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INSURANCE LAW

*Philip K. Maxwell**

I. STOWERS LIABILITY

A. *Liability of Primary Carrier to Excess Carrier for Judgments in Excess of Primary Coverage*

IN *American Centennial Insurance Co. v. Canal Insurance Co.*¹ the court of appeals addressed an issue of first impression in Texas: whether an excess carrier can maintain a *Stowers* cause of action against a primary carrier.² In this case two people died in a car accident involving a car rented from General. General had primary coverage with Canal and was represented in the accident suit by the law firm of Giessel, Stone, Barker & Lyman. The excess carriers requested that Canal settle the accident suit with its own funds. Canal refused and as a result the excess carriers settled the case.

The excess carriers sued Canal and the law firm, alleging breach of duty of good faith and fair dealing, gross negligence, DTPA violations,³ and violations of article 21.21 of the Texas Insurance Code.⁴ The defendants moved for summary judgment, arguing that they owed no duty of good faith and fair dealing to the excess carriers and that the suit was barred by the statute of limitations. The trial court granted summary judgment.

Examining out-of-state authorities, the court found three theories used to permit recovery by the excess carrier from the primary carrier: direct duty, triangular reciprocity, and equitable subrogation. The doctrine of direct duty is the idea that the primary carrier owes a direct duty to the excess carrier to settle a claim against the insured within the policy limits of the primary policy when a reasonable primary insurer under the same facts would have done so.⁵ The doctrine of triangular reciprocity demonstrates

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1. 810 S.W.2d 246 (Tex. App.—Houston [1st Dist.] 1991, writ granted).

2. *G.A. Stowers Furniture Co. v. American Indemn. Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved). The *Stowers* court held that a liability carrier has a duty to handle the insured's lawsuit as an ordinarily prudent person would in the management of his own business. *Id.* at 548. The duty has been extended to all aspects of the liability carrier's handling of a claim. *Ranger County Mut. Ins. Co. v. Guinn*, 723 S.W.2d 656, 659 (Tex. 1987).

3. TEX. BUS. & COM. CODE ANN. § 17.41 (Vernon 1987 & Vernon Supp. 1992).

4. TEX. INS. CODE ANN. art. 21.21 (Vernon 1981 & Vernon Supp. 1992).

5. See *American Centennial Ins. Co. v. American Home Assurance Co.*, 729 F. Supp. 1228, 1232 (N.D. Ill. 1990); *National Union Fire Ins. v. Liberty Mut. Ins. Co.*, 696 F. Supp. 1099, 1101 (E. D.La. 1988); *Argonaut Ins. Co. v. Hartford Accident & Indemn. Ins. Co.*, 687

that the relationship of the insured, the primary carrier, and the excess carrier creates a three-way reciprocal duty of care in the conduct of settlement negotiations.⁶ The doctrine of equitable subrogation mandates that when an insurer pays a loss under a policy, that insurer steps into the shoes of the insured and becomes equitably subrogated to any cause of action the insured may have against a third party who caused the loss.⁷

The court opted for the equitable subrogation theory. First, the court stated that equitable subrogation does not increase the primary insurer's responsibilities because the duty owed to the excess carrier is identical to the duty to the insured.⁸ Second, the court reasoned that allowing this cause of action should decrease the risk of excess judgments, which, in turn, should decrease the amount of excess coverage premiums.⁹ Third, the court believed that allowing the cause of action would discourage primary carriers from "gambling" with excess carriers' coverage when potential judgments are close to the primary's policy limits. This would encourage fair and reasonable settlements and would promote judicial economy.¹⁰

Still, the court of appeals held that the *Stowers* duty is only applicable to the insurer and not to the insurer's agents.¹¹ The excess carrier therefore could not maintain the cause of action against the law firm.¹²

B. Liability of Primary Carrier to Insured for Excess Judgments

In *Garcia v. American Physicians Insurance Exchange*¹³ Dr. Garcia was sued for medical malpractice by Cardenas. Both Insurance Corporation of America (ICA) and American Physicians Insurance Group (APIE), managed by American Physicians Service Group, Inc. (APSG), insured Garcia

F. Supp. 911, 914 (S.D.N.Y. 1988); *Bohn v. Sentry Ins. Co.*, 681 F. Supp. 357, 362 (E.D. La. 1988), aff'd, 868 F.2d 1269 (5th Cir. 1989); *Estate of Penn v. Amalgamated Gen. Agencies*, 148 N.J.Super. 419, 372 A.2d 1124, 1127 (App. Div. 1977); *Hartford Accident & Indemn. Co. v. Michigan Mut. Ins. Co.*, 93 A.D.2d 337, 462 N.Y.S.2d 175, 178 (App. Div. 1983), aff'd 61 N.Y.2d 569, 463 N.E.2d 608, 475 N.Y.S.2d 267 (1984).

6. See *Transit Casualty Co. v. Spink Corp.*, 94 Cal.App.3d 124, 132, 35, 156 Cal. Rptr. 360, 365-67 (Ct. App. 1979).

7. See *Hartford Accident & Indem. Co. v. Aetna Casualty & Sur. Co.*, 164 Ariz. 286, 291, 792 P.2d 749, 754 (1990); *Northwestern Mut. Ins. Co. v. Farmers Ins. Group*, 76 Cal.App.3d 1031, 1050-1051, 143 Cal.Rptr. 415, 427 (Ct. App. 1978); *Ranger Ins. Co. v. Travelers Indem. Co.*, 389 So.2d 272, 274-76 (Fla. Dist. Ct. App. 1980); *Home Ins. Co. v. North River Ins. Co.*, 192 Ga. App. 551, 385 S.E.2d 736, 740 (Ct. App. 1989); *Fireman's Fund Ins. Co. v. Continental Ins. Co.*, 308 Md. 315, 319-21, 519 A.2d 202, 204-205 (1987); *Commercial Union Ins. Co. v. Medical Protective Co.*, 426 Mich. 109, 119, 393 N.W.2d 479, 483 (1986); *Continental Casualty Co. v. Reserve Ins. Co.*, 307 Minn. 5, 8, 238 N.W.2d 862, 864 (1976); *Centennial Ins. Co. v. Liberty Mut. Ins. Co.*, 62 Ohio St. 2d 221, 404 N.E.2d 759, 762 (1980); *Maine Bonding & Casualty Co. v. Centennial Ins. Co.*, 298 Or. 514, 520, 693 P.2d 1296, 1300 (1985). *Accord Ins. Co. of N. Am. v. Medical Protective Co.*, 570 F. Supp. 964, 975 (D.Kan. 1983); *Home Ins. Co. v. Royal Indem. Co.*, 68 Misc.2d 737, 327 N.Y.S.2d 745, 748 (Sup. Ct. 1972), aff'd, 39 A.D.2d 678, 332 N.Y.S.2d 1003 (App. Div. 1972).

8. *American Centennial Ins. Co.*, 810 S.W.2d at 252.

9. *Id.* at 253.

10. *Id.*

11. *Id.* at 254.

12. *Id.*

13. 812 S.W.2d 25 (Tex. App.—San Antonio 1991, writ granted).

during the period he treated Cardenas. ICA and APIE agreed to share equally the defense costs and to allocate any settlement or verdict in proportion to the respective amounts of coverage. Within a week before trial, APIE informed Garcia that it would not provide coverage since Cardenas' pleadings did not allege any acts of negligence during APIE's policy period. Cardenas amended his pleadings to reflect negligent acts that occurred during APIE's coverage period but APIE refused to reenter the case.

Garcia and Cardenas agreed to an assignment of Garcia's claims against the insurers, providing that Cardenas would look only to the proceeds of the policies to satisfy any judgment against Garcia. The trial court rendered judgment of \$2,235,483.30 plus interests and costs against Garcia.¹⁴ Garcia, in turn, sued ICA and APIE, alleging negligence and mishandling his defense, breach of contract by abandoning his defense and failing to investigate, negotiate, and settle the suit, DTPA violations, Insurance Code violations, and breach of duty of good faith and fair dealing.

Before the second Garcia case was tried, ICA paid \$2 million to Cardenas in return for a full release, and APIE paid \$500,000 in exchange for a continuance and an agreement that its liability would not exceed \$2.5 million. The jury returned a favorable verdict to Garcia on each of his theories. The jury also found ICA negligent and allocated responsibility of 84% to ICA and 16% to APIE. The award included actual damages of \$2,235,000, exemplary damages of \$250,000, additional damages of \$250,000, and attorneys fees of \$820,500. The trial court rendered judgment against APIE and APSG, jointly and severally, in the amount of \$1,331,574 plus post-judgment interest.¹⁵

Both sides appealed. The court of appeals increased the judgment against APIE to \$2 million.¹⁶ The court held the correct amount of actual damages amounted to \$635,483.30, calculated by the Cardenas judgment (\$2,235,483.30) less the applicable policy limits of \$1,600,000 (\$1,100,000 for ICA and \$500,000 for APIE).¹⁷ The court rejected APIE's argument that the insurers had already paid \$2.5 million and, therefore, Garcia suffered no harm. The court held any belated attempt by the insurers to offer policy limits or offer payment of excess judgment only after it has been rendered in settlement does not allow the insurer to escape liability under article 21.21¹⁸ for failing to settle.¹⁹ The court concluded that the \$500,000 paid by APIE purchased only a release from liability above \$2 million.²⁰ Furthermore, APIE was not entitled to any benefit from ICA's \$2 million payment.²¹ APIE argued it was entitled to an 84% reduction in damages since the jury found 84% of Cardenas' harm committed during ICA's coverage

14. *Id.* at 30.

15. *Id.* at 29.

16. *Id.* at 36.

17. *Id.* at 30.

18. TEX. INS. CODE ANN. art 21.21 (Vernon 1981 & Vernon Supp. 1992)

19. *Garcia*, 812 S.W.2d. at 30.

20. *Id.* at 31.

21. *Id.* at 32.

period. The court held that the failure to defend was an "indivisible" injury to Garcia and damages therefore should not have been apportioned on a pro rata basis.²² Relying on the court of appeal's opinion in *Stewart Title Guaranty Co. v. Sterling*²³ the court further held there is no statutory right to indemnification from other defendants in actions under article 21.21 of the Texas Insurance Code.²⁴

APIE argued that the nonexecution agreement between Garcia and Cardenas nullified any damages Garcia sustained from the excess judgment and therefore, APIE should not be held liable. APIE relied on *Whatley v. City of Dallas*²⁵ which held that "a covenant not to enforce a judgment against an insured individually will prevent recovery against an insurer in excess of policy limits."²⁶ The court of appeals distinguished *Whatley* because it did not involve excess liability resulting from insurer negligence and bad faith.²⁷ Furthermore, the court reasoned that the covenant not to execute did not eliminate Garcia's damages and thus did not affect APIE's liability to Garcia.²⁸ The court held that a covenant not to execute is a contract and not a release.²⁹ Accordingly, the "tortfeasor is still 'legally obligated' to the injured party, and the insurer is still bound by its contractual promise to pay."³⁰

The court rejected APIE's arguments that the nonexecution agreement violated a "no action" provision in the policy and was against public policy because it undermined the "personalized relationship based on confidence and trust" between the insurer and insured.³¹ First, the court held that an insurance company cannot insist on compliance with the policy after it has refused to perform its policy obligation to defend or settle.³² Next, the court held there is no violation of public policy in upholding nonexecution agreements unless they are procured through collusion. The court reasoned

22. *Id.* at 31-32.

23. 772 S.W.2d 242 (Tex. App.—Houston [14th Dist.] 1989) *rev'd* 822 S.W.2d 1 (Tex. 1992). In *Stewart* the supreme court decided the issue of whether a judgment against one tortfeasor should be credited by the amount of the settlement obtained from the other tortfeasors. The primary holding of the case is that a non-settling defendant is entitled to a post-trebling credit for the amount paid to the injured plaintiff in compensation of a claim for an injury under the one satisfaction rule and the contribution scheme in TEX. PRAC. & REM. CODE § 32.001 (1986). *Id.* at 323. Hence, Stewart Title's damages were assessed at \$200,000 while the amount of the total settlements from the settling tortfeasors were equal to \$400,000. *Id.* at 321. Under this scenario, the supreme court opined that first you treble the actual damages found against Stewart (i.e., $\$200,000 \times 3 = \$600,000$) and then subtract the amount of settlements received from the settling tortfeasors (i.e., \$400,000) to come up with a net recovery of \$200,000 in favor of the plaintiff under the one satisfaction rule. *Id.* at 321-322. The supreme court noted that the one satisfaction rule applies to prevent a plaintiff from obtaining more than one recovery for the same injury. *Id.* at 322.

24. *Garcia*, 812 S.W.2d at 32.

25. 758 S.W.2d 301, 310 (Tex. App.—Dallas 1988, writ denied).

26. *Garcia*, 812 S.W.2d at 32.

27. *Id.*

28. *Id.* at 32-33.

29. *Id.* at 32.

30. *Id.*

31. *Garcia*, 812 S.W.2d at 33.

32. *Id.*

"once an insured has been left alone to defend himself it is reasonable that he covenant against his own liability and hold the costs of his defense to a minimum if he can."³³

APIE argued there could be no liability for refusing to settle without evidence that the injured party would have agreed to the insured's policy limits. APIE also claimed it was never given the opportunity to settle with Cardenas without ICA. The court cited several instances in which Cardenas attempted to negotiate with APIE, but to no avail.³⁴ The court reasoned that the insurer is not required to respond to an unconditional settlement offer but does have the duty to "investigate, prepare for the defense of the lawsuit, try the case and make reasonable attempts to settle."³⁵ Relying on *Stowers*,³⁶ the court concluded that an insurer is liable for damages when he refuses a settlement offer that an ordinary, prudent person in the same situation would have accepted.³⁷ The court upheld the jury findings that APIE's refusal to negotiate or settle violated the DTPA and article 21.21 of the Insurance Code.³⁸

C. Duty of Excess Carrier to Insured

In *Arkwright-Boston Manufacturers Mutual Insurance Co. v. Aries Marine Corp.*³⁹ the Fifth Circuit held the excess liability insurer has no duty to defend the insured after the primary carrier becomes insolvent.⁴⁰ Lynch was injured while working on a ship owned by Aries. Lynch filed suit against Aries. Glacier, the primary carrier, defended Aries in the suit until the insurer became insolvent. Arkwright, the excess carrier, participated in the case to protect its excess coverage. Arkwright settled with Lynch without objection from Aries. The controversy arose in deciding whether Arkwright or Aries should bear the amount of Glacier's \$500,000 liability. Aries refused to contribute other than the amount of the deductible (\$25,000). Arkwright funded the entire settlement and sought indemnification from Aries.

Arkwright sued Aries for reimbursement of the \$500,000 retained limit. The district court held that Arkwright had assumed the defense of Aries by intervening in the settlement negotiations and, as a result, was estopped from seeking indemnity.⁴¹ The Fifth Circuit disagreed. The court held that insurers are estopped from denying coverage when they initiate a defense without a reservation of right to later deny coverage upon a policy defense.⁴² Still, the court held that the duty to reserve rights is part of the duty to defend

33. *Id.*

34. *Id.* at 33-34.

35. *Id.* at 34.

36. *Stowers*, 15 S.W.2d at 547.

37. *Garcia*, 812 S.W.2d at 34.

38. *Id.* at 34-35.

39. 932 F.2d 442 (5th Cir. 1991).

40. *Arkwright-Boston*, 932 F.2d at 445. See *Emscor, Inc. v. Alliance Ins. Group*, 804 S.W.2d 195, 198-199 (Tex. App.—Houston [14th Dist.] 1991, no writ).

41. *Arkwright-Boston Mfrs. Mut. Ins. Co. v. Aries Marine Corp.*, 736 F. Supp. 1447, 1451-52 (S.D. Tex. 1990), *rev'd* 932 F.2d 442 (5th Cir. 1991).

42. *Arkwright-Boston*, 932 F.2d at 445.

and, as excess carrier, Arkwright had no duty to defend.⁴³ The court went further in finding that participation by legal representation in settlement negotiations was not tantamount to assuming the defense.⁴⁴ Therefore, Arkwright was not estopped from denying coverage on the \$500,000.

Aries argued that the language in the excess carrier policy indicated that the primary carrier's policy limit was covered under the excess carrier policy since the event of Glacier's insolvency was not otherwise covered.⁴⁵ The court interpreted the language to hold that the claim was covered by underlying insurance through Glacier because the policy covered injuries aboard the ship.⁴⁶ "The fact that the insurance was not collectible because of Glacier's insolvency is irrelevant."⁴⁷

The court also rejected the argument that Arkwright settled the Lynch suit as a "volunteer."⁴⁸ The court recognized that Arkwright consistently informed Aries of its intent and efforts to seek indemnification and that Arkwright paid only out of a desire to avoid greater liability.⁴⁹

Finally, the court concurred with Aries in the notion that a joint tortfeasor who settles with the injured cannot later seek indemnity from the nonsettling tortfeasor.⁵⁰ The court held, however, that Arkwright was not a joint tortfeasor with Aries. Consequently, Arkwright's right to indemnification stemmed not from negligence but from a contractual right to enforce the retained limit of the policy.⁵¹

D. Statute of Limitations

In *American Centennial Insurance Co.*⁵² the primary carrier refused to settle an accident suit. As a result, the excess carrier settled and then sued the primary carrier for breach of the *Stowers* duty. Addressing the statute of limitations issue, the court of appeals stated that an action based on the *Stowers* doctrine must be brought within two years of the day the cause of action accrues.⁵³ The court explained that the cause of action for breach of the *Stowers* duty accrues when the judgment in the underlying suit is final.⁵⁴ The judgment in the accident suit was signed on February 3, 1986, while the excess carrier filed suit against the primary carrier on January 21, 1988. The

43. *Id.*

44. *Id.*

45. *Id.* at 446. The language reads "[L]imits of Liability- Underwriters shall only be liable for the excess of either- . . .(b) \$25,000. Ultimate Net Loss in respect of each occurrence not covered by said underlying insurances").

46. *Id.*

47. *Id.*

48. *Id.* at 447.

49. *Id.*

50. *Id.*; see also *Beech Aircraft Corp. v. Jinkins*, 739 S.W.2d 19, 21 (Tex. 1987).

51. *Id.*

52. 810 S.W.2d 246. For full discussion of the facts see *supra* note 1 and accompanying text.

53. *Id.* at 254 (relying on TEX. CIV. PRAC. & REM. CODE ANN. § 16.003(a) (Vernon 1986)).

54. *Id.* (citing *Street v. Honorable Second Court of Appeals*, 756 S.W.2d 299, 301 (Tex. 1988)).

court thus found the cause of action for breach of the *Stowers* duty was not barred by the statute of limitations.⁵⁵

II. DUTY OF GOOD FAITH AND FAIR DEALING

A. *Standing to Sue*

In *Bowman v. Charter General Agency, Inc.*⁵⁶ Bowman suffered injury to her car when she collided with Lee. She signed a waiver of release against Lee. Charter, Lee's insurer, offered payment to Bowman if she would sign a waiver of recompense for the rental vehicle and lost time at work. Bowman refused to sign the waiver and, as a result, Glover, the insurance adjuster, declined to surrender the check for repairs. Bowman sued the carrier for negligent and intentional infliction of mental anguish, gross negligence, fraud, and violations of the Insurance Code. The trial court granted summary judgment against Bowman without stating the basis for its decision.⁵⁷

The court of appeals upheld the summary judgment, concluding that the defendant did not owe Bowman a duty of good faith and fair dealing.⁵⁸ The court reasoned that the duty of good faith and fair dealing is imposed on an insurer because of the "disparity of bargaining power" between the insurer and the insured.⁵⁹ The court held that this rationale does not apply when dealing with third parties because no contractual relationship exists between the insurer and the third party.⁶⁰

In *St. Paul Guardian Insurance Co. v. Luker*⁶¹ the court of appeals found that an insurer owes a duty of good faith and fair dealing to a third party when the policy was purchased to protect the third party's interest. Kim and Teri Luker lived in a house owned by Kim's father. Kim personally paid the full insurance premium on the house and \$27,000 of contents. Jofrion, the insurance agent, assured Kim that he was covered by the policy even though the policy was held in his father's name, since he was the legal owner of the house.

The house burned and there was evidence of arson. St. Paul paid Emmett Luker's claim for the house but refused Kim's claim on the contents. St. Paul denied the content claim on three grounds: Kim and his wife, Teri, or someone instructed by them, caused the fire; Kim and Teri misrepresented their losses; and the policy insured only the father's interest in personal property on the premises.

The court held that "[w]hen a person contracts with an insurer for the benefit of another, both the person contracting and the third party have the right to expect that the insurer would owe the same duty to the designated

55. *Id.* at 255.

56. 799 S.W.2d 377 (Tex. App.—Corpus Christi 1990, writ denied).

57. *Id.* at 379.

58. *Id.* at 381.

59. *Id.* at 380. See *Aranda v. Insurance Co. of N. Am.*, 748 S.W.2d 210, 212 (Tex. 1988).

60. *Bowman*, 799 S.W.2d at 380.

61. 801 S.W.2d 614 (Tex. App.—Texarkana 1990, no writ).

third party as it would to the person making the contract."⁶² The court concluded that the insurer agreed to insure a third party beneficiary and therefore owed that party the same duty of good faith and fair dealing as it did to the purchaser of the policy.⁶³ *Luker* is the first case that explicitly extends the duty of good faith and fair dealing to third party beneficiaries.⁶⁴

B. Definition of Duty: Jury Charge

The supreme court held that insurers owe a duty of good faith and fair dealing to their insureds in *Arnold v. National County Mutual Fire Insurance Co.*⁶⁵ The duty arises as a result of the special relationship caused by disparity of bargaining power between the insurer and insured and the exclusive control the insurer has over claims.⁶⁶ The *Arnold* court held that a cause of action for breach of the duty of good faith and fair dealing is stated when there is no reasonable basis for denial or delay of a claim or for the insurer's failure to determine whether there is any reasonable basis for the denial or delay.⁶⁷

The supreme court revisited the duty of good faith and fair dealing in holding that a workers' compensation claimant is entitled to the duty from the insurance carrier in *Aranda v. Insurance Co. of North America*⁶⁸ The court held that a breach of the duty of good faith and fair dealing is established when the claimant proves the lack of a reasonable basis for denying or delaying payment of a claim and that the insurer knew or should have known that there was not a reasonable basis for denial or delay.⁶⁹ The court explained that the first element of the test required an objective determination, while the second element "balances the right of an insurer to reject an invalid claim and the duty of the carrier to investigate and pay compensable claims."⁷⁰

In *Automobile Insurance Co. of Hartford Connecticut v. Davila*⁷¹ the court of appeals determined the appropriate jury instruction regarding breach of the duty of good faith and fair dealing.⁷² As the result of a disagreement between David and Donna Davila, David called the police. While the police were questioning David, Donna discovered a fire in her closet. She immedi-

62. *Id.* at 618.

63. *Id.* (citing *Quilter v. Wendland*, 403 S.W.2d 335, 337 (Tex. 1966) (third party beneficiary has cause of action to enforce a contract)).

64. In *Aranda v. Insurance Co. of N. Am.* the supreme court held the duty of good faith and fair dealing extended to worker's compensation claimant. *Aranda*, 748 S.W.2d at 212.

65. 725 S.W.2d 165, 167 (Tex. 1987).

66. *Id.* ("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 . . .").

67. *Id.* The court found the duty of good faith and fair dealing equivalent to the *Stowers* duty when the insurer is held to the same degree of care a prudent man would exercise in the management of his own business. See *Stowers* 15 S.W.2d at 547.

68. *Aranda*, 748 S.W.2d 210.

69. *Id.* at 213.

70. *Id.*

71. 805 S.W.2d 897 (Tex. App.—Corpus Christi 1991, writ denied).

72. *Id.* at 903-04.

ately accused David of setting fire to her clothes. The insurer denied the claim based on this accusation. Consequently, the Davilas sued for breach of contract, breach of the duty of good faith and fair dealing, and violation of the DTPA. The jury found for the Davilas on all counts and awarded \$333,008.22.⁷³

The court of appeals addressed Automobile's contention of an improper jury instruction regarding bad faith. The trial judge offered as instruction:

In order for the conduct of an insurance company in denying or delaying payment of a claim to constitute a failure to exercise good faith, it must be shown that the insurer had no reasonable basis for denying the claim or delaying payment or the insurer failed to determine whether there was any reasonable basis for the delay.⁷⁴

The insurer offered its own version of a proper jury instruction:

In order for the conduct of the insurance company in denying or delaying payment of a claim to constitute a failure to exercise good faith, it must be shown that the insurer denied or delayed payment of the claim at a time when it knew it had no reasonable basis for denying the claim or delaying the payment of the claim or the insurer failed to determine whether there was any reasonable basis for delay.⁷⁵

The court noted that the instruction actually submitted tracked *Arnold*, while the instruction tendered by the insurance company tracked *Aranda*.⁷⁶ The court recognized that the *Aranda* formulation requires that the insurer must know it had no reasonable basis for denying the claim, but that this requirement is met by actual knowledge "or by establishing that the carrier, based on its duty to investigate, should have known that there was no reasonable basis for denial or delay."⁷⁷ Since the submitted instruction included failure to investigate, which "relates to what the insurer 'should have known' about the reasonableness of its denial," the submitted instruction was not erroneous.⁷⁸

C. Reasonable Basis for Denial or Delay

1. Recovery Denied; "Bona Fide Dispute"

In *National Union Fire Insurance Co. v. Hudson Energy Co.*⁷⁹ Hudson was insured as a private pilot. While in flight with his instructor, Bishop, Hudson lost control of the plane. Both pilots regained control and landed safely until the nose sank and caused the plane to flip over. Hudson Energy filed a claim for damage to the plane. National Union denied coverage on the basis that Hudson was not qualified as a private pilot and that the policy

73. *Id.* at 901.

74. *Id.* at 903.

75. *Id.*

76. *Id.* at 904.

77. *Id.* (quoting *Aranda*, 748 S.W.2d at 213).

78. *Id.*

79. 780 S.W.2d 417 (Tex. App.—Texarkana 1989), *aff'd*, 811 S.W.2d 552 (Tex. 1991). Note that, although the court of appeals decision was handed down before the Survey period, it is included in this paper to explain the bona fide dispute issue.

did not cover multi-person control of the plane. Hudson sued, claiming improper application of the policy exclusions and breach of the duty of good faith and fair dealing. The jury found for Hudson, and the trial court awarded \$114,440 in actual damages, \$75,000 in exemplary damages, and \$40,000 in attorney fees.⁸⁰

The court of appeals affirmed the award of policy benefits but reversed the exemplary damage award based on breach of the duty of good faith and fair dealing. The court found that since there was a reasonable fact question as to who was actually piloting the plane at the time of the accident, as well as a legitimate question of policy interpretation, there was no evidence of bad faith.⁸¹ The court of appeals held that a bona fide controversy is a reasonable basis for denial or delay in payment of a claim.⁸² The court concluded that questions regarding Hudson's control over the aircraft at the time of loss, as well as Hudson's qualifications as represented in the insurance application, were reasonable grounds for the insurer to deny the claim.⁸³

Furthermore, the court held that delay or refusal to pay are not unreasonable when policy interpretation is legitimately at issue.⁸⁴ The court reasoned that since National Union's interpretation was reasonable, the controversy justified denial of the claim.⁸⁵ The supreme court affirmed *Hudson Energy* on grounds of contract interpretation.⁸⁶

Several cases have cited *Hudson Energy* in reasoning that a bona fide dispute justifies delay or denial of payment. For example, in *St. Paul Guardian Insurance Co. v. Luker*⁸⁷ the insurer, St. Paul, argued that the question of whether the Lukers were covered under a policy bought for their benefit, but not specifically naming them as insured, was a bona fide controversy that justified the denial of the claim.⁸⁸ St. Paul further contended that denial of the claim was appropriate since the issue of coverage of third parties was one of first impression. The court of appeals conceded that the controversy was bona fide and was a proper basis for denial or delay of payment.⁸⁹ Still, the court held that the bona fide controversy ceased to exist when St. Paul filed a stipulation with the court, agreeing that the policy extended coverage to the Lukers.⁹⁰

In *St. Paul Lloyd's Insurance Co. v. Fong Chun Huang*⁹¹ Fong applied for property insurance for his restaurant. Two days after Fong confirmed cover-

80. *Id.* at 419.

81. *Id.* at 427.

82. *Id.* at 426.

83. *Id.*

84. *Id.* at 427.

85. *Id.* National Union argued that the policy excluded coverage for losses incurred when more than one person piloted the aircraft or when an unqualified person piloted it. *Id.*

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

87. *Luker*, 801 S.W.2d at 614. For full discussion of facts see *supra* note 61 and accompanying text.

88. *Id.* at 620.

89. *Id.*

90. *Id.*

91. 808 S.W.2d 524 (Tex. App.—Houston [14th Dist.] 1991, writ denied).

age, the restaurant burned. St. Paul's investigation revealed the restaurant was uninsured six months prior to the fire and was in financial trouble. The fire department investigation found evidence of arson and that the building was secure at the time of the fire, which presumes someone with access to the building set the fire. St. Paul denied Fong's claim on the evidence of arson.

Fong sued for breach of contract and the duty of good faith and fair dealing. Though both parties stipulated the fire was caused by arson, Fong argued bad faith in that St. Paul had not diligently sought the identity of the true arsonist. The jury found St. Paul had breached its good faith duty and awarded damages for the cash value of the policy.

The Houston court of appeals held St. Paul had a reasonable basis for denying the claim in presenting a reasonable fact question as to whether the arson was committed by Fong or someone paid by Fong.⁹² The court relied on the *Arnold*⁹³ and *Aranda*⁹⁴ tests for the legality of denying a claim.⁹⁵ The court cited *Hudson Energy*⁹⁶ in stating that a bona fide controversy is a reasonable basis for the insurer to delay or deny payment.⁹⁷ The court went even further in stating that "the insurer need only show that it had a reasonable basis for believing the insured was at fault" to defeat allegations of breach of duty of good faith and fair dealing.⁹⁸

The so-called bona fide dispute defense revolves around whether or not an insurance company is entitled to summary judgment where there is some evidence of a bona fide dispute relating to the nonpayment of the underlying claim. Opponents of the so-called bona fide dispute defense have argued that in addition to requiring plaintiffs at the summary judgment level to meet a directed verdict standard, any evidence of good faith and fair dealing on the part of the insurance company would defeat a plaintiff's jury verdict on appeal.⁹⁹

Conversely, proponents of the so-called bona fide dispute defense point to the Fifth Circuit applying Texas law which recently recognized that under the *Arnold* and *Aranda* formulations, an insurer is entitled to summary judgment on bad faith claims as long as it can establish it had a "reasonable basis

92. *Id.* But see *Commonwealth Lloyd's Ins. Co. v. Thomas*, No. 05-90-00785-CV (Tex. App.—Dallas, Sept. 13, 1991 n.w.h.) (issue of reasonable basis left to the jury); see also 10 Texas Consumer Law Reporter 103, 104 (jury has responsibility of determining the reasonableness of the basis for denial or delay. "If every 'reason,' as viewed by the appellate court is automatically 'reasonable,' then the right to a jury trial is denied.").

93. See *supra* text accompanying note 65.

94. See *supra* text accompanying note 68.

95. *Huang*, 808 S.W.2d at 526.

96. *Hudson Energy*, 780 S.W.2d at 426.

97. *Huang*, 808 S.W.2d at 526.

98. *Id.* (citing *Plattenburg v. Allstate Ins. Co.*, 918 F.2d 562, 563 (5th Cir. 1990)).

99. For two discussions criticizing the bona fide dispute defense. See Jenks Garrett & John N. Holland, 'Bona Fide' Dispute: No Defense To The Statutory And Common Law Duties Of Insurance Companies To Their Insured 2 TEXAS BAD FAITH BULLETIN Oct. 1990 at 5-9; Philip K. Maxwell, *Justifying Insurance Claims Denials: Is Every 'Reason' a 'Reasonable' Basis?*, Speech at the University of Texas Third Annual DTPA Conference (Dec. 1991) (on file with *Southwestern Law Journal*).

for believing" in the lack of coverage.¹⁰⁰

The Texas supreme court has held, under traditional summary judgment review, that where the facts are disputed and raise some question as to whether or not a claim was denied in bad faith, it will be submitted to the jury.¹⁰¹ It would seem that the standards as set forth in *Arnold* would almost always constitute jury questions whenever there was any kind of factual dispute relating to the insurance company's conduct or motives.

In *Koral Industries v. Security-Connecticut Life Insurance Co.*¹⁰² Koral sought a new life insurance policy for one of its key employees, Lindsey. Lindsey failed to disclose prior medical treatment in his application, including hospitalization on three separate occasions and treatment for depression and alcohol abuse. Security issued a \$1 million life insurance policy naming Koral as beneficiary. Lindsey died in 1986 and Koral submitted a claim for the policy proceeds. Upon discovery of the misrepresentations in the application, Security denied payment and declared the policy null and void by tendering all premiums plus interest to Koral.

Koral sued Security, claiming breach of contract, DTPA violations, and breach of the duty of good faith and fair dealing. The jury determined that Lindsey had made false representations to induce Security to issue the policy but that Security was aware of facts that would put it on notice to make an inquiry and as a result uncover Lindsey's fraud. The trial court rendered judgment for Koral. The court of appeals reversed, relying on Texas authority that provides an insurer must have actual knowledge of the misrepresentation before the insured can defeat a claim of fraudulent inducement.¹⁰³ Furthermore, the court of appeals held that the misrepresentation defense is sufficient to deny recovery on the alleged DTPA and good faith/fair dealing violations.¹⁰⁴

The Texas supreme court denied Koral's application for writ of error and expressly agreed with the court of appeals that the insurer's misrepresentation defense is not defeated by the fact that it "should have known" of the insured's misrepresentations.¹⁰⁵ The court agreed that the defense of misrepresentation was valid to Koral's breach of contract claims and held that the jury answers, as they related to Security, "negated" the breach of good faith and fair dealing claims and the actions under the DTPA.¹⁰⁶

In *Plattenburg v. Allstate Insurance Co.*¹⁰⁷ Jessie Plattenburg was involved in an auto accident where she was struck in the rear by an uninsured motorist while backing onto a public street. The investigating officer's report con-

100. See *Plattenburg v. Allstate Insurance Company*, 918 F.2d 562, 563 (5th Cir. 1990) *Texas 'Bad Faith' Law Since Arnold & Aranda: Evolution of the 'Bona Fide Dispute' Defense*, 3 TEXAS BAD FAITH BULLETIN 1 April 1991, at 1-10.

101. *Marino v. State Farm Fire & Cas. Ins. Co.*, 787 S.W.2d 948, 950 (Tex. 1990).

102. 788 S.W.2d 136 (Tex. App.—Dallas 1990), *writ denied per curiam*, 802 S.W.2d 650 (Tex. 1990).

103. *Id.* at 146.

104. *Id.* at 147.

105. *Koral*, 802 S.W.2d at 651.

106. *Id.*

107. 918 F.2d 562 (5th Cir. 1990).

cluded that Plattenburg was at fault. Plattenburg later gave a recorded statement to an Allstate employee in the presence of her attorney of similar effect. Furthermore, Plattenburg received a citation for "back[ing] not in safety."¹⁰⁸

Plattenburg received \$5,000 from Allstate, which was the limit under the personal injury protection coverage of the insurance policy. Allstate denied payment on her claim for uninsured motorists' benefits based on its determination that Plattenburg caused the accident and was therefore excluded under the policy. Plattenburg sued Allstate, asserting it had breached its duty of good faith and fair dealing and was negligent in its claim handling.

The district court granted summary judgment for the insurer and the Fifth Circuit affirmed. The court held that Allstate "had a reasonable basis for believing that Plattenburg was at fault" given the officer's report, Plattenburg's own statement, and the citation.¹⁰⁹ The court stated that the facts at hand did not necessarily legally establish that Plattenburg caused the accident and therefore a summary judgment might not be appropriate in an ordinary automobile negligence case.¹¹⁰ Still, the court held Allstate met the standard in showing it had a reasonable basis for the denial.¹¹¹

Next, the court assumed that an insurance company has the duty to reasonably investigate claims.¹¹² Based on this assumption, the court held "a finding that an insurer had a reasonable basis to deny a claim constitutes a finding that the insurer reasonably investigated the claim."¹¹³ Therefore, since the court concluded that Allstate had a reasonable basis for denying the claim, it affirmed summary judgment on the action for negligent claim handling.¹¹⁴

In *St. Paul Guardian Insurance Co. v. Luker*¹¹⁵ the court of appeals reversed a jury award for damages caused by breach of the duty of good faith and fair dealing. St. Paul denied Luker's claim on the contents lost in a fire on grounds that the fire was caused by arson. On appeal, St. Paul argued insufficient evidence on the bad faith claim. St. Paul presented evidence that no one broke into the house, the Lukers had keys, and testimony of a witness who claimed to have seen Mr. Luker on the premises hours before the house burned. The Lukers offered rebuttal evidence that no personal belongings had been removed and that they were told by a real estate agent of a potential buyer for the house.

108. *Id.* at 563.

109. *Id.* (citing *Arnold and Aranda*).

110. *Id.*

111. *Id.*

112. *Id.* at 564.

113. *Id.*

114. *Id.* See 7 *Bad Faith Law Report*, 15, Feb. 1991 (argues there is no way the insurer can conduct a negligible investigation and still come up with a reasonable basis for denial.) The court imposed sanctions of \$500 against Plattenburg's attorney to warn all attorneys to be more selective in their choice of appellate cases and more efficient in their efforts as representatives. *Plattenburg*, 918 F.2d. at 564.

115. 801 S.W.2d 614 (Tex. App.—Texarkana 1990, no writ). For full discussion of the facts, see *supra* note 61 and accompanying text.

The court of appeals found insufficient evidence to support the jury finding of bad faith and reversed the award for exemplary damages.¹¹⁶ The court recognized the conflicting evidence but concluded that the Lukers did not provide sufficient evidence to show that St. Paul did not have a reasonable basis for denying the claim.¹¹⁷ And yet, after reviewing precisely the same evidence, the court found that there was sufficient evidence to support the jury's finding that the Lukers did not commit arson and were entitled to the policy proceeds.¹¹⁸

In *General Manufacturing Co. v. CNA Lloyd's of Texas*¹¹⁹ the court of appeals upheld the jury's findings of a reasonable basis for denial.¹²⁰ Rockwall manufactured and sold windows to homebuilders in the Dallas/Fort Worth area. Rockwall replaced over 10,000 cracked windows at a cost of over \$1.1 million in efforts to preserve business goodwill and mitigate damages. Rockwall then filed a claim with CNA for coverage under its comprehensive general liability policy. "CNA denied coverage based on the business risk/products exclusion in the policy."¹²¹ The jury found against Rockwall on its bad faith claims. The court of appeals agreed that the exclusion was properly applied to this situation and CNA was reasonable in denying payment.¹²²

In *Rangel v. Hartford Accident & Indemnification Co.*¹²³ the court extended the issue of reasonable basis for denial or delay only so far as the parties stipulated.¹²⁴ Rangel was injured on the job. He settled his compensation claim with Hartford, signing an agreement that stated: "The liability of the carrier or the extent of the injury or illness is uncertain, indefinite, or incapable of being satisfactorily established."¹²⁵ The Industrial Accident Board expressly approved the settlement agreement during a prehearing conference.

Rangel sued for breach of the duty of good faith and fair dealing in delaying payment of this claim. Hartford moved for summary judgment, contending that Rangel's suit was barred by the statement regarding uncertainty of liability of the carrier. Hartford relied on collateral estoppel, equitable estoppel, and judicial admissions.

The trial court rendered summary judgment for Hartford and the court of appeals affirmed. In applying *Aranda*, the court of appeals agreed with

116. *Id.* at 623.

117. *Id.* at 622.

118. *Id.* at 623. *But see* 10 TCLR 15, Jan. 1991 (one wonders how the court could find insufficient evidence of arson and also find insufficient evidence on bad faith. "[T]he jury determined there was no arson and thus there was no reasonable basis for denying the claim. Thus, the finding of bad faith cannot be said to be manifestly unjust.").

119. 806 S.W.2d 297 (Tex. App.—Dallas 1991, writ denied).

120. *Id.* at 298.

121. *Id.* at 299 (policy excluded "property damage to work performed by or on behalf of the named insured arising out of the work or any portion thereof, or out of materials, parts, or equipment furnished in connection therewith. . .").

122. *Id.*

123. No. 05-90-00678-CV (Tex. App.—Dallas, Aug. 13, 1991, writ requested).

124. *Id.* at 5.

125. *Id.* at 3.

Hartford that uncertainty of the carrier's liability or uncertainty of the extent of injury gave Hartford a reasonable basis for delaying payment.¹²⁶ The court held that Rangel was collaterally estopped from refuting the uncertainty of Hartford's liability by the settlement judgment determined in the workers' compensation proceeding.¹²⁷ The court further held that the disjunctive wording of the compromise agreement was insignificant in issue preclusion.¹²⁸ Finally, the court held that the uncertainty of liability as stipulated by the parties was a reasonable basis for denial of payment.¹²⁹

*Torchia v. Aetna Casualty and Surety Co.*¹³⁰ is similar to *Rangel*. Torchia sustained a work injury. Aetna provided the workers' compensation insurance. Aetna filed suit to set aside the Torchia award by the Industrial Accident Board. The parties settled on an agreed judgment whereby Aetna would pay Torchia \$32,500 cash and past medical expenses not to exceed \$35,500. Almost 18 months later, Torchia and his wife sued Aetna, claiming that Aetna had breached its duty of good faith and fair dealing in its disposition of Torchia's claims by settlement and agreement. Torchia argued that his release of claims against Aetna in the settlement was without consideration, a unilateral mistake, and procured through bad faith and disparate bargaining power. The trial court rendered summary judgment for Aetna on grounds that Torchia released any claims he had¹³¹ and the court of appeals affirmed.

The court of appeals held that the \$32,500 was consideration for release of both the worker's compensation and breach of duty of good faith and fair dealing claims.¹³² The court held that one consideration could support the release of more than one claim.¹³³ The court also held that the money served as consideration even though Aetna obtained the entire amount through subrogation.¹³⁴ It reasoned that Aetna was entitled by law to the subrogation amount so that the right to subrogation did not serve as an admission that only the compensation claim was released.¹³⁵ The court held Torchia was collaterally and judicially estopped from claiming lack of consideration since he previously conceded the uncertainty of Aetna's liability.¹³⁶

The judgment specifically provided that the settlement extended to all causes of action by Torchia arising out of the manner in which Aetna handled, settled, or defended any of Torchia's claims.¹³⁷ Further, Torchia exe-

126. *Id.* at 5.

127. *Id.*

128. *Id.* at 6.

129. *Id.*

130. 804 S.W.2d 219 (Tex. App.—El Paso 1991, writ denied).

131. *Id.* at 221.

132. *Id.* at 223.

133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.* at 224.

137. *Id.* at 222. The relevant portion of the judgment read:

The parties further expressly agreed that their settlement extends to all claims, demands, and causes of action, which cross-plaintiff [Torchia] may have now or

cuted an affidavit in which he acknowledged that if the court approved the settlement he would not be able to collect any further money based on Aetna's manner in handling, settling, or defending the claim.¹³⁸ Finally, Torchia admitted that the claim was uncertain.

The court held Aetna's duty of good faith ended when Torchia signed the release, and therefore Aetna could not be held liable for any acts amounting to bad faith.¹³⁹ This is especially so since the court further held that the parties acted with equal bargaining power.¹⁴⁰ Torchia could not persuade the court that he signed the release as a result of his unilateral mistake in failing to read the settlement documents first. The court held that parties have a duty to read what they sign and unilateral mistake is not grounds for rescission of a release, absent fraud in procuring the signature.¹⁴¹

In *Gomez v. Hartford Co. of the Midwest*¹⁴² several members of the Gomez family suffered injuries when they were hit by a truck driven by Hawthorne, who had been drinking at Dudley's. Gomez sued Dudley's, alleging negligence in serving alcoholic beverages to the already intoxicated Hawthorne. Dudley's had a Texas commercial multi peril policy issued by Hartford. Hartford refused to defend based on a "liquor liability" exclusion in the policy. Gomez received a \$7 million judgment, and Dudley assigned all claims against Hartford to Gomez.

Gomez then sued Hartford and its agent, alleging gross negligence and intentional bad faith in refusing to defend and settle the claims against Dudley's. The trial court granted summary judgment for Hartford, whose case was severed from the claims against the agent.

On appeal, Gomez argued that there was a fact issue whether the policy could reasonably be interpreted to impose the duty to defend all personal injury claims onto Hartford notwithstanding the exclusion. Gomez argued that Dudley's assumed the policy would include coverage for alcohol-related incidents since the policy was sold to a tavern. The court of appeals rejected this argument, because Dudley's belief as to what the policy covered did not raise a fact issue on coverage, absent allegations that Hartford or its agent represented to Dudley's that the policy did cover such incidents.¹⁴³

Gomez next argued that the policy provision affording coverage was ambiguous. The language in the policy read:

The Company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies. . . . This insurance does not apply:

in the future, arising out of the manner in which cross-defendant [Aetna], and its counsel, handled, settled, or defended any of the cross-plaintiff's claims under the Texas Workers' Compensation Act.

Id.

138. *Id.*

139. *Id.* at 223

140. *Id.* at 224-25.

141. *Id.* at 224.

142. 803 S.W.2d 438 (Tex. App.—El Paso 1991, writ denied).

143. *Id.*

(h) to bodily injury or property damage for which the insured or his indemnitee may be held liable

(1) as a person or organization engaged in the business of manufacturing, distributing, selling or serving alcoholic beverages. . . .¹⁴⁴

The court held that this language was unambiguous and therefore did not impose on Hartford the duty to defend.¹⁴⁵

Gomez argued that an insurer should not be allowed to represent coverage and defense of bodily injury or property damage and then later refuse to defend. The court rejected this argument, finding no claim or evidence that Hartford or its agent represented that the policy included defense and coverage to all suits seeking personal injury or property damages.¹⁴⁶

3. Recovery Allowed

*State Farm County Mutual Insurance v. Moran*¹⁴⁷ provides an example of an inadequate investigation by an insurer. Moran and his nephew, Rubio, attempted to tow Moran's truck by attaching a chain from Rubio's truck to Moran's. En route the tow chain got caught in the front axle of Moran's truck, causing it to hit Rubio's truck and then roll over. Shortly thereafter, Texas Department of Public Safety troopers arrested Rubio for driving while intoxicated. Moran was hospitalized after complaining of chest pains.

Moran subsequently filed claims under an automobile policy with State Farm that included basic liability coverage and personal injury protection and damages caused by uninsured/underinsured motorists. State Farm settled Moran's claim for property damage to his truck and \$2,461 for medical expenses covered under the \$2,500 person injury protection policy. Moran applied for additional benefits of \$25,000, alleging that Rubio, uninsured, contributed to the accident when another car entered their lane and Rubio lost control of his vehicle, which caused the tow chain to wrap around Moran's truck.

State Farm denied the claim for additional benefits on the ground that either the third car or Moran's own negligence caused the accident or that Moran assumed the risk when he allowed Rubio to tow his vehicle. Moran sued State Farm on the basis that he sustained injury as a direct and proximate result of Rubio's negligence, and that State Farm breached its duty of good faith and fair dealing by denying the claim without any reasonable basis or a proper investigation of the claim. The jury returned a verdict in favor of Moran, and the trial court awarded judgment on the verdict.¹⁴⁸

The appellate court overruled State Farm's challenge to the sufficiency of evidence that there was no reasonable basis to deny Moran's claim and found that State Farm would have known there was no basis for denial had

144. *Id.*

145. *Id.* at 442.

146. *Id.*; see also *Thornhill v. Houston Gen. Lloyds*, 802 S.W.2d 127, 130 (Tex. App.—Fort Worth 1991, no writ).

147. 809 S.W.2d 613 (Tex. App.—Corpus Christi 1991, writ denied). Note that this case was reversed on lack of evidence to support allegations of DTPA violations.

148. *Id.* at 617 (citing *Aranda*, 748 S.W.2d 210, 213 (Tex. 1988)).

it properly investigated the claim. The court referred to *Aranda*, holding that the insured must establish (1) the absence of a reasonable basis for denial or delay of payment of a claim and (2) that the insurer knew or should have known that there was not a reasonable basis for denial or delay.¹⁴⁹ The court held that, had State Farm conducted an investigation that included questioning both Rubio and Moran, it would have discovered that Rubio was attributed blame for the accident and that such an investigation would have revealed that no reasonable basis for denial existed.¹⁵⁰

*State Farm Mutual Automobile Insurance Co. v. Zubiata*¹⁵¹ also involved the failure to adequately investigate. Sylvia Zubiata suffered personal injury and damage to her vehicle when she collided with a truck in Juarez, Mexico. She filed claims with State Farm for collision, personal injury, and liability defense in Mexico since Mexican law permits civil or criminal charges against drivers, uninsured motorist coverage, and rental car proceeds. State Farm responded with a reservation of rights letter claiming there was a question as to whether the accident took place within twenty-five miles of the boundary of the United States, as required by her policy. Zubiata was denied rental car coverage because of the twenty-five-mile issue.

State Farm denied coverage based on the conclusion formed by its adjuster, who took a recorded statement from Zubiata, that the accident occurred 158 kilometers from the border, which is 98.7 miles. Zubiata received the denial letter forty-five days after the recorded statement took place. On June 30 State Farm received a letter from Zubiata's attorney stating that State Farm had erred on the twenty-five-mile border issue. State Farm responded with a promise to look into the issue again if the attorney could provide proof. No further correspondence took place between the attorney and State Farm.

Zubiata filed suit claiming breach of good faith and fair dealing. Shortly thereafter, State Farm hired an independent investigator to further investigate the Zubiata claim. The investigator interviewed the wrecker service company and an ambulance service, though not the correct service. The investigator concluded that the incident occurred more than twenty-five miles from the border by measuring a wall map with a ruler. Finally, fifteen months after the accident, State Farm requested that the investigator visit the site of the accident. The investigator reported that the accident did in fact take place within the twenty-five-mile coverage range. Two days later, State Farm's representative testified on deposition that the claims were denied on the ground that the accident occurred more than twenty-five miles from the point of entry, abandoning the twenty-five-mile-from-the-border argument. This was the first time in the case that point of entry was mentioned. Twenty months after the accident State Farm paid the collision, personal injury, liability defense costs, and uninsured motorists' claims.

At trial on the bad faith claim, the jury awarded the Zubiates \$165,000 in

149. *Id.* at 618.

150. *Id.*

151. 808 S.W.2d 590 (Tex. App.—El Paso 1991, writ denied).

mental distress damages and \$15 million in punitive damages, plus prejudgment interest. The court of appeals affirmed but reduced the punitive damages to \$600,000. The court held that a "cause of action for breach of duty of good faith and fair dealing will arise when 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."¹⁵² The court found evidence of bad faith in the fact that State Farm had denied coverage for more than fifteen months without conducting an on-site investigation and the fact that State Farm relied on the investigator's discussions with the wrecker and ambulance services, and on the Mexican police report in denying the claim.¹⁵³ The court also recognized that Zubiate contested State Farm's denial the entire time, suggesting that State Farm had a duty to investigate those disputes.¹⁵⁴ Furthermore, the court acknowledged that State Farm interposed its "'point of entry'" interpretation of the contract "too late in the 'game.'"¹⁵⁵

In *Seale v. American Motorist Insurance Co.*¹⁵⁶ the court of appeals held that a reasonable basis to deny a claim does not exist simply because the claimant has not yet incurred the expenses.¹⁵⁷ Patricia Seale suffered an on-the-job injury and made claim to her employer's workers' compensation carrier, American Motorist. The carrier referred Seale to Dr. Cloud, who recommended bariatric treatment for weight gain and other effects resulting from the work injury. American Motorist refused to authorize the treatment and refrained from investigating whether Seale's weight gain was a result of the work injury or whether the bariatric treatment was actually necessary. Seale sued for breach of the duty of good faith and fair dealing.

In reversing the summary judgment in favor of the carrier, the appeals court found a breach of the duty of good faith and fair dealing in the carrier's failure to investigate the propriety of the claim.¹⁵⁸ The court reasoned that unreasonable denial of necessary but unincurred medical expenses would cause additional financial burden on the injured.¹⁵⁹ Doctors would be reluctant to render medical assistance to an injured covered under a workers' compensation policy because they could not be certain whether the carrier would choose to contest the services based on necessity and/or reasonableness of charges.¹⁶⁰

In *Automobile Insurance Co. of Hartford Connecticut v. Davila*¹⁶¹ the court of appeals upheld a jury verdict finding breach of the duty of good faith and fair dealing due to lack of a reasonable basis for denial of the Davi-

152. *Id.* at 597.

153. *Id.*

154. *Id.* at 598.

155. *Id.*

156. 798 S.W.2d 382 (Tex. App.—Beaumont 1990, writ denied).

157. *Id.* at 903

158. *Id.* at 389.

159. *Id.* at 390.

160. *Id.* at 389.

161. 805 S.W.2d 897 (Tex. App.—Corpus Christi 1991, writ denied). For full discussion of the facts see *supra* note 71 and accompanying text.

las' claim as a result of a house fire.¹⁶² Fire broke out in an upstairs closet while the Davilas were contending with police after a domestic dispute. Donna Davila immediately accused her husband of starting the fire. Automobile Insurance denied the claim based on arson.

The insurer argued it had a reasonable basis for believing David Davila started the fire based on Donna Davila's initial accusation. The court disagreed and charged the insurer with failure to investigate the matter to determine whether there was a reasonable basis for denying payment based on the accusation of arson.¹⁶³ The evidence showed that the fire started in the upstairs closet which contained wiring for the bathroom whirlpool. The most intense charring from the fire was around the wiring. Still, the insurer never investigated the wiring. Also, the court found it implausible to suspect that David had started the fire with the police on the scene and while downstairs.¹⁶⁴ The court held the jury could have inferred that arson was impossible.¹⁶⁵

The court in *Commonwealth Lloyd's Insurance Co. v. Thomas*¹⁶⁶ upheld the jury determination of lack of reasonable basis. Fire destroyed the Thomas house on February 2, 1981, while the Thomas' were out of the country. On May 4, 1981, Commonwealth denied payment on the basis of arson. Thomas brought suit for breach of contract. The jury found for Thomas and the court of appeals affirmed.¹⁶⁷

After the Texas supreme court rendered the *Arnold* decision, Thomas sued Commonwealth for breach of duty of good faith and fair dealing. The jury found for Thomas again and the trial court awarded \$708,800 in actual damages, \$2,000,001 in exemplary damages, and \$1,000,637.60 in prejudgment interest.¹⁶⁸

Commonwealth argued that the evidence was insufficient to support the jury verdict and damages. The court concluded from *Arnold* that the trier of fact determines the reasonableness of the basis for denial or delay in payment and whether the insurer knew or should have known there was no reasonable basis.¹⁶⁹ Furthermore, a jury finding can be set aside only when it is "so contrary to the overwhelming weight of the evidence that it is clearly wrong and unjust."¹⁷⁰ The court found the jury findings supported by testimony offered by Thomas' expert fire investigator, who reported that Commonwealth's own investigation failed to identify the origin of the fire and, therefore, Commonwealth could have no reasonable basis for claiming arson.¹⁷¹

The court held that testimony that Commonwealth's agent neglected to

162. *Id.* at 903.

163. *Id.* at 905.

164. *Id.* at 906.

165. *Id.*

166. No. 05-90-00785-CV (Tex. App.—Dallas, Jan. 15, 1992).

167. *Commonwealth Lloyd's Ins. Co. v. Thomas*, 678 S.W.2d 278, 282 (Tex. App.—Fort Worth 1984, writ ref'd n.r.e.).

168. *Commonwealth Lloyd's Ins. Co.*, No. 05-90-00785-CV at 2.

169. *Id.* at 15 (citing *Arnold*, 725 S.W.2d at 167).

170. *Id.* at 14. (citing *Cain v. Bain*, 709 S.W.2d 175, 176 (Tex. 1986) (per curiam)).

171. *Id.* at 59.

tell Thomas the correct procedure in submitting claims was more evidence of breach of duty of good faith and fair dealing.¹⁷² Given this and expert testimony controverting arson, the court concluded the jury could infer lack of a reasonable basis for denial.¹⁷³

In *Beacon National Insurance Co. v. Reynolds*¹⁷⁴ Beacon denied Reynolds' claim for two stolen four-wheelers. Reynolds sued for breach of the duty of good faith and fair dealing. The trial court entered judgment in favor of Reynolds.¹⁷⁵

The court of appeals upheld the jury verdict, finding that Beacon had violated its duty of good faith and fair dealing.¹⁷⁶ The court relied on evidence that the company denied the claim without investigation and that no attempt was made to determine if the four wheelers were licensed as motor vehicles or farm equipment.¹⁷⁷ Beacon offered a letter at trial from an attorney who opined that case law would support excluding a four-wheeler from a homeowner's policy because it was a motor vehicle. The court held Beacon acted in bad faith in denying the claim before it requested and relied upon legal advice that the four-wheeler was a motor vehicle.¹⁷⁸ Furthermore, Reynolds did not receive any information regarding the denial of this claim until after he requested it.

D. Statute of Limitations

In *Murray v. San Jacinto Agency, Inc.*¹⁷⁹ the Texas supreme court held that the statute of limitations on an action for breach of the duty of good faith and fair dealing accrues on the date of wrongful delay or denial of payment.¹⁸⁰ Several decisions have been handed down within the last year expanding and interpreting the Murray holding. For example, in *Liberty Mutual Fire Insurance Co. v. Richards*¹⁸¹ the court of appeals held that *Murray* applies retroactively.¹⁸² Liberty Mutual terminated Richards' workers' compensation benefits without reason on January 12, 1983. Richards sued Liberty Mutual for breach of contract and was granted final judgment on April 30, 1986, with an award of \$80,000 compensatory damages and \$3.5 million in punitive damages. On March 7, 1986, she sued Liberty for bad faith. While this case was pending, the supreme court decided *Arnold*, holding that the two-year statute of limitations begins to run on an action for breach of the duty of good faith and fair dealing when the contract claims have been fully resolved.¹⁸³

172. *Id.* at 16.

173. *Id.* at 17.

174. 799 S.W.2d 390 (Tex. App.—Fort Worth 1990, writ denied).

175. *Id.* at 398.

176. *Id.*

177. *Id.*

178. *Id.* at 14.

179. 800 S.W.2d 826 (Tex. 1990).

180. *Id.* at 830.

181. 810 S.W.2d 232 (Tex. App.—Houston [14th Dist.] 1991, writ denied).

182. *Id.* at 234.

183. *Id.* at 233 (citing *Arnold*, 725 S.W.2d at 168).

The court of appeals reversed. The court recognized that *Murray* modified *Arnold* in holding that the cause of action for breach of good faith and fair dealing accrues when the injury is incurred, which is when the claim is denied and/or delayed and not the date the underlying contract claims are resolved.¹⁸⁴ Since the general rule is that a supreme court decision is retroactive and since there was no indication in the opinion to the contrary, the court held that *Murray* controlled Richards' cause of action, which was therefore barred by limitations as a matter of law.¹⁸⁵

The court of appeals in *Commonwealth Lloyd's Insurance Co. v. Thomas*¹⁸⁶ explored how the statute of limitations accrues on bad faith claims. Commonwealth denied payment to Thomas, alleging arson. Thomas sued on bad faith claims and Commonwealth argued the claim was barred by limitations.

On appeal, the court rejected Commonwealth's contention that the statute of limitations barred the claim.¹⁸⁷ Commonwealth relied on *Murray* in finding the suit barred, since Commonwealth denied the claim in 1981 and the Thomases filed suit in 1987.¹⁸⁸ The court of appeals conceded that Thomas had filed suit after the applicable statute of limitations, but because Commonwealth did not file its amended motion for judgment n.o.v. within thirty days after the judgment was signed, its amended motion regarding the statute of limitations was void.¹⁸⁹

Next, the court rejected the argument that *Arnold* should not be applied retroactively. The court relied on *Sanchez v. Schindler*, holding that retroactivity depends on the extent of public reliance on the former rule and the foreseeability of the change in the law.¹⁹⁰ The court reasoned that reliance is not an issue since insurers who act in good faith never need to rely on an action for bad faith.¹⁹¹ The court also held the *Arnold* decision foreseeable in that many other jurisdictions had already recognized a cause of action for breach of duty of good faith and fair dealing.¹⁹² The court of appeals considered whether courts could administer the *Arnold* rule without retroactive application and whether retroactive application would burden court efficiency. It concluded that the *Murray* modification to the limitation rule greatly reduces the negative effect retroactive application of *Arnold* might have.¹⁹³ Finally, the court justified retroactivity of *Arnold* since holding otherwise "favor[s] shielding a party from liability for bad faith."¹⁹⁴

184. *Id.* at 234.

185. *Id.* (citing *Sanchez v. Schindler*, 651 S.W.2d 249, 254 (Tex. 1983)).

186. *Commonwealth Ins. Co.*, No. 05-90-00785. For full discussion of facts see supra note 166 and accompanying text.

187. *Id.* at 7.

188. *Id.* (citing *Murray v. San Jacinto Agency, Inc.*, 800 S.W.2d 826 (Tex. 1990)).

189. *Id.* at 9.

190. *Id.* at 11 (citing *Sanchez v. Schindler*, 651 S.W.2d 249, 254 (Tex. 1983)).

191. *Id.*

192. *Id.*

193. *Id.* at 12.

194. *Id.*

*Beacon National Insurance Co. v. Reynolds*¹⁹⁵ defined the extent of limitations in a bad faith claim where the issue involved the identity of the specifically liable carrier. The carrier was a member of an insurance group whereby each company issued policies. Defendant argued plaintiff identified the wrong carrier in the initial pleadings. The court of appeals relied on the supreme court holding in *Enserch Corp. v. Parker* that indicated the statute of limitations is tolled when parties have "intentionally confusing identities and close ties," even though no party was injured by the confusion.¹⁹⁶ Beacon's cause of action was not barred by limitations even though outside the two-year period.

In *Tectonic Realty Investment Co. v. CNA Lloyd's of Texas Insurance Co.*¹⁹⁷ the court of appeals dealt with the difficulties in determining the date of accrual under *Murray*.¹⁹⁸ Fire destroyed TRICO's condominium project on July 5, 1984. CNA tentatively agreed that the cash value of the loss was \$973,929. CNA declined to pay the total loss in a lump sum, but instead offered to advance \$650,000 on September 26, 1984, and the remainder as repairs were made. TRICO accepted the \$650,000 and submitted a proof of loss (which reduced the deductible and payments already made from the agreed loss value).

TRICO then requested immediate payment of \$282,483, the difference between the proof of loss and the \$650,000 advance. TRICO's adjuster wrote CNA on November 1, 1984, contending CNA had no right to withhold payment pending repairs or audit of repairs. CNA responded on January 18, 1985, claiming that it did not deny coverage but was merely deferring payment until repairs were made or audited.

TRICO's attorney then sent a demand letter to CNA, threatening suit. On April 2, 1985, the first lien holder foreclosed on the property. On August 27, 1985, CNA paid \$380,000 into the court registry and interpleaded TRICO, the first lien holder, and others. TRICO filed a counterclaim against CNA on March 20, 1987, alleging breach of duty of good faith and fair dealing.

The court of appeals affirmed the summary judgment dismissing the bad faith claim on limitations. The court held the claim accrued when TRICO received CNA's January 18, 1985, letter. The court reasoned that TRICO's February 9, 1985, letter to CNA showed that TRICO knew it had a cause of action as a result of bad faith.¹⁹⁹

The court recognized the problems in determining the accrual date in situations involving delay in payment. It stated:

Insurance companies generally do not pay claims the day after the loss occurs. Even when the insurance carrier does not challenge its liability, the company will want an adjuster to investigate the claim and calculate

195. 799 S.W.2d 390 (Tex. App.—Fort Worth 1990, writ denied).

196. *Id.* at 395-96 (citing *Ensearch Corp. v. Parker*, 794 S.W.2d 2 (Tex. 1990)).

197. 812 S.W.2d 647 (Tex. App.—Dallas 1991, writ denied).

198. *Id.* at 652.

199. *Id.* at 653.

the loss. Once the adjuster or a claims analyst has confirmed the value of the claim, the company may still take a reasonable time to pay without giving the insured a cause of action.²⁰⁰

The court referred to *Murray's* recognition of "string[ing]" an insured but found no evidence that TRICO was strung out since CNA did not continuously promise to pay if TRICO remained patient.²⁰¹ The court explained that, as a matter of public policy, the insurer should not deny coverage and then wait weeks to inform the insured of the denial.²⁰² "Unreasonableness" with regard to delay in payment is the point at which the insured learns of the facts that would put a reasonable insured on notice of bad faith.²⁰³ The court concluded that a cause of action will normally accrue on the date the insured received a denial of coverage notice.²⁰⁴

E. Remedies

1. Punitive Damages

In *Pacific Mutual Life Insurance Co. v. Haslip*²⁰⁵ the United States Supreme Court set objective criteria for procedural protections in awarding punitive damages.²⁰⁶ Lemmie Ruffin, agent for Pacific Mutual, misappropriated insurance premiums remitted for health and life insurance by employees of Roosevelt City, including Haslip. As a result, the health coverage lapsed and notices were forwarded to Ruffin, though not to the insureds. Haslip discovered the errors when she incurred medical expenses but was denied coverage. Haslip sued Ruffin for fraud and Pacific Mutual under the theory of respondeat superior. The jury awarded \$1 million against the defendants, which included punitive damages exceeding four times the amount of compensatory damages. The state courts upheld the award and the United States Supreme Court affirmed, rejecting Pacific Mutual's due process challenge.²⁰⁷

Pacific Mutual argued that Ruffin acted individually and not within his authority as agent. As a result, the punitive damages were improperly focused on Pacific Mutual's financial status and not Ruffin's.²⁰⁸ The Court upheld the jury finding that Ruffin acted as an employee, stating it was supported by the record.²⁰⁹ The Court reasoned that imposing punitive damages under the theory of respondeat superior minimizes fraud by creating incentive for the insurer to control the agent.²¹⁰

200. *Id.* at 652.

201. *Id.* at 653 (citing *Murray*, 800 S.W.2d at 828, note 2).

202. *Id.* at 3.

203. *Id.* at 652.

204. *Id.* at 653.

205. 111 S. Ct. 1032 (1991).

206. See *Eichenseer v. Reserve Life Ins. Co.*, 934 F.2d 1377, 1385 (5th Cir. 1991).

207. *Id.* at 1035.

208. *Id.*

209. 111 S. Ct. at 1041. The agent had actual authority to sell the life insurance policies. He worked out of Pacific Mutual's branch office and corresponded on Pacific Mutual's letterhead for both life and health policies. 111 S. Ct. at 1040.

210. 111 S. Ct. at 1041.

The Court held that the punitive damages in this case did not violate the Due Process Clause of the Fourteenth Amendment.²¹¹ Recognizing the deterrent and retributive purposes in awarding such damages, the Court admitted that the instructions gave the jury significant but not unlimited discretion.²¹² The jury award was reviewed by the trial court in a post verdict hearing, where the Court balanced the amount of the award as compared to the goals of deterrence and retribution.²¹³ The Supreme Court found further procedural protection when the state supreme court reviewed the award and found that it was reasonable in light of its possible deterrent effect.²¹⁴

In *Eichenseer v. Reserve Life Insurance Co.*²¹⁵ the Fifth Circuit recently addressed the constitutional issues of punitive damages in light of *Haslip*. Eichenseer was hospitalized with acute pelvic inflammatory disease and underwent a complete hysterectomy. She made a claim for \$67,000 in medical bills to Reserve on a medical policy effective only eighteen days before her hospitalization. Reserve denied the claim, arguing that it was a preexisting illness, since Eichenseer's doctor noted that she had been experiencing pain during the prior two or three years. Reserve's defense for denial was reliance on the doctor's notes without any actual conversations with the doctor or any Reserve in-house physicians.

Reserve requested medical records, but lost the first set. Eichenseer sent a second set, but Reserve did not acknowledge receipt of them for two months. A Reserve employee told Eichenseer that the claim would not be paid until the doctor altered the medical records to clarify the length of symptoms. The doctor refused, believing it to be ethically prohibited, but he did agree to sign an affidavit that admits the patient had only suffered abdominal pains for two or three days, not years. Reserve received this affidavit, but claimed to have lost it.

Eichenseer demanded payment or an explanation. Two years after hospitalization, Eichenseer received a letter from Reserve, reaffirming its denial and basing that decision on the doctor's failure to correct the hospital records. Three years and three months after her initial request for payment, Reserve paid the claim. Eichenseer sued for contractual and extracontractual damages.

The trial court awarded \$1,000 compensatory damages and \$500,000 in punitive damages. Upon original consideration, the Fifth Circuit affirmed the punitive damages award.²¹⁶ The Supreme Court granted certiorari and remanded the case to the Fifth Circuit for reconsideration in light of

211. *Id.* at 1044.

212. *Id.* The instructions explain the deterrent purpose of punitive damages and the discretion the jury maintains in considering the amount of the award. *Id.* at 1037, n.1.

213. *Id.* at 1045.

214. *Id.* at 1046.

215. 934 F.2d 1377 (5th Cir. 1991). Although this case arose in Mississippi, it is relevant to Texas law since the court decided it under federal due process standards in light of *Haslip*.

216. *Id.* at 1380.

Haslip.²¹⁷

Again, the Fifth Circuit affirmed the punitive damages award.²¹⁸ The court held that under *Haslip* punitive damages are constitutional "if the circumstances of the case indicate that the award is reasonable and the procedure used in assessing and reviewing the award imposes a sufficiently definite and meaningful constraint on the discretion of the factfinder."²¹⁹ The court stated that under *Haslip* the amount of the award as compared to the amount of compensatory damages is not dispositive in determining constitutionality of the award, but instead serves as a relevant factor to be considered.²²⁰

The circumstances of the case create a narrow scope of review by which the appellate courts are to assess the reasonableness of the punitive damage award. The court stated that it is not the court's position to opine on the amount of the award, but instead "the court may only consider whether the circumstances of the case offer some support for the amount of the award."²²¹ The court stated

If there are any circumstances of probative force that support the amount of the award, then the award meets the "reasonableness" prong of the due process test in *Haslip*.²²²

The court concluded that Reserve's conduct in failing to interview the doctor, submit the claim to its own in-house physician, and respond to Eichenseer's attempt to activate a more thorough investigation, including competent clerical upkeep of records, was egregious and a significant factor that supported the award for punitive damages.²²³ The court also held consideration of Reserve's net worth of more than \$150 million was necessary to reach an award that achieves deterrence for future misconduct.²²⁴ Finally, the court reflected on a previous punitive damage award of \$150,000 against Reserve for similar conduct.²²⁵ The court held that this information is probably most relevant in assessing the proper amount of punitive damages since the previous amount did not effectively deter such conduct.²²⁶ Though Reserve argued the award unconstitutional per se because it was a 500 to one ratio of the compensatory damages, the court held the damages reasonable considering the evidence.²²⁷

The court reviewed the procedural safeguards implemented to control the discretion of the factfinder, including comprehensive jury instructions ex-

217. *Id.*

218. *Id.* at 1381-82.

219. *Id.* at 1382.

220. 934 F.2d at 1382.

221. *Id.*

222. *Id.* at 1383.

223. *Id.*

224. *Id.*

225. *Id.* at 1384. The previous case involved an incident where Reserve failed to investigate the medical history of the insured before it issued a policy and then denied a claim under the policy. See *Reserve Life Ins. Co. v. McGee*, 444 So.2d 803 (Miss. 1983).

226. 934 F.2d at 1384.

227. *Id.* at 1382.

plaining the nature and purpose of punitive damages, state laws limiting the amount and applicability of punitive damages, and forms of appellate review.²²⁸ The court found the procedural safeguards afforded under Mississippi law adequate to support the award in this case.²²⁹ Mississippi limits the amount to that which is necessary for effective specific punishment and deterrence, as well as is a warning to other tortfeasors.²³⁰ Mississippi courts also consider the financial worth of the defendant and the nature of the injury.²³¹ The court concluded that these criteria imposed by Mississippi law were sufficient in limiting the discretion of the court in the present case.²³² The court did find it significant that the award was given in a bench trial rather than by a jury.²³³ Still, the court stated that the fact the award was from the bench did not in itself support constitutionality, but instead afforded even more procedural safeguards since the court was required to explain in detail the basis for the award.²³⁴

In *State Farm Mutual Insurance Co. v. Zubiate*²³⁵ the court of appeals allowed the jury to consider evidence of the insurer's net worth in awarding punitive damages.²³⁶ State Farm denied coverage for an automobile accident that occurred within the Mexican border. The court of appeals upheld the jury verdict, finding State Farm negligent in its investigation of the accident.²³⁷ The court reflected on the evidence that State Farm denied coverage for over fifteen months without conducting an on-site investigation and despite Zubiate's continuing protest of the denial.²³⁸ The court also recognized that State Farm changed its initial interpretation of the policy provision excluding coverage on accidents outside twenty-five miles of the border to a "point-of-entry" angle.²³⁹ The court of appeals held that this evidence was sufficient to support punitive damages.²⁴⁰

The court rejected State Farm's assertion that introduction of evidence of net worth violated constitutional due process, equal protection, and fair trial rights.²⁴¹ The court instead held that evidence of net worth was proper in determining the amount necessary to produce a deterrent effect.²⁴² Citing *Haslip* the court did not find a due process violation since the jury was appropriately instructed on the intent and purpose of punitive damages, and the trial court conducted a post verdict hearing.²⁴³ The court concluded

228. *Id.* at 1385.

229. *Id.*

230. *Id.*

231. 934 F.2d at 1385.

232. *Id.*

233. *Id.*

234. *Id.* at n.13.

235. 808 S.W.2d at 590 (Tex. App.—El Paso 1991, writ denied).

236. *Id.* at 598

237. *Id.*

238. *Id.*

239. *Id.*

240. *Id.*

241. *Id.* at 602.

242. *Id.* at 602-603 (citing *Lunsford v. Morris*, 746 S.W.2d 471 (Tex. 1988); *Farah Mfg. Co. v. Alvarado*, 763 S.W.2d 529, 534 (Tex. Civ. App.—El Paso 1988, affirmed)).

243. *Id.* at 603, (citing *Pacific Mut. Life Ins. Co. v. Haslip*, 111 S. Ct. 1032, 113 L.Ed.2d 1

that the \$15 million award was not unconstitutionally excessive or in violation of due process since the jury was instructed to consider many factors in determining the amount.²⁴⁴

The court next determined, however, that the evidence was factually insufficient to support so large an award. The court suggested a remittitur that would reduce the award to \$660,000.²⁴⁵ In response to why the evidence was not sufficient to support the \$15 million jury award, the court said: "[b]ecause it just is."²⁴⁶

In *Automobile Insurance Co. v. Davila*²⁴⁷ the court of appeals upheld the jury verdict of breach of duty of good faith and fair dealing but overturned its award for exemplary damages.²⁴⁸ The court of appeals upheld the finding of breach of the duty of good faith and fair dealing based on evidence that the insurer neglected to investigate the point of origin of a fire, even though arson was suspected.²⁴⁹ Furthermore, there was evidence negating arson that the insurer could have found in a proper investigation. Also, the court held that since the insured was downstairs at the time of the fire, which was upstairs, the jury was justified in concluding that the insured could not have started the fire.²⁵⁰

The court concluded this same evidence insufficient, however, to show the insurer acted with a conscious indifference to support exemplary damages.²⁵¹ The court cited an example in *Underwriters Life Insurance Co. v. Cobb*²⁵² where it found the insurer's denial based on a cursory investigation sufficient to support exemplary damages since there were clear indications of agent misdealings and the insurer either performed a negligent investigation or ignored the result of the investigation.²⁵³ The court did not equate Automobile Insurance's denial to conscious indifference, as demonstrated in *Cobb*.²⁵⁴ It held that none of the evidence in the Davila case indicated that the insurer knew its denial was false when it denied the claim, explaining the reasoning behind the court's finding that the insurer lack conscious indiffer-

(1991) (upholding four-to-one ratio of punitive damages to contract damages against due process arguments)).

244. *Id.* at 604. The jury considered:

- (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 an award needed to deter similar wrongs in the future. *Id.*

245. *Id.* at 606.

246. *Id.* at 605.

247. 805 S.W.2d 897 (Tex. App.—Corpus Christi 1991, writ denied). For full discussion of the facts see *supra* note 71 and accompanying text.

248. *Id.* at 909.

249. *Id.* at 904.

250. *Id.* at 906.

251. *Id.* at 911.

252. 746 S.W.2d 810 (Tex. App.—Corpus Christi 1988, no writ).

253. *Davila*, 805 S.W.2d at 909, (citing *Cobb*, 746 S.W.2d at 817).

254. *Id.*

ence necessary to support punitive damages.²⁵⁵

In *Commonwealth Lloyd's Insurance Co. v. Thomas*²⁵⁶ the court of appeals found evidence supporting the jury award of more than \$2 million in punitive damages.²⁵⁷ Commonwealth denied the Thomases' claim as a result of a fire that destroyed their house, alleging arson. The court held Commonwealth's inadequate investigation evidenced conscious indifference because it focused only on leads consistent with arson and neglected to disclose suspicions of arson to the insured for his own defense.²⁵⁸ The court overruled Commonwealth's contention that the punitive damages were excessive, deprived it of property without due process of law, and violated the "excessive fines" provision of the Texas Constitution.²⁵⁹ The court found the ratio of exemplary to actual damages, three to one, proportionate.²⁶⁰ Nor did the amount of damages violate due process since the jury was properly instructed to consider the deterrent purpose of the damages.²⁶¹

In *Transportation Insurance Co. v. Moriel*²⁶² Moriel won an award from the Industrial Accident Board (IAB). The company appealed the award to the trial court and Moriel counterclaimed for the medical expenses. Prior to this, the trial court entered a partial judgment based upon a settlement agreement.²⁶³ The judgment indicated that the medical expenses were uncertain, but any liability arising from bad faith is excluded from the agreement of uncertainty.²⁶⁴ The final judgment included a jury award for Moriel of \$101,000 compensatory damages and \$1 million in punitive damages.²⁶⁵

Transportation appealed the punitive damage award, claiming the agreed settlement found the liability for medical expenses uncertain and that failure to pay those "uncertain" expenses cannot constitute heedless and reckless conduct. The court of appeals rejected this contention, noting that the "uncertainty" language appeared in the "preamble" portion of the judgment and is controlled by the "decretal" portion of the judgment.²⁶⁶ Furthermore, evidence showed that the partial judgment excluded bad faith claims from the uncertainty provision, and there was no evidence that Moriel agreed to

255. *Id.*

256. No. 05-90-00785-CV (Tex. App.—Dallas, Sept. 13, 1991, no writ) (not designed for publication). For full discussion of facts see *supra* note 166 and accompanying text.

257. *Id.*

258. *Id.* at 25.

259. TEX. CONST. art. I, §§ 13, 19.

260. *Commonwealth*, No. 05-90-00785-CV at 27 (citing *Pac. Mut. Life Ins Co. v. Haslip*, 111 S. Ct. 1032, 1044 (1991)).

261. *Id.* at 28. The instructions to the jury were "'Exemplary damages' means a discretionary amount awarded to the Plaintiffs that punishes the Defendant and serves as a warning to others situated like the Defendant to avoid committing like offenses or wrongs in the future." *Id.* at 27.

262. 814 S.W.2d 144 (Tex. App.—El Paso 1991, no writ).

263. *Id.* at 145.

264. *Id.* The partial trial court judgment read: "[a]nd it appearing to the Court that the extent of the injury and liability for compensation or medical expenses are uncertain and that under the agreement of settlement, Plaintiff Transportation Insurance Company, is to pay. . . ." *Id.*

265. *Id.*

266. *Id.*

the uncertainty of Transportation's liability.²⁶⁷

The court held that the jury could have inferred heedless and reckless conduct from evidence showing that the insurance company believed the nature of the injury (impotence) would dissuade litigation and, as a result, made a conscious decision to implement inconsistent and delayed action regarding the claim.²⁶⁸ The carrier delayed payment of claims for a period of years and required letters from Moriel's doctors, confirming the necessity of treatment and testing for sleep disorders and impotency.

Citing *Haslip*, the court rejected the argument that the punitive damage award violated federal and state constitutions.²⁶⁹ The court held that the jury was properly given guidelines by which to assess punitive damages such as: the nature of the wrong, the character of the conduct involved, the degree of culpability of the wrongdoer, the situation and sensibilities of the parties, the extent to which such conduct offends a public sense of justice and propriety, the frequency of the wrong committed, and the size of the award necessary to deter similar wrongs in the future.²⁷⁰

2. *Mental Anguish*

The court in *State Farm Mutual Automobile Insurance Co. v. Zubiato*²⁷¹ upheld mental anguish damages.²⁷² State Farm denied Zubiato's claim based on a policy exclusion of accidents that occur within twenty-five miles of the Mexican border. State Farm also denied a defense in Zubiato's criminal prosecution in Mexico. Payment of Zubiato's claim was delayed for more than fifteen months. State Farm argued on appeal that the evidence did not support mental anguish damages since there was no evidence of physical manifestations.

Relying on *St. Elizabeth Hospital v. Garrard*, the *Zubiato* court held that proof of physical manifestations is not required to recover for negligent infliction of mental anguish.²⁷³ The court conceded that the accepted standard of recovery for mental anguish demanded that the plaintiff prove more than mere worry, anxiety, vexation, embarrassment or anger.²⁷⁴ The court recognized that part of the proof of mental anguish includes the witnesses' demeanor, voice modulation, and feelings they project to the jurors.²⁷⁵ The court also recognized that the evidence of events in the plaintiff's life as a

267. *Id.* at 146.

268. *Id.* at 148.

269. *Id.* at 149.

270. *Id.* at 150.

271. 808 S.W.2d 590 (Tex. App.—El Paso 1991, writ denied). For full discussion of facts see *supra* note 147 and accompanying text.

272. *Id.* at 599 (citing *St. Elizabeth Hosp. v. Garrard*, 730 S.W.2d 649, 654 (Tex. 1987)).

273. *Id.* (citing *Town East Ford Sales v. Gray*, 730 S.W.2d 796, 803-804 (Tex. App.—Dallas 1987, no writ); *Ryder Truck Rentals v. Latham*, 593 S.W.2d 334 (Tex. Civ. App.—El Paso 1979, writ ref'd n.r.e.)).

274. *Id.* at 599-600 (citing *Herbert v. Herbert*, 754 S.W.2d 141, 147 (Tex. 1988)).

275. *Id.* at 600 (citing *City of Ingleside v. Kneuper*, 768 S.W.2d 451, 460 (Tex. App.—Austin 1989, writ denied)).

result of the injury is equally important.²⁷⁶

Zubiate testified that she felt intimidated, confused, frightened, angry, scared, and devastated by the treatment she received from State Farm. She detailed the trouble she had in appearing frequently in Mexico to contend with the criminal charges. Zubiate's husband testified about the economic harm caused by State Farm's denial, including damage to his credit when he stopped making payments on the wrecked vehicle. Other testimony showed that the State Farm representative demanded that Mr. Zubiate obtain a copy of the Mexican police report, while State Farm later obtained a copy but refused to provide a copy to the insureds.

The court concluded that, given the existence of mental anguish, there are no objective facts by which to quantify that anguish.²⁷⁷ The court held that much discretion must be given to the jurors and that no court is free to replace the jury award.²⁷⁸

The court of appeals upheld a jury award of damages for emotional distress in *Davila*.²⁷⁹ The insurer denied Davila's claim based on Mrs. Davila's initial accusation that her husband started the house fire. The trial court and court of appeals found evidence supporting a breach of the duty of good faith and fair dealing since the insurer did not investigate the incident to determine how the fire actually occurred.²⁸⁰ The Davilas did not testify as to their emotions or mental distress as a result of the denial. Nor was there any other form of direct evidence supporting damages for mental anguish.

The court of appeals held that circumstantial evidence supported the award of \$20,000 each for past mental anguish suffered as a result of the denial of the claim.²⁸¹ The court recognized that the emotional distress found by the jury would have to be inferred from the unrepaired condition of the house and the Davila's shortage of clothes and furniture since they were unable to replace them without insurance coverage.²⁸² Mr. Davila testified that they were forced to live in the downstairs part of the house. Mrs. Davila testified that they were without clothing for five months after the fire. They both testified to incurring large telephone bills in efforts to procure cooperation with the insurer. The court also relied on evidence that the Davilas were of the sort to react with intense emotions to events.²⁸³ Yet, the court did not find evidence to support the award of future mental anguish damages.²⁸⁴

In *Commonwealth Lloyd's Insurance Co. v. Thomas* the court of appeals held that evidence of loss of business and credibility with business associates, as well as deteriorative living conditions, supported the jury's award for

276. *Id.* at 601.

277. *Id.*

278. *Id.*

279. *Automobile Ins. Co. of Hartford Conn., v. Davila* 805 S.W.2d 897, 907. For full discussion of the facts see *supra* note 71 and accompanying text.

280. *Id.* at 907.

281. *Id.* at 908.

282. *Id.*

283. *Id.* at 907.

284. *Id.* at 908.

mental anguish damages.²⁸⁵ Thomas testified that the local newspaper covered the fire that burned his house and that business associates were aware of the arson accusations. This, in turn, affected his ability to borrow money to facilitate the Thomases' real estate and home building businesses. Having moved from their home to a hotel apartment and then, ultimately, into a travel trailer caused stressful living conditions. The court also considered Commonwealth's direct contacts with the Thomases in upholding damages for mental anguish.²⁸⁶

3. *Prejudgment Interest*

In *Potomac Insurance Co. v. Howard*²⁸⁷ Potomac issued an insurance policy to Howard with uninsured motorists policy limits of \$45,000. Howard sued Potomac for breach of contract and breach of the duty of good faith and fair dealing after she was denied coverage for injuries she sustained from a hit and run accident. The trial court awarded Howard the policy limits of \$45,000 plus prejudgment interest at the rate of ten percent compounded daily.

On appeal, Potomac asserted that the trial court award exceeded the policy limits and was, therefore, improper. Potomac further argued that the prejudgment interest was for damages and not for the use of money. The court affirmed the trial court award, holding that "[i]f a judgment provides plaintiffs only the amount of damages sustained at the time of the incident, plaintiffs are not fully compensated."²⁸⁸ The court reasoned that prejudgment interest promotes quick compensation to victims and ensures that the plaintiff receives the actual amount of his loss.²⁸⁹

In *Commonwealth Lloyd's Insurance Co. v. Thomas* the court of appeals remanded the case solely to recompute the Thomases award of prejudgment interest, using an arbitrary accrual date of six months after the date of the incident giving rise to their cause of action.²⁹⁰ Commonwealth denied coverage for damages caused by a house fire, alleging arson. Thomas sued for breach of the duty of good faith and fair dealing. The court of appeals upheld the jury verdict for Thomas.²⁹¹

The court held that prejudgment interest damages are allowed to compensate the plaintiff for the loss of the available use of money from the time of injury to the date of judgment.²⁹² Thomas argued the date of claim denial was the date of injury. The court relied on *Cavnar v. Quality Control Parking, Inc.* where the supreme court adopted an arbitrary date of accrual of six

285. *Commonwealth Ins. Co.*, No. 05-90-00785-CV at 19-20. For full discussion of the facts see *supra* note 166 and accompanying text.

286. *Id.*

287. 813 S.W.2d 557 (Tex. App.—Houston [14th Dist.] 1991, no writ).

288. *Id.* at 558.

289. *Id.*

290. *Commonwealth Lloyd's Ins. Co.*, No. 05-90-00785-CV at 30.

291. *Commonwealth* at 30.

292. *Id.* at 28.

months after the incident giving rise to the cause of action.²⁹³ In *Cavnar* the supreme court reasoned that a system requiring litigants to determine the precise date when each element of damage was incurred “would impose an onerous burden on both the trial bench and bar.”²⁹⁴ Although the *Cavnar* court applied this arbitrary method of determining prejudgment interest to tort actions of wrongful death, personal injury, and survival action, the court of appeals found *Cavnar*’s holding compelling and applicable in this case.²⁹⁵ The court of appeals remanded the case for the sole purpose of recalculating prejudgment interest, using an accrual date that was six months after the denial of the claim.²⁹⁶

4. Other

a. *Loss of Credit*. The court of appeals reversed a jury award for damages for past and future loss of credit in *Automobile Insurance Co. v. Davila*²⁹⁷ The Davilas’ house burned, but Automobile Insurance denied their claim, alleging arson. The Davilas stopped making payments on furniture purchased on credit before the fire because all their savings went to new clothing and necessary household repairs. After repeated demands for payment, the Davilas returned the furniture to the creditor for a credit on the unpaid balance. There was no evidence of harm to their credit as a result of the incident, other than Mrs. Davila’s testimony that their credit was “totally ruined.” The court held that the evidence reflected only a scintilla that the Davilas suffered credit loss as a result of the insurer’s denial.²⁹⁸

b. *Loss of Consortium*. In *Torchia v. Aetna Casualty & Surety Co.*²⁹⁹ Torchia accepted \$32,500 in exchange for his release of Aetna for any liability that arose out of the way Aetna “handled, settled, or defended” any of Torchia’s workers’ compensation claims. Eighteen months after the settlement, Torchia sued Aetna for breach of the duty of good faith and fair dealing, alleging lack of consideration for the settlement agreement, unilateral mistake, and disparity in bargaining power. Torchia’s wife alleged loss of consortium resulting from Aetna’s negligence in handling her husband’s compensation claim.

Relying on *Whittlesey v. Miller*, the court recognized that a release by Torchia could not preclude his wife’s claim for loss of consortium.³⁰⁰ Still, Torchia’s unconditional approval of the final judgment and affidavit confirming the uncertainty of Aetna’s liability gave Aetna a reasonable basis for

293. *Id.* at 30 (citing *Cavnar v. Quality Control Parking, Inc.*, 696 S.W.2d 549 (Tex. 1985)).

294. *Cavnar*, 696 S.W.2d at 555.

295. *Commonwealth*, No. 05-90-00785-CV at 31.

296. *Id.*

297. 805 S.W.2d at 909. For full discussion of facts see *supra* note 71 and accompanying text.

298. *Id.*

299. 804 S.W.2d 219 (Tex. App.—El Paso 1991, writ denied). For full discussion of the facts see *supra* note 130 and accompanying text.

300. *Id.* at 225. (citing *Whittlesey v. Miller*, 572 S.W.2d 665, 667 (Tex. 1978)).

not paying compensation.³⁰¹ Therefore, neither Torchia nor his wife could show that Aetna was liable for any injuries sustained by Torchia as a result of Aetna's refusal to pay compensation.

III. DECEPTIVE TRADE PRACTICES ACT

A. *Standing to Sue*

In *Employers Casualty Co. v. International Trucking Co.*³⁰² the court of appeals defined "consumer" with regard to recovery under the DTPA.³⁰³ A truck owned by International collided with a truck owned by Williams Drilling Company. International sued Williams for negligence. International also sued Williams' insurers, Employers Casualty Co. and Employers National Co., and two claims adjusters, Page and Veale, for deceptive trade practices and unfair insurance practices. International nonsuited Williams. The claims against Page were based on allegations that she contacted International shortly after the accident and instructed the president, Alexander, to initiate repairs and she would assist in the matter in any way. After completion of repairs, Veale denied payment as representative of the insurer.

The trial court granted all defendants summary judgment on the unfair insurance practice claims.³⁰⁴ The court then granted directed verdicts for Page and Veale, but the jury found the insurers had knowingly violated the DTPA and caused damages to International, awarding treble damages.³⁰⁵

On appeal, the court addressed whether International was a "consumer" so that it could maintain a cause of action under the DTPA.³⁰⁶ The statute requires that the claimant sought or acquired goods or services.³⁰⁷ International relied on *Hermann Hospital v. National Standard Insurance Co.*³⁰⁸ in arguing it was a consumer of the "settlement services" rendered by Page and Veale and as an intended beneficiary under the automobile liability policy owned by Williams.³⁰⁹ In *Hermann Hospital* the court allowed a hospital to recover from a patient's insurer for misrepresentations regarding the patient's coverage.³¹⁰ The court rejected the *Hermann* analogy because it held the controlling factor in *Hermann* was the express and direct relationship the insurer had with a health care provider.³¹¹

301. *Id.*

302. No. 04-90-00012-CV (Tex. App.—San Antonio, June 26, 1991).

303. *Id.* at 132.

304. *Id.* at 131.

305. *Id.*

306. *Id.* at 132. See also TEX. BUS. & COM. CODE ANN. § 17.45(4) (Vernon 1987) ("consumer" is "an individual, partnership, corporation, this state, or a subdivision or agency of this state who seeks or acquires by purchase or lease, any goods or services, except that the term does not include a business consumer that has assets of \$25 million or more, or that is owned or controlled by a corporation or entity with assets of \$25 million or more").

307. *Id.* at 133 (citing *Hi-Line Elec. Co. v. Travelers Ins. Co.*, 587 S.W.2d 488 (Tex. Civ. App.—Dallas 1979), writ ref'd per curiam, 593 S.W.2d 953 (Tex. 1980)).

308. 776 S.W.2d 249 (Tex. App.—Houston [1st Dist.] 1989, writ denied).

309. *Employers Casualty Co.*, No. 04-90-00012-CV at 134-136.

310. *Hermann Hosp.*, 776 S.W.2d at 253.

311. *Employers Casualty Co.*, No. 04-90-00012-CV at 135.

The court recognized that Texas law finds an injured party to be a third-party beneficiary, but that party cannot enforce the policy directly against the insurer until the insured's legal obligation to pay damages to the injured party has been established by judgment or agreement.³¹² The court concluded that International lacked standing to sue as a consumer under the DTPA since the liability of the insured had not previously been established.³¹³

B. Actionable Conduct

1. Recovery Denied

In *State Farm County Mutual Insurance Co. v. Moran*³¹⁴ the insured denied Moran's claim for uninsured motorist benefits, arguing that Moran assumed the risk of incurring damages when he allowed his nephew to tow his truck by attaching a chain between the two vehicles. Moran sued under the DTPA, alleging that when he initially purchased the policy State Farm misrepresented the extent of coverage when referring to it as "full coverage."

On appeal, the court agreed with State Farm that the evidence did not support a jury finding that State Farm had violated the DTPA. The court determined that State Farm made no misrepresentation when it told Moran he had "full coverage" under the policy.³¹⁵ The court concluded that State Farm's representation was a term of art used in the insurance industry to describe a level of insurance coverage.³¹⁶ Therefore, Moran did not receive anything less than a full coverage policy as represented by State Farm.³¹⁷

2. Recovery Allowed

In *Weyant v. Acceptance Insurance Co.*³¹⁸ the Weyants purchased cargo, liability, and collision insurance on their flatbed truck from Acceptance (out-of-state insurer) through Southwestern (independent surplus lines agent). Acceptance had authority to provide insurance in Texas through Southwest-

312. *Id.* at 136 (relying on *Great Am. Ins. Co. v. Murray*, 437 S.W.2d 264, 265 (Tex. 1969) (established injured as third-party beneficiary) and *State Farm County Mut. Ins. Co. v. Ollis*, 768 S.W.2d 722 (Tex. 1989) (insured's liability must be established)).

313. *Id.* at 137. International also brought causes of action under article 21.21 of the Texas Insurance Code. The court used the same analysis, requiring that International qualify as a consumer to have standing to sue. Article 21.21 does not require the injured be a consumer but merely a "person". While the DTPA and article 21.21 overlap in granting the same cause of action for the same types of conduct, excluding unconscionability and breach of warranty under the DTPA, article 21.21 is more expansive because it offers actionability on the claims to anyone who has suffered damages. See 10 TCLR 206, Sept. 1991.

314. 809 S.W.2d 613 (Tex. App.—Corpus Christi 1991, writ denied). For full discussion of facts see *supra* note 147 and accompanying text.

315. *Id.* at 621.

316. *Id.*

317. *Id.* But see *Pennington v. Singleton*, 606 S.W.2d 682, 687 (Tex. 1980) (holding that misrepresentations of material fact not the result of "puffing" or opinion are actionable under the DTPA even though they may be broad descriptions);

318. 917 F.2d 209 (5th Cir. 1990).

ern from article 1.14-2 of the Texas Insurance Code.³¹⁹ Mr. Weyant asked Southwestern to cancel his policies. Southwestern, in turn, forwarded notices of cancellation. Weyant then requested that the unearned premiums on the cancelled cargo and liability policies be applied to "save" the collision policy. Southwestern instructed Weyant to disregard the cancellation notice on the collision policy, but never forwarded a written endorsement. Later, Weyant filed a claim for damages to the flatbed. Acceptance denied the claim, asserting that the policy had lapsed. Two days later, Weyant received a check from Southwestern representing a refund of the unearned premiums from the three policies. Weyant sued Acceptance, alleging misrepresentations in violation of the DTPA.

The trial court held that since Southwestern never received written approval from Acceptance to reinstate the policy, then it acted outside its contractual and statutory authority.³²⁰ The trial court granted summary judgment for Acceptance.³²¹

The Fifth Circuit reversed. The court found evidence that the agency agreement between Southwestern and Acceptance specified that Southwestern has discretion in cancelling policies.³²² The court held that Southwestern's reinstatement assurances were actually retractions of notice to cancel since they were made before the effective date of cancellation.³²³ Furthermore, the trier of fact could infer the implied or apparent authority to retract a cancellation from the express authority to cancel a policy.³²⁴

The court then considered Southwestern's statutory authority as a surplus lines agent. The court held that neither article 1.14-2 nor the agency contract specifically determined Southwestern's authority as surplus line agent.³²⁵ The court found the present situation similar to other cases dealing with the scope of a surplus lines agent's duties. In *Bellefonte Underwriters Insurance Co. v. Brown* the court of appeals found a principal-agent relationship between the surplus line agent and the unauthorized insurer based on evidence that the surplus line insurer assisted in the risk evaluation of the insured, provided policy forms, collected premiums, and delivered the policies to the insureds.³²⁶ In *Foundation Reserve Insurance Co. v. Wesson* an-

319. TEX. INS. CODE ANN. art. 1.14-2 (Vernon 1987) (unauthorized insurer may provide insurance in Texas through licensed independent surplus line insurer).

320. *Id.* at 212 (contract between Acceptance and Southwestern requires specific approval for agent authorization of changes); TEX. INS. CODE ANN. art. 1.14-2, § 6(d) (surplus line agent must obtain written approval from surplus line insurer to reinstate policy) and 6(e) (requires written document evidencing any change made to surplus line policy).

321. *Id.* at 209.

322. *Weyant*, 917 F.2d at 212. The agreement states: "The Agent shall not obligate the Company beyond the limitations set forth herein or as specified in instructions issued by the Company, either orally or in writing, or alter, modify, waive or change any of the terms, rates or limitations of the Company's policies. . . ." *Id.* "[T]o cancel such policies is the discretion of the Agent, where such cancellation is legally possible. . . ." *Id.*

323. *Id.* (reasoning that it would be impossible to reinstate a policy that had never effectively been cancelled).

324. *Id.* at 213.

325. *Id.*

326. *Id.* at 214 (citing *Bellefonte Underwriters Ins. Co. v. Brown*, 663 S.W.2d 562, 585-86 (Tex. App.—Dallas 1983, writ denied)).

other court of appeals determined that status as a surplus line agent does not determine the agent's authority.³²⁷ The issue of scope of authority must be determined by all the circumstances.³²⁸ The court concluded that this was a genuine issue for the trier of fact so that summary judgment was inappropriate for determining Southwestern's scope of authority as surplus line agent for Acceptance.³²⁹

IV. CONTRACT CLAIMS

A. Policy Interpretation

In *McLaren v. Imperial Casualty and Indemnity Co.*³³⁰ Imperial insured the City of Bedford, the Bedford Police Department and employees of both. The policy in question covered damages resulting from "wrongful acts arising out of Law Enforcement activities."³³¹ Furthermore, the policy specified that the insurer was obligated to defend the insured only when the claims were against the insured as a result of acts or omissions during the scope of employment.

McLaren sued Taylor, a Bedford police officer, for sexual assault. Taylor notified Imperial of the claim and Imperial denied coverage, arguing the assault was not an activity of law enforcement or within the scope of employment.³³² Taylor also demanded defense and Imperial refused. McLaren took a \$7,018,045 judgment against Taylor, and later Taylor assigned his rights against Imperial to McLaren.

McLaren sued Imperial for failure to pay her claims on Taylor's behalf and failure to defend Taylor. The district court first addressed the issue of whether Taylor committed the sexual assault during the scope of his employment. Evidence showed that Taylor was on duty and in his patrol car during the incident. Still, the court found that Taylor's acts were not in the furtherance of law enforcement but, instead, were committed for purposes of personal desires.³³³

McLaren argued the defendants were collaterally estopped from questioning the existence of scope of employment since she was awarded attorney's fees when the district court found Taylor acted under the color of state law at the time of the assault and therefore, acted within the scope of his employment. The court relied on *Hargis v. Maryland American General Insurance Co.* in holding that the issues of the insured's liability and of coverage are separate, so that prior judgment on liability does not resolve issues of coverage.³³⁴ Furthermore, the court reasoned that no privity of contract existed

327. *Id.* (citing *Foundation Reserve Ins. Co. v. Wesson*, 447 S.W.2d 436, 438 (Tex. Civ. App.—Dallas 1969, writ ref'd)).

328. *Foundation*, 447 S.W.2d at 438.

329. *Weyant*, 917 F.2d at 215.

330. 767 F. Supp. 1364 (N.D. Tex. 1991).

331. *Id.* at 1367.

332. *Id.*

333. *Id.* at 1371.

334. *Id.* at 1372 (citing *Hargis v. Maryland American*, 567 S.W.2d 923 (Tex. Civ. App.—Eastland 1978, writ ref'd n.r.e.)).

between McLaren and Imperial, thus precluding the application of collateral estoppel.³³⁵

McLaren argued that the duty to defend exists, despite conclusive proof of lack of coverage. The court rejected the "allegations of complaint" rule where the duty to defend depends on the allegations of the underlying complaint, whether true or not.³³⁶ The court held that such a rule arises when the insurer refuses to defend on the basis that the insured is not liable.³³⁷ Here, the insurer has the duty to defend. The rule is also applicable when the allegations included facts that fall within an exclusion in the policy.³³⁸ The insurer has no duty to defend in this instance. The court concluded that this case involved allegations of the second category since the liability of Taylor was not the result of acts committed in the furtherance of his employment.³³⁹

McLaren argued that Imperial was estopped from claiming an exclusion from coverage because the policy was not approved by the State Board of Insurance. The court rejected this argument, holding that there was no evidence the form of the policy was not approved.³⁴⁰ Also, the court reasoned that denial of coverage was not based on a policy exclusion, but instead was based on the policy language which limited the extent of coverage.³⁴¹ Finally, the court could find no damage to Taylor from Imperial's failure to defend and/or failure to obtain approval over the policy form from the State Board of Insurance.³⁴² The court ordered judgment denying recovery to McLaren on any basis alleged and pleaded.³⁴³

In *Balderama v. Western Casualty Life Insurance Co.*³⁴⁴ the Balderamas purchased accident and sickness insurance from Western. Upon the insurer's acceptance, Balderama received four documents, including a copy of the application, the "Catastrophic Medical Hospital Policy," the "Accident Policy," and an endorsement. The hospital policy specified no coverage over newborns, while the accident policy referred to the policy schedule in the application, which recognized coverage of newborns, including those with congenital defects.

One year after receiving these documents the Balderamas had a fourth child. When they claimed for the newborn's medical expenses resultant from health problems, Western denied, asserting that the newborn was not covered because she was not named in the application. The Balderamas sued for breach of contract, negligence, breach of the duty of good faith and fair dealing, DTPA violations, and Insurance Code violations.

Specifically, the Balderamas alleged that Western violated article 3.70-

335. 767 F. Supp. at 1372.

336. *Id.*

337. *Id.*

338. *Id.* at 1373.

339. *Id.*

340. 767 F. Supp. at 1376.

341. *Id.*

342. *Id.*

343. *Id.*

344. 35 Tex. Sup. Ct. J. 46 (Tex. 1991).

2(E) of the Texas Insurance Code by issuing a single policy that excluded coverage on congenital defects of newborns.³⁴⁵ The district court held that there were two individual policies and, therefore, the Insurance Code was not violated.³⁴⁶ The court of appeals affirmed.³⁴⁷

The Texas supreme court reversed.³⁴⁸ Western argued that the documents constituted two separate policies. Alternatively, Western argued that even if the documents were viewed as one policy, that one policy provided two separate coverages. The supreme court disagreed, holding that the "Accident Policy" could not stand on its own because it lacked the policy schedule.³⁴⁹ Furthermore, the fact that there was a single policy number and a single monthly premium suggested one policy.³⁵⁰ The court concluded that the policy violated the Insurance Code since it did not provide the same extent of coverage for the newborn as it did for the other Balderama children.³⁵¹

In *Gaulden v. Johnson*³⁵² a rear-end collision resulted when Gaulden slowed to prevent hitting Johnson. Leimer hit Gaulden instead. Gaulden sued Johnson, uninsured, and Leimer, insured. Gaulden later settled with Leimer without the consent of Gaulden's insurer, USF&G. Gaulden then got a default judgment against Johnson and sought to recover from USF&G under her uninsured motorist coverage. USF&G denied coverage under a clause in the policy that refuses uninsured/underinsured motorist coverage for any insured who settles without the insurer's consent.³⁵³ USF&G asserted that "the claim" referred to any claim against any person, insured or uninsured, arising out of the accident at issue. According to this interpretation, Gaulden's settlement with Leimer would prevent Gaulden from collecting on her claim against Johnson. The trial court granted summary judgment for USF&G.³⁵⁴

The court of appeals reversed, finding the policy ambiguous.³⁵⁵ The court held that the language was not standard.³⁵⁶ Furthermore, the language was included in the section of the policy dealing with an uninsured/underinsured motorist, which "leads the reader to the logical conclusion that it refers to claims against those types of motorists."³⁵⁷

345. TEX. INS. CODE ANN. art. 3.70-2(E). This section of the code prohibits issuance of an accident/sickness policy that covers newborns but limits coverage to a particular time frame or excludes congenital defects. Coverage for newborns should be to the same extent as coverage for other applicable children.

346. *Balderman*, 35 Tex. Sup. St. J. at 46.

347. *Id.*

348. *Id.*

349. *Id.* at 48.

350. *Id.*

351. *Id.*

352. 801 S.W.2d 561 (Tex. App.—Dallas 1990, writ denied).

353. *Id.* at 563. The provision states "[w]e do not provide Uninsured/Underinsured Motorists Coverage for any person . . . If that person or the legal representative settles the claim without our consent." *Id.*

354. *Id.* at 562.

355. *Id.* at 564.

356. *Id.*

357. *Id.*

USF&G relied on language in the policy giving it subrogation rights and requiring that the insured do nothing to prejudice those rights. The court reasoned that USF&G could validly require a right to be subrogated, but that the language in the policy did not clearly place the insured on notice that she should not settle with anyone involved in the accident or else forfeit her right to uninsured coverage.³⁵⁸

In *Upshaw v. Pleasant*³⁵⁹ the court of appeals addressed the issue of intra policy stacking of underinsured motorist coverage.³⁶⁰ George Upshaw died as the result of an accident with Pleasant. The decedent had a single multi vehicle insurance policy issued by Trinity Companies, providing uninsured/underinsured motorist protection for \$20,000 per person and \$40,000 per accident. Trinity tendered \$20,000, but Upshaw's executors contended they were entitled to the \$40,000.

During the suit against the driver for negligence and against Trinity, the executors sought declaratory relief to determine that the uninsured/underinsured motorist coverage could be intra-stacked to recover the \$40,000, based on the fact that there were multiple vehicles insured under one policy.³⁶¹ The trial court denied the relief.

The court of appeals rejected the argument that intra-stacking should be allowed since the policy was ambiguous.³⁶² The court held that the relevant provisions of the policy have been approved by the State Board of Insurance and have not been rejected by any court.³⁶³ Furthermore, the court held that the legislature intended to provide for two limits of uninsured/underinsured liability, as indicated in article 5.06-1(2)(d) of the Texas Insurance Code.³⁶⁴

The court also rejected the argument that public policy mandates intra stacking. Recognizing the issue as one of first impression, the court held that the legislature was perfectly clear in the statute that the limits specified in the policy control the amount of recovery by an underinsured motorist claimant.³⁶⁵ Furthermore, review of Texas cases indicated that unless it is clear from the terms of the policy that an added premium charge to a basic policy for additional vehicles was for the purpose of increasing the policy

358. *Id.* at 564-65.

359. 812 S.W.2d 353 (Tex. App.—San Antonio 1991, no writ).

360. *Id.* at 354.

361. *Id.* ("[s]tacking' refers to the ability of the insured, when covered by more than one insurance policy, to obtain benefits from a second policy on the same claim when recovery from the first policy alone would be inadequate 'Intra-policy stacking is the aggregation of the limits of liability for uninsured-motorist coverage of each car covered in one policy, whereas inter-policy stacking involves the aggregation of coverage under more than one policy'"). *Id.*

362. *Id.*

363. *Id.* at 354.

364. *Upshaw*, 812 S.W.2d at 355. See also TEX. INS. CODE ANN. art. 5.06-1(2)(d) (Vernon 1981) ("total aggregate limit of liability to any one person who sustains bodily injury or property damage as the result of any one occurrence shall not exceed the limit of liability for these coverages as stated in the policy and the total aggregate limit of liability to all claimants, if more than one, shall not exceed the total limit of liability per occurrence as stated in the policy").

365. *Id.* at 356.

limits, intra-policy stacking will not be permitted, and the limits listed on the policy will control the maximum amount recovered from any given policy.³⁶⁶ The court concluded that intra policy stacking of underinsured motorist coverage is not permissible unless specified within the policy.³⁶⁷

The court of appeals considered the issue of whether the surrender of one life insurance policy can serve as consideration for the issuance of a new policy in *Taylor v. Bonilla*.³⁶⁸ Scott Taylor had a whole life policy with New York Life Insurance Co. He met with New York's agent, Bonilla, to discuss surrendering the policy. During that meeting, Taylor completed and signed an application for a new term policy and forms to surrender the existing whole policy for cash value. Bonilla noted on the application that the whole life policy would terminate when the new term policy was issued. Taylor never paid a premium on the new policy but did receive and negotiate a check in full settlement of the claims under the whole life policy before he was killed in a car wreck. Bonilla informed Mrs. Taylor that her husband was not covered under either policy.

Mrs. Taylor brought suit claiming breach of contract, breach of fiduciary duty, breach of the duty of good faith and fair dealing, DTPA violations, and Insurance Code violations. The trial court granted summary judgment against Taylor on the term policy contract claim for lack of consideration.³⁶⁹ The trial court also granted directed verdict against Taylor on the whole life policy contract claim because the policy had been surrendered.³⁷⁰ The jury found for the defendants on the remaining extracontractual claims.

On appeal, the court addressed an issue of first impression, concluding that Mr. Taylor's surrender of the whole life policy could serve as consideration for the new term policy if there was evidence that Taylor surrendered the old policy in return for the new policy.³⁷¹ The question turned on intent of the parties. The court held that Bonilla was an interested witness and his testimony was not proper as the basis for rendition of a summary judgment.³⁷² Since Bonilla's testimony was the only evidence offered by defendants and since defendants did not present evidence to otherwise negate Taylor's intent that surrender of the whole policy served as consideration for the term policy, the court reversed the summary judgment.³⁷³

The court of appeals next considered the directed verdict on the whole life policy claim. The plaintiff argued that the surrender of the whole life policy and the application for the term policy were part of one transaction to avoid a gap in coverage. The defendants argued that the surrender was unconditional because the surrender request form indicated the surrender would be effective immediately. The court of appeals recognized Bonilla's notation on

366. *Id.*

367. *Id.*

368. 801 S.W.2d 553, 556 (Tex. App.—Austin 1990, writ denied).

369. *Id.* at 557.

370. *Id.* at 558.

371. *Id.*

372. *Id.* at 557.

373. 801 S.W.2d at 559.

the application, that the whole life policy would terminate when the new policy was issued, as more than a scintilla of evidence of the parties intent.³⁷⁴ The court reasoned that the whole life policy contained an offer to remit cash upon unconditional surrender of the policy.³⁷⁵ Bonilla's notation on the application could serve as a counteroffer that necessitated a response by New York Life.³⁷⁶ The court of appeals concluded that this evidence raised fact issues to be determined by the jury and reversed the directed verdict.³⁷⁷

B. Policy Exclusions

In *General Manufacturing Co. v. CNA Lloyd's*³⁷⁸ the issue on appeal was whether the general liability policy excluded Rockwall's loss for defective windows it manufactured, sold, and installed. Rockwall replaced over 10,000 cracked windows at a cost of more than \$1.1 million in efforts to preserve business good will and mitigate damages. Rockwall then filed claim with CNA for coverage. CNA denied coverage based on the business risk/products exclusion in the policy which excluded "property damage to work performed by or on behalf of the named insured arising out of the work or any portion thereof, or out of materials, parts, or equipment furnished in connection therewith. . . ."³⁷⁹

The court of appeals agreed with the trial court in holding that the exclusion was properly applied to this situation and that CNA was reasonable in denying payment.³⁸⁰ The court found the exclusion unambiguous, relying on previous cases in which the same exclusionary provision had been found unambiguous.³⁸¹

The court also rejected Rockwall's argument that it should be allowed to recover for the diminution in value of the buildings as a result of property damage caused by the cracking windows.³⁸² The court found no record of evidence alleging Rockwall liable to third-parties for this diminution of value and therefore held that no recovery was justified.³⁸³

In *National Union Fire Insurance Co. v. Hudson Energy Co.*³⁸⁴ the supreme court interpreted another policy exclusion.³⁸⁵ National Union denied Hudson's claim for damages incurred to his aircraft during a landing,

374. *Id.* at 560.

375. *Id.*

376. *Id.* at 558.

377. *Id.* at 361.

378. 806 S.W.2d 297 (Tex. App.—Dallas 1991, writ denied). For a full discussion of the facts see *supra* 119 and accompanying text.

379. *Id.* at 299.

380. *Id.*

381. *Id.* (citing *Bateson Constr. Co. v. Lumbermans Mut. Cas. Co.*, 784 S.W.2d 692, 694-95 (Tex. App.—Houston [14th Dist.] 1989, writ denied); *Travelers Ins. Co. v. Volentine*, 578 S.W.2d 501, 503 (Tex. Civ. App.—Texarkana 1979, no writ); *Eulich v. Home Indemn. Co.*, 503 S.W.2d 846, 849 (Tex. Civ. App.—Dallas 1973, writ ref'd n.r.e.)).

382. *Id.* at 299-300.

383. *Id.* at 300.

384. 811 S.W.2d 552 (Tex. 1991). For a full discussion of the facts of this case see *supra* note 79 and accompanying text.

385. *Id.* at 553.

arguing that the incident fell within a policy exclusion because both Hudson and his flight instructor had control over the plane at the time of the accident. The policy stated that when in flight the plane would be piloted by Hudson, provided he was a qualified private pilot, or by any other qualified pilot.³⁸⁶ National Union argued that the policy excluded simultaneous piloting, meaning piloting by several different people. National Union also argued that the clause excluded Hudson since evidence at trial demonstrated that Hudson could not produce a Federal Aviation Administration certificate confirming private pilot qualifications. Hudson argued that the policy exclusion was drafted only to ensure that a qualified pilot controlled the plane.

The supreme court affirmed the trial court's holding in favor of Hudson. The court held that the exclusion clause was ambiguous and should therefore be construed in the light most favorable to the insured.³⁸⁷ The court held that an intent to exclude coverage must be written in clear and unambiguous language.³⁸⁸ The court concluded that because National Union had failed to clearly state the exclusion in the policy and Hudson's interpretation of the exclusion was reasonable, the exclusion should be read in Hudson's favor, which mandated coverage.³⁸⁹

In *United Services Automobile Association v. Pennington*³⁹⁰ Gary Lochte ran a quarter horse breeding business with his father. He purchased a quarter horse to test a new racehorse training system. The purchase was made apart from the breeding business. Lochte and a friend ran an advertisement for a beginner jockey to test the horse. Penny Pennington responded and was injured when the horse fell on top of her, breaking her pelvis.

Pennington sued Lochte. Lochte requested defense from his homeowner's insurer, USAA. USAA refused to defend, relying on an exclusion in the policy for business pursuits. The trial court rendered judgment against Lochte for \$277,576.77. Lochte assigned his claims against USAA to Pennington in exchange for her agreement not to execute the judgment against him personally. Pennington sued USAA. The jury held Lochte's purchase was not a business pursuit and found USAA breached its duty to defend. The jury also found USAA grossly negligent in handling Lochte's claim. It awarded \$25,000 for mental anguish, lost wages, and attorney's fees, and \$25,000 as exemplary damages.

On appeal, the court held that Lochte's purchase of the quarter horse was not a business pursuit. No Texas court has construed the meaning of the term business pursuit until now. This court defined business pursuit as having two elements: "(1) continuity or regularity of the activity; and (2) a

386. *Id.* at 554.

387. *Id.* at 555 (citing *Barnett v. Aetna Life Ins. Co.*, 723 S.W.2d 663, 667 (Tex. 1987); *Ramsey v. Maryland Am. Gen. Ins. Co.*, 678 S.W.2d 936, 938 (Tex. 1984); *Brown v. Palatine*, 89 Tex. 590, 595, 355 S.W. 1060, 1061 (1896)).

388. *Id.*

389. *Id.*

390. 810 S.W.2d 777 (Tex. App.—San Antonio 1991, writ denied).

profit motive."³⁹¹ Lochte's testimony that the horse was a hobby and not purchased for business, and lack of evidence of any regularity in purchasing horses for this type of endeavor supported the jury finding that the ownership of the horse was not a business pursuit.³⁹² Although Lochte claimed depreciation for the horse on his tax return, the court held that the jury was the final arbiter on the profit motive, and there was evidence to support the jury finding.³⁹³

USAA argued Pennington could not bring a cause of action for negligent claims handling since refusal to defend is a breach of a contractual duty. The court held that in order to find a tort action out of a breach of a contractual duty the tort action must be independent of the contract.³⁹⁴ The court explained that the claim is contractual if the conduct imposes liability only as a result of the breach of contract.³⁹⁵ The court reasoned that without the homeowner's insurance policy there would have been no duty to defend.³⁹⁶ Therefore, the claim was contractual in nature.³⁹⁷

In *S.S. v. State Farm Fire & Casualty Co.*³⁹⁸ the Austin court of appeals distinguished between intentional injury and intentional acts with regard to policy exclusions.³⁹⁹ S.S. contracted genital herpes from G.W. after having sex at G.W.'s house. G.W. notified State Farm of S.S.' claim and requested defense. State Farm agreed to defend but refused to admit liability or coverage. G.W. rejected the qualified defense, entered into an agreed judgment awarding S.S. \$1 million, assigned to S.S. all coverage claims against State Farm, and assigned one-third of any causes action he had for State Farm's claims handling.

State Farm sought declaratory relief to establish lack of coverage. State Farm relied on the policy provision excluding coverage for "bodily injury . . . caused intentionally by . . . the Insured" and argued public policy prohibited insurance coverage for negligent transmission of sexual diseases.⁴⁰⁰ Alternatively, State Farm claimed it had no obligation to defend or indemnify G.W. since he failed to cooperate and engaged in collusion, fraud, and conspiratorial conduct.

G.W. and S.S. counterclaimed, alleging coverage over the injury and that State Farm's conduct was in bad faith. The trial court rendered summary judgment for State Farm, holding lack of coverage over the injury.⁴⁰¹

The court of appeals reversed and remanded.⁴⁰² The court found that

391. *Id.* at 780.

392. *Id.* at 780-82.

393. *Id.* at 782.

394. *Id.* at 783 (relying on *Southwestern Bell Tel. Co. v. DeLanney*, 809 S.W.2d 493, 494 (Tex. 1991)).

395. *Id.*

396. *Id.*

397. *Id.*

398. 808 S.W.2d 668 (Tex. App.—Austin 1991, writ denied).

399. *Id.* at 670.

400. *Id.* at 669.

401. *Id.*

402. *Id.* at 672.

State Farm failed to prove that G.W. intended to cause injury to S.S., differentiating between intentional acts and intentional injury.⁴⁰³ Furthermore, the record did not show that the conduct in question "was so extreme or outrageous that intent to harm [could] be inferred as a matter of law."⁴⁰⁴

The court rejected State Farm's argument that allowing coverage for transmission of genital herpes violates public policy by encouraging the spread of sexual diseases.⁴⁰⁵ The court's response in analogy was "it cannot be said that enforcement of the indemnity provisions of an automobile insurance policy encourages collisions."⁴⁰⁶ The court concluded that S.S. was not entitled to summary judgment on the contract claim since she did not conclusively show G.W. lacked intent to injure her.⁴⁰⁷

C. Premium Rating

The Houston court of appeals recently held, in *National Union Fire Insurance Co. of Pittsburgh v. Clemtex, Inc.*⁴⁰⁸ that an insurer could not recover additional premiums because of an experience rating assigned to the insurer by the State Board of Insurance.⁴⁰⁹ National insured Clemtex under a general comprehensive liability policy which provided for premium adjustment at the end of each policy period based on Clemtex's sales. National sought an additional \$231,146 from Clemtex at the end of a policy period based on the State Board's experience rating plan.⁴¹⁰ Clemtex refused to pay the additional amount and instead claimed it was due a refund based on its decreased sales over the year. National filed suit, and the trial court granted summary judgment to Clemtex.⁴¹¹

The court of appeals affirmed.⁴¹² First, the court held the policy itself did not allow for retroactive assessment of additional premiums based on the State Board's experience rating plan.⁴¹³ Furthermore, the court found evidence that National neglected to secure an endorsement to the experience rating plan from Clemtex prior to applying the plan to that specific policy.⁴¹⁴ The court then upheld the award for a refund to Clemtex based on its decreased sales.⁴¹⁵

The legislature has amended article 5.14 of the Texas Insurance Code by specifically addressing the issue of rates for general liability and commercial

403. 808 S.W.2d at 670.

404. *Id.*

405. *Id.* at 671.

406. *Id.*

407. *Id.* at 672.

408. 807 S.W.2d. 824 (Tex. App.—Houston [14th Dist.] 1991, writ denied).

409. *Id.* at 826.

410. See TEX. INS. CODE ANN. art. 5.14 (Vernon Supp. 1992). The experience rating plan involves a formula used to increase or decrease the annual premium paid by the insured. *Id.*

411. *National Union Fire Ins. Co.*, 807 S.W.2d at 825.

412. *Id.* at 824.

413. *Id.* at 825-26. The policy read: "[A]ll premiums for this policy shall be computed in accordance with the company's rules, rates, rating plans, premiums and minimum premiums applicable to the insurance afforded herein." *Id.* at 825 (emphasis in original).

414. *Id.* at 826.

415. *Id.* at 826-27.

property insurers in article 5.13-2.⁴¹⁶ The new article requires that the insurance forms of subject insurers avoid misleading and deceptive language.⁴¹⁷ It also provides standard forms where necessary.⁴¹⁸ The statute also provides a mechanism by which the aggrieved insured can get a Board hearing on the rates, supplementary rating information, and any supporting information filed with the Board by the insurer to establish the appropriate premiums.⁴¹⁹

D. Defenses

In *Flowers v. United Insurance Co.*⁴²⁰ Mr. and Mrs. Flowers bought a joint life insurance policy from United. In answering the health questions, Mr. Flowers denied having had high blood pressure, any disease or disorder of the heart or circulatory system, or having consulted a physician within the past five years. Mr. Flowers subsequently died and Mrs. Flowers filed a claim for life insurance proceeds. United refused to pay, alleging misrepresentation by Flowers. The trial court granted summary judgment⁴²¹ for United based on evidence that showed Mr. Flowers had completed a medical form three years before, in which he indicated he had high blood pressure. Furthermore, evidence showed that Mr. Flowers had taken medication for that condition for two years and had been diagnosed with cardiomegaly (enlargement of the heart).

The court of appeals listed the five elements an insurer must plead and prove to establish a misrepresentation defense: "(1) the making of a misrepresentation; (2) the falsity of the misrepresentation; (3) reliance on the misrepresentation by the insurer; (4) the intent to deceive on the part of the insured in making the misrepresentation; and (5) the materiality of the misrepresentation."⁴²²

The only issue in dispute was whether United proved Mr. Flowers' intent to deceive as a matter of law.⁴²³ United argued that the fact Mr. Flowers knew of his health problem showed an intent to deceive. The court of appeals disagreed and found that the evidence raised a fact question as to intent.⁴²⁴ The court reversed and remanded for trial.⁴²⁵

In *Filley v. Ohio Casualty Insurance Co.*⁴²⁶ the Filleys suffered damages to their building as a result of Matthews' demolition work on adjacent property. They complained to Matthews in 1984, and he informed them of his insurance with Ohio Casualty. The Filleys sued Matthews but after unsuc-

416. TEX. INS. CODE ANN. arts. 5.14(b), 5.13-2 (Vernon Supp. 1992).

417. *Id.* arts. 5.13-2(1)(a)(5), (8)(a),(e).

418. *Id.*

419. *Id.* § 5.13-2(5)(c).

420. 807 S.W.2d 783 (Tex. App.—Houston [14th Dist.] 1991, n. w.h.).

421. *Id.* at 784.

422. *Id.* at 785 (citing *Mayes v. Massachusetts Mut. Life. Ins. Co.*, 608 S.W.2d 612, 616 (Tex. 1980)).

423. *Id.*

424. *Id.* at 786.

425. *Id.*

426. 805 S.W.2d 844 (Tex. App.—Corpus Christi 1991, writ denied).

cessful efforts to find him, took a default judgment. The Filleys then sued Ohio Casualty to recover on Matthew's liability policy. The trial court rendered judgment for Ohio Casualty based on Matthews' failure to comply with policy requirements of giving notice of claims and cooperating with the insurer.⁴²⁷

The court of appeals affirmed.⁴²⁸ The court noted that the liability policy provided that no action would lie against the insurer unless, as a condition precedent, the insured fully complied with all the terms of the policy.⁴²⁹ The policy required the insured to give notice regarding any occurrence as soon as practicable, to immediately forward any suit papers to the insurer, and to cooperate with the company in making settlements and defending against the claim.⁴³⁰ Evidence that Ohio Casualty was not informed of the claim immediately after the Filleys complained to Matthews and that Matthews could not be found to help in the defense supported the court's conclusion that Matthews failed to comply with the policy and therefore prejudiced Ohio Casualty enough to relieve it of any obligation to the Filleys.⁴³¹

The court recognized that "[l]ittle authority exists to explain what constitutes sufficient prejudice to relieve an insurer of liability."⁴³² Still, the court concluded that "[t]he failure to notify an insurer of a default judgment until that judgment has become final results in such prejudice to the insurer that it is entitled to the benefit of the failure of notice policy defense."⁴³³

The court of appeals then held that the Filleys were not third-party beneficiaries until they obtained a judgment against the insured.⁴³⁴ Reasoning that the Filleys obtained the rights and obligations of the insured only at the time of judgment, the court held that since Matthews did not comply with the policy requirements "Ohio Casualty had no contractual obligations to the Filleys."⁴³⁵

In *Members Insurance Co. v. Branscum*⁴³⁶ Members hired an independent adjuster to investigate an accident claim involving Branscum and Members' insured. Settlement negotiations failed, and Branscum's attorney told the adjuster of intent to file suit. Branscum served the insured and Branscum's attorney advised the adjuster that suit had been filed. The insured did not inform Members of the suit or forward the suit papers as requested by the adjuster and required by the policy. Branscum received a default judgment

427. *Id.* at 845.

428. *Id.*

429. *Id.* at 846. The no action clause provided:

No action shall lie against the company unless, as a condition precedent thereto, there shall have been full compliance with all of the terms of this policy, nor until the amount of the insured's obligation to pay shall have been finally determined either by judgment against the insured after actual trial

Id.

430. *Id.*

431. *Id.* at 847.

432. 805 S.W.2d at 847.

433. *Id.*

434. *Id.*

435. *Id.* at 848.

436. 803 S.W.2d 462 (Tex. App.—Dallas 1991, n.w.h.).

and thereafter demanded payment of the policy limits from Members. Members refused.

In the suit between Branscum and Members, Members argued that the insured's failure to cooperate by transmitting the suit papers, resulting in default judgment, prejudiced Members in the defense of the claim since it was not informed of the judgment until after the appropriate time period to have the judgment set aside. The trial court held that Members did not prove substantial prejudice by the insured's failure to notify of the suit since Members had actual notice of the suit in time to protect its interest.⁴³⁷ The court awarded Branscum the policy limits.⁴³⁸

On appeal, Members argued that the insured's failure to comply with the policy requirements prejudiced it as a matter of law and no coverage should be available to Branscum. Members contended it was prejudiced because the breach of policy provisions denied Members the opportunity to defend the claim as well as the suit. The court held that prejudice was determined by whether Members received notice or not.⁴³⁹ Branscum argued that Members had actual notice of the suit in proper time to defend since his attorney informed the adjuster of the intent to sue. The court differentiated between notice of suit and notice of claim, holding that actual knowledge of a claim does not equate to knowledge of a suit.⁴⁴⁰ Branscum's assertion of intent to file suit was not appropriate notice to Members to impose a duty to take action on the claim.⁴⁴¹

The court also addressed the level of prejudice necessary to succeed in a lack of notice defense, although this question was not at issue.⁴⁴² The court rejected the general rule that an insurer shows prejudice only when the insured fails to cooperate or forward papers and the insurer can show that it was substantially prejudiced by the breach.⁴⁴³ Instead, the court relied on the Texas State Board of Insurance Order No. 22582 in holding that no element of substantiality is required in showing prejudice to the insurer by the insured's failure to forward suit papers.⁴⁴⁴ The court of appeals reversed the trial court judgment and ordered that Branscum take nothing.⁴⁴⁵

*Hirsch v. Texas Lawyers' Insurance Exchange*⁴⁴⁶ involved issues of notice to the insurer with respect to claims-made policies. Hirsch and his corporation were insured by two TLIE malpractice policies, one in effect from April 3, 1986, to April 3, 1987, and the other from June 5, 1987, to June 5, 1988. Hirsch, individually, and the corporation were sued for malpractice on April 21, 1986. Hirsch notified TLIE of the suit on December 14, 1987. TLIE denied coverage, asserting that the late notice precluded coverage since this

437. *Id.* at 463.

438. *Id.*

439. *Id.* at 466.

440. *Id.* at 466-67.

441. 803 S.W.2d at 466-67.

442. *Id.* at 467.

443. *Id.* (citing J. APPLEMAN, *INSURANCE LAW AND PRACTICES* § 4771 (1962)).

444. *Id.*; see Tex. State Bd. of Ins. Order No. 22582 (Jan. 1973).

445. *Members Ins. Co.*, 803 S.W.2d at 467.

446. 808 S.W.2d 561 (Tex. App.—El Paso 1991, writ denied).

was a claims-made policy⁴⁴⁷ in which coverage depended on the claim being made and reported during the policy period. In a declaratory judgment, the trial court agreed with TLIE.⁴⁴⁸

The court of appeals rejected the argument that Hirsch and the corporation were separate entities and that the corporation gave timely notice.⁴⁴⁹ The court held that while the corporation was a separate entity, it could only act through its officers and agents.⁴⁵⁰ When Hirsch, as president of the corporation, learned of the claim, notice was also given to the corporation.⁴⁵¹ Furthermore, Hirsch's letter to TLIE referenced both the action against himself individually and that against the corporation.⁴⁵²

Hirsch argued that TLIE denied coverage based on the gap in coverage but later inappropriately claimed denial based on the late notice defense. The court held that TLIE's letter of denial must be read in its entirety and, in so doing, the letter specified details of effective notice.⁴⁵³ Therefore, TLIE did not waive its late notice defense.⁴⁵⁴

Next, Hirsch argued that strict compliance with the claims-made notice provisions violated Texas law and public policy because they failed to include extended reporting provisions. The court rebutted this argument by finding the policy unambiguous in stating that coverage extends only to claims made and reported within the policy period.⁴⁵⁵ The court also found that policy was not unjust and that there was ample freedom of contract since the policy was unambiguous.⁴⁵⁶

Finally, Hirsch argued that TLIE should have been required to show prejudice from his failure to give timely notice. The court of appeals held that "[t]o require a showing of prejudice for late notice would defeat the purpose of "claims-made" policies, and in effect, change such a policy into an "occurrence" policy."⁴⁵⁷

The court of appeals dealt with another notice issue involving a claims-made policy in *Komatsu v. United States Fire Insurance Co.*⁴⁵⁸ Komatsu and his attorney, Murad, were sued as guarantors on various loans. Komatsu filed a cross-claim against Murad, alleging fraudulent inducement. The cross-claim was filed on the last effective day of Murad's claims-made

447. *Id.* at 563 (occurrence policy differs in that coverage attaches once the occurrence takes place even though the claim may not be made until much later); *see also* *Edinburgh Consol. I.S.D. v. INA*, 806 S.W.2d 910, 913, 914 (Tex. App.—Corpus Christi 1991, n.w.h.) (claim in claims-made policy included actions taken by terminated teacher such as termination hearings before the school district Board of Trustees and the Texas Education Agency, as well as instigation of actual suit against the school district).

448. *Hirsch*, 808 S.W.2d at 562.

449. *Id.* at 563.

450. *Id.*

451. *Id.*

452. *Id.*

453. 808 S.W.2d at 564.

454. *Id.*

455. *Id.* at 565.

456. *Id.*

457. *Id.*

458. 806 S.W.2d 603, 604 (Tex. App.—Fort Worth 1991, writ denied).

malpractice insurance policy with USFIC. Murad notified USFIC of the cross-claim five days after the policy expired.

Murad settled Komatsu's cross-claim by agreed judgment and assigned his rights under the USFIC policy to Komatsu. When Komatsu sued USFIC to collect on the agreed judgment, the insurer asserted the suit was barred under the claims-made language in the policy.⁴⁵⁹ Komatsu admitted that notice was given beyond the policy period, but argued that the requirement was unenforceable under Texas law, which finds void any contract stipulation requiring less than ninety days notice of claim of damages as a condition precedent to right to sue.⁴⁶⁰ The trial court and court of appeals granted summary judgment for USFIC.⁴⁶¹

The court of appeals found that the history of section 16.071 of the Texas Civil Practice and Remedies Code and prior cases construing the statute had limited its application to claims that were causes of action between the contracting parties.⁴⁶² The court reasoned that Komatsu's claim against Murad did not give rise to a claim for damages in Murad's behalf against USFIC.⁴⁶³ Furthermore, the claims-made notice period makes policies more affordable to the public.⁴⁶⁴ Judicial expansion of that period would be unbargained for.⁴⁶⁵

E. Apportionment of Excess Carriers' Liability

In *Utica National Insurance Co. v. Fidelity & Casualty Co.*⁴⁶⁶ George Pocock recovered \$2.2 million for injuries sustained in an automobile accident in which he was a passenger in a car driven by Landfair. Both persons carried primary and excess insurance. Primary insurance coverage amounted to \$1,350,000, resulting in a balance of \$850,000 which was paid by Utica, Pocock's insurer. Utica sought contribution from Fidelity. Both companies conceded to liability under the excess coverage policies but Fidelity argued that Landfair's remaining excess carriers were responsible, and the court should apportion the amount of contribution to reflect their percentages of coverage.⁴⁶⁷ The trial court held that the other excess policies should not be considered when determining the pro rata share between Fidelity and Utica.⁴⁶⁸ The trial court apportioned liability in a ratio of Utica's \$10 million collectible excess to Fidelity's \$5 million collectible excess (2:1

459. See *supra* note 446 and accompanying text for the difference between claims-made and occurrence policies.

460. *Komatsu*, 806 S.W.2d at 605 (construing TEX. CIV. PRAC. & REM. CODE ANN. § 16.071 (Vernon 1986)).

461. *Id.* at 604.

462. *Id.* at 605-07.

463. *Id.* at 607.

464. *Id.*

465. *Id.*

466. 812 S.W.2d 656 (Tex. App.—Dallas 1991, writ denied).

467. In addition to an initial \$5,000,000 excess policy carried by Fidelity, another \$45,000 in excess coverage was carried by Fidelity and three other insurers.

468. *Id.* at 658.

ratio) resulting in indemnification of \$283,333.33 by Fidelity to Utica.⁴⁶⁹

The court of appeals affirmed.⁴⁷⁰ Fidelity contended that the pro rata apportionment was incorrect because it did not include all of the excess policies. The court of appeals rejected this argument, finding the policy language unambiguous with regard to the third level excess carriers obligations.⁴⁷¹ To hold otherwise "would render meaningless the conditions precedent that the underlying insurance must be exhausted."⁴⁷²

V. CONTRIBUTION

A. Multiple Carriers

In *M.J.R. Corp. v. Scottsdale Insurance Co.*⁴⁷³ M.J.R. Corp. operated several night clubs and had liability coverage through Western Lloyds and Scottsdale. Jacobs was injured in a fight that occurred at M.J.R.'s Fare Club. M.J.R. demanded defense and coverage from both insurers. Western Lloyd's agreed, but Scottsdale declined, arguing that the policy excluded occurrences at Fare Club. Jacob received judgment for \$12,000. Western Lloyds paid the judgment and then sued Scottsdale for contribution.

Both insurers issued multi peril policies that contained first-party property coverage and third-party liability coverage. Each policy contained two insuring endorsements. The first, TXCMP-200, provided coverage for liability for bodily injury or property damage, but excluded coverage for claims arising out of operations of premises other than insured premises. The second endorsement, TXCMP-202, also provided coverage for bodily injury and property damage but did not contain the exclusion for uninsured premises.

Scottsdale argued that TXCMP-202 was premises-restricted since it designated Geno's Lounge and other premises but did not specifically designate Fare Club. The court held that although TXCMP-200 specifically limited coverage to designated premises, the TXCMP-202 endorsement had to be read separately.⁴⁷⁴ Because TXCMP-202 did not limit coverage to designated premises, M.J.R. was entitled to coverage and defense.⁴⁷⁵ The court held that Scottsdale was liable as co-insurer for half the amount of the underlying judgment and half the defense costs.⁴⁷⁶

469. *Id.*

470. *Id.* at 663.

471. *Id.* at 661-62. The Beasley policy read:

2. LIMIT OF LIABILITY - UNDERLYING LIMITS

It is expressly agreed that liability shall attach to the Company only after the Underlying Umbrella Insurers [Fidelity and Utica] have paid or have been held liable to pay the full amount of their respective ultimate net loss liability

Id. at 662.

472. *Id.* at 662-63.

473. 803 S.W.2d 426 (Tex. App.—Dallas 1991, n.w.h.).

474. *Id.* at 430.

475. *Id.* at 431.

476. *Id.*

B. Agent Contribution

In *Hartford Casualty Insurance Co. v. Walker County Agency*⁴⁷⁷ Hartford denied Jackson's workers' compensation claim. Jackson received a favorable judgment from the IAB and Hartford appealed to the district court. Jackson then raised bad faith claims against Hartford. The parties settled before trial but Hartford continued the suit by filing a cross-action against agent Walker County for contribution, indemnity, fraud, and breach of fiduciary duty. Walker County argued that although Hartford was a joint tortfeasor, it was not entitled to contribution or indemnity because it had settled. Hartford argued that the causes of action against Hartford were the result of Walker's actions as insurance agent. Hartford also argued statutory indemnification rights since Jackson's original claims were based on the DTPA. The trial court granted Walker's motion for summary judgment.⁴⁷⁸

The court of appeals held that Hartford and Walker were not joint tortfeasors.⁴⁷⁹ The court reasoned that Hartford, as insurer, owed the worker contractual and statutory duties to provide coverage and the common law duty of good faith and fair dealing.⁴⁸⁰ Although the insurer incurred these duties, the agent did not and therefore was not a co-tortfeasor.⁴⁸¹

The court recognized that common law indemnity between joint tortfeasors does not exist in Texas.⁴⁸² The court held, however, that Hartford could be indemnified for the amount paid to settle the claim based on the principal-agent relationship.⁴⁸³ Furthermore, Hartford could also recover exemplary damages in the form of attorney's fees incurred in defending the suit that Hartford would not have been required to participate in but for Walker's actions.⁴⁸⁴

Finally, the court rejected Hartford's assertion that it was entitled to statutory indemnification under the DTPA.⁴⁸⁵ The DTPA allows contribution from one who may have liability for the action of which the consumer complains.⁴⁸⁶ The court held that Jackson's workers' compensation claim was not brought under the DTPA and therefore Hartford had no statutory right of indemnification.⁴⁸⁷ Although Jackson's breach of good faith and fair dealing claim was brought in part under the DTPA, the court held that because there was no finding of liability for breach of this duty against Walker, and Hartford had voluntarily settled that claim, Hartford had no

477. 808 S.W.2d 681 (Tex. App.—Corpus Christi 1991, no writ).

478. *Id.* at 683-84.

479. *Id.* at 686-87.

480. *Id.* at 686.

481. *Id.*

482. *Id.* at 689 (relying on *Aviation Office, Inc. v. Alexander & Alexander, Inc.*, 751 S.W.2d 179, 180 (Tex. 1988)).

483. *Id.*

484. *Id.*

485. *Id.*

486. *Id.*; see TEX. BUS. & COM. CODE ANN. § 17.555 (Vernon 1987).

487. *Hartford Cas. Ins. Co.*, 808 S.W.2d at 689.

right to indemnification under the DTPA.⁴⁸⁸

VI. JURISDICTION

A. Choice of Forum

In *City of Rose City v. Nutmeg Insurance Co.*⁴⁸⁹ the Fifth Circuit held that a service of suit endorsement gave the insured or its assignee the right to select a forum.⁴⁹⁰ After Smith secured a judgment against Rose City in the amount of \$3,500,000, Rose City assigned its rights in a general liability policy issued by Nutmeg to Smith. Smith then brought an action against Nutmeg in Texas state court seeking to satisfy its judgment. Nutmeg removed the case to federal court. The court denied Smith's motion to remand and granted Nutmeg's motion for summary judgment.⁴⁹¹ The Fifth Circuit vacated the judgment of the district court and remanded to the state court.⁴⁹²

Smith argued that the insurance policy contained a service of suit endorsement by which Nutmeg waived its right to remove the action from state court. The endorsement provided:

In the event of our . . . failure to pay any amount claimed to be due under your . . . policy, we, at your request agree to submit to the jurisdiction of any Court of Competent jurisdiction within the United States and will comply with all requirements necessary to give such Court jurisdiction and all matters arising hereunder shall be determined in accordance with the law and practice of such Court.⁴⁹³

The Fifth Circuit held that this language allows the policyholder to choose the forum in which any dispute will be heard.⁴⁹⁴

B. Service of Process

A Texas court of appeals held that service of the president of an insurance company is insufficient to assert jurisdiction over the company in *Commodore County Mutual Insurance Co. v. Tkacik*.⁴⁹⁵ Tkacik sued Commodore County Mutual Insurance Co. (CCM) for breach of contract and breach of the duty of good faith and fair dealing. After the time period for CCM to answer and appear expired, Tkacik was awarded a default judgment in the amount of \$107,600 plus ten percent postjudgment interest and costs. The appellate court found that the trial court had not attained jurisdiction over CCM due to a lack of effective service.⁴⁹⁶ Tkacik failed to produce a record, as required by article 1.36 of the Texas Insurance Code, affirmatively showing that service was had at either CCM's home office or principle place of

488. *Id.* at 689-90.

489. 931 F.2d 13 (5th Cir. 1991), *cert. denied*, 112 S. Ct. 301 (1991).

490. *Id.* at 15.

491. *Id.* at 14.

492. *Id.*

493. *Id.*

494. *Id.* at 16.

495. 809 S.W.2d 630, 632 (Tex. App.—Amarillo 1991, writ denied).

496. *Id.* at 631.

business.⁴⁹⁷

The court found that while it may be logical that the office of the president will be located at the company's home office, because it was not necessarily so the court could not make that assumption.⁴⁹⁸ The court held that although the record affirmatively showed that Tkacik attempted service, it was ineffective under the insurance code.⁴⁹⁹

C. *In Personam Jurisdiction over Foreign Companies*

In *El Paso Reyco, Inc. v. Malaysia British Assurance*⁵⁰⁰ the El Paso court of appeals held that in personam jurisdiction over a foreign insurance company was proper because the company had purposefully established contacts with the forum state and the exercise of jurisdiction comported with fair play and substantial justice.⁵⁰¹ In a prior suit, Nabham had obtained a judgment against El Paso Reyco for \$95,000. These parties joined together in a suit against Pioneer for failure to defend and indemnify Reyco in the earlier suit. A jury found for Pioneer, but after a new trial was granted Pioneer became insolvent, and a default judgment was entered against it for treble damages and attorney's fees.⁵⁰²

The suit in the present case sought to recover on that judgment against Malaysia British, the reinsurer for Pioneer. In response to this suit, Malaysia British filed a special appearance to contest the trial court's jurisdiction. The trial court sustained the special appearance of the foreign reinsurer.⁵⁰³ The court of appeals reversed and remanded the case for trial on the merits.⁵⁰⁴

In deciding whether a Texas court could exercise jurisdiction over a foreign insurer that had never done business in this state, but that had entered into a reinsurance agreement with a primary insurer that insured a Texas corporation, the court considered the due process requirements that the non-resident defendant purposefully establish minimum contacts with the forum state and that the exercise of jurisdiction comport with fair play and substantial justice.⁵⁰⁵ The court determined that Malaysia British had purposefully availed itself of the privilege of conducting activities in Texas and thereby invoked the benefits and protections of Texas' laws by agreeing to provide reinsurance coverage for policies issued by Pioneer to Texas residents.⁵⁰⁶ By doing so, Malaysia British knew that claims under those policies could be litigated in Texas courts.⁵⁰⁷

The court also concluded that the exercise of jurisdiction comported with

497. TEX. INS. CODE ANN. art 1.36 (Vernon Supp. 1989).

498. *Commodore County Mut. Ins. Co.*, 809 S.W.2d at 630.

499. *Id.* at 631.

500. 808 S.W.2d 529 (Tex. App.—El Paso 1991, writ requested).

501. *Id.* at 530-31.

502. *Id.* at 530.

503. *Id.* at 529.

504. *Id.* at 530.

505. 808 S.W.2d at 530.

506. *Id.* at 530-31.

507. *Id.* at 531.

fair play and substantial justice.⁵⁰⁸ Texas has a strong interest in maintaining avenues of relief for Texas residents whose insurers fail to pay claims.⁵⁰⁹ Residents of the state would be unfairly burdened if forced to follow an insurance company to a foreign state in order to hold it legally accountable.⁵¹⁰

But in *Guardian Royal Exchange Assurance, Ltd. v. English China Clays, P.L.C.*⁵¹¹ the Texas supreme court held that exercising in personam jurisdiction over a foreign insurer violates notions of fair play and substantial justice.⁵¹² Southern Clay, a Texas corporation, was a subsidiary of English China, an English corporation, that was insured by Guardian, an English insurer. The Guardian insurance extended to all subsidiaries of English China, and Southern Clay had a separate liability policy with U.S. Fire Insurance Co (USFIC). In 1982 a Southern Clay employee was killed on the job. The employee's family filed wrongful death suits against English China and Southern Clay. USFIC contributed approximately \$600,000 to settle the claims and then brought a subrogation suit against Guardian seeking reimbursement based on the theory that Guardian was the primary insurer.

Guardian filed a special appearance arguing that it did not have sufficient minimum contacts with Texas to allow the court to exercise personal jurisdiction without offending traditional notions of fair play and substantial justice. The trial court agreed and dismissed the case.⁵¹³ The court of appeals reversed.⁵¹⁴ The supreme court reversed and upheld the decision of the trial court.⁵¹⁵

The supreme court held that the first element of the jurisdictional formula is whether the defendant has purposefully established minimum contacts with Texas.⁵¹⁶ This requires "a 'substantial connection' " between the non-resident defendant and Texas arising from the action or conduct of the non-resident defendant purposefully directed towards Texas.⁵¹⁷ The second requirement is that the assertion of personal jurisdiction comport with fair play and substantial justice.⁵¹⁸ Once minimum contacts are shown, the defendant must "present 'a compelling case that the presence of some consideration would render jurisdiction unreasonable.' "⁵¹⁹

In this case, the court found that Guardian established minimum contacts by insuring all subsidiaries of English China, including those in the United States.⁵²⁰ Guardian could reasonably foresee that a subsidiary would become involved in disputes resulting in litigation in the United States.⁵²¹ The

508. *Id.*

509. *Id.*

510. *Id.*

511. 815 S.W.2d 223 (Tex. 1991).

512. *Id.* at 232.

513. *Id.* at 225.

514. *Id.*

515. *Id.* at 233.

516. 815 S.W.2d at 230.

517. *Id.* (footnote omitted).

518. *Id.* at 231.

519. *Id.*

520. *Id.* at 231-32.

521. 815 S.W.2d at 230.

court found that in this particular case, however, exercise of personal jurisdiction would violate the second factor.⁵²² To require an English insurer unaffiliated with American companies to litigate a dispute with its English insured in the judicial system of another nation would be burdensome since all acts relating to the creation and performance of the policy had occurred in England.⁵²³

The court was careful to point out that the regulatory interest of the forum state is significant. Texas has an interest in maintaining an effective means of redress when insurers fail to pay claims.⁵²⁴ The state's residents "would be at a severe disadvantage if they were forced to follow the insurance company to a distant state to hold it legally accountable."⁵²⁵ These considerations did not tip the balance in this case because this was a suit for reimbursement by USFIC rather than a suit by the family of the deceased employee of Southern Clay.⁵²⁶ Because neither Guardian nor USFIC were Texas consumers or insureds, the interest of Texas in adjudicating the dispute was considerably diminished.⁵²⁷ The court concluded that Texas did not have a compelling interest in providing a forum for the resolution of disputes between foreign insurers.⁵²⁸

Justice Mauzy dissented. He viewed the pertinent inquiry as being whether Guardian should have reasonably foreseen that it would be " 'haled into court' in Texas."⁵²⁹ He argued that Guardian should have foreseen this possibility when it agreed to insure an entity with substantial contacts with Texas.⁵³⁰ He also argued that USFIC stood in the shoes of the insureds and should have the benefit of the substantial interest Texas has in providing a forum for its residents.⁵³¹ In his view, the result should not vary depending on whether the suit was brought by the insured or by the insurer seeking subrogation.⁵³² Texas has an interest in subrogation claims since the claims facilitate plaintiff's recoveries and allow the allocation of loss according to responsibility.⁵³³ Based on these considerations, Justice Mauzy concluded that asserting personal jurisdiction would not violate due process.⁵³⁴

From these two cases it is clear that the test for in personam jurisdiction is whether the company has established minimum contacts with the forum state and whether exercising personal jurisdiction would violate notions of fair play and substantial justice. Meeting the first part of the test is relatively simple. Contacts can be established even though the company has never

522. *Id.*

523. *Id.*

524. *Id.* at 229, 233.

525. *Id.* at 233.

526. 815 S.W.2d at 232-33.

527. *Id.*

528. *Id.*

529. *Id.* at 233 (Mauzy, J., dissenting).

530. *Id.*

531. 815 S.W.2d at 234.

532. *Id.*

533. *Id.*

534. *Id.*

dealt directly with Texas or a Texas company. The supreme court has found that location of the home states or countries of the parties is relevant to the second part of the inquiry. The forum state has a diminished interest in providing a forum if all parties are nonresidents.

VII. ERISA

A. Applicability of ERISA

In *MDPhysicians & Associates, Inc. v. Wrotenbery*⁵³⁵ the federal district court for the Northern District of Texas held that state law can require a self-funded multiple employer welfare plan to obtain a certificate of authority as a Texas insurer.⁵³⁶ MDPhysicians & Associates was the administrator of the MDP plan, a self-funded multiple employer welfare arrangement (MEWA). The State Board of Insurance required the MDP plan to obtain a certificate of authority to do business as an insurer. The MDP plan sought a declaratory judgment, asserting it was an ERISA plan and therefore could not be governed by state law. The district court held to the contrary.⁵³⁷

The issue turned on whether the MDP plan as a MEWA was also a valid ERISA employee benefit plan. The court held that not all MEWA's are also protected under ERISA.⁵³⁸ An ERISA welfare plan is defined as a:

- 1) . . . plan, fund or program
- 2) established or maintained
- 3) by an employer or by an employee organization, or by both,
- 4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits
- 5) to the participants or their beneficiaries.⁵³⁹

The MDP plan was established by a group of physicians. The plan was not fully insured and participants had an option of seeking treatment from a planned provider at ninety percent (90%) coverage or from a non-network medical service provider at eighty percent (80%) coverage. The plan was not limited to employees of the physicians but instead was offered to various employers.

The court found the MDP plan was not an employee welfare benefit plan under ERISA and, as a result, the court dismissed the suit for want of subject matter jurisdiction.⁵⁴⁰ The court reasoned that the employees of subscribing employers were not employees as related to the plan since the plan did not employ the participants and there was no economic relationship between the two.⁵⁴¹ The court held that "[t]he relationship between employees and the Plan is like the relationship between a private insurance company

535. 762 F. Supp. 695 (N.D. Tex. 1991).

536. *Id.* at 699.

537. *Id.*

538. *Id.* at 696.

539. *Id.* at 697 (citing *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988) (quoting *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) (en banc))).

540. *MDPhysicians*, 762 F. Supp. at 697.

541. *Id.*

and the beneficiaries of a group insurance program.”⁵⁴²

The court found it insignificant that the plan was well-organized and complied with ERISA by filing the necessary documents, including a written summary plan description.⁵⁴³ The court also rejected the argument that each individual employer participant could qualify as an ERISA plan.⁵⁴⁴ MDPhysicians did not plead suit as a fiduciary for participants nor did it prove that each plan was “‘established’ and ‘maintained’ as an employee welfare benefit plan” by the individual employers.⁵⁴⁵

Finally, the court held that regardless of whether the plan was determined to be an employee welfare benefit plan under ERISA, because the plan was not fully insured it would still be subject to state law.⁵⁴⁶ Underinsured MEWA’s are subject to state laws to the extent that state laws are not inconsistent with ERISA.⁵⁴⁷ The court held that the state requirement of a certificate of authority to conduct business in Texas is not inconsistent with ERISA’s requirement of a filed plan description, modifications, annual reports, and supplemental reports with the Secretary of Labor.⁵⁴⁸

In *Burghart v. Connecticut General Life Insurance Co.*⁵⁴⁹ the court of appeals discussed how to determine whether an insurance plan constitutes an ERISA plan.⁵⁵⁰ Edna Burghart purchased disability insurance from her employer. After becoming disabled, Burghart was denied payment and sued Connecticut General under DTPA and article 21.21. The trial court granted summary judgment for Connecticut General, holding that Burghart’s claims were preempted by ERISA.⁵⁵¹ The court of appeals reversed.⁵⁵²

The court held that there was sufficient evidence to raise an issue of material fact as to whether the insurance plan was an ERISA plan.⁵⁵³ Burghart presented evidence that the plan fit within an exception to ERISA’s definition of employee benefits. She established that no contributions were made by her employer, participation in the program was voluntary, her employer’s only function was to collect premiums through payroll deductions, and that the employer received no consideration for its action with regards to the plan. The court held that although this evidence could establish an exception to ERISA, whether a plan is in fact an ERISA plan must be determined in light of all the circumstances.⁵⁵⁴ The court recognized that the purchase of insurance absent ERISA’s required elements, does not in itself establish an ERISA plan.⁵⁵⁵

542. *Id.*

543. *Id.* at 698.

544. *Id.*

545. *MDPhysicians*, 762 F. Supp. at 698.

546. *Id.*

547. *Id.* at 698-99 (citing 29 U.S.C. 1144(b)(6)(A)(ii) (1988)).

548. *Id.* (citing 29 U.S.C. 1021(b) (1988)).

549. 806 S.W.2d 324 (Tex. App.—Texarkana 1991, n.w.h.).

550. *Id.* at 327.

551. *Id.* at 325-26.

552. *Id.* at 325.

553. *Id.* at 327.

554. *Id.* (citing Employee Benefit Welfare Plan, 29 C.F.R. 2510.3-1(j) (1988)).

555. *Id.* (citing *Donovan v. Dillingham*, 688 F.2d 1367, 1375 (11th Cir. 1982) (en banc)).

Alternatively, the court held that even if there was an ERISA plan, Burghart's pleadings would be liberally construed to state a claim for benefits under ERISA.⁵⁵⁶ Burghart alleged the existence of the disability policy and claimed she was entitled to benefits. The court held that the evidence presented entitled her to present her case to a jury whether it be under ERISA or state law.⁵⁵⁷

In *Hansen v. Continental Insurance Co.*⁵⁵⁸ Martin Hansen's wife died in an automobile accident. Hansen filed a claim with his employer (Fairfield), who served as benefits administrator for the group accidental death and dismemberment insurance policy issued by Continental. Continental tendered Hansen a check for \$80,000 but Hansen refused the check and demanded payment of \$120,000 as dictated by the policy. Continental denied the payment and Hansen sued in state court, alleging violations of article 21.21 and the DTPA, breach of the common law duty of good faith and fair dealing, and breach of contract. Continental contended that the plan was covered under ERISA and removed the case to federal district court. The district court held that the Fairfield plan was covered by ERISA but that Continental had violated ERISA so that Hansen was entitled to the \$120,000 plus interest and attorney's fees.⁵⁵⁹

The Fifth Circuit affirmed the judgment in all respects.⁵⁶⁰ The court began by discussing whether the Fairfield plan was an ERISA employee welfare plan.⁵⁶¹ The Department of Labor developed criteria that excludes benefits plans from ERISA coverage.⁵⁶² The regulations specify that ERISA does not include group insurance programs offered to employees in which

- (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 due checkoffs.⁵⁶³

The court found that Fairfield had made no contributions to the plan, that

556. *Id.*

557. *Id.*

558. 940 F.2d 971 (5th Cir. 1991).

559. *Id.* at 975.

560. *Id.* at 973.

561. *Id.* at 975-78.

562. *Id.* at 976.

563. 940 F.2d at 976 (quoting Employee Welfare Benefit Plan, 29 C.F.R. 8 2510.3-1(j) (1988)).

participation was completely voluntary, and that Fairfield had received no compensation from the program.⁵⁶⁴ Still, evidence of Fairfield's involvement showed that Fairfield endorsed the plan and distributed a booklet in its own name encouraging employees to participate in the plan.⁵⁶⁵ Therefore, the plan was not excluded from ERISA by the Department of Labor regulations.⁵⁶⁶

The court investigated further to establish whether the Fairfield program qualified as a plan under the ERISA definition.⁵⁶⁷ The court concluded that a plan did exist and was an ERISA plan because Fairfield established and maintained the plan by administration and payment of benefits and premiums.⁵⁶⁸

With the conclusion that the plan is an ERISA plan, preemption is applicable.⁵⁶⁹ The court rejected the savings clause argument since the claims were for remedies not offered under ERISA.⁵⁷⁰ The savings clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."⁵⁷¹ Recognizing exclusive jurisdiction over ERISA claims, the court held that "[e]ven if Hansen is correct that ERISA provides no adequate remedy, . . . his state law claims would still be preempted."⁵⁷²

The court agreed that Hansen should receive the \$120,000 as designated on the summary plan description.⁵⁷³ The court held that ambiguities in the policy should be resolved against the insurer and that the summary plan description controlled over the master plan since there was an ambiguity between them and the summary plan description favored the insured.⁵⁷⁴

The district court lacked subject matter jurisdiction because the plan in question did not affect commerce in *Sheffield v. Allstate Life Insurance Co.*⁵⁷⁵ Sheffield sued Allstate in state court for costs of medical treatment, asserting breach of contract and misrepresentation. Allstate removed the case to federal court contending that ERISA governed. The federal court ordered the case remanded because ERISA coverage did not extend to Sheffield's employer since interstate commerce was not affected to the degree required by ERISA's jurisdictional limit.⁵⁷⁶

There was no dispute that the medical plan at issue was an employee wel-

564. *Id.* at 977.

565. *Id.*

566. *Id.*

567. *Id.*

568. 940 F.2d at 978.

569. *Id.* at 979.

570. *Id.*

571. 29 U.S.C. § 1144(b)(2)(A) (1988).

572. *Hansen*, 940 F.2d at 979.

573. *Id.* at 981-83.

574. *Id.* at 981-82; *see also* *Edwards v. State Farm Mut. Auto. Ins. Co.*, 851 F.2d 134, 136 (6th Cir. 1988) ("statements in a summary plan are binding and if such statements conflict with those in the plan itself, the summary shall govern").

575. 756 F. Supp. 309, 310 (S.D. Tex. 1991).

576. *Id.*

fare benefit plan as defined in ERISA.⁵⁷⁷ ERISA coverage extends, however, "only to plans established by employers engaged in an industry or activity affecting commerce."⁵⁷⁸ The court held that in order to affect commerce, the labor relations of the business had to affect interstate commerce.⁵⁷⁹ Sheffield's employer's business had only two employees and involved activities mainly within Texas. The court concluded that it did not have subject matter jurisdiction over the case and remanded it to state court.⁵⁸⁰

In *Shirley v. Maxicare Texas, Inc.*⁵⁸¹ Shirley was covered by health insurance through her employer, the Aldine Independent School District. After Shirley was diagnosed as needing a liver transplant, Maxicare changed the policy to cease coverage over transplants. Shirley sued in state court seeking a declaration that Maxicare could not apply this change retroactively. Maxicare claimed ERISA preemption and removed the case to federal court. The court ordered arbitration.⁵⁸² The arbitrator ruled that coverage existed for a reasonable time after the change and that the transplant would be covered if it took place within three years. The arbitrator also awarded Shirley \$25,000 in attorney's fees for the arbitration. Maxicare sought district court approval of the arbitration award and Shirley appealed.

The court of appeals held that the federal district court lacked subject matter jurisdiction since ERISA does not apply to governmental plans.⁵⁸³ The court also held void the district court's arbitration order since it lacked subject matter jurisdiction to begin with.⁵⁸⁴ Maxicare argued that acceptance of the arbitration award of attorney's fees estopped Shirley from challenging the validity of arbitration. The court of appeals held that when subject matter jurisdiction is at issue "the consent of the parties is irrelevant and principles of estoppel do not apply."⁵⁸⁵ The court concluded that Shirley could challenge the court's subject matter jurisdiction despite the award.⁵⁸⁶

B. ERISA Preemption

In *Cathey v. Metropolitan Life Insurance Co.*⁵⁸⁷ the Supreme Court of Texas held that ERISA preempts suits brought under the DTPA and arti-

577. *Id.* at 309.

578. *Id.* (citing 29 U.S.C. 1003(a) (1988)).

579. *Id.* at 309, 310.

580. *Id.* at 310.

581. 921 F.2d 565 (5th Cir. 1991).

582. *Id.* at 566.

583. *Id.* at 567 (citing 29 U.S.C. 1003(b) (excludes governmental plans); 1002(32) (defines governmental plan as a plan established and maintained for it employees by the United States government or any state government or any political subdivision, agency, or instrumentality of a government) (1988)).

584. *Id.* at 568.

585. *Id.* (quoting *Insurance Corp. v. Compagnie des Bauxites*, 456 U.S. 694, 702 (1982) (principles of estoppel do not apply to issues of subject matter jurisdiction)).

586. *Id.* at 569.

587. 805 S.W.2d 387 (Tex. 1991), *cert. denied*, 111 S. Ct. 2855 (1991).

cles 21.21 and 3.62 of the Texas Insurance Code.⁵⁸⁸ James Cathey was employed by Dow Chemical. He and his wife were insured by the Dow Medical Care Program. Mrs. Cathey was diagnosed as having severe multiple sclerosis, and her doctor ordered twenty-four-hour nursing care. The expenses were paid under the Dow Medical Care Program until 1985, when Metropolitan Life Insurance Company (MET) refused to continue payment. Michael Maddolin, group claim consultant for MET, told Cathey the claims were discontinued because there was no medical necessity for the constant nursing care.

The Catheys filed suit in state court against Dow, MET, and Maddolin, alleging violations of the DTPA and articles 3.62 and 21.21 of the Texas Insurance Code. The trial court rendered summary judgment in favor of all three defendants on the basis that the claims were preempted by ERISA.⁵⁸⁹ The court of appeals affirmed.⁵⁹⁰

The supreme court recognized that ERISA preempts all state laws to the extent that they relate to employee pension and welfare benefit plans.⁵⁹¹ The preemption clause is limited by ERISA's savings clause, which provides that ERISA shall not "be construed to exempt or relieve any person from any state law that regulates insurance, banking, or securities."⁵⁹² The savings clause is, in turn, limited by the deemer clause, which provides that no employee benefit plan "shall be deemed to be an insurance company or other insurer . . . for purposes of any law of any state purporting to regulate insurance companies."⁵⁹³

The court relied on *Shaw v. Delta Airlines, Inc.*, in which the United States Supreme Court held that "[a] law 'relates to' an employee benefit plan . . . if it has a connection or reference to such a plan."⁵⁹⁴ Given this expansive definition⁵⁹⁵ and citing multiple cases in which the United States Supreme Court found tort claims have an effect on employee benefit plans that call for ERISA preemption,⁵⁹⁶ the court held that the Catheys' claims were also preempted.⁵⁹⁷

Next, the court addressed the savings clause whereby state laws are not preempted if they regulate insurance.⁵⁹⁸ The court followed the United States Supreme Court in holding that ERISA's remedies are exclusive. "The Court has decided that ERISA's civil enforcement scheme could not be supplemented by state law remedies."⁵⁹⁹

588. *Id.* at 388.

589. *Id.*

590. *Cathey v. Metropolitan Life Ins. Co.*, 764 S.W.2d 286 (Tex. App.—Houston [1st Dist.] 1988), *aff'd*, 805 S.W.2d 387 (Tex. 1991).

591. *Cathey*, 805 S.W.2d at 389 (citing 29 U.S.C. 1144(a) (1988)).

592. *Id.* (citing 29 U.S.C. 1144(b)(2)(A) (1988)).

593. *Id.* (citing 29 U.S.C. 1144(b)(2)(B) (1988)).

594. *Id.* (citing *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97 (1983)).

595. *Id.* at 390.

596. 805 S.W.2d at 390.

597. *Id.*

598. *Id.* at 391 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)).

599. *Id.* (relying on *Pilot Life Ins. Co.*, 481 U.S. at 54).

Moreover, the court announced that even if the remedies the Catheys claimed could regulate the insurance industry for exclusion from the ERISA preemption, the claims were still preempted because they were inconsistent with the remedies offered through ERISA.⁶⁰⁰ Though Maddolin did not plead the ERISA preemption, the court held that, because he acted as employee of MET, the preemption of the Catheys' claims against Dow and MET would extend to Maddolin.⁶⁰¹

Another case addressing the definition of relate to as applied to ERISA preemption is *Hermann Hospital v. Aetna Life Insurance Co.*⁶⁰² Hermann Hospital admitted and treated Prochnow, an employee of Sam White Oldsmobile Company, based on Aetna's representation that coverage was effective under a group plan, despite the fact that Prochnow's employment had terminated one month prior to hospitalization. Prochnow executed an assignment of benefits to Hermann. Aetna denied payment on grounds of lack of coverage. Hermann filed suit, alleging negligent misrepresentation, equitable estoppel, and deceptive and unfair trade practices. The trial court granted Aetna's motion for summary judgment on ERISA preemption grounds.⁶⁰³

The court of appeals drew a distinction between derivative claims as assignee of benefits and independent claims as third party.⁶⁰⁴ The court relied on the Fifth Circuit opinion of *Memorial Hospital System v. Northbrook Life Insurance Co.*⁶⁰⁵ In *Memorial*, the Fifth Circuit held that breach of contract was derivative from the employee's rights under the insurance plan, related to the employee benefit plan, and was preempted.⁶⁰⁶ The *Memorial* court found that claims under article 21.21 were unrelated and not preempted since they were not benefits sought under the policy.⁶⁰⁷ The court of appeals held that Hermann's causes of action for negligent misrepresentation and article 21.21 violations were not derivative of the policy as Prochnow's assignee.⁶⁰⁸ Instead, Hermann sought damages independently as a hospital that relied upon the insurer's misrepresentations. The court of appeals affirmed the trial court's judgment as to the claim of equitable estoppel in holding preemption but reversed and remanded the claims of negligent misrepresentation and deceptive trade practices under article 21.21.⁶⁰⁹

In *Gorman v. Life Insurance Co.*⁶¹⁰ the Texas supreme court held that the ERISA preemption defense can be raised for the first time on appeal only

600. *Id.*

601. *Id.*

602. 803 S.W.2d 351, 352-54 (Tex. App.—Houston [14th Dist.] 1990, writ denied).

603. *Id.* at 351.

604. *Id.* at 353 (citing *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990)).

605. *Memorial Hosp. Sys.*, 904 F.2d at 250.

606. *Id.*

607. *Hermann Hosp. Sys.*, 803 S.W.2d at 354.

608. *Id.*

609. *Id.* at 355.

610. 811 S.W.2d 542 (Tex. 1991), *cert. denied*, 112 S. Ct. 88 (1991).

when it affects choice of forum and not choice of law.⁶¹¹ Dale Gorman died in an automobile accident during the course of employment. Gorman was insured through an employee benefit plan of which policies were issued by Life Insurance Company of North America (LINA). LINA denied coverage upon the recommendation of Gorman's Employer, Tenneco. Gorman's beneficiaries sued Tenneco and LINA for breach of contract, fraud, breach of fiduciary duty, breach of the duty of good faith and fair dealing, negligence, violations of article 21.21 of the Texas Insurance Code, violations of rules and regulations of the State Board of Insurance, and DTPA violations. The jury rendered a verdict for Gorman but the trial court granted defendants' motion for judgment n.o.v.⁶¹²

The court of appeals reversed the judgment based on ERISA preemption.⁶¹³ The court found that the pleadings were broad enough to include claims under ERISA but that the plaintiffs were not entitled to recover since they did not prove arbitrary and capricious conduct.⁶¹⁴

The supreme court began by addressing the issue of ERISA preemption as elaborated in *Cathey v. Metropolitan Life Insurance Co.*⁶¹⁵ The court held that when ERISA preemption is asserted as a defense to claims within the concurrent jurisdiction of the state courts, preemption is an affirmative defense that must be timely pled and proved or is otherwise waived.⁶¹⁶ This category of concurrent jurisdiction includes claims to recover benefits due under a plan, actions to enforce rights under a plan, and actions to clarify rights to future benefits.⁶¹⁷ Based on this reasoning, the court concluded that the ERISA preemption defense involved the state court's subject matter jurisdiction.⁶¹⁸ As such, the plaintiff's claim against Tenneco for breach of fiduciary duty was preempted by ERISA.⁶¹⁹

The court next considered the plaintiff's claims against LINA. The court found that the evidence supported the jury finding that Gorman died in the course of employment, giving rise to the contract claim against LINA.⁶²⁰ Since this claim was for relief also available under ERISA (recovery of benefits due) the state and federal courts had concurrent jurisdiction.⁶²¹ Concurrent jurisdiction raises a question of choice of law.⁶²² The court held that a de novo review of ERISA claims is applicable (versus an arbitrary and capricious standard of review) unless the plan expressly authorizes discretionary authority to the plan administrator or fiduciary in determining eligibility of

611. *Id.* at 545.

612. *Id.* at 544.

613. *Gorman*, 752 S.W.2d 710, 714 (Tex. App.—Houston [1st Dist.] 1991), *rev'd*, 811 S.W.2d 542 (Tex. 1991).

614. *Id.* at 714.

615. *Gorman*, 811 S.W.2d at 544-45; *see also Cathey*, 805 S.W.2d at 391.

616. *Gorman*, 811 S.W.2d at 546.

617. *Id.* at 548-49 (footnote omitted) (citing 29 U.S.C. §§ 1132(a)(1)(B), (e) (1988)).

618. *Id.* at 549.

619. *Id.*

620. *Id.*

621. 811 S.W.2d at 549.

622. *Id.*

benefits or construing the terms of the plan.⁶²³ Because LINA did not have explicit discretionary authority to determine eligibility of benefits, de novo review was appropriate.⁶²⁴

The court concluded that attorney's fees may be awarded under ERISA and therefore the trial court had authority to award them in this case.⁶²⁵ The trial court could not, however, award delay penalties under article 3.62 of the Texas Insurance Code, mental anguish damages, or exemplary damages because these are forms of relief preempted by ERISA.⁶²⁶

*Pan American Life Insurance Co. v. Erbauer Construction Co.*⁶²⁷ involved the application of *Gorman*. Gill worked for Erbauer, which provided group health insurance to its employees through Pan American Life Insurance Company. Gill's two year old daughter suffered severe burn and smoke inhalation injuries in a fire and was taken to Hermann Hospital. Erbauer and Pan American both confirmed coverage, but later Pan American denied payment. Hermann Hospital sued Erbauer and Pan American for payment of the accrued bills, and Erbauer cross-claimed against Pan American alleging unfair claims settlement practices and violations of the DTPA and the Texas Insurance Code. The trial court found Pan American liable for treble damages and interest totaling \$4.7 million.⁶²⁸ The court of appeals originally held that ERISA did not preempt Erbauer's claims since they were extracontractual. On rehearing the court held that Pan American waived the preemption defense by not raising it until appeal.⁶²⁹

In light of *Cathey* and *Gorman*, the supreme court held that Erbauer's claims were preempted by ERISA.⁶³⁰ Furthermore, since the claims at issue were not in the category of concurrent jurisdiction with the state court, the defendants could have raised the defense of ERISA preemption for the first time on appeal.⁶³¹ The supreme court reversed the judgment of the court of appeals and rendered judgment for Pan American.⁶³²

The court of appeals held that ERISA preempted causes of action under the Texas Insurance Code in *Silva v. Aetna Life Insurance Co.*⁶³³ Silva injured his foot while employed with Baker Marine. Aetna refused to pay the medical expenses based on a policy exclusion for occupational injuries. Silva sued Aetna, alleging arbitrary and capricious actions in violation of ERISA and violations of article 21.21.

The court of appeals held that ERISA preempted Silva's state law

623. *Id.* at 548 (citing *Firestone Tire & Rubber Co. v. Burch*, 489 U.S. 101 (1989)).

624. *Id.*

625. *Id.*

626. *Id.* at 549.

627. 805 S.W.2d 395 (Tex. 1991) (per curiam), cert. denied, 112 S. Ct. 86 (1991); see also *Southland Life Ins. Co. v. Estate of Small*, 806 S.W.2d 800 (Tex. 1991).

628. *Pan Am. Life Ins. Co.*, 805 S.W.2d at 395.

629. *Pan Am. Life Ins. Co. v. Erbauer Constr. Co.*, 791 S.W.2d 146 (Tex. App.—Houston [1st Dist.] 1991, writ granted), rev'd, 805 S.W.2d 395 (Tex. 1991) (per curiam), cert. denied, 112 S. Ct. 86 (1991).

630. *Pan Am. Life Ins. Co.*, 805 S.W.2d at 395.

631. *Id.* at 396; see *Gorman*, 811 S.W.2d at 545.

632. *Pan Am. Life Ins. Co.*, 805 S.W.2d at 395.

633. 805 S.W.2d 820, 823-24 (Tex. App.—Corpus Christi 1991, n.w.h.).

claims.⁶³⁴ Silva argued that the causes of action were saved from preemption by virtue of the savings clause of ERISA that exempts from preemption state laws that regulate insurance. Relying on *Pilot Life Insurance Co. v. Dedeaux*, the court held that ERISA is intended to preempt all remedies except those specifically provided for by ERISA.⁶³⁵

The court next addressed Silva's ERISA claim for breach of fiduciary duty. The court held that Silva must establish that Aetna acted arbitrarily and capriciously to succeed on this claim.⁶³⁶ The court found that Aetna's refusal to pay was proper since the injury was incurred during the course of business and was therefore occupational.⁶³⁷ The court concluded that this type of policy exclusion was a "satisfactory explanation" for Aetna's failure to pay benefits under the policy.⁶³⁸

In *Petrolite Corp. v. Barnhouse*⁶³⁹ the court of appeals held that ERISA can preempt claims in which the occurrence giving rise to the claim happened before the enactment of ERISA.⁶⁴⁰ Barnhouse worked for Petrolite Corporation and in 1959 was allegedly promised enhanced retirement benefits in return for his work in Venezuela. Barnhouse relied on this promise until his employment ended in 1971. In 1984, when he sought the retirement benefits, the company refused on the basis that Barnhouse was not entitled to those benefits until age 65. Barnhouse sued for fraud, breach of contract, breach of fiduciary duty, and failure to pay benefits in accordance with the terms of the retirement plan. The jury returned a verdict in his favor and awarded \$80,000 in actual and exemplary damages. The court of appeals reversed and rendered a take nothing judgment against Barnhouse.⁶⁴¹

Barnhouse argued that ERISA preemption was inapplicable based on the statutory exception to preemption of any claim arising, or any act or omission occurring, before January 1, 1975.⁶⁴² The court held that the issue turned on the proper interpretation of the phrase "acts or omissions."⁶⁴³ The court accepted the majority view in holding that the act or omission in this case was the denial of the claim that occurred in 1984, after ERISA's effective date, and that preemption was applicable.⁶⁴⁴

The court next considered the effect of preemption in this case. Having determined that ERISA preemption was applicable, the court relied on *Gorman* in holding Barnhouse's claims for breach of contract and for declaratory relief were within the state court's concurrent jurisdiction, and that

634. *Id.* at 824.

635. *Id.* at 823-24 (relying on *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987)).

636. *Id.* at 824 (citing *Reilly v. Blue Cross and Blue Shield*, 846 F.2d 416, 419 (7th Cir. 1988), *cert. denied*, 488 U.S. 856 (1989)).

637. *Id.* at 825.

638. *Id.*

639. 812 S.W.2d 341 (Tex. App.—Corpus Christi 1991, n.w.h.).

640. *Id.* at 345.

641. *Id.* at 343.

642. *Id.* (citing 29 U.S.C. § 1144(b)(1) (1988)).

643. *Id.* at 344.

644. *Id.* at 345.

ERISA operated to displace state law in favor of federal law as to those claims.⁶⁴⁵ The remaining claims fell within the exclusive jurisdiction of the federal court because they are not specified in 29 U.S.C. section 1132(a)(1)(B) and (e) as claims of concurrent jurisdiction.⁶⁴⁶

The court then held that Barnhouse could not successfully maintain his claims for breach of contract and declaratory relief under ERISA.⁶⁴⁷ Because section 1102(a)(1) of ERISA "mandates that all employee benefit plans must be established and maintained pursuant to a written instrument," ERISA claims therefore cannot be based on oral representations not also written within the terms of the plan.⁶⁴⁸ After justifying the written requirements as a means of ensuring stability and solvency of retirement plans, the court acknowledged that refusing to enforce oral representations is a "betrayal without remedy" when an employee relies on an employer's "empty oral assurances."⁶⁴⁹ Nevertheless, the court felt constrained to follow ERISA's explicit preference for written agreements.⁶⁵⁰

VIII. WORKERS' COMPENSATION

A. Wrongful Discharge

In *International Union UAW v. Johnson Controls, Inc.*⁶⁵¹ Sullivent incurred an occupational injury. He filed a workers' compensation claim and requested a leave of absence pursuant to the collective bargaining agreement between his employer, Johnson, and the Union. Johnson responded to a subsequent request for leave of absence by advising Sullivent to see the plant physician for an examination. Johnson informed Sullivent that he would be discharged if he did not see the plant physician. Sullivent sued Johnson, Wausau, and American (workers' compensation carriers), alleging that the practice of requiring physical examinations and the express intent to terminate injured employees for failure to visit the plant physician violated article 8306, section 7 and article 8307, section 4 of the Texas Workers' Compensation Act and IAB rules.⁶⁵² Sullivent further alleged that Johnson tortiously interfered with his right to contract for legal services by not communicating directly with Sullivent's attorney concerning the injury and that the insurance carriers violated the DTPA and article 21.21 of the Insurance Code. The trial court granted summary judgment to Johnson and Wausau.⁶⁵³ The

645. *Id.*; see *Gorman*, 811 S.W.2d at 545; see also 29 U.S.C. § 1132(a)(1)(B) (1988).

646. *Petrolite Corp.*, 812 S.W.2d at 345-46.

647. *Id.* at 346.

648. *Id.* (citing *Degan v. Ford Motor Co.*, 869 F.2d 889, 895 (5th Cir. 1989)).

649. *Id.*

650. *Id.*

651. 813 S.W.2d 558 (Tex. App.—Dallas 1991, writ denied).

652. See Act of May 18, 1983, 68th Leg., R.S. ch. 483, § 6, 1983, Tex. Gen. Laws 2822, repealed by Act of Dec. 11, 1989, 71st Leg., 2nd C.S., ch. 1, § 16.01(7), 1989 Tex. Gen. Laws 1, 4414 (employee has sole right to select or choose the persons or facilities to furnish medical aid); art. 8307 § 4 (Vernon Supp. 1991) (authorizes IAB to require claimant to submit to examination before it or someone acting under its authority and to an examination by a physician of insurance carrier's choice).

653. *International Union UAW*, 813 S.W.2d at 562.

court of appeals dismissed the action with prejudice against American.⁶⁵⁴ The supreme court reversed and remanded to the appellate court for consideration.⁶⁵⁵

Preliminarily, the court of appeals held that Sullivent's pleadings were sufficient to allege a cause of action under article 8307c, section 1, for wrongful discharge, even though the original petition did not specifically address article 8307c.⁶⁵⁶ Furthermore, the court held that the district court properly had jurisdiction over the case because it involved statutory interpretation and there is no legislative authority specifically delegating exclusive jurisdiction to the IAB.⁶⁵⁷

The court found that articles 8306, section 7 and 8307, section 4 do not apply to employers since they are not part of the association to which the statutes by definition apply.⁶⁵⁸ As a result, the court overruled Sullivent's cause of action against Johnson for violation of these articles.⁶⁵⁹ The court of appeals would not uphold the orders of summary judgment, however, because it concluded that there were genuine issues of material fact to be addressed.⁶⁶⁰ Specifically, those issues included: (1) Johnson's motive in requesting a plant physician examination and threats of termination, and (2) whether Johnson's failure to correspond with Sullivent's attorney was based on a good faith belief in its right to do so.⁶⁶¹

In *Stoker v. Furr's, Inc.*⁶⁶² Stoker was employed by Safeway. Safeway was purchased by Furr's and Furr's offered Stoker a position with them. After the interview Stoker informed the interviewer of a workers' compensation claim she maintained against Safeway. Stoker's employment offer was revoked. Stoker sued Furr's, alleging employment discrimination in violation of article 8307c of the Workmen's Compensation Act.⁶⁶³

The court of appeals discussed two issues on appeal. The first concerns the existence of an employee/employer relationship.⁶⁶⁴ The court reviewed the definition of employee within the Workmen's Compensation Act.⁶⁶⁵ The court held there was no such relationship because service of employment had not physically commenced and Furr's had no right to control Stoker

654. *Id.* at 563.

655. *International Union UAW*, 786 S.W.2d 265 (Tex. 1991) (per curiam).

656. *International Union UAW*, 813 S.W.2d at 564.

657. *Id.* at 566.

658. *Id.* at 567 n.4. (construing Act of May 18, 1983, 68th Leg., R.S., ch. 483, § 6, 1983 Tex. Gen. Laws 2815, 2822 (repealed 1989) (association is defined as the Texas Employers' Insurance Association or any other insurance carrier authorized under the Act to insure workers' compensation payments)).

659. *Id.*

660. *Id.* at 568.

661. *Id.*

662. 813 S.W.2d 719 (Tex. App.—El Paso 1991, writ requested).

663. See TEX. REV. CIV. STAT. ANN. art. 8307c (Vernon Supp. 1991).

664. *Stoker*, 813 S.W.2d at 721.

665. See of May 12, Act 1959, 56th Leg., R.S., ch. 355, § 1, 1959 Tex. Gen. Laws 778, repealed by Act of Dec. 11, 1989, 71st Leg., 2nd C.S., ch. 1, § 16.01(15), 1989 Tex. Gen. Laws 1,715 (employee defined to "mean every person in the service of another under any contract of hire, expressed or implied, oral or written").

until service had commenced.⁶⁶⁶

The second issue was whether section 8307c of the Workmen's Compensation Act, dealing with employment discrimination⁶⁶⁷ contemplated prospective employers.⁶⁶⁸ Stoker argued that person meant any person, including a prospective employer. The court rejected this argument, discussing the legislative history of the act, which showed that the primary purpose was to benefit and protect employees who are injured during the course of their employment.⁶⁶⁹ The court adhered to the Act's definition of employee, which includes "every person in the service of another under any contract of hire, . . ."⁶⁷⁰ and concluded that a person could not discharge another person unless he was that person's employer.⁶⁷¹ The court concluded that the legislature could have specifically created a cause of action against any person for discrimination based on a workers' compensation claim but did not.⁶⁷²

Another case involving employer/employee relations is *Crawford & Co. v. Garcia*.⁶⁷³ Garcia was injured on her job with Mountain Pass. After several episodes of continuing problems, she called her regular physician but he was out of town. She then contacted her employer, Mountain Pass, which advised her to visit a physician recommended by Crawford, the workers' compensation carrier. She did so but did not return to work despite his release to do so. Upon return to work Garcia was informed of her termination based on a company policy to terminate anyone absent for three consecutive days without satisfactory excuse. Garcia sued for wrongful discharge against Mountain Pass and the insurance carriers. Mountain Pass settled and the jury returned a verdict in Garcia's favor against the remaining defendants.

On appeal, the court held there was no evidence that any conduct of the insurance carriers caused Garcia damages.⁶⁷⁴ The court reasoned that Garcia was fired by Mountain Pass for failure to comply with company policy and that the defendants played no part in her termination.⁶⁷⁵ The court also held that the insurance carriers did not commit deceptive trade practices in recommending examination by a doctor other than Garcia's choice.⁶⁷⁶ The court held that such a referral did not interfere with Garcia's right to be treated by the doctor of her choice because the purpose of the examination

666. *Stoker*, 813 S.W.2d at 721-22.

667. TEX. REV. CIV. STAT. ANN. art. 8307c (1) ("[n]o person may discharge or in any other manner discriminate against any employee because the employee has in good faith filed a claim, hired a lawyer to represent him in a claim, instituted, or caused to be instituted, in good faith, any proceeding under the Texas Workmen's Compensation Act").

668. *Stoker*, 813 S.W.2d at 733.

669. *Id.*

670. *Id.* (citing Act of May 12, 1959, 56th Leg., R.S., ch. 355, § 1, 1959 Tex. Gen. Laws 778 (repealed 1989)).

671. *Id.*

672. *Id.*

673. 817 S.W.2d 98 (Tex. App.—El Paso 1991, writ requested).

674. *Id.* at 102.

675. *Id.*

676. *Id.* at 102-03.

was to determine her eligibility to return to work.⁶⁷⁷ The court of appeals reversed and rendered judgment for the insurance carriers.⁶⁷⁸

B. *Subscriber Status and Exclusivity*

In *Harris v. Varo, Inc.*⁶⁷⁹ Harris was injured when returning from lunch to her employment with Varo. The IAB denied her workers' compensation claim, asserting that the injury was not incurred during employment. Harris sued Varo under premises liability theory and fraud. The trial court granted Varo's motion for summary judgment.⁶⁸⁰ The court of appeals reversed the trial court's decision regarding Harris' fraud claim.⁶⁸¹

The controversy concerned the identity of the workers' compensation carrier. Varo changed its carrier before Harris' accident, but did not inform the IAB. Harris contended this was an intentional deception that had caused or would cause her damages. Harris also argued that Varo's failure to notify the IAB of the change in carriers caused Varo to lose its subscriber status and therefore prevented Varo from asserting exclusion from liability under the Workers' Compensation Act. The court held that Varo maintained its subscriber status despite the change in carriers because the statute mandates that the insurer notify the IAB of cancellation, relieving the employer of that duty.⁶⁸² The court held further that Harris could not succeed on her argument that Varo should be equitably estopped from asserting the defense of exclusion because of alleged misrepresentation of the carrier's identity in order to prevent an increase in premiums.⁶⁸³ The court held that since Harris action had been filed against the correct carrier she was not harmed by the misrepresentation.⁶⁸⁴

Next, the court addressed Harris' cause of action for fraud.⁶⁸⁵ Varo argued that in order for an intentional tort to defeat the exclusive remedy provision of the Workers' Compensation Act, the employer must intend the injury and the injury must actually occur. The court relied on *Aranda* in determining that the exclusivity provision precludes only claims based on work-related injuries.⁶⁸⁶ The court reasoned that since an employee is not barred from bringing a separate claim against the insurer for breach of good faith and fair dealing, it is logical that an employee should also be able to bring a separate claim against the employer for fraudulent misrepresentation.⁶⁸⁷ The court concluded that since Harris' claim for fraud was separate

677. *Id.* at 103.

678. *Id.*

679. 814 S.W.2d 520 (Tex. App.—Dallas 1991, n.w.h.).

680. *Id.* at 521.

681. *Id.* at 526.

682. *Id.* at 524 (quoting Act of May 25, 1987, 70th Leg., R.S., ch. 829, 1987 Tex. Gen. Laws 2862, repealed by Act of Dec. 11, 1989, 71st Leg., 2nd C.S., ch. 1, 16.01(15), 1989 Tex. Gen. Laws 114.

683. *Id.* at 525.

684. 814 S.W.2d at 525.

685. *Id.* at 525-26.

686. *Id.* at 526; see *Aranda v. Ins. Co.*, 748 S.W.2d 210, 214-15 (Tex. 1988).

687. *Harris*, 814 S.W.2d at 526.

from her claim for recovery for her injuries, the fraud cause of action was not excluded by the Workers' Compensation Act.⁶⁸⁸

C. Right to Subrogation

In *E.V.R. II Associates, Ltd. v. Brundige*⁶⁸⁹ Brundige was injured while serving as security employee for Southern Property Management. Liberty Mutual (Southern's workers' compensation carrier) paid benefits to Brundige for the injury. Brundige sued Enclave (EVR) for premises liability, and Liberty intervened for subrogation from Brundige to any recovery from EVR up to the amount paid as benefits. A jury found in favor of Brundige and awarded \$46,500 to Liberty out of Brundige's award.

On appeal EVR challenged the trial court's rulings that allowed Liberty Mutual to advise the jury of its right to subrogation. EVR argued that this information was prejudicial to EVR. EVR further argued that the case should have been bifurcated, as suggested in EVR's oral motion at trial. The court of appeals referred to Rule 411 of the Texas Rules of Civil Evidence, which proves that evidence of insurance can be offered if done so for issues other than liability.⁶⁹⁰

The court held that although the supreme court has found evidence of insurance benefits confusing to the jury, the evidence should be allowed in this case for three reasons.⁶⁹¹ First, the court held that an objection to such evidence without a motion to sever or at least limit the jury's consideration of the evidence to Liberty Mutual's cause of action would deprive Liberty Mutual of the right to recovery.⁶⁹² Secondly, limiting evidence with regards to Liberty Mutual would be contrary to Rule 411.⁶⁹³ Finally, evidence of paid benefits was necessary for Liberty Mutual to prove the specific amount it was entitled to recoup.⁶⁹⁴

IX. LEGISLATION

The 1991 Texas Legislature passed House Bill 2⁶⁹⁵ and House Bill 62⁶⁹⁶ which affected numerous and significant changes in the laws governing the business of insurance in Texas. These changes affected, among other areas, rate regulation, reinsurance, capital and surplus requirements,

688. *Id.*

689. 813 S.W.2d 552 (Tex. App.—Dallas 1991, n.w.h.).

690. *Id.* at 554-55.

691. *Id.* at 554 (citing *Myers v. Thomas*, 143 Tex. 502, 504-508, 186 S.W.2d 811, 812-13 (1945) (evidence of insurance and compensation benefits prejudicial because of confusion to the jury)).

692. *Id.* at 555; see TEX. REV. CIV. STAT. ANN. art. 8308-4.05(b) (Vernon Supp. 1991) (insurance carrier has right to subrogation from employee where person other than worker's employer held liable for compensable injury).

693. *E.V.R. II Assocs., Ltd.*, 813 S.W.2d at 555.

694. *Id.*

695. Tex. H.B. 2, 72d Leg. R.S., (1991) (codified in scattered sections of TEX. INS. CODE ANN.).

696. Tex. H.B. 62, 72d Leg., 2d C.S. (1991) (codified in scattered sections of TEX. INS. CODE ANN.).

cancellation and non-renewal of policies, holding companies, and created an insurance fraud unit and the office of public insurance counsel to represent consumers' interests in all lines of insurance.⁶⁹⁷ The reform legislation also

697. Because of the extent of reform of the insurance code, we have only touched on areas concerning the relationship between the insured and the insurer. Below is a summary of the amendments and additions made to the Insurance Code during 1991:

TEX. INS. CODE ANN. art. 1.01A(b) (Vernon Supp. 1992) (creates Texas Department of Insurance (TDI) to regulate the business of insurance); art. 1.02(e) (governor shall attempt to appoint members of minority groups); art. 1.04(b) (State Board of Insurance (Board) to determine policy for TDI and develop forms, rules and rates); art. 1.04(f) (judicial review of Board's rulings subject to substantial evidence rule. Court may vacate decisions of the Board in the interests of justice); art. 1.04(h) (TDI to establish a program to facilitate resolution of policy holder complaints); art. 1.06(b) (directors, officers, attorneys, agents, and employees of insurance companies, insurance agents, insurance brokers, or insurance adjusters are ineligible to be employed by TDI); art. 1.06 (after one ceases to be affiliated with TDI, one may not represent anyone before the Board for two years); art. 1.06D (persons representing clients before the board more than twice must register); art. 1.09-5 (conditions under which TDI employees may appear before the board in a proceeding to set rates); art. 1.10 § 7(a) (each failure to comply with provisions of code subject to forfeiture not to exceed \$25,000); art. 1.10C (for good cause, TDI may obtain criminal history information on applicants for authorization to engage in the business of insurance); art. 1.10D (creation of Insurance Fraud Unit); art. 1.14A (TDI may not issue an certificate of authority to, and may revoke the certificate of, any insurance company whose corporate officer has been convicted of a felony involving moral turpitude or a breach of fiduciary duty); art. 1.17A (legislature intends that TDI be sufficiently funded to obtain highly qualified examiners and actuaries); art. 1.19-1(b) (examination of materials out of state); art. 1.19-1(b) (information obtained under subpoena is not a public record for the duration of the investigation); art. 1.35A (Office of Public Insurance Counsel replaces Division of Consumer Protection); art. 1.35A(h) (public counsel may intervene in matters involving rates, forms, and various types of insurance and on behalf of consumers and may recommend legislation); art. 1.35B (insurers to pay assessment to defray the costs of the office of public counsel); art. 1.35D (TDI to maintain a toll-free information and complaint number); art. 1.40(b) (a person is immune from liability arising from filing reports or other information relating to fraudulent insurance acts if the information was received from certain enumerated persons or agencies); art. 2.02(b) (board may require capital and surplus levels in excess of statutory levels under certain circumstances); art. 2.20(c) (schedule for existing insurance companies to increase to minimum capital and surplus requirements); art. 3.02 § 1(b) (powers of Commissioner where insurance co. fails to meet minimum capital and surplus requirements); art. 3.02 § 2A (board may require excess capital and surplus levels up to a specified maximum); art. 3.02 § 3A (fraternal benefit societies are subject to the risk capital rules in § 2A); art. 3.10 (changes in reinsurance regulations); art. 3.28 (life insurance companies to submit an actuary's opinion of reserves to the Board annually); arts. 3.50-2, 3.50-3, 3.51-5A (serious mental illness is defined. Persons providing health care coverage under these sections may not contract for coverage that is less extensive for serious mental illness than for physical illness); art. 5.01-1 (subchapter M applies to motor vehicle insurance); art. 5.03-2 (recognizes stolen vehicle recovery systems and a discount for motor vehicles so equipped); art. 5.05 (recorded loss experience and other data to be available at least annually); art. 5.06 81 (board to develop or approve policy forms and endorsements for motor vehicle insurance); art. 5.06 § 7 (insurance policy forms and endorsements to be in plain language); art. 5.07-1 (insurer may not limit coverage by specifying repair parts to be used and may not limit selection of a shop to repair damage); art. 5.13-2 (regulations for general liability and commercial property coverage rates); art. 5.21 (offense to knowingly misrepresent the value of property to achieve a rate advantage); art. 5.22(a) (board may suspend agent's license for failure to comply with an order); art. 5.25(b) (subchapter M applies only to rates for homeowners and farm and ranch owners, residential fire and allied lines insurance); art. 5.35 (board to develop policy forms and endorsements for fire and allied lines insurance regulated under subchapter M); art. 5.43-2 § 9(b) (alarm and monitoring devices sold after April 14, 1989, shall carry a label of a testing laboratory approved by the Board); art. 5.43-2(b); (alarm devices originally placed before the approved labelling requirement was adopted need not comply); art. 5.43-2(c) (alarm devices not required by statute are exempt if approved by local authority); art. 5.53(g); (subchapter M does not apply to inland marine insurance, rain insurance, or insurance

made clear that persons engaged in the business of insurance are subject to Texas anti-trust laws.⁶⁹⁸

The major changes that may affect litigation under Article 21.21 and the DTPA concern the prompt payment of claims,⁶⁹⁹ the burden of proof on policy exclusions,⁷⁰⁰ and the creation of a private right of action pursuant to article 21.21-2 (Unfair Claims Settlement Practices Act).⁷⁰¹

against loss by hail on crops); art. 5.73 § 1 (insurers may not receive final rates or profit or expense recommendations from advisory organizations); art. 5.73 § 3(2)(6) (insurers and advisory organizations may not attempt to monopolize, boycott, or otherwise unreasonably restrain trade in an insurance market); art. 5.73 § 4 (Board to require audit of any advisory organizations that provide rate information to the Board); art. 5.75-1 (changes in reinsurance regulations); art. 5.96(c) (30 days notice required before the Board makes changes relating to motor vehicle, fire and allied, workers' compensation, or multiperil insurance); art. 5.96(a-1) (art. 5.96(c) does not apply to setting flexibility and benchmark rates under subchapter M); art. 5.97(c) (10 days notice required before the Board makes changes relating to inland marine, rain, hail, home warranty insurance, or insurance under subchapter B); art. 5.101 (creation of subchapter M, a pilot program on flexible rating for certain insurance lines); art. 9.07A (Board to establish policy forms for residential real estate transactions); art. 9.38(c) (required disclosures for title insurance agents); art. 17.22(b) (subchapter M does not apply to county mutual insurance companies); art. 18.23A (restrictions on assuming risk covered by a policy written by a Lloyd's); art. 19.12A (restrictions on assuming risk covered by a policy written by a reciprocal exchange); art. 21.07 § 10A (TDI may not issue an agent's license to, and may revoke the license of, anyone convicted of a felony involving moral turpitude or a breach of fiduciary duty); art. 21.07-3 (restrictions on managing general agents); art. 21.07-7 (reinsurance intermediary licensing requirements; regulation of brokers' and managers' transactions with insurers); art. 21.11-1 (cancellation of agency contracts by fire and casualty companies); art. 21.21(d) (deleted requirement that damages be limited to those incurred prior to two years before the institution of the action); art. 21.21-5 (TDI to study and adopt rules to end discrimination in rate setting and policy nonrenewal); art. 21.24-1 § 3 (insurer may not restrict the right of insured to assign benefits under a health care policy to the furnisher of those benefits); art. 21.28 § 12(d) (state auditor to conduct an annual audit of the liquidator); art. 21.49 § 6A(a) (general and structural requirements for insurable properties under the Catastrophe Property Insurance Pool Act); art. 21.49 § 8A (windstorm and hail insurance replacement cost coverage); art. 21.49 § 8 (windstorm and hail insurance liability limits); art. 21.49 § 9A(b) (venue for an action against the Texas Catastrophe Property Insurance Association is in the county where the covered property is located or in Travis County if the Board is joined); art. 21.49-2B (regulation of cancellation and nonrenewal of certain property and casualty policies); art. 21.49-2C (insurer must file a plan of orderly withdrawal with the commissioner before withdrawing from writing a line of insurance); art. 21.49-3b (Joint Underwriting Association Licensing Act); art. 21.55 § 2 (prompt payment of claims; insurer to notify claimant of acceptance or rejection of claim within 15 days of receipt of complete claim); art. 21.56(b) (insurer to notify insured within 30 days of initial offer to settle claim against insured under a casualty policy); art. 21.57 (prohibited practices regarding withdrawal of premium payments from a person's account); art. 21.58(b) (insurer has burden of proof as to any affirmative defense or avoidance, including any language of exclusion and any exception to coverage); art. 21.58A § 3 (standards for utilization review; Utilization review agents must be certified by Commissioner); art. 21.58B (members and employees of the Board of Chiropractic Examiners restricted from some consultant activities); art. 21.69 (Board may contract for premium and loss data); art. 21.71(c) (insurers to maintain a toll-free information and complaint number); art. 21.79E(b),(c) (insurer to bring action for deductible against third party within six months or notify insured that it will not do so); art. 21.79E (charging different prices for the same service is an offense); art. 21.79E(a) (insurers authorized to issue credit involuntary unemployment insurance); art. 22.13 § 2(d) (minimum issued, outstanding, and stated capital required to assume liability under a health, accident, sickness or hospitalization policy).

698. See TEX. BUS. COM. CODE ANN. § 15.03(5) (Vernon Supp. 1991).

699. TEX. INS. CODE ANN. art. 21.55 (Vernon Supp. 1992).

700. *Id.* art. 21.58(b).

701. *Id.* art. 21.21-2.

A. Prompt Payment of Claims

The legislation enacted article 21.55 as part of the insurance reform entitled "Prompt Payment of Claims" which applies to all claims filed with an insurer on or after September 1, 1991.⁷⁰² This statute replaces articles 3.62 and 3.62-1 which were repealed as of September 1, 1991.⁷⁰³

Article 21.55 makes an insurer violating its provisions liable to the holder of the policy or beneficiary making the claim for, "in addition to the amount of the claim, 18% per annum of the amount of such claim as damages, together with reasonable attorney's fees as may be determined by the trier of fact."⁷⁰⁴ The remedy provided by this statute is not exclusive, but is in addition to any other remedy or procedure provided by any other law or at common law.⁷⁰⁵

Article 21.55 imposes a duty upon the insurer within fifteen business days after receiving written notice of a claim to acknowledge receipt of the claim, commence investigation, and request from the claimant all items, statements, and forms that the insurer reasonably believes will be required.⁷⁰⁶ Within fifteen business days after receiving all items, statements, and forms required by the insurer in order to secure final proof of loss, the insurer must provide written notice to the claimant of acceptance or rejection of the claim and must state the reasons for the rejection.⁷⁰⁷ If the insurer is unable to accept or reject within the fifteen-business-day period, it must notify the claimant of the reasons why additional time is needed and within forty-five days of that notice either accept or reject the claim.⁷⁰⁸ The insurer also has the duty to make payment within five business days of the notice of acceptance and within sixty days after the insurer receives all items, statements, and forms reasonably requested and required as provided in the statute.⁷⁰⁹

Article 21.55 applies to almost all insurers and all types of claims. Moreover, article 21.55 changes the remedy from the penalty article 3.62 to eighteen percent damages.⁷¹⁰

By deeming the recovery to be damages rather than a penalty, this new item of damages may be subject to doubling in the event that the conduct resulting in the delay in payment was committed knowingly under article 21.21 § 16.⁷¹¹

New Article 21.56 requires written notification within ten days of settlement offers made under casualty insurance policies, excluding policies that require the insured's consent to settlement of a claim against him.⁷¹² The

702. Act of May 27, 1991 72d Leg., R.S., ch. 242, 1991 Tex. Gen. Laws. 939.

703. *Id.* § 6.

704. *Id.* § 7.

705. *Id.* § 2.

706. *Id.* § 3.

707. *Id.* § 3(e).

708. *Id.* § 4.

709. *Id.* § 1(4), (5).

710. *Id.* § 6.

711. TEX. INS. CODE ANN. art. 21.21 § 16 (Vernon Supp. 1991).

712. TEX. INS. CODE ANN. art. 21.56(a), (b) (Vernon Supp. 1992).

insurer must notify the insured within thirty days of settlement of a claim.⁷¹³

B. Burden of Proof

Another significant change made by House Bill 2 is now seen in article 21.58 of the Insurance Code which imposes on the insurer the burden of proving policy exclusions.⁷¹⁴ Prior law was that the insurer only had to plead policy exclusions and the insured then had to disprove them.⁷¹⁵ Article 21.58 applies to all insurers, without exception, and applies to pending litigation since it is only a procedural change in the law.⁷¹⁶

C. Private Cause of Action under 21.21-2 (The Unfair Claims Settlement Practices Act)

In the regular session of 1991, article 21.21-2 was amended to delete the requirement that the insurer engage in unfair claims settlement practices "without cause and with such frequency" before the State Board of Insurance could take any action against the company.⁷¹⁷ Additionally, the State Board of Insurance can now require an insurer to make periodic reports without the insurer being "substantially out of line" as it relates to complaints of unfair claims settlement practices.⁷¹⁸

In the Second Special Session of the Summer of 1991, the legislature again amended article 21.21-2, specifically making a violation of this statute a deceptive trade practice actionable under the DTPA.⁷¹⁹

D. Standard of Review

In *Commercial Life Insurance Co v. Texas State Board of Insurance*⁷²⁰ Commercial applied to the Board of Insurance (Board) to reserve the name "Commercial Life Insurance Company" for its future corporate charter. The Board denied the reservation because the name was similar to other

713. *Id.* art. 21.56(c).

714. TEX. INS. CODE ANN. art. 21.58(b) (Vernon Supp. 1992).

715. *Sherman v. Provident Am. Ins. Co.*, 421 S.W.2d 652, 654 (Tex. 1967); *see also American Home Assur. Co. v. Brandt*, 778 S.W.2d 141, 143 (Tex. App.—Texarkana 1989, writ denied); *National Fire Ins. Co. v. Valero Energy Corp.*, 777 S.W.2d 501 (Tex. App.—Corpus Christi 1989, writ denied); *Britt v. Cambridge Mut. Fire Ins. Co.*, 717 S.W.2d 476, 482 (Tex. App.—San Antonio 1986, writ ref'd n.r.e.); Tex. R. Civ. P. 94.

716. *See Holder v. Wood*, 714 S.W.2d 318 (Tex. 1986); *Chislum v. Home Owners Funding Corp.*, 803 S.W.2d 800 (Tex. App.—Corpus Christi 1991, writ denied).

717. TEX. INS. CODE ANN. art. 21.21-2 (Vernon Supp. 1992). This amendment codified *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 134-35 (Tex. 1988) (no proof of frequency required to find unfair claim settlement practice actionable under art. 21.21).

718. TEX. INS. CODE ANN. art. 21.21-2 § (Vernon Supp. 1992).

719. *Id.* § 2. This enactment overruled *Russell v. Hartford Casualty Insurance Co.*, 548 S.W.2d 737 (Tex. Civ. App.—Austin 1977, writ ref'd n.r.e.) and its progeny, all of which held that article 21.21-2 of the Insurance Code did not confer a private cause of action upon individuals injured by unfair claims settlement practices. *See McKnight v. Ideal Mutual Insurance Co.*, 534 F. Supp. 362 (N.D. Tex. 1982); *Lone Star Life Insurance Co. v. Griffin*, 574 S.W.2d 576 (Tex. Civ. App.—Beaumont 1978, writ ref'd n.r.e.); *Alvarez v. Westchester Fire Insurance Co.*, 562 S.W.2d 263 (Tex. Civ. App.—San Antonio (rev'd on other grounds sub. nom. *Westchester Fire Ins. Co. v. Alvarez*, 576 S.W.2d 771 (Tex. 1978)).

720. 808 S.W.2d 552 (Tex. App.—Austin 1991, writ denied).

registered insurance companies. Commercial sued for judicial review of the Board's order.⁷²¹ Initially, the trial court dismissed the cause of action because Commercial neglected to file a timely motion for rehearing with the Board.⁷²² The court of appeals affirmed.⁷²³ The supreme court reversed.⁷²⁴

At issue was whether the appropriate standard of review was trial de novo or substantial evidence.⁷²⁵ The Board contended that the issue of name similarity invokes legislative, not judicial considerations. Therefore, the Board argued, article 1.04(f) of the Insurance Code, mandating judicial review by trial de novo, violates the separation of powers requirement of Article II, section 1 of the Texas Constitution. Relying on *Key Western Life Insurance Co. v. State Board of Insurance*, the court of appeals rejected the Board's constitutional argument.⁷²⁶ The court held that the Board's action over the name reservation was quasi-judicial since its only function was to determine whether the requested name was statutorily sufficient.⁷²⁷ The court concluded that article 1.04(f) was constitutional, denying a substantial evidence scope of review.⁷²⁸

The legislature recently addressed the issue of standard of review. It amended article 1.04(f) of the Insurance Code by eliminating the trial *de novo* review and replaced it with a substantial evidence review of any Board "ruling, action, decision, regulation, order, rate, rule, form, act, or administrative ruling."⁷²⁹

721. See TEX. INS. CODE ANN. art. 1.04(f) (Vernon Supp. 1992) (causes of action determined upon a trial de novo).

722. *Commercial Life Ins.*, 808 S.W.2d at 554.

723. *Id.*

724. *Id.*

725. See TEX. REV. CIV. STAT. ANN. art. 6252-13a § 19(e) (Vernon Supp. 1991) In a trial de novo the reviewing court cannot receive evidence regarding a previous agency decision but must determine the issue independent of the agency decision. Under a substantial evidence standard of review, the record of agency proceedings is considered and determinative unless substantial rights of the plaintiff have been prejudiced.

726. *Commercial Life Ins.*, 808 S.W.2d at 556 (citing Tex. Const. Ann. art. II § 1 (Vernon 1984) (relying on *Key W. Life Ins. Co. v. State Bd. of Ins.*, 163 Tex. 11, 25, 350 S.W.2d 839, 849 (1961))).

727. *Id.*

728. *Id.*

729. TEX. INS. CODE ANN. art. 1.04(f) (Vernon Supp. 1992).