life*, 885 S.W.2d at 99.
438. *Id.*
439. *Id.* at 98-99.
440. *Id.*

Unfortunately the court's opinion on rehearing in *Celtic Life* did not do the insured any good in *Shandee Corp. v. Kemper Group*.[441] Shandee sued Kemper and its agent, Johnston, for Johnston's misrepresentations. Prior to expiration of a general liability policy Shandee had with Kemper, Johnston told Shandee that it and Shandee's other policies would be renewed and merged into a single Texas Multiple Perils (TMP) policy. After Johnston told Shandee that it would be covered, he issued certificates of insurance reflecting the existence of a general liability policy with effective dates from July 20, 1986, through July 20, 1987. During the fall of 1986, Shandee experienced several losses and submitted claims to Kemper. Initially, Kemper paid those claims but later informed Shandee that the general liability policy had not been renewed and demanded reimbursement for payment of the claims.

The jury found that Kemper and Johnston were guilty of fraud. In its original opinion, written before the supreme court's first opinion in *Celtic Life*, the court concluded that Johnston had apparent authority from Kemper to make representations about coverage to Shandee and, therefore, held Kemper liable for its agent's misrepresentations.[442] This conclusion was based on the evidence that the policies were usually renewed with no correspondence from Kemper.[443] When Shandee received a billing statement indicating that the general liability policy was not renewed, Shandee contacted Johnston who said not to worry because he was securing a TMP policy that would encompass general liability coverage. Shandee had purchased insurance coverage through Johnston since 1971 and had purchased insurance coverage from Kemper since 1982. Kemper had never notified Shandee that Johnston was not authorized to secure insurance coverage. In fact, internal memos from Kemper regarding the discussion about a TMP policy indicated that Kemper acknowledged Johnston's authority to make representations to Shandee that he was securing a TMP policy and not renewing the former general liability policy.

The court held in its first opinion that Johnston had the authority to secure coverage for customers such as Shandee and to assure them that they were covered.[444] The evidence also showed that the representations of coverage were false and that Johnston knew, or should have known, that they were false. Furthermore, Shandee relied on the representations and did not secure other coverage. Instead, Shandee submitted claims, which Kemper initially paid, indicating to Shandee that Johnston's representations were true. Kemper's actions, tending to ratify Johnston's representations, also kept Shandee from securing additional coverage. The court held that there was some evidence of Johnston's apparent authority

441. 880 S.W.2d 409 (Tex. App.—Houston [14th Dist.] 1994, writ denied).

442. Nos. C14-92-00126-CV, C14-92-00480-CV, 1993 Tex. App. LEXIS 2628, *9-10. (Tex. App.—Houston [14th Dist.], Sept. 30, 1993), *withdrawn & substituted*, 1994 Tex. App. LEXIS 610.

443. *Id.* at *8.

444. *Id.* at *9.

to make the representations he made to Shandee.[445] Thus, the court held that there was sufficient evidence to establish Kemper's vicarious liability for Johnston's fraud.[446]

On rehearing, the court did an about face. The court, relying on the supreme court's first opinion in *Celtic Life*,[447] held that Kemper would be liable for Johnston's conduct only if Kemper gave Johnston the authority to make representations outside the scope of the written policy.[448] The court concluded that Johnston did not have apparent authority to make misrepresentations about coverage because there was no evidence that Kemper knowingly and voluntarily permitted Johnston to act in an unauthorized manner.[449] Strangely enough, the supreme court, even after it withdrew its first opinion in *Celtic Life*, let this erroneous opinion go uncorrected by denying the application for writ of error.

V. DEFENSE BASED ON INSURED'S MISREPRESENTATIONS

In *Fredonia State Bank v. General American Life Insurance Co.*,[450] the insurer attempted to avoid liability under a life insurance policy contending that the insured made misrepresentations about his medical history in the application. The application, however, was not attached to the policy and thus, the Bank, acting as executor of the insured's estate, argued that the insurer could not assert a defense made on misrepresentation in the application. The Texas Supreme Court agreed, holding that under the pre-1989 version of article 21.35 of the Texas Insurance Code, representations made in an application for life insurance not attached to the policy cannot be the basis of a misrepresentation defense.[451]

Article 21.35 now provides that "every contract or policy of life insurance . . . shall be accompanied by a . . . copy of the application . . . ."[452] However, prior to 1989, article 21.35 did not contain the word "life." Because of a perceived conflict between the statutory provisions giving life insurers the option of attaching the application to the policy[453] and the statute providing that the application is a part of the policy and there of the insurance contract,[454] several courts throughout the years have held that article 21.35, before it mentioned life insurance, did not apply to life insurance policies. Thus, according to these decisions, the application did not have to be attached to the policy before the insurer could rely on a misrepresentation therein as a defense.[455]

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445. *Id.*
446. *Id.*
447. 36 Tex. Sup. Ct. J. 1259 (Sept. 10, 1993).
448. *Shandee Corp.*, 880 S.W.2d at 412.
449. *Id.* at 413.
450. 881 S.W.2d 279 (Tex. 1994).
451. *Id.* at 288.
452. TEX. INS. CODE ANN. art. 21.35 (Vernon Supp. 1994).
453. TEX. INS. CODE ANN. art. 21.24 (Vernon Supp. 1994).
454. TEX. INS. CODE ANN. art. 3.44(3) (Vernon Supp. 1994).
455. *See* First Texas Prudential Ins. Co. v. Pedigo, 50 S.W.2d 1091 (Tex. Comm'n App. 1932, holding approved); Wise v. Mutual Life Ins. Co., 894 F.2d 140 (5th Cir.1990).

The supreme court overruled *First Texas Prudential Ins. Co. v. Pedigo*[456] and disapproved of *Wise v. Mutual Life Ins. Co.*[457] by deciding that prior to the 1989 amendment, article 21.35 applied to life insurance policies and, therefore, representations in an application not attached to the policy cannot be the basis of a misrepresentation defense.[458] The court rejected the notion that articles 21.24 and 3.44(3) were in conflict, but held, even if there were a conflict, article 21.35 still applies to life insurance policies.[459]

In *Union Bankers Insurance Co. v. Shelton*[460] the issue was whether an insurer must prove that the insured made misrepresentations on an application for health insurance with the intent to deceive the insurer before the insurer can void the policy within the first two years of its issuance. In this case, the jury failed to find that Shelton intended to deceive Union Bankers by misrepresenting his health history.[461] Union Bankers argued that this was irrelevant to its defense because article 3.70-3(A)(2)(a)[462] implies that an insurer may cancel a health insurance policy within two years of its issuance if the insured makes even an innocent misrepresentation in the application.[463]

In considering this issue, the court first looked to the history of section 3(A)(2)(a) of the Uniform Individual Accident & Sickness Policy Provision Law promulgated by the National Association of Insurance Commissioners (NAIC), from which article 3.70-3(A)(2)(a) was derived. According to the court, the NAIC intended this language to allow insurance policies to be canceled after two years based on fraudulent misrepresentations when traditionally policies were not contestable after two years for any reason.[464] Section 3(A)(2)(a) did not address contesting a policy within two years of issuance.

The court then looked to the language of article 3.70-3(A)(2)(a) itself, which says that it does not affect the requirements for contesting policies within the first two years. Thus, the court held that article 3.70-3(A)(2)(a) does not provide any assistance in determining the requirements for contesting a policy within two years of its issuance.[465]

The court then referred to article 21.16, which requires a material misrepresentation before an insurance policy can be canceled. The court also looked to the common law requiring proof of the insured's intent to deceive before the insurer can cancel a policy. In light of the statutory and common law, the court determined that an insurer can cancel a health insurance policy within two years of its issuance only if the insured

456. 50 S.W.2d 1091 (Tex. Comm'n, App. 1932, holding approved).
457. 894 F.2d 140 (5th Cir. 1990).
458. *Fredonia State Bank*, 881 S.W.2d at 288.
459. *Id.*
460. 889 S.W.2d 278 (Tex. 1994).
461. *Id.* at 279.
462. TEX. INS. CODE ANN. art. 3.70-3(A)(2)(a) (Vernon Supp. 1994).
463. *Shelton*, 889 S.W.2d at 280.
464. *Id.* at 281.
465. *Id.*

makes a misrepresentation on the application with intent to deceive the insurer.[466] Because the jury failed to find that Shelton intended to deceive Union Bankers, the court held that Union Bankers, as a matter of law, breached the insurance policy by improperly canceling it based on an innocent misrepresentation.[467]

VI. AUTOMOBILE INSURANCE

A. SETTLEMENT WITHOUT CONSENT

In *Hernandez v. Gulf Group Lloyds*,[468] the Texas Supreme Court held that an insurer must prove that it was prejudiced by an insured's settlement before it can avoid coverage under an uninsured/underinsured motorist policy that contains a settlement-without-consent clause.[469]

In 1987, Elizabeth Hernandez died in a car accident. She had uninsured motorist insurance coverage through her parents' policy from Gulf Group Lloyds in the amount of $100,000. Hernandez's parents settled all of her claims against the driver of the car for the $25,000 policy limit of his insurance. Gulf Group refused to pay any amount of underinsured motorist coverage, because the Hernandezes had not obtained Gulf Group's consent to settle.

After a bench trial, the trial court rendered judgment for $100,000, plus costs, interest, and attorney's fees.[470] The trial court concluded that Gulf Group was not prejudiced due by the Hernandezs' failure to comply with the settlement-without-consent exclusion, and that application of the exclusion would deprive the Hernandezes of protection required by the Texas Uninsured/Underinsured Motorist statute.[471]

The court of appeals, relying on *Guaranty County Mutual Insurance Co. v. Kline*,[472] held that the settlement without the insured's consent barred the Hernandezes from recovering under their own policy.[473] Thus, the court of appeals reversed the judgment in favor of the Hernandezes and rendered a take-nothing judgment.[474] The supreme court reversed the judgment of the court of appeals and affirmed the trial court's judgment in favor of the Hernandezes.[475]

The supreme court noted that insurance policies, like other contracts, are subject to the rule "that when one party to a contract commits a material breach of that contract, the other party is excused from any obligations to perform."[476] Likewise, if the breach is not material, the

466. *Id.* at 282.
467. *Id.* at 282-83.
468. 875 S.W.2d 691 (Tex. 1994).
469. *Id.* at 691, 694.
470. *Id.* at 692.
471. *Id. See* TEX. INS. CODE ANN. art. 5.06-1 (Vernon Supp. 1994).
472. 845 S.W.2d 810 (Tex. 1992).
473. *Hernandez*, 875 S.W.2d at 692.
474. *Id.*
475. *Id.* at 694.
476. *Id.* at 692.

nonbreaching party is not excused from performing under the contract.[477] Whether a breach is material is determined by considering the extent to which the nonbreaching party will be deprived of a benefit that it could have reasonably anticipated from full performance.[478]

According to the court, "in the context of an underinsured motorist claim, . . . an insured's settlement without the insurer's consent [may prevent] the insurer from receiving the benefit" of a subrogation right against the wrongdoer.[479] However, if the subrogation right has no value, then the insurer will not be deprived of the contract's expected benefit.[480] In such a situation, the insured's breach of the settlement-without-consent clause is not material. The court, therefore, held that an insurer who was not prejudiced by an insured's settlement may not deny coverage under an uninsured/underinsured motorist policy that contains a settlement-without-consent clause.[481] Because there was no evidence that Gulf was prejudiced by the settlement, the supreme court reversed the court of appeals and affirmed the trial court.[482]

B. Assignment of Rights

In *Texas Farmers Insurance Co. v. Gerdes*,[483] the Fort Worth Court of Appeals upheld a clause in an automobile policy prohibiting assignment of insurance without insurer's consent.[484] Gerdes was injured while riding as a passenger in a vehicle driven by Saldano. The automobile was insured by Texas Farmers. The insurance policy covered any passenger injured while occupying a covered automobile. The policy also provided that the insured could not assign her rights under the policy without the insurer's written consent.

Gerdes began a series of treatments for her injuries at Griffin Chiropractic Clinic and assigned her rights to the clinic without the written consent of Texas Farmers. Thereafter, Texas Farmers paid Gerdes $1003 for the treatments. Gerdes never paid Griffin Chiropractic. Griffin Chiropractic sued Texas Farmers for payment based on the assignment of rights executed by Gerdes. Both parties moved for summary judgment. The trial court granted summary judgment in Griffin Chiropractic's favor.[485]

According to the court of appeals, the summary judgment was proper only if a valid assignment existed.[486] In considering this issue, the court of appeals noted that an insurance contract "is subject to the same rules

477. *See id.* at 694.
478. *Hernandez*, 875 S.W.2d at 692-93.
479. *Id.* at 693.
480. *Id.*
481. *Id.* at 693.
482. *Id.*
483. 880 S.W.2d 215 (Tex. App.—Fort Worth 1994, writ denied).
484. *Id.* at 216.
485. *Id.*
486. *Id.* at 217.

of construction as other contracts."[487] When it is not ambiguous, a court will interpret the contract as a matter of law.[488] The court held that the non-assignment clause was unambiguous.[489] It also held that non-assignment clauses have been consistently enforced by Texas courts, and that the prohibition against the assignment of rights by a named insured to an insurance contract has been previously upheld by the court.[490]

Griffin Chiropractic conceded that the clause barred assignment by the named insured, but contended that the clause did not apply to Gerdes as a third-party beneficiary. However, according to the court, "[a] third-party beneficiary 'steps into the shoes' of the named insured and is bound by the policy's terms."[491] Thus, a beneficiary does not have greater rights and cannot acquire a better standing to enforce a contract than the contracting party.[492]

C. INDIRECT CONTACT RULE

In *Collier v. Employers National Insurance Co.*,[493] Collier sued Employers National Insurance Company seeking compensation under the uninsured motorist provisions of an automobile policy for gunshot injuries he received from a passing vehicle. While Collier was driving a friend's car in Houston, an unidentified vehicle pulled alongside him and fired two shots. Collier sustained injuries from the shooting and sought payment under the uninsured motorist coverage of his friend's auto insurance policy. Employers was granted summary judgment by the trial court.[494] The court of appeals affirmed.[495]

The court first held that Collier's injuries did not "arise out of the ownership, maintenance, or use of an uninsured motor vehicle as required by the policy."[496] The court held that "use" means "use of the automobile, as an automobile."[497] The court refused to broadly define "use" as any act which occurs in, on, or around the vehicle.[498] The court stated that its narrow definition was harmonious with the other provisions of the insurance policy which, taken together, revealed the parties' intent to insure only against automobile collisions.[499]

The court next looked to Appleman's treatise on insurance law as support for its conclusion. Appleman provides a three-part test for construing the "use" requirement of uninsured motorist coverage, as follows:

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487. *Id.*
488. *Texas Farmers*, 880 S.W.2d at 217.
489. *Id.*
490. *Id.* at 218.
491. *Id.*
492. *Id.* at 219.
493. 861 S.W.2d 286 (Tex. App.—Houston [14th Dist.] 1993, writ denied).
494. *Id.* at 287.
495. *Id.*
496. *Id.* at 288.
497. *Id.*
498. *Collier*, 861 S.W.2d at 288-89.
499. *Id.* at 288.

1. The accident must have arisen out of the inherent nature of the automobile, as such;
2. The accident must have arisen within the natural territorial limits of [the] automobile, and the actual use, loading, or unloading must not have terminated; and
3. The automobile must not merely contribute to the cause of the condition which produces the injury, but must itself produce the injury.[500]

The court reasoned that the attack on Collier "did not arise out of the inherent nature of the automobile" because the same type of injury was possible in circumstances not involving an automobile as the site of the shooting.[501] The court stated that "[t]he shotgun, not the automobile, was the instrument that caused Collier's injury."[502] Thus, according to the court, "the term arising out of the use of the uninsured motor vehicle [did] not encompass drive by shootings and shootings from moving vehicles."[503]

The court next concluded that there was no coverage under the policy because there was no actual physical contact with an uninsured vehicle.[504] The policy defined "uninsured motor vehicle" as: "a land motor vehicle . . . [w]hich is a hit and run vehicle whose operator or owner cannot be identified and which hits: (a) you or any family member; (b) a vehicle which you or any family member are occupying; or (c) your covered auto."[505]

According to the court, the Insurance Code requires that in order to recover under the uninsured motorist coverage, "actual physical contact must have occurred between the motor vehicle owned or operated by such unknown person and the person or property of the insured."[506] The court reasoned that Collier failed to show that his injury resulted from actual, direct physical contact with the uninsured vehicle.[507]

The court further held that the shotgun blast did not meet the "indirect contact rule."[508] The court acknowledged that the indirect contact rule allows recovery under a policy's uninsured motorist provisions when an uninsured vehicle collides with a third-party vehicle and propels it into the insured vehicle.[509] However, the court stated that "[t]he rule is inapplicable when the unidentified vehicle does not hit any car."[510] Absent

500. *Id.* at 289 (quoting 6B JOHN A. APPLEMAN, INSURANCE LAW AND PRACTICE 4317 (Buckley ed.)(1979)).
501. *Id.* at 289.
502. *Id.*
503. *Collier*, 861 S.W.2d at 289.
504. *Id.*
505. *Id.* (emphasis added by the court).
506. *Id.* (quoting TEX. INS. CODE art. 5.06-1(2)(d) (Vernon Supp. 1994)).
507. *Id.* at 290.
508. *Collier*, 861 S.W.2d at 290.
509. *Id.*
510. *Id.* (citing Guzman v. Allstate Ins. Co., 802 S.W.2d 877 (Tex. App.—Eastland 1991, no writ); Goen v. Trinity Universal Ins. Co., 715 S.W.2d 124 (Tex.App.—Texarkana 1986, no writ).

any physical contact by the uninsured vehicle, the court concluded that the indirect contact rule did not apply.[511]

D. Owned-But-Unscheduled-Vehicle Exclusion

In *American Economy Insurance Co. v. Tomlinson*,[512] Tomlinson was injured in an automobile accident while she was driving a Mercedes Benz that had belonged to her father, George Rashti. Rashti had died approximately two years earlier. Under Rashti's will, Tomlinson and her sister each inherited an undivided one-half interest in their father's estate, including the Mercedes. Rashti's will had been admitted to probate, but the administration of the estate had not closed at the time of the accident. The certificate of title was still in Rashti's name.

American Economy Insurance Company (AEIC) issued an automobile policy to Tomlinson, but the Mercedes was not listed on the policy as a covered automobile. After the accident, Tomlinson filed a claim for personal injury protection and uninsured motorist coverages under the policy. AEIC then filed this suit seeking a declaration that it was not obligated to pay under the policy. AEIC relied on two "owned-but-unscheduled" vehicle exclusion clauses. These excluded coverage for personal injury protection and uninsured motorist coverage for any injury that Tomlinson suffered while she occupied an automobile that she owned but was not listed as a covered vehicle. The district court granted AEIC's motion for summary judgment and entered a final judgment declaring that AEIC was not obligated to pay Tomlinson's claim.[513] The Fifth Circuit affirmed.[514]

The Fifth Circuit concluded that, because Tomlinson did own the car, the owned-but-unscheduled-vehicle exclusions precluded her "from recovering personal injury protection and uninsured motorists coverage for the injuries she suffered."[515] Tomlinson countered by arguing that the exclusions were invalid because they deprived her of coverage required by the Texas Insurance Code. The court rejected this argument, noting that the Austin Court of Appeals had faced that very issue and concluded that the owned-but-unscheduled-vehicle exclusions were enforceable and did not violate the Texas Insurance Code.[516] The court noted that there were some earlier cases holding the exclusions invalid, but the most recent cases from the courts of appeals have all found the exclusions to be valid and enforceable.[517]

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511. *Collier*, 861 S.W.2d at 290.

512. 12 F.3d 505 (5th Cir. 1994).

513. *Id.* at 506.

514. *Id.*

515. *Id.* at 509.

516. *Id.* (citing Conlin v. State Farm Mut. Auto. Ins. Co., 828 S.W.2d 332 (Tex. App.—Austin 1992, writ denied)).

517. *Tomlinson*, 12 F.3d at 510.

E. Notice of Suit

In *Harwell v. State Farm Mutual Automobile Insurance Co.*,[518] the court was faced with the issue of whether the insurer had liability under an automobile policy when the insured did not comply with the notice of suit provision of the policy. Tammy Hubbard died as a result of an automobile accident with Leatherman. State Farm was Hubbard's insurer. Three days shy of two years after the accident, Leatherman filed suit against "Tammy D. Hubbard, Deceased."[519] On the same day Harwell was appointed temporary administrator of Hubbard's estate. About seven months later Groce, the attorney representing Leatherman, sent a copy of the petition to State Farm and asked it to file an answer within a month to avoid a default judgment.

When State Farm had still not filed its answer after a couple of months, Groce calls Anderson, the attorney representing State Farm. Groce informed Anderson that he was going to make Harwell's temporary administration permanent, amend the pleadings, obtain service on Harwell, and proceed to judgment. Anderson told Groce that State Farm was not going to spend any money representing Harwell or furnish her with a defense because limitations had run. Groce did as he promised and Leatherman obtained a judgment against "Tammy D. Hubbard, Deceased."[520] Thirty-one days later, Groce sent a copy of the judgment to State Farm and demanded payment. State Farm refused to pay the judgment and, instead, filed this declaratory judgment action. State Farm claimed that it had no obligation under the policy because Harwell did not promptly comply with the policy's notice provision and because the judgment was rendered against the wrong party. The trial court granted a summary judgment in favor of State Farm.[521] The court of appeals affirmed, holding that "State Farm was prejudiced, as a matter of law, by Harwell's failure to comply with the policy's notice of suit provision in the policy. . . ."[522]

VII. PREEMPTION OF STATE LAW

A. Employee Retirement Income Security Act (ERISA)

1. How Far Does ERISA's Preemption Extend?

In *Universe Life Insurance Co. v. Giles*,[523] Universe Life denied Giles' health insurance claims for her hospitalization for cardiac problems and a bypass operation several months later, contending that they were the result of preexisting conditions. Universe Life drew this conclusion from the statement in the medical records of Dr. Sanford, one of Giles' physi-

518. 876 S.W.2d 494 (Tex. App.—Fort Worth 1994), *aff'd*, 38 Tex. Sup. Ct. J. 458 (Mar. 30, 199).
519. *Id.* at 495.
520. *Id.* at 496.
521. *Id.* at 497.
522. *Id.* at 499-500.
523. 881 S.W.2d 44 (Tex. App.—Texarkana 1994, writ requested).

cians, reflecting that she had experienced chest pain and hypertension for two to three years. Dr. Sanford corrected his statement and informed Universe Life that the chest pain had only been experienced for two to three weeks, with no hypertension. Universe Life, however, continued to deny the claim.

The jury found in favor of Giles and a judgment was rendered for Giles. Universe Life appealed, arguing that Giles' state law claims were preempted by ERISA. According to the court, the mere "purchase of insurance, when the purchasing employer neither directly nor indirectly owns, controls, administers, or assumes responsibility for the policy . . . is not covered by ERISA."[524] A plan is not an employee welfare benefit plan under ERISA if:

(1) No contributions are made by an employer or employee organization;
(2) Participation [in] the program is completely voluntary for employees or members;
(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.[525]

In applying this four-part analysis, the court noted that "the exclusion of a plan from ERISA protections would occur only if all four of factors were shown to exist."[526] Otherwise, preemption would occur.[527] The evidence showed: (1) that "[n]o contributions were made by [Giles'] employer;" (2) "[t]he funds were deducted directly from her personal bank account;" (3) "[p]articipation in the program was completely voluntary;" and (4) "the employer was in no way responsible for administering, controlling, or assuming responsibility for either the policy or its benefits."[528] Accordingly, the court of appeals held that the trial court was correct not to apply ERISA.[529]

2. *How an ERISA Plan is Established*

The court of appeals in Dallas held in *Waddell v. Kaiser Foundation Health Plan of Texas*,[530] that an ERISA plan is established "[i]f from the surrounding circumstances a reasonable person can ascertain the in-

524. *Id.* at 50.
525. 29 C.F.R. § 2510.3-1(j) (1987).
526. *Universe Life*, 881 S.W.2d at 51.
527. *Id.*
528. *Id.* at 51.
529. *Id.*
530. 877 S.W.2d 341 (Tex. App.—Dallas 1994, writ denied).

tended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits."[531]

Waddell was an employee of J.C. Penney and a member of the Kaiser HMO plan, the provider of medical and dental benefits to employees and dependents. Heather, Waddell's daughter, was admitted to the hospital for psychiatric care and remained there for nine days. At that time, her primary care physician was informed that Heather no longer met Kaiser's eligibility for psychiatric care coverage. After her release from the hospital, Kaiser continued to pay for Heather's out-patient psychiatric care.

Waddell filed suit after Kaiser refused to provide in-patient psychiatric care for Heather. Waddell asserted various causes of action, including breach of contract, negligence, gross negligence, violations of the Insurance Code, violations of the DTPA, breach of the implied duty of good faith and fair dealing, negligent and intentional infliction of emotional distress. She also sought a declaratory judgment. Kaiser moved for summary judgment under the preemptive provisions of ERISA.

"Kaiser asserted that it was an 'employee welfare benefit plan' entitled to the protections of ERISA," and that federal law preempted Waddell's state law claims.[532] The trial court dismissed the majority of Waddell's claims on Kaiser's first motion for summary judgment, although it allowed the breach of contract claim and declaratory judgment action to stand as possible civil actions under the ERISA civil enforcement provisions.[533] Kaiser then filed a motion for complete summary judgment, asserting that Waddell did not pray for damages recoverable under ERISA. The motion was granted by the trial court.[534]

Waddell argued that Kaiser failed to establish itself as an "employee welfare benefit plan" "entitled to protection under ERISA because: (1) Kaiser did not comply with the claims procedure prescribed by ERISA; (2) [the] doctors were not 'fiduciaries' under the HMO plan; and (3) Kaiser was not listed as the 'Plan administrator.' "[535] The court determined that an ERISA plan must meet the statutory definition in 29 U.S.C. section 1002(1) and is established "if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits."[536] Because the Kaiser plan meet those criteria, the court held it was an ERISA plan.[537]

531. *Id.* at 346.
532. *Id.* at 344.
533. *Id.*
534. *Id.*
535. *Waddell*, 877 S.W.2d at 345.
536. *Id.* at 346.
537. *Id.*

3. Contract Interpretation/Standard of Review Under ERISA

In *Ramsey v. Colonial Life Insurance Co. of America*,[538] Diane Ramsey, and her dependents, including her husband, William, were covered under a group health insurance policy issued by Colonial to Ramsey's employer, Moulden Supply Company. While the policy was in force, William Ramsey fell off a ladder and fractured his spine. This accident left him a quadriplegic in need of medical treatment and care for the remainder of his life.

Some time after Colonial began paying the medical expenses incurred by Ramsey, Moulden's premiums were dramatically escalated, causing Moulden to cancel the policy. The Ramseys then sought to secure a conversion policy from Colonial that would afford the same benefit level they had been provided under the group policy. Colonial issued a conversion policy to the Ramseys with a $20,000 maximum life-time benefit, rather than a $2 million limit, which the group policy had provided. After the conversion policy terminated, Colonial refused to pay any further medical expenses and the Ramseys filed suit against Colonial in state court. Colonial removed the action to federal court claiming ERISA preemption.

The district court dismissed the Ramseys' state law causes of action and proceeded with the cause of action under ERISA to obtain benefits due under an employee benefit plan.[539] The district court held that the Ramseys: (1) were entitled to benefits under the original group policy until his disability came to an end or until he obtained other insurance; (2) that any premiums paid under the conversion policy were unnecessary and should be refunded; and (3) that there should be no award of attorney's fees under ERISA.[540] The Fifth Circuit affirmed.[541]

Colonial argued that the district court misinterpreted the insurance policy and that it had no obligation to pay benefits upon termination of the policy. Before considering this argument, the court first had to determine the standard of review.[542] Relying on *Firestone Tire & Rubber Co. v. Bruch*,[543] the Fifth Circuit held that a denial of benefits under ERISA is to be reviewed under de novo standard unless the benefit plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan.[544] Because there was no allegation that Colonial exercised its discretionary authority in denying the Ramseys' benefits, the court held that there should be a de novo review of Colonial's decision to terminate Ramsey's coverage.[545]

538. 12 F.3d 472 (5th Cir. 1994).
539. *Id.* at 473.
540. *Id.* at 473-74.
541. *Id.* at 474.
542. *Id.* at 478.
543. 489 U.S. 101 (1989).
544. *Ramsey*, 12 F.3d at 478.
545. *Id.*

The provision of the policy that governed whether Colonial was required to extend coverage to the Ramseys was entitled "Extension of Medical Benefits" and read:

> If you or a dependent are totally disabled when premium payments stop, medical benefits will be continued, until the earlier of:
> a. 12 months from the day you become disabled;
> b. the date total and continuous disability ends;
> c. you or the dependent are insured for similar medical benefits under another group plan. The plan must pay benefits for the injury or sickness that caused the total disability.[546]

Colonial argued that it was not required to extend benefits to the Ramseys because premium payments had stopped more than twelve months from the day he became disabled. The court held, however, that the language in subsection (a) was "inapplicable to Ramsey by its very terms and, therefore, [Colonial was required] to offer an extension of [the] insurance benefits under the old policy."[547]

The court reasoned that the insurance policy made a consistent differentiation between the terms "you" and "your dependents."[548] Thus, because it did not make reference to dependents, subsection (a) only applied to the insured.[549] By contrast, subsection (c) stated that benefits would continue until "you or the dependent are insured for similar medical benefits under another group plan."[550] The court held that, had Colonial intended subsection (a) to cover Ramsey, it should have written it in a similar fashion as to subsection (c) to include the term "your dependents."[551]

The court further determined that, even if the policy were not entirely consistent in distinguishing between the employee and dependents, the section on extension of medical benefits was ambiguous.[552] Therefore, the court held that the contra drafter rule on contract interpretation requires the policy to be construed in favor of the insured and against the insurer.[553]

Because the Fifth Circuit determined that Colonial was required to extend benefits to Ramsey under the original group policy, it concluded that there was no reason for the Ramseys to have purchased a conversion policy.[554] Thus, the district court was correct in rendering judgment that Colonial refund the premiums paid for the conversion policy.[555]

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546. *Id.* at 475.
547. *Id.* at 478.
548. *Id.*
549. *Ramsey*, 12 F.3d at 475.
550. *Id.*
551. *Id.*
552. *Id.*
553. *Id.*
554. *Ramsey*, 12 F.3d at 480.
555. *Id.*